However, innovative College tutors would no doubt find ways of enabling trainees to learn from other experienced teachers organising services – especially for those trainees who may not have a chance to be attached to that particular service during a rotation. This experience could be gained through grand rounds, sessional attachments and attendance by consultants and trainees at case conferences.

JOHN COX, *Dean, Royal College of Psychiatrists*

What about a Trainer's Charter?

Sir: We read with interest the Trainees' Charter (Collegiate Trainees' Committee, 1994). Since the introduction of the Patients' Charter many individuals have expressed the view that charters for health professionals should be introduced. Perhaps the introduction of a Trainer's Charter may act as an eye-opener and pave the road for the development of such charters.

We would propose the following to be included in such a charter:

(a) a certain proportion (e.g. 50%) of time should be spent on service commitment. This would enable a balance to be struck between training and service needs.
(b) the trainee at the offset should inform the trainer of what they intend to learn from the post. This would ensure the time is appropriately directed towards clinical and training commitments.
(c) the trainee would ensure that clinical notes are kept to a high standard.
(d) the trainee would ensure that under supervision discharge summaries and clinical letters are done promptly.
(e) the trainees make arrangements among themselves for adequate cover to be provided for the hospital. This could prove difficult as it is possible for all the trainees to be away on a course on a particular day. In such circumstances, an understandable and flexible approach should be undertaken. This is extremely important in the present economic climate.
(f) the trainer should be mandated to continue their own postgraduate medical education. They should attend all local teaching events and appropriate national courses.
(g) adequate time should be available for the trainer to pursue his or her interests, e.g. research, psychotherapy supervision etc.
(h) the health authority trust should (of course) employ a trainee who is willing to learn.

There are considerable resource implications if these charters are to be exercised successfully. In the current climate, obsessed with market forces, one is left wondering how these opposing obligations can be accommodated. Perhaps the College could take a more active role in helping clinical directors obtain the necessary resources (time, funds, people etc). After all what one is aiming for are high standards of training and psychiatric care (College Bye-laws 11,2).

ROYAL COLLEGE OF PSYCHIATRISTS COLLEGIATE TRAINEES' COMMITTEE (1994) Trainees' Charter, *Psychiatric Bulletin*, **18**, 440.

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The use of the Mental Health Act in the elderly in another health district

Sir: I applaud Drs Morris & Anderson's pioneering study (*Psychiatric Bulletin*, 1994, **18**, 195–246). A parallel retrospective survey conducted from April 1988 to December 1993 revealed important differences.

The Mental Health Act was used 41 times for 37 admissions in 34 patients. Section 2 was used more frequently (78%) and section 3 less so (28%). Section 5(2) and 136 were used twice, section 4 and 47 once. There was no recorded use of guardianship orders or the National Assistance Act.

The ratio of 'organic' to 'functional' illnesses was the reverse of that reported by Morris & Anderson. In this study 62% suffered dementia and 38% functional illness (half with affective disorders, half with schizophrenia). An important precipitant of admission was self-neglect (75%, severe in 9%) often accompanied by physical or verbal violence and help-resistive behaviour (66%).

Sixty per cent of patients were deluded, and three patients were suicidal. During stay in hospital those with functional illnesses showed moderate to marked improvement, those with organic brain syndrome showed little cognitive but marked behavioural improvement. Ten patients were discharged into residential care, three to nursing homes, seven back home and three to long-stay wards. (Nine had no specified location).

Is the use of the Mental Health Act caring or coersive? The study suggests elderly patients admitted under the MHA suffered no harm. Of note the three patients with severe self-neglect settled well post-discharge (Clark *et al*, 1975). Patients unable to comprehend the complexity of the situation may often simply be led into hospital. Perhaps demented patients who are at risk but able to protest are those requiring legal powers and raising ethical dilemmas (Cybulska & Rucinski, 1986).

Possibly they form a sub-type of dementia (frontal lobe type) in which character and social conduct are affected prior to overt cognitive decline (Orrell & Sahakian, 1991). This study shows fewer patients with affective disorders being admitted compulsorily, suggesting the difference in practice. A reliable explanation necessitates a detailed prospective study with larger samples and adequate follow-up, enabling a greater consensus as to good and ethical practice.

CLARK, A. N. G., MANIKAR, G. D. & GREY, I. (1975) Diogenes Syndrome. *Lancet*, **i**, 366–368.

CYBULSKA, E. & RUCINSKI, J. Gross self-neglect in old age. *British Journal of Hospital Medicine* (July 1986) 21-25.

ORRELL, M. & SAHAKIAN, B. (1991) Dementia of frontal lobe type. *Psychological Medicine*, **21**, 553–556.

JANE GLEESON, *Stone House Hospital, Thameslink NHS Trust, Dartford, Kent*

Primary care and the severely mentally ill

Sir: In recent months many of our patients have had difficulty registering with local general practitioners (GPs). This problem has frequently been compounded as patients have been removed from their GPs' lists as a result of their behaviour disturbance while acutely psychotic.

This problem was recently highlighted by a 51-year-old Afro-Caribbean man, with one previous admission for a schizophrenic illness, who had two years previously moved to our catchment area. He had tried, but had been unsuccessful in registering with a local GP, and had not been referred to our service. His prescription of 20 mg flupenthixol depot fortnightly was continued on FP10s by his previous GP. His hallucinatory experiences were not controlled on this regime and he eventually presented himself to our hospital. At this point, he had been self administering depot flupenthixol 20 mg fortnightly into his arm for two years.

This case raises a number of concerns:

(a) the use of an adequate dose of medication via a potentially hazardous route (*Journal of the Medical Defence Union*, 1994)
(b) the failure of a patient with a mental illness (even when highly motivated) to find a GP who would accept him/her onto his/her list
(c) the difficulty of supervising mentally ill patients not registered with a GP.

While this difficulty may have been caused by local GP shortages in an inner city area, it may represent a reluctance of GPs to take on patients perceived as dangerous or time-consuming. If this were to represent a trend it would present a significant problem in providing 'community care' for our patients.

Journal of The Medical Defence Union (1994) **10**, 41.

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Continuing professional development

Sir: I welcome the College's initiative on continuing professional development (CPD). However, I was concerned to receive recently notification of CPD workshops at the College later this year. The notice given for such meetings is quite inadequate to all but a handful of psychiatrists I suspect. I doubt very much that here in North Yorkshire my workload is more onerous than elsewhere in the country, yet my clinics are booked up