Correspondence

Mental Health Review Tribunals

Sir: It has recently been brought to my attention that the number of suitably qualified psychiatrists available to Mental Health Review Tribunals is very limited. This seems puzzling at first because it is work that can be undertaken up until the age of 70 years, and I would have expected, therefore, quite a number of retired psychiatrists to be interested in a few years of this kind of activity. I have been told the difficulty in recruiting suitable psychiatrists is the age rule imposed by the Lord Chancellor's Department. This says that no one shall be appointed to MHRT work after the age of 62 years. This will not be a problem for psychiatrists who retire at 60 or before, but for those who go on to 65 years, it is obviously a problem as most of them will not think about such work until it is too late.

I have written to the Executive Committee of the Forensic Section to canvass their support in trying to get this changed. I have written to the Department of Health, and I will be writing to the Lord Chancellor's Department in the same vein.

In the meantime, however, it strikes me that it would be sensible for doctors who would like to undertake MHRT work to get themselves appointed to a tribunal before the age of 62. I am assured that if the doctor concerned was pre-retirement and busy with other clinical work, then no particular demands would be made until time was more freely available to him or her.

JOHN GUNN, *Department of Forensic Psychiatry, Institute of Psychiatry, London SE5 8AF*

Trial by tribunal

Sir: Although a consultant psychiatrist since 1989, only recently have I started work as a responsible medical officer in terms of the Mental Health Act of 1983 and had my first experience of 'trial by tribunal', i.e. a Mental Health Review Tribunal (MHRT). Having read of others' experiences I faced the day with trepidation because the circumstances were not ideal for a learning experience. A 48-hour notice section 2 appeal had been lodged by a female psychiatric nurse with a long-standing paranoid illness, who had worked in the hospital in which she was detained, and who had assaulted two police officers and myself during the initial detention process.

Having made arrangements for somebody else to cover my senior house officer's ECT session, so he could do my out-patient clinic and thereby keep the patients, community mental health trust colleagues and GP fund-holders happy that everybody who needed seeing on the last working day but one before Christmas had been seen, I re-read my report and waited and waited and was called about 30 minutes later than advised by the MHRT. Over the next 90 minutes the convoluted circumstances of my patient's situation were explored, discussed and then re-explored, interrupted every ten minutes or so by her having to visit the WC because of a 'nervous bladder' exacerbated by drinking lots of cold water because of medication and stress induced dry mouth. As the tribunal proceeded, the patient became increasingly distressed through hearing her symptoms and circumstances questioned and challenged by her solicitor who seemed oblivious to his client's distress. Much to my relief, the patient accepted the tribunal confirmation of her detention without the violence we anticipated.

However, I am forced to ask three questions. Is the MHRT process actually benefiting or exacerbating the patient's illness and its treatment? Do solicitors acting for the patient get any specific training or briefing in the peculiarities of MHRT procedures? What would the average general hospital consultant make of such a procedure being applied to their patients and themselves?

D. M. HAMBRIDGE, *Rauceby Hospital, Sleaford, Lincolnshire NG34 8PP*

Teaching nurses about ECT

Sir: The College is currently making great efforts to try to ensure that consultants involved in ECT are adequately trained and updated. This was much needed and is greatly welcomed. While this process is taking place, I

think we need to encourage nurse trainers to similarly review their teaching.

I recently became aware that student nurses at a local college were being taught about ECT by being shown a BBC film made in 1983. The same college does not currently involve any medical staff in their teaching on ECT. The film included information, not revised, including indications for unilateral ECT, the position of the electrodes, describable seizure length and the incidence of memory disturbance. Much more disturbing than this, however, were scenes (historically interesting no doubt) of patients, and a series of animals, receiving ECT without anaesthetic.

We all have a responsibility to be teaching nurses the most up to date knowledge available. This is of paramount importance when dealing with the emotive subject of ECT about which there are so many unhelpful myths.

D. KINGHAM, *Mental Health Services, Barrow Hospital, Barrow Gurney, Bristol BS19 3SG*

The development of a generic psychiatric in-patient facility

Sir: I feel that the experience that I have had over the past three years of developing combined psychiatric in-patient treatment for all patients over the age of 16 may be of interest to those working in the more isolated areas of the community.

The original 20-bedded ward, part of an acute general hospital re-build, was designed for psychiatric patients over the age of 65. With the advent of care in the community, the commitment for offering service close to the patient's own home, and the development of long-term nursing home beds, we felt we would pilot a scheme in which all psychiatric patients over the age of 16 could be admitted locally. Our only caveat was that aggressive, violent patients would be admitted directly to the intensive care beds in the central unit at Cheltenham.

The Cirencester population served is 38,000 of whom over 16% are elderly. It is a country area of several market towns, farming, service and light industry forming the principal occupations. We already had a thriving resource centre, with a committed day hospital and ECT facilities. With the total support of all staff a pilot scheme was instigated. The trust agreed to fund small structural alterations, enabling us to use our beds more flexibly, and with the loss of one bed. We designated 14 beds to the elderly and five for the adult patients.

Our review after a year showed we had treated 117 adults, of whom only four had had to be admitted to Cheltenham, and they had been transferred back after a short stay. A complete range of illness had been treated, the length of stay perhaps a little shorter than might have been expected, and we had offered some short-term asylum care. All other objective targets had been achieved, and the subjective reports from staff, patients and relatives had been very good. Patients mixed well, and all gained from the mixed therapeutic milieu. Of course, the cost of pharmacy and catering had risen, as expected, but care had been achieved with no increase of staff numbers.

The trust, encouraged by these results, agreed to the permanent change of use of the ward. Purchasers agreed to pay for the service, and the Mental Health Commission was satisfied at the last visit. We feel that a generic psychiatric ward in either a community or small general hospital unit may be the way forward for offering a quality psychiatric service to an isolated community.

A. M. WILSON, *Kinnaird, London Road, Poulton, Cirencester GL7 5JQ*

Defeat Depression Campaign: attitudes to depression

Sir: We are grateful to Professor Priest for his response to our article (*Psychiatric Bulletin*, 1994, **8**, 573–574) (572–573), criticising the methodological basis of the College's Defeat Depression Campaign. As he points out, he does not answer the theoretical objections which we consider fundamental and serious, well established in the field of epidemiology, public health and medical anthropology. We are surprised that he agrees the experimental method is not appropriate, but then justifies the campaign on which it is based.

If the credibility of the MORI results are doubted by Priest himself, we have difficulty understanding his paragraph outlining plans to 'correct' one (just one) impression revealed in the MORI survey: that of antidepressants being addictive. As we noted in detail there is evidence in public health research that such 'impressions' are unstable, contextual and