the columns

correspondence

Selection of inquiry members

Sir: As a past member of inquiry panels I have been following the correspondence in the *Bulletin* recently and was interested in the suggestion by Dr Duncan Veasey (*Psychiatric Bulletin*, November 1999, **23**, 690) that some sort of truly independent authority should be set up by the Government with multiple representation to deal with public inquiries of all kinds. However, I wonder if this isn't a rather bureaucratic approach to seek to ensure that 'appropriate' psychiatrists are selected as inquiry members? Dr Veasey does not address the issue of what makes a suitable inquiry member, but implies that the choice will continue to be drawn from the expert witness community.

I believe that there are no specific qualities that define the necessary characteristics of those psychiatrists fit to be members of inquiry panels. The problem lies more in establishing a uniform, acceptable process by which the terms of reference of an inquiry panel can be fulfilled. For some years, for example, the College Council has endorsed the principle that draft and preliminary findings of panels should be shared at an appropriate stage with colleagues who might be criticised, particularly in order to not only confirm the accuracy of the facts but also to establish the reasonableness and fairness of the opinions. Criticism, of course, can never be wholly avoided but the complaints of your correspondents have highlighted a perceived unfairness of process which inevitably undermines the credibility of inquiry report conclusions.

I would suggest that what is needed is for the College to ensure that potential members of inquiries have had induction training for hte role similar to processes increasingly accepted for becoming Examiners, Advisers and even members of the expert witness community.

M. R. Lowe, Consultant Psychiatrist, Basildon Hospital, Basildon SS16 5NL

Questions about Community Treatment Orders

Sir: Tom Burns (*Psychiatric Bulletin*, November 1999, **23**, 647–648) is right to suggest that different ways of asking the question 'what are Community Treatment Orders (CTOs) for?' will lead to different conclusions as to their usefulness. He formulates the question as "is there a group of patients who are poorly served by the present legislation, who are currently repeatedly subject to compulsory admission and whose welfare would be better served by CTO?" and concludes, yes, there is. This is a small group of patients, 'a handful per team'. An examination of the annual reports of the Mental Welfare Commission for Scotland or the Mental Health Act Commission for England and Wales show the rise over time of the use of compulsory measures since their introduction. Use of leave of absence (LOA) over 12 months rose in Scotland from 22 patients in 1988 to 129 patients in 1994 (Atkinson *et al*, 1999). At 31 December 1994 there were 92 patients on LOA over 12 months, of whom 30 had been on LOA over 24 months. This would seem to be less than the 'handful per team' suggested by Burns and would suggest that CTOs would be used more extensively as time goes on.

In Scotland leave of absence has functioned as a *de facto* CTO and could be used indefinitely, until restricted to 12 months by the 1995 Patients' in the Community Act. The Act also introduced Community Care Orders (CCOs). CCOs are constantly referred to as a failure because so few are used. Is a power only seen as successful if it is used a lot?

The Green Paper (1999) is widening the number of patients who could be subjected to a CTO from those subject to LOA. Nevertheless, it is worth considering what has happened to the patients on LOA beyond 12 months following the new restriction. We are currently analysing data on this very question, but it is clear, even anecdotally, that many patients discharged from extended LOA have done well with no measure of compulsion; they have not all been put on CCOs, nor have they all been returned to hospital. A number of psychiatrists have commented to us 'maybe I was too cautious'.

We use past behaviour as the best predictor of future behaviour. Following this principle, and looking at the behaviour of psychiatrists, we can assume that any sanction which exists will be used and as time goes on used more extensively.

Reference

ATKINSON, J. M., GILMOUR, W. H., DYER, J. A. T., *et al* (1999) Retrospective evaluation of extended leave of absence in Scotland 1988–1994. *Journal of Forensic Psychiatry*, **10**, 139–155.

***Jacqueline M. Atkinson**, Senior Lecturer, **Helen C. Garner**, Research Assistant, **Lesley E. Patterson**, Research Assistant, Department of Public Health, University of Glasgow, 2 Lilybank Gardens, Glasgow G12 8RZ

Sir: It is good to see the debate concerning Community Treatment Orders (CTOs) opening again in the *Bulletin* (Moncreiff & Smyth, *Psychiatric Bulletin*, November 1999, **23**, 644–646).

In response, we would like to make the following points. Moncrieff & Smyth portray a dismal picture of response and tolerability to neuroleptic medication. As they note, a proportion of patients do not improve with conventional neuroleptics. Sensibly, this minority group would be excluded from compulsory treatment orders. Strict inclusion criteria would determine this. Relapse prevention is not all gloom either. Although around 55% of patients with schizophrenia may relapse during one year without medication, this compares with 20–25% on antipsychotic drugs (Dixon *et al*, 1995). Psychosocial interventions may further enhance this reduction in relapse.

The hazards of extrapyramidal side-effects are also cited. These are, most commonly dose-dependent. Lower doses (i.e. less than 600 mg chlorpromazine equivalent) may be equally efficacious (Dixon *et al*, 1995) and better tolerated than higher ones. The welcome advent of atypical neuroleptics has offered our patients alternative treatments that have a much lower incidence of these unwanted effects. The risk of more permanent neurological damage, for example, tardive dyskinesia is a recognised complication of long-term

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