interest far outweigh the negative aspects. Indeed, such an option may be the only practical way to provide meaningful research experience to trainee psychiatrists in peripheral units.

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### *References*

HAMBIDGE, D. M. & JOHNSTONE, D. N. (1986) Folate vitamin and mood change in alcoholics; theoretical and research observations. *Abstract of The Royal College of Psychiatrists Quarterly Meeting*, October 1986.

—— (1987) Cognitive impairment in alcoholics. *Abstracts of the VII International Conference on Alcohol Related Problems*, Liverpool, April 1987.

## *Management training for Scottish senior registrars in psychiatry*

DEAR SIRS

Consultant psychiatrists have long been involved in different aspects of management. With the advent of the Griffiths' Report (1984), it became necessary for clinicians to acquire new management skills. To address some of these issues the Scottish Division of the Royal College of Psychiatrists formed Management Group in 1986. Part of their remit was to incorporate management skills into general professional and higher professional training.

In 1989, this Group joined forces with the Management Development Group of the Scottish Health Service to establish two week-long residential courses for all Scottish senior registrars in psychiatry. We attended the first of these courses in March 1989 in Edinburgh. The course was based around two facilitators and was supplemented by a number of guest speakers. Management skills were acquired from a mixture of factual and experiential learning covering a number of topics — including communication, team work and leadership, conflict and negotiation, committee work and time management. At the end of the week a review session was held at which participants resolved to make use of newly acquired management skills.

It is clear that close co-operation and improved understanding between managers and clinicians is essential for the future provision of a good service to the patient. The course which we attended undoubtedly offered an insight into different aspects of management, and all Scottish senior registrars now have the opportunity for management training organised by the Management Group of the Scottish Division. We write to urge the College to create similar courses nationwide. It is also our belief that an effort should be made to educate non-medical managers about the needs of the clinician.

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## *Compulsory treatment of patients remanded by Courts*

DEAR SIRS

In November 1988 we admitted under Section 25 of the Criminal Procedure (Scotland) Act 1975 a 35 year-old man who had been charged with attempted murder. At this stage in the legal process he had not pleaded to the charge and the Court had "continued the case for further examination" and under section 25 (1) of the above Act had "remanded or committed for trial a person charged with any offence who appears to the Court to be suffering from mental disorder".

By the end of November 1988 two separate consultant opinions had been given to the Court and both were of the opinion that the accused was insane in bar of trial and that disposal by means of Section 174 (1) and (3) of the Criminal Procedure (Scotland) Act 1975 was appropriate, i.e. a Hospital Order should be imposed. However, as is often the case in Scotland, the case has not yet gone back to Court for the Court's disposal. The 110 day rule applies to this case, i.e. if the accused is not brought to trial within 110 days of the first day of incarceration then he must be liberated on day 110.

The problem which then developed was that the patient, or is he a quasi-prisoner, showed a deterioration in his condition, rejected the offer of any drug treatment and began to cut back on his diet, believing his food to be poisoned. The diagnosis made was of paranoid psychosis.

Concerned about the possibility of a life-endangering situation developing, we contacted the Mental Welfare Commission for advice regarding compulsory treatment. It was our opinion that this man was a quasi-prisoner and, as in the case of prisoners, compulsory treatment could not be instituted. However, the Vice-Commissioner, who is a psychiatrist, took the view, speaking 'colleague to colleague', that after two doctors had registered their opinion that the man suffered from a psychiatric disorder and was insane in bar of trial they were implying that he required treatment and that compulsory treatment would be justifiable.

Taking the matter further with the Central Legal Office of the Scottish Home and Health Department, the opinion from there was: 'Having looked at the Acts, particularly Section 70 of the Mental Health (Scotland) Act 1984 we feel with removal to hospital

https://doi.org/10.1192/pb.13.10.569-a Published online by Cambridge University Press

of persons under Prison Authority control – Section 70 deals with an application to be made to the Court for transfer to an appropriate hospital and Section 70 (3) of the same Act states that a Transfer Order would have like effect as a Hospital Order – they come under the treatment aspect of Detained. This situation is analogous. Section 60 of the Act which deals with the effects of Hospital Orders specifically Section 62 states that a person admitted to a hospital in pursuance of a Hospital Order be treated as if under Part 3 of the Act.

