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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.

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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

https://doi.org/10.1192/pb.24.3.116-b Published online by Cambridge University Press

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neuroleptic treatment. However, it has been observed in untreated populations and should not be a reason to bar medication.

Moncrieff & Smyth at least concede that our patients may prefer to live in the community. If we had at our disposal a chance to keep them there in better mental health, surely this would lead to a duty to facilitate this process.

Reference

DIXON, L. B., LEHMAN, A. F. & LEVINE, J. (1995) Conventional antipsychotic medications for Schizophrenia. *Schizophrenia Bulletin*, **21**, 567–577.

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Problems with appraisal

Sir: The National Service Framework for Mental Health highlights the need for rigorous performance management in services, and for the support and empowerment of staff. The Health Secretary, in his recent document, *Supporting Doctors, Protecting Patients* underlined that effective appraisal is an essential part of achieving those aims. However, at a recent Appraisal Training Workshop for Specialist Registrars in Psychiatry, trainees' reflections on their experiences of appraisal showed a wide variation in its quality.

Appraisal can be a positive experience, especially when it is a dialogue that is both respectful and honest. An effective appraiser will provide a structured way to address issues, building on the trainee's previous experience. Concerns need to be acted on as soon as possible and followed up. There should also be an opportunity to explore areas of weakness, without fear that the trainee's reference will be adversely affected.

Trainees have also had negative experiences. At worst, appraisal has been non-existent, or merely 'going through the motions' with an unmotivated appraiser. Trainees may feel reluctant to insist on regular meetings with an already overworked consultant. Meetings can become focused on service needs and used as an opportunity to delegate work, to the detriment of training requirements. Appraisers can also fail to take a balanced approach, either concentrating solely on the appraisee's strengths or by being overly critical.

In order to improve standards in this area, there needs to be appraisal of the appraisers themselves, and the provision of adequate training to facilitate such an improvement.

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Evidence-slaved medicine

Sir: I would like to comment on an aspect of Laugharne's analysis of evidence-based medicine (EBM) (*Psychiatric Bulletin*, November 1999, **23**, 641–643). He states that the philosophy underlying EBM consists of rational and measurable interventions that should prove beneficial to patients. This does not do much to resolve the tension between EBM and user involvement. If these principles are not integrated to other basic concepts, then he has outlined the basis of what I call 'evidence-slaved medicine'.

Sacket *et al* (1996) define EBM as "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients . . .", and ". . . external clinical evidence can never replace individual clinical expertise and it is this expertise that decides whether the external evidence applies to the individual patient at all, and, if so, how it should be integrated into a clinical decision".

Laugharne stresses the extent to which medicine must catch up with aspects of non-linear dynamics and quantum mechanics. However, realising the observations made by Poincaré (19th century) and Planck (20th century) might not help him much here. He may find that the observations about games that Bayes made in the 18th century are much more useful.

Laugharne's dilemma may be approached by using concepts of decision analysis, a slowly evolving aspect of EBM. Roughly, a clinical decision process must include the patient's relative preferences (e.g. utilities), or better still, the values that the patient assigns to such utilities. Only when a patient cannot do this, might the clinician alone quantify these utilities. In either case, the final decision may not necessarily favour the option best supported by the external evidence.

Reference

SACKET, D. L., ROSENBERG, W. M. C., GRAY, J. A. M., *et al* (1996) Evidence-based medicine: what it is and what it isn't. *British Medical Journal*, **312**, 71–72.

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Halloween spooks and schizophrenia

Sir: Many of us will have been involved with or subjected to the ritual 'trick or treat' routines of the 31st October. I was surprised to open the door to a group of 10–11-year-olds who had dressed up as people with schizophrenia rather than the more traditional ghosts, witches, demons, devils, grim reapers and so forth. I was informed by their accompanying parent that they had some teaching at school about mental illness. They were sufficiently intrigued and terrified by what they had heard to enact their impressions in the above way.

While there are many ways in which public awareness campaigns can be misunderstood, I had not previously come across this one. I have written to the local director of education with this feedback, but thought that the College may also like to be aware of this particular interpretation.

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the college

Honorary Fellowships

Nominations to the College's Honorary Fellowship will be discussed at the October meeting of the Court of Electors.

The regulations of the College state under Bye-Law Section VI that:

> "Subject to the Regulations the College may elect as an Honorary Fellow any person, whether or not he is a member of the medical profession, who either is eminent in psychiatry or in allied or connected sciences or disciplines or has rendered distinguished service to humanity in relation to the study, prevention or treatment of mental illness or to subjects allied thereto or connected herewith or has rendered notable service to the College or to the Association."

Nomination forms are available from Ms Beverley Fiddimore, Department of Postgraduate Educational Services, to whom nominations for the Honorary Fellowship should be sent by 1 September 2000. Such nominations must contain recommendations by no less than six Members of the College, and include full supporting documentation.

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https://doi.org/10.1192/pb.24.3.116-b Published online by Cambridge University Press