such treatment to be delivered in the patient's home.

Finally, we should remember that for each uncooperative patient there is likely to be an over-compliant one. Quietly tolerating adverse effects from over zealous drug regimens, they may believe that 'the doctor knows best' or indeed be unaware that they are free to refuse treatment (Eastwood & Pugh, 1997).

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Care Programme Approach: equivalent developments in Australia

Sir: The Care Programme Approach (CPA) has clearly generated a significant amount of controversy in Britain. The Victorian Government (Australia) has published a series of policy documents (Psychiatric Services Division, 1994) which have created expectations that a case management model of care, similar to the CPA system, will be provided by all public psychiatric services. The recommended model includes formal intake, the appointment of a case manager, team review, individual service planning and case closure for all patients treated. This model is being gradually adopted statewide as funding agreements demand.

The Geelong psychiatric services embarked on adopting this case management model in 1994. As discussed by Ferguson (1996), we found these attempts, without an integrated patient information system, laborious, frustrating to monitor and greeted with considerable resistance.

Over the past three years we have designed new patient record documents corresponding to each of the processes in the case management model and a computerised mental health patient information management system (MH-PIMS), on which is recorded some basic data on each patient and allows each patient to be tracked through the system until case closure. MH-PIMS produces reports on a weekly basis, which are of value to teams in conducting their everyday business and review meetings. This includes lists of patients due for review; patients discharged from the in-patient unit in the previous month and case-load lists.

In the year ending October 1997, the average active case-load of case managers was 25; each case manager took on an average of 23 new cases and discharged 22.5 cases in the same period. This throughput was maintained by adhering to the case management model and monitoring this in individual supervision and in team meetings.

Although the introduction of this structured system has been demanding on management and challenging to clinicians, our staff now have a positive attitude towards the system and we believe our perseverance has yielded results.

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Need for local policies on Section 135 of the Mental Health Act 1983

Sir: There are important differences in the provisions of Sections 135(1) and 135(2) of the Mental Health Act 1983. Section 135(1) applies to people who are not yet admitted to psychiatric facilities. In this case, an approved social worker applies for the warrant, and the named constable to whom it is addressed must be accompanied, in the execution of the warrant, by an approved social worker and a registered medical practitioner. All very clear.

Section 135(2), on the other hand, applies to detained patients who are absent from hospital without due authority. In this case, any constable, or any other person authorised under the Mental Health Act 1983 or under Section 83 of the Mental Health (Scotland) Act 1960 to take or retake a patient may apply for the warrant. In the execution of the warrant, it is not mandatory that the constable must be accompanied by anyone: he or she may be accompanied by a registered medical practitioner, or by any person authorised, under the Act, to take or retake a patient.

Those authorised, under Section 18 of the Mental Health Act 1983, to take or retake a patient, are: an approved social worker, an officer on the staff of the hospital (including nurses and doctors), any constable and any person(s) authorised in writing by the managers

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of the hospital to do so. This is potentially a source of conflict because any of several people could go to court to apply for the warrant. Each of them could say that they were too busy to go to court, or that they had been doing so more often than the others, and the matter would remain unresolved, to the detriment of the patient whose mental state might be deteriorating while he or she is out of hospital and without treatment.

We therefore recommend that the health and social services providing care for the residents of every locality should agree a local policy regarding the implementation of Section 135, and that such a policy should specifically address the question of who should go to court to apply for the warrant under Section 135(2).

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Rapid tranquillisation: the cost of treatment

Sir: Hyde and colleagues concluded that zuclophenthixol acetate was less costly than haloperidol for rapid tranquillisation in a psychiatric intensive care unit (*Psychiatric Bulletin*, March 1998, **22**, 186–190). The reason for this was entirely based on differences in special nursing costs. However, it is not clear why the haloperidol group required more special nursing. This we are not told and the objective data gives little hint as to why this should have been the case. One prediction might have been that the haloperidol group would have been involved in more violent incidents (because of the shorter half-life of the drug) requiring more frequent rapid tranquillisation. In fact, the mean number of incidents per patient were the same in both groups. The key to the apparent paradox appears to lie in the preference of nursing staff for zuclopenthixol acetate. The most common reason for their choice was a reduction in the number of injections required, which is not congruent with the facts reported in this study. Given that the decision for special nursing is mainly a nursing one, I would proffer an alternative explanation for the results, which is that the nurses were more confident with zuclopenthixol acetate and, therefore, the requirement for special nursing was reduced.

In an open study such as this, it is impossible to resolve these different interpretations. Pharmacotherapy plays one part in the management of violent patients, with staff confidence and skills equally important. The extra cost of zuclopenthixol acetate may be a small price to pay for greater confidence, but it would be a shame if this was at the cost of losing the ability to titrate the treatment to match the situation. Titration is much easier with a shorter acting drug.

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Video newsletter

Sir: Some years ago I looked at the possibility of producing a quarterly video newsletter for those interested in psychiatry. Clinical tutors with a very long memory may even recall seeing a pilot programme. In the event I thought the amount of support for the venture at the time seemed marginal, particularly in view of the significant start up costs for the project.

Over the years events have moved on. Continuing education commands greater awareness. Production and distribution costs have fallen significantly. There are also innovative developments in distribution and digital technology. Therefore, now may be an appropriate moment to re-visit the idea.

I had in mind a programme with a number of different items covering current affairs in psychiatry, an illustrated lecture and possibly some advertising such as rotational training scheme and hard to fill consultant appointments. No doubt there are many other ideas that can usefully be explored, such as conference reports. For the venture to be successful it would need to command widespread support and the active contributions from a number of enthusiasts. I would be most interested to hear from anyone who would like to cooperate with such an academic venture.

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