have found their contact with psychiatric services useful, but I find that I need to let go of the desire to solve all their problems or offer them a way of escaping all their difficulties. This is how it is with mental illness generally. I believe we need to be more realistic about what we can offer our patients in terms of 'recovery' while at the same time always working with them to alleviate their difficulties in the hope that things will improve.

Jon Goldin, Specialist Registrar Child and Adolescent Psychiatry, The Tavistock & Portman NHS Trust, 120 Belview Lane, London NE3 5BA

Community Treatment Orders

Sir: Two recent articles (*Psychiatric Bulletin*, November 1999, **23**, 644–646 and *Psychiatric Bulletin*, November 1999, **23**, 647–648) continue the debate surrounding the proposed introduction of Community Treatment Orders (CTOs). Having experience in the use of CTOs in Victoria, Australia it is our contention that a CTO does not confer any advantage to the patient in comparison with a comprehensive community care. Indeed, we observed that their use frequently served to alienate patients from mental health services.

In reviewing CTO usage McIvor (1998) highlights the paucity of research in this area despite their widespread implementation in Australia and New Zealand and suggests the need for controlled trials in order to justify their continued use. Burns poses the question, 'is there a group of patients who are poorly served by the present legislation who are currently repeatedly subject to compulsory admission and whose welfare would be better served by a CTO?'. In our endeavour to practise evidence-based psychiatry surely the question must be, 'Can a patient be subject to a CTO in the absence of proven efficacy?'.

Reference

MCIVOR, R. (1998) The community treatment order: clinical and ethical issues. *Australian and New Zealand Journal of Psychiatry*, **32**, 223–228.

***Feargal Leonard**, Specialist Registrar in Old Age Psychiatry, Priority House, Hemitage Lane, Maidstone, Kent ME16 9PH, **Michael Ventress**, Senior House Officer in Forensic Psychiatry, Trevor Gibbens Unit, Maidstone

Sir: I think Professor Burns (*Psychiatric Bulletin*, November 1999, **23**, 647–648) is quite right to point out that most psychiatrists can think of 'a handful' of patients who would truly benefit from a Community Treatment Order (CTO). The criticism though that Moncrieff & Smyth are posing the wrong question (*Psychiatric Bulletin*, November 1999, **23**, 644–646) "How can psychiatry control antisocial behaviour?" is slightly unfair. The genesis of the currently proposed reforms can be traced back to Frank Dobson's widely publicised comments on the Michael Stone case, that community care had failed because psychiatrists had not been using their power to treat people in the community. Of course psychiatry possessed no such power at the time of Mr Dobson's ill-informed comments, but Mr Dobson never retracted this statement and the government has gone on to propose CTOs. College caveats aside, it is, therefore, correct to view the CTO as the Government's attempt to hold psychiatrists accountable for the behaviour of dangerous people who have had contact with psychiatric services.

Andrew Al-Adwani, Locum Consultant Psychiatrist, Department of Psychiatry, Scunthorpe General Hospital, Cliff Gardens, Scunthorpe, North Lincolnshire DN15 7BH

Sir: I write regarding the two articles on Community Treatment Orders by Moncrieff & Smyth and Burns (*Psychiatric Bulletin*, November 1999, **23**, 644–646 and 647–648).

My concern is that occasionally a patient who stops his or her antipsychotic medication, against advice, remains well for some years at least.

I know of no way to predict this. Thus, some people may be forced indefinitely to take medication they do not need.

Robert J. Doig, Consultant Psychiatrist, St Ann's Hospital, St Ann's Road, London N15 3TH

Mobile telecommunications and agoraphobia – a modern treatment advance?

Sir: I wish to report how the advent of new technologies may be influencing the ways in which patients manage their own symptoms.

