

the Hospital which perpetuates his name. Charles Darwin studied patients at the Hospital and sought advice from Crichton-Browne for his work *Expression of Emotion in Man and the Animals*.

Those taught to think that the history of the mental hospitals is a 'bad thing' will be reoriented by this illuminating account of clinical, scientific, managerial and humane endeavour. The reading of the book may prompt a visit to the museum at Stanley Royd Hospital: open Wednesdays 10 a.m.–1 p.m. and 1.30–4 p.m. Mr Ashworth may be contacted by phone: 0924 201688.

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Section 5(4) of Mental Health Act, 1983

DEAR SIRS

Drs Bowler and Cooper's paper about the use of Section 5(4) of the 1983 Mental Health Act (*Psychiatric Bulletin*, March, 1993, 17, 147–149) is an important contribution to the limited literature on this subject. An inner-related, and arguably just as important, issue is the number of patients who are detained by nurses without using the provisions of the Act.

In our study (Allen & Johnstone, 1992), we found that out of 98 nurses who were eligible to detain patients, 22 admitted to having detained them by use of restraint without using Section 5(4). Interestingly, an earlier survey of the same cohort by us revealed just 12 nurses who were willing to admit this; we postulated that this was due to the feedback given in our second survey which enabled nurses to be more open about this rather difficult question.

A potentially worrying finding was the apparent lack of correlation between the decision to prevent patients leaving and their potential 'detainability'; out of 22 patients detained by restraint without using Section 5(4) only 12 were deemed by nurses to have a 'serious mental illness' so, by their own definition, would not have been detainable under the Act.

Restraint was only for a few minutes in 20 cases but for up to an hour in two cases, and over an hour in another; the latter three being 'seriously mentally ill'. We concluded that there may well be grounds for restraining people under common law for their own protection but that this did not normally include detaining them in hospital against their will and we questioned whether nurses were making reasoned judgements when deciding whether to exercise the provisions of the Act.

It was particularly interesting that during the period of our survey, which lasted for six months, Section 5(4) was used on ten occasions, compared with its previous use: ten times in the four and a half

years since the implementation of the Act. We suggested that raising staff awareness and confirming the acceptability of the Section influenced their behaviour.

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Reference

ALLEN & JOHNSTONE (1992) The use of section 5(4) of the Mental Health Act, 1983. *British Journal of Clinical & Social Psychiatry*, 8, 72–76.

Questioning clinical judgement

DEAR SIRS

If Dr Akinkunmi (*Psychiatric Bulletin*, March 1993, 17, 175) continues in old age psychiatry, he will soon become accustomed to having his clinical judgement queried by all sorts of people, not just Members of Parliament – although I admit it is not usual for MPs to get over-involved in person, choosing usually to write to Chairmen of Health Authorities or to the Health Services Commissioner.

One of the worst examples in my experience (some years ago now) was with a County Councillor who, hearing that an elderly depressed man was to be allowed home, went to the ward and bullied the nursing staff into letting her make a full "examination" of the patient, which included testing his ability to walk and climb stairs; in due course I was telephoned and given her opinion that my patient was not ready for discharge. This was conveyed to the family who resisted discharge so effectively that it could not take place; the patient just "gave up" and died a few months later.

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Training in liaison psychiatry

DEAR SIRS

I am delighted to see liaison psychiatry having a higher profile but have to say that the recommendations from the Liaison Psychiatry Group Executive Committee do not go far enough. What is missing is an explicit recognition of the essential quality of liaison psychiatry, which is the relationship between the psychiatrist and the hospital department where he or she works. Trainees who are simply supervised on clinical work will fail to understand what is happening to them, and to their colleagues if this is not addressed in supervision. As we all know, regular doctors mistrust psychiatrists, and a major part of the liaison task is joining the department or ward being served. This is comparable to an anthropological exercise, and requires some discussion between

trainee and supervisor. It is not sufficient just to have lunch or play golf with one's colleagues!

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Returning home

DEAR SIRS

Dr Araya's sad article (*Psychiatric Bulletin*, February 1993, 17, 109–110) is a reminder of the obstacles faced by overseas doctors attempting to return home (Patel & Araya, 1992). I have resisted the desire to return to India, since the regulations imposed by the Medical Council of India virtually ensure that I could never work in an academic setting. For example, a research proposal I had submitted to the Indian Council of Medical Research to study traditional healing and mental illness in primary care in India was rejected on the technical ground that my postgraduate qualifications were not recognised by them. Ironically, I received a three year grant from the Beit Trust to conduct a similar study in Zimbabwe.

Many institutions in the UK which "assist" doctors from the developing world by bringing them to the UK for "training" entertain a naive view that, regardless of exposure to material wealth and political stability in the UK, these doctors would voluntarily return to their homes. Many have no means to re-establish a career, lack of financial support and failure of academic bodies in their home countries to recognise the value of their experience in the UK being the main problems.

However the Royal Colleges and the WHO could establish a direct communication with policy making bodies in developing countries to discuss cross-recognition of postgraduate qualifications to facilitate transfer of health care personnel around the world. An international "doctors job bureau" to match individual doctors' needs with those of different clinical settings is long overdue, as is the establishment of research or resettlement funds for doctors returning to the developing world.

I disagree with Dr Araya on one point; I do not believe that legislative controls are useful. Doctors are individuals who have the right to search for and establish a lifestyle of their own. Many doctors from the Indian subcontinent would return home if the right opportunity arose. In place of coercion we need recognition of our difficulties and help to establish means to return home. The only other recourse would be to stay in the West, or return home to full-time private medical practice.

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Reference

PATEL, V. & ARAYA, R. (1992) Trained overseas, unable to return home: plight of doctors from developing countries. *Lancet*, 339, 110–111.

Audit in the psychiatry of learning disabilities

DEAR SIRS

We were interested in Carpenter & Kanagaratnam's account of group audit in the South Western Region (*Psychiatric Bulletin*, February 1993, 17, 91–92). Given the complex needs of adults with learning disabilities (LD), regional audit with specialist peers is complementary to local audit activities with multi-disciplinary teams and general psychiatry colleagues. Since 1990, our four-monthly Psychiatry of LD Sub-speciality Committee meetings have included a two hour audit session attended by all consultants and senior registrars in the South East Thames region.

Initially, case-notes were peer-reviewed using a specially designed audit questionnaire to compare the quality of note-keeping, clinical assessment and management practices. We record essential socio-demographic, historical, functioning and management data but have difficulties applying the ICD-9/10 and DSM-III-R diagnostic classification to clients' diverse mental health needs (MHN). Peer-review of previously audited case-notes assesses the implementation of clinical management plans and evidence for client and carer satisfaction.

Specific audit projects completed include a regional survey of depot neuroleptic usage, pilot survey of services for adults with LD and MHN, and a district survey of GP satisfaction. Current projects include a regional survey on use of the Mental Health Act and district audit on the appropriateness of referrals. Our pilot survey revealed a lack of specific data on service-users and we are currently undertaking a regional survey of health and social care services for adults with LD and MHN.

We agree that establishing regional audit requires a well-attended and supportive peer-review group with individuals willing to coordinate audit projects. Our current audit cycle difficulties also concern agreeing and revising process standards for the assessment and care of specific client groups. Future hospital and community audit projects could include less well-defined client groups such as those with depression, schizophrenia, dementia or challenging behaviours. Audit should also demonstrate that our interventions maintain or improve the functioning and quality of life for clients with various MHN (Gravestock *et al*, 1991). Given that many clients have multiple chronic health and social care needs,