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correspondence

Patient suicide

Sir: Yousaf *et al* (*Psychiatric Bulletin*, February 2002, **26**, 53–55), have added important findings to the work that Courtenay and Stephens (*Psychiatric Bulletin*, February 2001, **25**, 51–52) carried out among trainees in South Thames. In our paper 54% of respondents had experience of patient suicide compared to 43% in Yousaf's sample and 47% found by Dewar *et al* (*Psychiatric Bulletin*, January 2000, **24**, 20–23). These findings suggest that patient suicide is a relatively common occurrence during the training years of psychiatrists.

An interesting element of Yousaf's survey is the use of the Impact Events Scale (Chemtob *et al*, 1988) to measure the personal impact of patient suicide events on trainees and on their professional practice. Certain themes are shared by the findings in the papers. Many trainees related that in the aftermath of the suicide their practice was affected to the extent that they were more meticulous in assessing the level of risk that patients were presenting. In some cases patient suicide had a beneficial effect on the doctor's training and that consultant support was important in coming to terms with the event. In a positive way patient suicide can be a formative experience and potentially adaptive for the trainee.

Having experienced the suicide of patients since the paper was published has afforded me the experience to learn that patient suicide does not necessarily become easier for the doctor to bear. The reaction is largely dependent on the level of clinical interaction that the clinician had with the person. Even with help from senior mental health staff the impact on the trainee can be aggravated by the attitude of the organisation to patient suicide and to his/her employees' response to the event. Training programme directors have much to offer in shaping the expectations of trainees following the death of a patient through suicide and the responsibilities of hospital trusts towards their staff.

CHEMTOB, C. M., HAMADA, R. S., BAUER, G., *et al* (1988) Patients' suicides: frequency and impact on psychiatrists. *American Journal of Psychiatry*, **145**, 224–227.

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Amphetamine prescribing

Sir: We were interested to read of the survey by Moselhy *et al* about amphetamine prescribing (*Psychiatric Bulletin*, February 2002, **26**, 61–62). In England and Wales, dexamphetamine is the second most commonly prescribed controlled drug, accounting for 4.4% of such prescriptions, with an estimated 900–1000 people receiving the drug as a harm reduction measure (Strang & Sheridan, 1997).

There is more extensive evidence than that cited by Moselhy *et al* for the efficacy of dexamphetamine, but this is largely based on opportunistic clinical evaluation. Recognising this deficiency, the Department of Health has funded a pilot (n=60) randomised controlled trial of dexamphetamine and best available treatment in Manchester and South Wales. The strict inclusion and exclusion criteria are both pragmatic and clinically relevant. We have used a modified version of the Opiate Treatment Index (Barrowcliff *et al*, 1999) to evaluate progress, supported by urine testing for continued use of street amphetamine. We would be interested to know if the services surveyed routinely tested their patients using this technique, which has been available for some time (Tetlow & Merrill, 1996). We have prescribed tablets only, as we have no evidence that these are crushed and injected.

In the absence of trial evidence we would agree that amphetamine prescribing should be restricted to specialist services. We intend that one of the outcomes of our study should be some clearer clinical guidelines for the treatment of dependent amphetamine users.

BARROWCLIFF, A., CHAMPNEY-SMITH, J. & McBRIDE, A. J. (1999) Use of a modified version of the Opiate Treatment Index with amphetamine users: validation and pilot evaluation of a prescribing service. *Journal of Substance Use*, **4**, 98–103.

STRANG, J. & SHERIDAN, J. (1997) Prescribing amphetamine to drug misusers: data from the 1995 national survey of community pharmacies. *Addiction*, **92**, 833–838.

TETLOW, V. A. & MERRILL, J. (1996) Rapid determination of amphetamine stereo-isomer ratios in urine by gas chromatography–mass spectroscopy. *Annals of Clinical Biochemistry*, **33**, 50–54.

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Old age psychiatry services: long-stay care facilities in Australia and the UK

Sir: John Snowden and Tom Arie (*Psychiatric Bulletin*, January 2002, **26**, 24–26) covered a huge amount of ground, and inevitably omitted some features of service delivery in the two countries. One major difference is that hostel and nursing home care in Australia is accessed only after assessment by a geriatric medicine team, and the costs of care are largely met by the Commonwealth Government, which closely controls the number of beds it approves. Patients are funded on a sliding scale that can be viewed negatively as encouraging dependency, or positively as challenging nursing homes to tackle seriously ill patients. UK nursing homes seem not to attract additional funds for higher dependency care, which can lead to patients 'blocking' beds in acute general and psychiatric hospitals. The Australian systems of documentation of dependency can be a drain on nursing resources, directed at ensuring maximum funding rather than patient benefits.

