columns

Evidence base and economic impact of community treatment orders

The recent article by Owino (*Psychiatric Bulletin*, July 2007, **31**, 241–243) highlights that community treatment orders are not greatly different from the current provisions of section 17 leave. I believe that the evidence base and economic impact of the new orders require further consideration.

A well-resourced, systematic and independent review of community treatment orders was conducted by Churchill (2007). This large review considered the findings of 72 studies conducted in 6 different countries over the last 30 years and concluded that there is very little evidence to suggest that they are associated with any positive outcomes. Furthermore, there is some evidence, and widespread agreement, that they cannot work as intended without adequate resources, and it is widely acknowledged that they will not work without the general support of mental healthcare providers.

The Cochrane review by Kisely *et al* (2005), which only includes two trials of community treatment orders, concludes that compulsory community treatment results in no significant difference in service use, social functioning or quality of life compared with standard care. Regarding economic impact of the community treatment, the Kings Fund report by Lawton-Smith (2005) provides a detailed economic forecast. The report suggests that, over a period of 10–15 years, the number of people subjected to community treatment orders in England and Wales might rise to between 7800 and 13 000 at any one time. The financial cost predictions in England and Wales will be £3.4 million in the first year, later increasing to £21.2 million in 2014/15. This is to be considered against savings related to reduced use of hospital beds, of which it estimates saving £8.7 million in the first year, increasing to £47.7 million in 2014/15 (Department of Health, 2006).

Given the lack of credible evidence to support community treatment orders and the indication by Owino that they are not greatly dissimilar to the current provisions of section 17 leave, it is difficult to understand why the government has pursued their implementation. Arguments that they have been more convinced by the political notion that the orders will help improve public safety must also be considered against the evidence that they may also lead to cost savings through closure of in-patient beds.

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'Forensic' – yet another form of stigma

I read with interest the recent article by Turner & Salter (*Psychiatric Bulletin*, January 2008, **32**, 2–6) and O'Grady's commentary thereof (*Psychiatric Bulletin*, January 2008, **32**, 6–7) on the borderline between forensic and general adult psychiatry, and I have to disagree with authors. I think it would be more healthy to concentrate on the actual patient rather than various artificial classifications that have been cooked up over the past years.

Prior to returning to forensic psychiatry I was mainly involved with the seriously mentally ill and their treatment. I have noticed that in fact the patients have changed very little, it is just the surroundings and legal paraphernalia, etc. that have. We still see people with severe psychosis who have not responded to treatment for a variety of reasons, some of them having personality disorder alongside psychotic illnesses and some with personality disorder *per se*. Our role as psychiatrists with such patients is key to achieving the maximum stabilisation to enable them to live as normal a life as possible within a setting that is suitable for them. I regard the rest of the paraphernalia and surrounding status as largely irrelevant, from a purely psychiatric point of view.

It would appear that there are many people who seek to interfere with the treatment and care of these patients, in particular members of the legal profession who have on occasion given me detailed instructions on what medical treatment to deliver to their client. Clearly they are no more qualified in that, than I am in giving them legal advice for my patients. It would seem that the cause of the increased number of 'forensic' patients is merely due to a breakdown in the quality of care given to these people in the community. I think the current political idea that one system fits all has been an abject failure, as indeed are all generalised solutions to the needs of individual patients. Obviously most people with severe mental illness will be able to live in some capacity in the community without any problems with violence or suicide, but there still remains a significant number who will never be able to do this, however much politicians seek to deny this. I have met many of such people and I can recognise their mental pain as they struggle to come to terms with a rigid system into which they will never fit.

In addition to these problems, of course, millions of pounds have been spent to enable us to reach this situation and it is frightening to think where this money might have been spent more usefully.

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Recruitment and retention of psychiatrists in low-income countries

I have read the article Brown *et al* (*Psychiatric Bulletin*, November 2007, **31**, 411–413) with great enthusiasm as its contents appear to be very relevant to low-income countries as well.

Recruitment into psychiatry seems to be a global issue. In addition to problems in recruitment, many psychiatrists and psychiatric trainees leave low-income countries in order to find more lucrative jobs in high-income countries. For instance, the Postgraduate Institute of Medicine, University of Colombo, Sri Lanka, has trained a reasonable number of psychiatrists over the past few decades. However, there are about 35 psychiatrists working in the country at present (about 2 psychiatrists per 1 million people). Obviously, this figure is grossly inadequate. Shortage of other professionals in the multidisciplinary team adds to the problem further. As a result of concentration of most of the psychiatrists in the cities, peripheries are poorly served.

In the Doctor of Medicine (MD; psychiatry) training programme in Sri Lanka there is a component of overseas training after completion of MD (Psychiatry) part 2 examinations. A survey among the trainees revealed that the majority preferred the UK centres for their overseas training and all indicated that they would like to return to Sri Lanka after their overseas training (details are available from the author upon request). However, it seems that once exposed to the overseas training and the Western