15.2.92). Later, the *Sunday Times* made further use of what I said (11.10.92). Here is an example (supplied with the writer's interest and approval) of what people subsequently wrote to me:

> "After a severe depressive illness 25 years ago, I could write a book about the tortuous road back to so-called normality, having run the whole gamut of drugs, ECT, psychotherapy and abreaction etc. In order, hopefully, to be helpful and not presumptuous, could I make a few suggestions:
> 1. Let the patient try and tell you *exactly* how he/she feels and never tell him you know how he feels – you can't, possibly!
> 2. Participating treatments are far more useful than passive ones – even if the patient has to be cajoled into cooperation. An anxious depressive will probably be far more cooperative.
> 3. If your patients are reasonably articulate, why don't you follow them up, a year or so after they have been well, and ask them about their experience – how they felt about their illness – how the illness itself felt – which aspects of treatment helped them and which they found distinctly unhelpful.
> 4. If they are not particularly articulate, they may find it easier (and, from experience, *very* helpful) to write down their feelings, however jumbled the final result may seem.
>
> I write this entirely to give you suggestions from "the other side of the fence" and hope that maybe there is something useful."

Unexceptional suggestions, perhaps, but presumably things this very reasonable person did not find enough of in her long experience. Of course, different people may find different things helpful. Formal research and less formal audit may touch some of these areas, but only within the limits of the questions the *professional* chooses to ask.

May I suggest that, in its public campaigns, the College incorporates a genuine, open interest in receiving this kind of feed-back and advice, however much we may think it produces nothing we do not already do in our practice? Perhaps it should be a constant feature of specific campaigns like Defeat Depression, although why not a campaign of its own too? Wouldn't it be an impressive statement of the College valuing those who have been on "the other side of the fence" – indeed, it would show that psychiatrists seek collaboration not the divisiveness implied by "fences"?

I propose that the College – on its own, or co-operating with MIND and "user" groups – sets up a formal system to publicise the invitation, and then collects, edits, and publishes such correspondence into some easily accessible form. Perhaps there could be an appendix of references to other published subjective descriptions of the experience of mental health problems and their treatment (see Further reading, below, for examples)?

This project would certainly be a collaborative effort – both sides of the fence would equally find the result an extremely useful resource.

NICK CHILD

Child and Family Clinics
49 Airbles Road
Motherwell Scotland
ML1 2TJ

Further reading

GALLOWAY, J. (1989) *The Trick Is To Keep Breathing*. Minerva.

PLATH, S. (1963) *The Bell Jar*. Heinemann; Faber.

PODVOLL, E. (1990) *The Seduction of Madness*. Harper-Collins; Century.

RIPPERE, V. & WILLIAMS, R. (Eds) (1985) *Wounded Healers: Mental Health Workers' Experiences of Depression*. Wiley.

Reply

DEAR SIRS

Dr Child proposes, *inter alia*, formal systems for responding to the views and the correspondence from patients. I am sure that he will be pleased to hear that the College already has measures in place for such purposes.

In the 1992 annual report of the Royal College of Psychiatrists there was an article on the Patients' Liaison Group. One of the aims of this Group was to make the College aware of patients' concerns, and it was to provide a forum for a continuing dialogue between psychiatrists, patients' groups and carers. The Group is chaired by Professor Brice Pitt. It includes representatives from a wide variety of patients' and carers' associations. The Group reports to the President, to the Public Policy Committee, to the Executive and Finance Committee and to Council.

Patients' letters coming to the College are replied to usually by Professor Philip Seager. Letters particularly concerned with the Defeat Depression Campaign are replied to by Dr David Baldwin.

I shall pass Dr Child's letter on to Professor Pitt, Professor Seager and Dr Baldwin, since they may wish to take up some of Dr Child's other interesting proposals.

R. G. PRIEST

Chairman, Defeat Depression Campaign

Training in psychiatry

DEAR SIRS

The dispute between the Maudsley consultants and Professor Copeland (*Psychiatric Bulletin*, 1992, **16**, 798–799) about the training status of senior registrars seems old fashioned.

