DEAR SIRS

I read with great interest Dr Jelley's account of 'The Blues' and Psychiatry (*Psychiatric Bulletin*, April 1990, **14**, 227–229). It is not only the lyrics of blues songs that equate with clinical depression but also the names given to the blues artists themselves. Muddy Waters, Willie 'Poorboy' Lofton and Emil 'Stalebread' Lacoume are titles that might reflect low self-esteem and negative thinking. I wonder too whether Leadbelly could be an early version of Cotard's syndrome?

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## *Code of Practice*

DEAR SIRS

I saw the recent correspondence between the Director of the NSF and the College President (*Psychiatric Bulletin*, April 1990, **14**, 235–236).

I can see no incompatibility between the Code of Practice's "health *and* safety" and the Mental Health Act's "health *or* safety".

I will not consider the Memorandum of the Mental Health Act 1983.

The Mental Health Act itself clearly states "interests of his own health *or* safety".

Nevertheless, the context of the Code of Practice's "health *and* safety" (2.6) is that both should be considered (it is not defining the grounds, merely instructing that both criteria are considered). Clearly, if the conjunction *or* was used here it would imply that account should be taken only of one or the other and not both.

I certainly agree with the National Director of the NSF. I think both criteria should be considered and either one or the other or both are legal grounds for action.

This Code of Practice raises many other more contentious issues not least:

(a) the explicit powers of the Guardian
(b) the involvement of Management in clinical decisions such as continued seclusion.

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## *Mental health review clinic*

DEAR SIRS

I have recently worked at a hospital where the senior registrar held a once-weekly joint clinic with the community psychiatric nurses (CPNs) to review patients attending the depot clinic. The clinic was labelled 'Mental Health Review Clinic', and one of the main objectives was to review patients on long-term neuroleptics who had been lost to follow-up from either general practice or psychiatry, but were followed-up by the CPNs.

Up to four patients were jointly reviewed in one session and were often discussed with the team. A once-fortnightly meeting with the senior CPN and a Consultant Community Psychiatrist facilitated discussion on clinical, educational and administrative issues regarding the clinic.

There were several advantages resulting from such a clinic:

(a) With modern emphasis on small dose neuroleptics for prophylaxis in schizophrenia (Manchanda & Hirsch, 1988), we were able to reduce dosage in many patients without precipitating relapse and minimising side effects.
(b) This clinic became a forum where other concerns voiced by the CPNs were addressed; patients with acute psychiatric symptomatology and other patients the CPNs were concerned about were also reviewed.
(c) The clinic fostered close ties between the hospital-based Department of Psychiatry and psychiatrists and the predominantly community based nurses. This is particularly important in view of modern emphasis on community psychiatry.
(d) There were opportunities for mutual support and education.

Unfortunately there were some difficulties too:

(a) There was a 30% non-attendance rate, which is similar to that in follow-up psychiatric clinics (Shah & Lynch, 1990). This was despite a familiar CPN being present at the clinic.
(b) As these patients had been lost to follow-up, it was very difficult to acquire their previous hospital case-notes. This resulted in less complete assessment of patients.
(c) Occasionally patients being followed-up by other consultant teams were seen erroneously and this resulted in duplication.

The advantages seem to outweigh the disadvantages when one considers long-term side effects of neuroleptics and the development of close ties with the CPNs.

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