It recently came to my attention that a husband and wife had devised a method by which they had been able to extend the period of time in which a profoundly agoraphobic patient was able to be independent of their spouse, both inside and outside the home. By both parties of the marriage having a mobile telephone in their possession it allowed, in this case the husband affected with a considerable degree of agoraphobia, to spend considerable periods of time on his own without developing a severe degree of anxiety and fearfulness, with accompanying panic symptoms and an urge to either return home or seek the company of his wife. There is, therefore, an increased degree of security knowing that help is at hand if symptoms recur. An example of this is that he is now able to spend long periods of time fishing, away from the home, an activity he found intolerably stressful previously, as he became acutely concerned if he was not able to return home immediately, or did not have access to a means of transport to do so. Therefore, his anticipatory anxiety has been alleviated by the knowledge that he can contact his wife at any time, leading to a larger social repertoire. He developed a much better sense of control over his circumstances and has broken the cycle of dread of being alone in public places. While there are obviously dangers of dependency occurring because of this, I do feel it allows the patient to have more autonomy.

I am unaware of any other reports of mobile telecommunications being used in this way and it provides a good example of how new technologies may have serendipitous spin-offs for psychiatric patients.

John W. Coates, Consultant Psychiatrist, Mental Health Services, Rotherham General Hospital, Moorgate Road, Rotherham, South Yorkshire S60 2UD

A minister for adolescence?

Sir: We were encouraged to read Parkin's (*Psychiatric Bulletin*, October 1999, **23**, 587–589) review of the difficulties surrounding the admission and treatment of 16- and 17-year-olds under the Mental Health Act 1983. As a newly formed Community Adolescent Mental Health Team we have been grappling with the current legal confusion surrounding the status of adolescents on a daily basis. The concept of Gillick competence developed from a case regarding the rights of those under 16 to seek confidential contraceptive advice and, as such, it made sense – but it is now being extended into areas where it is increasingly nonsensical and legally untested, for example, should the parents of a cannabis-using 16-year-old be told about the drug use?

The confusion over adolescents' legal status appears to hinge on one issue: are rights acquired on reaching a certain age or a certain competence? The answer at the moment is 'it depends'. It depends on whether the issue in question is consent to sex or treatment, whether the patient is male or female, homosexual or heterosexual and consenting or refusing. Adolescents' legal rights should surely be either gained at a certain age, or based on their individual competence, but not the current mixture.

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columns

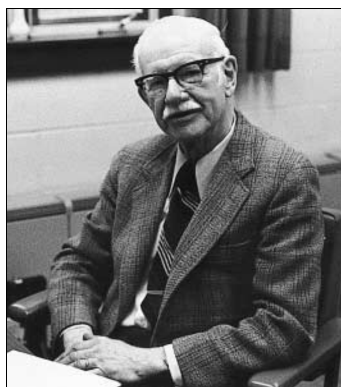
Women's groups were rightly heartened by the Labour Government's decision that all future legislation would be scrutinised for its effects on women's issues. A similar approach to adolescents seems overdue. Even the recently published *National Service Framework for Mental Health* (Department of Health, 1999) refers to 'working age adults'. Does that include 16- and 17-year-olds?

Reference

DEPARTMENT OF HEALTH (1999) *National Service Framework for Mental Health. Modern Standards and Service Models.*

***Joe McDonald**, Consultant Psychiatrist in Adolescent Mental Health, **Anthony Ross**, Community Nurse (Adolescent Mental Health), **Elizabeth Taylor**, Community Nurse (Adolescent Mental Health), **Allan Brownrigg**, Social Worker (Adolescent Mental Health), Barnes Unit, Adolescent Mental Health Team, Durham Road, Sunderland SR3 4AF

obituaries



Walter E. Barton

Formerly Professor Emeritus of Dartmouth Medical School, Lebanon, New Hampshire, USA

Walter Barton was born 29 July 1906 in Oak Park, Illinois, the oldest son of Alfred J. and Bertha (Kalish) Bartusch. He received his MD from the University of Illinois. He spent his internship at the West Suburban Hospital in Oak Park, Illinois and then moved to the Worcester State Hospital in Massachusetts for his residency in psychiatry. He stayed on to gain hospital administration training and because he had met Elsa, then superintendent of nurses, his future wife. In June 1938 he attended the National Hospital, Queen Square, London, England for further neurological training.