I would like to try and take the training issue forward. The College is to be congratulated on its stance. However the balance between senior registrars and more junior trainees may need to change. It would be difficult for senior registrars to give up their hard won privileges, but surely the emphasis in training ought to be on the least experienced not most.

The new funding arrangements for training posts should allow some principles to be established about the division between service and training. In Sheffield, as roughly half of the funding for SHO/registrars will come from Trent Postgraduate, at least half of their time will be allocated to training. For the moment, we will continue to regard senior registrars as "supernumerary".

I am hopeful that the new Dean of the College will introduce some new thinking on training in psychiatry. This is not a criticism of the current or past Deans, who I know have successfully countered arguments like those of the Maudsley consultants.

DUNCAN B. DOUBLE

Sheffield Pastgraduate and
Continuing Psychiatric Education
Middlewood Hospital
Sheffield S6 1TP

Crisis intervention

DEAR SIRS

I was interested to read Dr Parkes' articles on the crisis intervention service in Tower Hamlets. (*Psychiatric Bulletin* 1992, **16**, 748–753).

Redbridge, about ten miles from Tower Hamlets, has had a similar small multidisciplinary crisis intervention service operating during office hours since 1984. This complements the traditional in-patient, out-patient and CPN services and offers brief individual psychotherapy and family therapy supplemented where appropriate with medication. Similarly, psychiatrists do not see all cases. However, unlike Tower Hamlets, most cases are seen in the crisis team's office and self referrals are accepted.

We retrospectively examined all 119 patients referred from a single catchment area in 1989. Twenty-two per cent failed to attend with the remaining 78% attending for an average of 3.2 sessions. Only 10% were self referral, most being referred from psychiatrists or their GPs. Similar to Parkes' findings, there was a larger proportion of younger women with those in the 20 to 35 age group making up 36% of all those referred. Eighteen per cent of men and 33% of women were receiving psychotrophic medication on referral.

We followed up the group, an average of three years later, in mid 1992. Only seven patients had renewed contact with the crisis team during this period and five had attended psychiatric out-patients; 27% were on psychotrophic medication, usually a benzodiazapine or an antidepressant, although surprisingly this showed minimal correlation to use of medication in 1989. Of those who remained with their GPs, 41% were in regular contact for mental health problems. However, most of these had had no contact with any other psychiatric service in the previous six months.

Separately, as part of audit, we found a high level of patient satisfaction with this service.

RICHARD DUFFETT

Goodmayes Hospital
Barley Lane, Ilford
Essex IG3 8XH

Section 5(2) – following the rules?

DEAR SIRS

We audited the use of the Mental Health Act section 5(2) and found that we were not very good at following the workings of the Act of the Code of Practice. Forty-one per cent of our episodes involved patients who had been on the ward less than 12 hours, which raised questions about our definition of an in-patient (Code paragraph 8.4). This was complicated by the fact that patients were assessed for admission on the acute wards and not in the A & E department. Most applications (73%) were made by a senior house officer but only 18% sought advice, which the Code says should be done wherever possible. Approved social workers were involved only if a recommendation for admission under the Act was made, which the Code considers *not* to be good practice. Twenty per cent were 'allowed to lapse' after the second assessment which is contrary to the Act and receives regular criticisms from the Commission.

Our social work colleagues are more keen than we are to follow the letter of the legislation. Perhaps our priorities are different, evidenced by their frequent reference to paragraph 1.1 of the Code, that failure to follow the Code could be referred to in evidence in legal proceedings. They are in favour of policies and guidelines, and some have even suggested a maximum of six hours for the second assessment to be completed. As psychiatrists, our clinical freedom is *within* the Act and Code and my concern is that if we do not follow them more closely, more restrictive and rigid interpretations will be imposed. This would *really* affect our clinical freedom. We see this too often in social services and nursing; new untoward incidents lead to new policies.

Most Section 5(2)s are done by very junior trainees (41% were made by SHOs in their first psychiatric posts). When I asked junior trainees in two hospitals