



columns

after a normal electrocardiogram at the request of the family, when the psychosis re-emerged. A literature search also suggested this was a suitable drug following NMS. Sodium valproate was added for treatment of the epilepsy but has also been a very effective mood stabiliser.

Interestingly, when the patient emerged from her catatonic state, she used the hemiplegic arm without any difficulties for a few days before it returned to a spastic premorbid position. Finally, the family are extremely pleased with the patient's progress, believing her mental state to be the best they have ever seen it and this is echoed by all staff who have known this woman.

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## Clinical capacity assessment

Sir: Dr Raymont (*Psychiatric Bulletin*, February 2002, **26**, 201–204) is right to draw to our attention the complexities involved in the legal basis of our ministrations to the patient who may lack the capacity to give informed consent. We especially welcome discussion of the issue of belief and insight in this philosophical, legal and ethical morass, although we would have liked to see elaboration of terms like 'full insight' and 'greater level of capacity'. However, a particular suggestion made us wince.

Dr Raymont answers her own question, 'So how can we proceed currently with any physical treatment of those who lack capacity?' with 'Certainly a full psychiatric assessment should be made initially' – apparently before life-saving treatment. This presumably applies to many with major stroke or an acute cardiac event, a large number of the 30–60% admitted to medical wards with dementia or delirium (Ramsay *et al*, 1991; Treloar & Macdonald, 1997), a high proportion of all those in nursing homes (Macdonald *et al*, 2002) and every single unconscious patient. If by 'psychiatric assessment' she includes presenting complaint, history of presenting complaint, collateral history, and so on by mental health professionals, we wonder where all these professionals will come from?

Apart from this practical problem, we object on principle to the growing tendency for physicians and surgeons to involve psychiatrists in judgements about capacity to consent. Under current UK law (as opposed to some of the US jurisdictions in which the MacArthur Competence Assessment Tool for Treatment (MacCAT-T) (Appelbaum & Grisso, 1998) was developed) it is not

necessary to diagnose the cause of any impaired capacity in order to make the judgement that it is impaired. All professionals must surely be able to make such judgements in relation to each decision, great or small, confronting their patient if they are not to be constantly exposed to accusations of battery on the one hand or neglect of duty of care on the other.

Each trust must ensure that its doctors are competent to assess capacity and have policies in place for treatment when capacity is lacking. It is the responsibility of every treating physician to gain the informed consent for the treatment they are delivering and to take appropriate measures if they do not believe the person to have that capacity. These include timely interventions to save life and, when more leisurely interventions are allowed, involving the relatives, consulting colleagues (almost never a psychiatrist) and other measures, in accord with the Bolam standard (Bolam v. Friern, 1957).

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*Bolam v. Friern*. Hospital Management Committee [1957] 2 *AllER* 118, 1 *W*:R 582.

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## Off-label prescribing

Sir: We enjoyed reading the article by Lawrence *et al* (*Psychiatric Bulletin*, June 2002, **26**, 230–232). The findings complement some work that we have done in this area (Lowe-Ponsford, *Psychiatric Bulletin*, 2000, **24**, 415–417). Our postal questionnaire found that 65% of psychiatrists who replied had prescribed 'off-label' within the preceding month.

Medico-legal advice that we obtained (from the Medical Protection Society) was that, not only does Bolam (1957) need to be taken into account, but also the case of Bolitho (1997). This judgement means that the treatment has to withstand logical analysis as well as be accepted by a

body of opinion. These considerations need to be taken into account in prescribing, alongside the capacity of the patient.

Many psychiatrists are worried about off-label prescribing and our study showed that 4% of respondents had received complaints about this matter. In our paper, we suggested some guidelines that may avoid many future medico-legal problems for clinicians if they should prescribe off-label.

The College's Psychopharmacology Special Interest Group has discussed this matter and is setting up a small working group (chaired by D. B.) to review the practice of off-label prescribing. We would be delighted to receive the thoughts of colleagues on this subject.

*Bolam v. Friern*. Hospital Management Committee [1957] 2 *AllER* 118, 1 *W*:R 582.

*Bolitho v. City and Hackney Health Authority* [1997] 3 *WLR* 1151.

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## Community psychiatry in Nigeria

Sir: Accredited accommodation: an alternative to in-patient care in rural north Powys (Readhead *et al*, *Psychiatric Bulletin*, July 2002, **26**, 264–265).

Although separated by historical period, civilisation and culture, it is interesting to compare this scheme to a similar one in a developing country. The 'Aro village' in Nigeria is set in a semi-rural culture, and operated by the Department of Psychiatry, University of Ibadan. It was pioneered by Professor Adeoye Lambo, an eminent psychiatrist who later became the Deputy-Director of The World Health Organization. This initiative was the very first attempt in community psychiatry in Nigeria (Boroffka & Olatawura, 1976).

As in the case of the north Powys project, Aro village was adapted from the already existing infrastructure of a village community. It offered a social model of care and a rich rehabilitation resource.

Community confidence in the scheme was achieved through liaison between the psychiatrists and the community leaders, a delicate balance between traditionalists and Western psychiatry, a relationship based on trust and the prospect of mutual benefits from the project. In return, the Aro village witnessed infrastructural developments and on-site health clinics. Among other research interests, the project was the subject of an international research collaboration by Leighton *et al*, 1963.