The final opinion therefore is this patient can be treated as if on a Hospital Order and medication may be administered on a compulsory basis at this point".

As matters turned out the patient restarted an acceptable diet and, while we would have been pleased if he had accepted medication, he did not, but we felt his condition was such that we could await the disposal by Court. Hence the issue of compulsory treatment did not come to a head nor did the patient have the opportunity to test the matter in Court.

We feel, however, that it is important to alert colleagues to this issue and indicate the legal position which we have tested to a point just short of a Judge's decision.

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*References*

CRIMINAL PROCEDURE (SCOTLAND) ACT 1975, Chapter 21, 1975. London: HMSO.

MENTAL HEALTH (SCOTLAND) ACT 1984, Chapter 36, 1984. London: HMSO.

RENTON, R. W. & BROWN, H. H. (1982) *Criminal Procedure according to the Law of Scotland.* Edinburgh: W. Green & Son.

## *A personal experience of the high court*

DEAR SIRS

I recently had my first professional experience of the High Court. On a Friday evening, at 4.50 p.m. I mistakenly answered the telephone. I was asked by a 'friendly' barrister to give oral evidence in a case involving a family who had been assessed for treatment in the 'Families Unit' at the Cassel Hospital six months previously. As Senior Registrar in Psychotherapy and Manager of the Unit, I was requested, in the absence of my consultant, to attend court on the following Monday or Tuesday. I explained how inconvenient this would be for me, my patients, and the staff on the unit but was reminded, that I could and would be 'subpoenaed'. I chose to arrange a mutually convenient time at which to attend the court.

As a psychiatrist I had prepared many written reports for use in court, and had appeared before Mental Health Review Tribunals on a number of occasions. I was now being asked to appear in the High Court, a prospect which both filled me with anxiety and excited me. I discussed by predicament with a senior consultant at my hospital and attempted to phone the BMA for advice. Alas, the weekend was upon us.

Having spent two hours on Sunday evening preparing an affidavit, and having been phoned at 7.00 a.m. on the morning of the hearing to confirm final details, I set off at 10.45 a.m. from my hospital for central London and the High Court. The journey seemed to take ages. I reread my case notes as I anxiously counted out the sixteen stops before my destination. The High Court building is big and imposing. I asked directions to court number 50 in the Queens Building and arrived to find it deserted with a relieved Clerk of the Court enquiring if I was Dr Healy. The court had just been adjourned to enable the solicitors to trace me, to phone the hospital, etc. I was feeling rushed and breathless, I quickly had to read my typewritten affidavit, and sign and swear it in the presence of a 'nearby solicitor'. It struck me as odd but impressive to read my own statement couched in legal jargon.

"All stand . . . the plaintiff calls Dr Healy . . . I would like to apologise for Dr Healy's delay . . . he arrived shortly after you adjourned your Lordship" . . . I was in the witness box and taking the oath. "What is your name? And your address? No doctor, your professional address will do". I heard the plaintiff's barrister speaking to me and asking me about my qualifications, previous experience, current position. I was presenting myself as an expert witness.

I quickly became involved in the proceedings, directing my answers to the barrister questioning me. It had not dawned on me that the person I really should address was the Judge. Counsel nodded, gesticulated, and finally pointed directly towards his Lordship to draw my attention to the fact that his Lordship was attempting to write down much of what I said. I was asked to repeat points to aid him in this task and to talk slowly.

I had hoped to be finished my evidence by the lunch hour and had arranged appointments for the afternoon at the hospital. The barrister explained that it would take approximately half an hour after lunch to finish my evidence and then left saying he couldn't say more as I was still under oath. I had a pleasant lunch in the coffee shop, phoned the hospital to rearrange my afternoon commitments, and went for a stroll in the sunshine.

On reflection during the break I clarified what points I was really trying to make to the court, what points the opposing barrister was trying to elicit from

https://doi.org/10.1192/pb.13.10.569-a Published online by Cambridge University Press