His academic career included faculty teaching appointments at Smith College School of Social Work and at the Medical Schools of Tufts, George Washington, Georgetown, and Boston University, where he was Clinical Professor of Psychiatry. He also served as Chairman of the Massachusetts Psychiatric Faculty, Inc. When he 'retired' in 1974 he joined the Faculty of Dartmouth Medical School and was actively teaching there until his death.

Walter Barton was president of several major psychiatric organisations in the USA. He was honoured by being elected a Life Fellow by the American Psychiatric Association, the American Medical Association, and the American College of Physicians, as well as elected an Honorary Fellow of the Royal College of Psychiatrists of England and of the Australian and New Zealand College of Psychiatrists. He received a number of prestigious awards including the Salmon Medal for Achievement in Psychiatry by the New York Academy of Medicine in December 1974 and in 1975 he received the Distinguished Service Award of the American Psychiatric Association. In 1975 he was awarded an Honorary Doctor of Science by the University of Illinois Medical School, and in 1983 the American Psychiatric Association awarded him their first Administrative Psychiatry Award for outstanding contributions in the field.

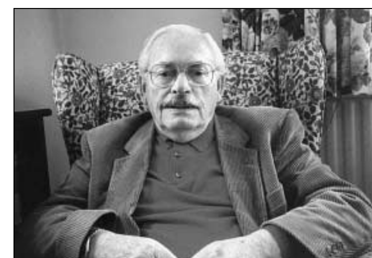
During his career in the 1930s he was in the Massachusetts National Guard and saw active service in the Second World War in the Philippines, for which he was awarded the Legion of Honour.

In the 1950s and 1960s he was appointed the Superintendent of Boston State Hospital in Massachusetts which he transformed into a leading service, teaching and research centre. There, through the Barton Mental Health Center he conducted one of the first community demonstration programmes out of which grew the Community Mental Health Movement.

From Boston he moved to Washington, DC and from 1963–1974 became the Medical Director of the American Psychiatric Association with great success. In the 1960s he helped to fashion the Veterans Administration's Physical Medicine Rehabilitation Program and led scientific exchanges to Japan, Scotland, Mexico, Scandinavia and the former USSR. His work has been published extensively, including 12 books and over 180 articles.

Walter Barton died on 26 January 1999, aged 92. He is survived by two children, grandchildren and great-grandchildren.

Gail M. Barton



Matthew Radzan

Formerly Honorary Consultant, Bexley Hospital Kent

Dr Matthew Radzan (Hugh) died aged 85 on 1 May 1999 from a myocardial infarction at this home in Bexley Kent. Hugh was born on the 5 January 1914 in Bethnal Green and lived in the London area most of his life. His father, an immigrant from Russia, settled in East London and followed his profession of jeweller and watchmaker. Hugh attended Raine's School, Stepney.

He obtained his MB BS (Lon) in 1939 from King's College, London, followed by a DPM in 1940. In 1971 he was elected FRCPsych. In the Second World War he served with the Royal Army Medical Corps in the Middle East from 1939 to 1945 achieving the rank of Major (specialist psychiatrist).

His first civilian psychiatric appointment was to Hellingly Hospital, Sussex and in 1948 he was appointed to Bexley Hospital, Kent. I met him in 1949 under happy circumstances and our association continued for a further 50 years until his recent death.

In those days Bexley Hospital, with over 2000 beds, served a large area of south-east London, to which was added an adjacent piece of Kent. The medical Superintendent then was Dr L. C. Cook whose Deputy was Dr Comerford. They were both distinctive characters and complemented each other in a way that led to a smooth running hospital. Many changes were taking place both in the

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