

Sometimes mentally disordered people are refused admission to a psychiatric unit or abruptly discharged because of a violent act or the suggestion of a history of violence. This certainly seemed to happen in the case of Christopher Clunis; the more disturbed he became the less effective his care became. Surely there should be research about how many patients are refused admission or abruptly discharged and what subsequently happens to them.

There seem to be problems about confidentiality when carers contact psychiatric services with their concerns over patients who are becoming violent or aggressive. There is a need for guidelines about how such calls from carers are handled by psychiatric units and those guidelines should be subject to clinical audit. Sometimes it seems that concerned carers are simply ignored and no action seems to be taken.

There seems to be hardly any research about the safety of carers. Life-threatening assault may be rare but frightening assaults and aggressive behaviour are very common. It can disrupt family life, leading to young family members staying away because of safety fears and chronic disruption of carers' sleep.

There seems to be a real problem with police liaison and patients sometimes fall between the police and the psychiatric services, neither willing to step in. There need to be guidelines about what information is passed onto the police.

I hope your readers find these thoughts of some help as they continue to try and make community care work; if it is to work carers need to be listened to.

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Protecting vulnerable elderly people from risk

Sir: Morris & Anderson's description and discussion of the use of the Mental Health Act in the elderly is a welcome presentation of the relevance of this provision in good psychiatric care in old age (*Psychiatric Bulletin*, August 1994, **18**, 459-461).

We would strongly endorse their view of the value of detaining patients with severe dementia who are at significant risk. We pursue an active policy of intervention when the community mental health team, in conjunction with the family, other caring agencies and the primary health care team, believe that the risks have become too great for an individual to remain at home in reasonable safety. The care programme approach has been helpful in formalising the process of consultation and decision making

(Broughton & Divall, 1994). The majority of patients brought into hospital in this way rapidly settle, cease to express the desire to return home, and can often be discharged to appropriate residential or nursing home accommodation.

We concur with their view that use of the Mental Health Act makes explicit the lack of competence on the part of the patient to make decisions about their care, and by so doing, gives them and their relatives proper legal safeguards.

We have argued similarly that guardianship is also an important power, allowing clarity about decision making for the incompetent dementing elderly, where total co-operation may be absent, usually through lack of insight and determinedly independent pre-morbid character. In the Bath Health District area of Avon County (approximate population over 65 of 22,000), we have been instituting about ten new guardianship applications per year for the last three years. In research, which is currently submitted for publication, we have demonstrated that the applications have achieved the aims they were intended to meet, and the use of guardianship has been well understood, and thought helpful by relatives of the patients and others concerned in their care.

We therefore believe that, even without amendment of the present legislation, guardianship does offer a way to protect vulnerable elderly people from risk, and safeguards their legal rights. We would encourage others to consider making more extensive use of this provision.

BROUGHTON, M. & DIVALL, P. (1994) The care programme approach: the experience in Bath. *Psychiatric Bulletin*, **18**, 77-79.

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Informed consent?

Sir: A. White (*Psychiatric Bulletin*, August 1994, **18**, 507) questions the acceptability of oral consent for ECT obtained from a man whose delusional system prevented him from signing a form he believed Satan had signed. There is no legal requirement for informed consent to be recorded in writing; oral consent is as valid but may result in problems should a dispute arise needing evidence. Hence written consent is the norm for many procedures.

A signed consent form does not necessarily mean informed consent has been given and may therefore give a false sense of security. To be valid, the patient needs to have understood, in broad terms, the nature, purpose, principal benefits, unwanted effects and alternatives to

the proposed treatment. For this to happen, the patient needs to be given the relevant information, to be able to understand and weight it and to state his or her choice. The patient must have the 'capacity' to do this and not be under duress.

White's patient had been given the information and the fact that he was able to withdraw his consent suggests he was not under duress. My concern is whether or not the patient's capacity to give consent was compromised by his illness. There are legal tests of capacity but these are not useful in clinical practice. A further dilemma is posed as, while wanting to respect the autonomy of patients, the alternatives available with respect to consent are perplexing. Many people with serious long-term mental illness cannot give informed consent but treating each under section 3 of the Mental Health Act would swamp the system, might mar therapeutic relationships and is often resisted by other staff.

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Antidepressant prescribing in New Zealand

Sir: I read with interest Dr Thompson's paper on antidepressant prescribing (*Psychiatric Bulletin*, August 1994, **18**, 461–462). Having worked in the same community team and at the local in-patient unit, I feel the article brought up an interesting point relating to the consultation fee that New Zealand residents pay to see their GP (but not to see a mental health professional).

This fee caused problems in the management of people with mental ill health. People developed a reluctance to visit their GP (often voiced in clinic) with a resultant pressure on GPs to have longer intervals between consultations and therefore having to write prescriptions to cover longer periods. This created problems, especially where there was a suicide risk as the patient could have a larger quantity of medication in his or her possession. There may therefore have been a reluctance to prescribe a therapeutic dose and to opt for a sub-therapeutic prescription. This perversely may leave patients at greater risk as their depression remains untreated. It was also my impression that referrals present earlier in the course of illness which may be a result of the fee. Finally, there was a lack of shared care between the GP and mental health team as a consequence of the reluctance of patients to see their GP, because of the financial burden. This may have a secondary effect of de-skilling the GP.

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Training in a home treatment team

Sir: Smyth & Bracken (*Psychiatric Bulletin*, July 1994, **18**, 408–409) describe their training experience in a home treatment team. Having worked as a registrar with the same team I share many of the experiences they describe. I would like to add a few further observations.

Smyth & Bracken describe how "working without the apparent security of hospital wards initially provoked anxiety." My previous working experience as a junior doctor in various hospital settings had not been free from anxiety. There were worries and uncertainties about patient and staff well-being and safety but more noticeable to me were anxieties provoked by the way 'hospital systems' operate. The need for control and request that the patient should fit into hospital routine are central to treatment within institutions. Behaviour that is unacceptable within these regimes will frequently be interpreted as part of mental illness and result in the increase of control in various forms. My anxieties were related to the fact that I often felt unsure whether 'mental illness' or the 'social context' were the source of a particular presentation.

My working experience with a home treatment team has not given me an altogether different picture of psychiatric illness. Psychotic experiences seen similar whether at home or in hospital. I was, however, struck by the different kinds of relationship that seem possible between patients in their own home environment and the professionals offering support. As a result I have started to look at psychiatric illness in a different light and I have become more aware of the extent to which 'the illness' is a social construct rather than a clear medical entity. This broader view of psychiatric illness has in my case led to a very positive and fulfilling working experience.

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Cardiopulmonary resuscitation

Sir: The study by McNaughton, Hall & Stark (*Psychiatric Bulletin*, July 1994, **18**, 403–404), revealing the poor technical proficiency of junior doctors in cardiopulmonary resuscitation (CPR), confirms the fears of many junior doctors who are often the only medical cover for a large number of in-patients. However, the recommendation of the authors that junior doctors receive regular refresher courses in cardio-pulmonary resuscitation is insufficient.

Many psychiatric hospitals are on extremely large sites, while many on-call duties involve covering a number of different sites. It is therefore essential that all clinical staff, especially