In view of these experiences, we would urge the College to debate these issues and to seek clarification of the role of managers tribunals *vis-à-vis* the MHARTs in the discharge of detained patients.

P. POWER-SMITH
M. EVANS

The Yews
Worrall Road
Sheffield S30 3AU

See also letter from Anne Farmer and Mark Winston; *Psychiatric Bulletin*, 1992, **16**, 567–568—eds.

Current operation of Mental Health Review Tribunals

DEAR SIRS

We have been commissioned by the Department of Health to carry out a one year study of current practices regarding the operation of Mental Health Review Tribunals, with a particular emphasis on patterns of delay. Over the next few months we will be contacting a random sample of general and forensic psychiatrists to ask for their views. However, we would be most grateful to hear from any member of the College who has views on this subject, and in particular for decreasing the length of time it takes to obtain a tribunal hearing. These views will influence both the nature of our study, and its conclusions. All views will, however, be received in strict confidence.

Finally, the study is only concerning the current situation in England.

STEPHEN BLUMENTHAL
SIMON WESSELY

Academic Department of Psychological Medicine
King's Healthcare
King's College Hospital
Denmark Hill
London SE5 9RS

Interpretation of the Mental Health Act

DEAR SIRS

There has been much correspondence recently concerning the interpretation of the Mental Health Act. It seems that even with guidelines there are still situations where interpretation of the Act is difficult.

A number of scenarios appear to cause particular problems, some involving differences of opinion between psychiatrists and social workers; for instance, a conflict between psychiatrists wishing to recommend a Section 3 Treatment Order for a patients whom they know well while the social worker may wish to use a Section 2 Assessment Order as being 'the least restrictive alternative'.

I would suggest that detailed case vignettes are devised and that the Mental Health Act Commission produce recommended guidelines as to how the Act should be interpreted in these cases. This should help the situation that can occur when there is an honest disagreement between disciplines as to correct management.

TREVOR FRIEDMAN

Leicester General Hospital
Leicester LE5 4PW

Prospective refusals of health authorities to fund psychiatric admissions

DEAR SIRS

Many colleagues may have received a clinical description of a patient of a health authority in south eastern England accompanied by a letter from that health authority refusing to fund any admission to a psychiatric bed without prior consultation with the patient's consultant. This is being circulated as a strictly confidential document. There are two aspects of this exercise that have caused me concern.

The first concern I have is entirely selfish but it should not be expected of me as a duty psychiatrist to bear in mind a list of the names of patients of other health authorities who should not be admitted to hospital on the basis of my judgement alone.

The second concern is an inevitable consequence of this exercise. For it to be effective it has been necessary to circulate the name and clinical description of the patient to every district health authority with a request that the information be circulated to all appropriate psychiatric units. In order for this to be then implementable the information must go either to the treasurer of all units or to every doctor who may be on-call to grant or refuse admission to a unit. I think such an exercise can hardly be described as strictly confidential.

I can well appreciate that health authorities need to try and keep some control over their liabilities but I really do think that this requires a rather wider debate before further exercises of this kind take place.

PHILIP STRANGEWAY

Campbell Centre
The Hospital Campus
Eaglestone
Milton Keynes MK6 5NG

Self-audit: benefits in training and clinical practice

DEAR SIRS

The monitoring and evaluation processes of audit were applied to the activities of a registrar during a

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six month attachment to a learning disabilities unit. Monitoring was by means of written records of all clinical contracts. Specially designed forms were used which encouraged a problem-orientated approach, recording interventions made and outcome. Evaluation occurred during consultant and pharmacist supervision, allowing changes in clinical approach to be introduced. The limitation of too close an adherence to a medical model were highlighted and the benefits felt of an outsider commenting on prescribing habits. Inter-disciplinary discussions were facilitated by the audit forms (in the community setting case notes are often absent) and the desire to measure outcome of medical interventions led to requests for information about client behaviour from nursing staff in an objective form, such as the charting of events or the use of rating scales. The audit highlighted differences in multidisciplinary involvement between long-stay in-patient and hostel patients. A medication review confirmed a large reduction in the use of neuroleptics for behaviour control had been achieved without deterioration in behaviour. Appraisal of the range of experience gained by the trainee was facilitated, so that deficiencies in training could be rectified. The benefits of a self-audit exercise merits advertisement to colleagues.

J.L. GILLOW
R. BANKS
P. PRATT

Brunswick House
299 Glossop Road
Sheffield S10 2HL

Environmental change and violent incidents

DEAR SIRS

I read with great interest the paper on environmental change and violent incidents (*Psychiatric Bulletin*, 1992, **16,** 489–490). The conclusion that "the reduction in violent incidents ... was primarily due to change of environment" needs to be challenged. The definition of violent incidents was not specified. Data on the validity and reporting reliability of violent incidents were not provided. For example, it may be that fewer staff in hostels or only 14 hour staffing in homes may result in a poor reporting reliability for violent incidents. A number of other factors need to be considered and have been summarised elsewhere (Shah *et al*, 1991). These include demographic characteristics of nonviolent patients, activity patterns (admission rates, length of stay and bed occupancy) and staff attitude, training and nature (temporary or permanent) in all three settings. Unless consideration is given to the above array of factors the conclusion becomes weak. Having said this, the study in question has attempted to address the important issue of changing environment for our patients, which is occurring at increasing frequency in the modern era of community care.

AJIT SHAH

St Vincent's Hospital Clinical School
University of Melbourne
Melbourne, Australia

References

SHAH, A. K., FINEBERG, N. A. & JAMES, D. V. (1991) Violence among psychiatric inpatients. *Acta Psychiatrica Scandinavica*, **84,** 304–309.

Reply

DEAR SIRS

I thank Dr Shah for his comments, but disagree that the conclusion is weak. Violent incidents are documented when an act causes or is intended to cause physical harm to a third party. Although validity and reporting reliability were not specified, the same staff rated incidents before and after transfer. There is no reason to suppose that their criteria or reporting reliability suddenly changed. Within the houses/hostels the average staff/patient ratio remained comparable to that of the ward. Houses are unstaffed between the hours of 21.00 to 07.00 hrs; this is the period when very little violence occurs, which is also acknowledged by Dr Shah, and is unlikely to significantly reduce reporting reliability.

The study suggested the reduction in violent incidents was due to the change of environment. The other factors mentioned by Dr Shah fall within the definition of environment. A number of interrelated variables were considered in the original paper, but I am grateful to Dr Shah for emphasising the huge array of factors, which obviously, require consideration. Quantifying the myriad of influencing factors appertaining to "the environment" would require an abundance of data which was not available.

C.W. RUSIUS

Walton Hospital
Chesterfield S40 3HN

Use of antidepressants by child psychiatrists

DEAR SIRS

I was interested to read Bramble & Dunkley's article about the prescribing habits of child psychiatrists (*Psychiatric Bulletin*, 1992, **16,** 396–398), but was perplexed by their apparently interchangeable use of the terms "antidepressant" and "tricyclic antidepressant" (TCA). In their opening discussion they state that there has never been a survey looking "specifically" at TCA use; the description of their