Western Australian old age psychiatry services have suffered age based fiscal discrimination in recent years, and consequently limited community services. UK social services provide substantial support care in the home that is not available in Australia. The system of community based assessment is well developed in Western Australia and emphasises early response by assessment teams of a social worker and community mental health nurse, followed by consultant intervention as required. The UK model favours consultant assessment in the community in the first

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instance. My somewhat heretical view is that this is costly and inefficient. Statistics of bed numbers are notoriously unreliable. In the absence of any independent audit to establish that each state is providing honest and accurate figures, and that we are talking about units with the same operating characteristics, it is impossible to establish validity. The 'throughput' issue is critical if comparing service delivery. 'Continuing care' units in the UK provide much of the permanent care seen in nursing homes in Australia. I understand the units in Victoria are essentially continuing care facilities despite the intentions, as are the confused and disturbed elderly (CADE) units in New South Wales. Services in Western Australia have always followed a firm policy of discharge only when difficult behaviours are abated. Western Australia Health Department attempts to shift a minority of long-term but behaviourally challenging patients into the private sector are misguided and so far unsuccessful. Every psychiatric patient, whether long term or acute, needs professional multi-disciplinary care until the reasons for that specialist care are no longer present. Poorly resourced 'continuing care' in either country is simply an excuse for rebuilding the 'back wards' of mental hospitals.

I must also gently disagree with the implication that making long-term care facilities domestic was intended to 'demedicalise' care. The drive for more domestic character was part of a deliberate process using environmental design to help modify and manage behaviours with for example, less use of medication. It was pioneered in Western Australia by Lefroy and also in the state psychogeriatric services well before the Victorian psychogeriatric nursing homes. The CADE units in New South Wales are also similarly influenced by design and behavioural management concepts, unfortunately often ignored in later developments in many states, including Western Australia.

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the college

Electoral registration – draft statement

Concerns have been raised by College Members regarding the lack of anonymity for people in vulnerable positions, particularly those working in forensic psychiatry services, because of the printing of names and addresses on the electoral register. This problem has become increasingly important in the light of internet databases of personal data that often use the electoral register as the basis for their information.

The College has learnt that some local authorities run electoral registers whereby names can be included at the end of the relevant ward list but without an address. However, there is no national guidance on this and the Department of Transport, Local Government and the Regions are continuing 'to review the possibility of anonymous registration, with a view to legislating in due course, if necessary' (personal communication, 2001).

The College would like to encourage its Members to contact their local electoral registration officer and ask if it is possible for names to be included on the register without an address and also to write to their local member of Parliament asking him/her to contact Right Honourable Nick Raynsford, Minister for Local Government and the Regions, asking that the Government legislate so local authorities have to allow for anonymous registration.

Psychiatrists' professional opinions to the media – revised guidelines

The College encourages psychiatrists to provide the media with expert and up-to-date information. The External Affairs Department retains a list of experts who are happy to deal with media inquiries.

Certain precautions need to be taken, especially when there is great pressure by the media for psychiatric opinions about individuals whose behaviour – often criminal or violent – has caused public concern. In these situations, it is essential that psychiatrists should (a) understand that they are absolutely entitled to make no comment; and (b) confine themselves to general statements about the behaviour or illness under discussion for the purpose of public education but avoid opinions about individuals. Psychiatrists should be particularly careful when the reporter is not known to them, or works for a tabloid known for sensational reporting – where the 'reporting' is often the sub-editing of the reporter's original material.

The American Psychiatric Association has issued ethical guidelines in this matter, as follows:

> 'On occasion psychiatrists are asked for an opinion about an individual who is in the light of public attention, or who has disclosed information about him/herself through public media. In such circumstances, a psychiatrist may share with the public his/her expertise about psychiatric issues in general. It is unethical for a psychiatrist to offer a professional opinion unless he/she has conducted an examination and has been granted proper authorisation for such a statement.' American Psychiatric Association, 2001; p. 11.

The College agrees with this principle. Speculation about persons a psychiatrist has never met could be damaging, both to the professional and to the profession as a whole.

The External Affairs Department is always willing to advise psychiatrists in their dealings with the media.

AMERICAN PSYCHIATRIC ASSOCIATION (2001) *The Principles of Medical Ethics*. Washington, DC: APA.

Nominees elected to the Fellowship and Membership under Bye Law III 2 (ii) Categories (a) (b) and (c)

At the meeting of the Court of Electors held on 26 February 2002, the following nominees were approved.

The Fellowship

Dr Saad Kamal Ahmed
Dr Christopher Robin Aldridge
Dr Ian Muir Anderson
Dr Robin Pierce Arnold
Dr David Stewart Baldwin
Dr Lynne Margaret Behennah
Dr Charles Joseph Kennedy Bouch
Dr Dallas John Brodie
Professor Traolach S. Brugha
Dr Richard Paul Caplan
Dr Janet Carrick
Dr Cathal Eustace Cassidy
Dr Paul Caviston
Dr Shashank Chattree
Dr Denise Cope
Dr Alison Corfield
Dr Janice Anne Culling
Dr Margaret M. A. Duane
Dr Christine M. Edwards
Dr Ali El-Hadi
Dr Sandra Irene Rosemonde Evans
Dr James Gallagher
Dr Simon John Groves
Dr Linda Ann Hardwick
Professor Paul Jeffrey Harrison
Dr Matthew Hodes
Dr Stephen Ronald Humphries
Dr David Hunsley
Dr Robert Hunter
Dr Anthony Jaffa
Dr Dorcas Kingham
Dr Annie Yin-Har Lau
Dr Rose-Marie Gudrun Lusznat
Dr George Mathew
Dr Joseph Patrick McKane
Dr Gyan Mehta
Dr Judith Frances Milne

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