the columns

correspondence

Dangerous severe personality disorder – not a new problem

Sir: People with dangerous severe personality disorder have long been recognised by psychiatrists to be beyond the remit of the psychiatric services. This point is nicely illustrated by a case summary of a patient admitted in 1838 to the newly opened Northampton Asylum (now St Andrew's Hospital).

A 26-year-old labourer said to be suffering from 'insanity caused by intoxication and sleeping at night in the open' was transferred to the asylum from Oakham Gaol. He had a history of violent assault and in prison had been kept heavily ironed. In hospital he continued to exhibit episodic violence. Thomas Prichard, the medical superintendent, wrote 'he went on very well until yesterday when he broke out into open mutiny. He is a reckless profligate'. He was not placed in mechanical restraints, as this was against the philosophy of the hospital, but solitary confinement and low rations were used. The patient exhibited no signs of 'insanity' throughout his stay. A month after admission Dr Prichard wrote 'I do not consider him a proper inmate for an establishment like ours. I very much doubt that we possess the power of reclaiming him (by moral management) and firmly believe the treadwheel or cat o' nine tails would be found more efficacious'. Prichard applied to the hospital governors for permission to discharge the patient. This being granted, 6 weeks after admission he was sent home and nothing more was heard of him.

Today, under the Government's new Mental Health Bill, his fate might be very different.

Camilla Haw, Consultant Psychiatrist, St Andrew's Hospital, Northampton NN1 5DG

The suicide bomber: is it a psychiatric phenomenon?

Sir: Harvey Gordon's paper (*Psychiatric Bulletin*, August 2002, **26**, 285–287) was refreshing on a worrying topic. I enjoyed the wide academic references to drive home an unemotional and rational argument. I was reassured by the conclusion that there was no need to apply a psychiatric analysis to the phenomenon.

But at one point academic rigour was dropped and that bothers me. The last paragraph states 'religion can be a force for good'. Where's the evidence for that?

Peter Bruggen, Retired Consultant Psychiatrist, London

Assessing alcohol-intoxicated patients

Sir: We agree with McCaffery *et al* (*Psychiatric Bulletin*, September 2002, **26**, 332–334) that there is little consensus among psychiatrists as to how to manage intoxicated patients when they present. We collected questionnaire data from 164 health professionals – 53 psychiatrists, 56 psychiatric nurses and 55 third year medical students. Opinions on appropriate care protocols for intoxicated patients presenting at accident & emergency (A&E) departments or psychiatric emergency clinics were sought. Over a third of the psychiatrists (35%) and nurses (39%) were of the opinion that intoxicated patients should 'often/always' be sent away and asked to return when sober and almost half of the nurses (44%) and the psychiatrists (44%) thought that an assessment should 'never/rarely' be attempted with an intoxicated patient. In contrast, 47% of the medical students were of the opinion that attempts to make an assessment should 'often/always' occur. Two-thirds of the psychiatrists (67%) and the medical students (68%) indicated that they thought intoxicated patients should 'often/always' be provided with a safe place in which to wait until sober (sobriety suite). Opinions among the nurses were broadly distributed, although very few (4%) indicated that this should 'never/rarely' be offered. Over half (55%) of the sample indicated that they did not think it possible to section an intoxicated patient under the Mental Health Act.

If the findings from our survey accurately reflect actual clinical practice, then intoxicated patients, some with suicidal ideation or other mental health problems, are being sent away without an assessment. This raises the question of who is responsible. Psychiatric cover in A&E departments is very variable: in some, but by no means all, teams of psychiatric liaison nurses staff A&E departments and emergency psychiatric clinics. Part of their role is to assist in the detection, assessment and management of alcohol dependent patients (Royal College of Physicians, 2001). Clearly there is ignorance over the use of the Mental Health Act, which can be used where there is a comorbid psychiatric disorder. Our findings support those of McCaffery *et al* and suggest a need for care protocols for when intoxicated patients present. We agree that there is a need for greater clarity on the management of such patients at both the local and national level.

ROYAL COLLEGE OF PHYSICIANS (2001) *Alcohol. Can the NHS afford it? Recommendations for a Coherent Alcohol Strategy for Hospital*. London: Royal College of Physicians.

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Monitoring patients on lithium

Sir: I read the recent paper by Nicholson and Fitzmaurice (*Psychiatric Bulletin*, September 2002, **26**, 348–351) with interest. Their literature review preceded the publication of our fairly recent study (Eagles *et al*, 2000) that investigated lithium monitoring before and after the distribution of clinical practice guidelines in the north-east of Scotland. From our findings, I would wish to extend, and to mildly contest, some of the points made by Nicholson and Fitzmaurice.

With regard to specific points within the Lothian Guidelines, there are two points. Thyroid dysfunction occurs, commonly, more in women than in men and especially during the first 2 years of lithium treatment (Johnston & Eagles, 1999). It is probably logical, therefore, certainly in the early years of lithium treatment, to monitor thyroid function at

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