Senior emergency department staff also need mental health training

As a junior doctor who has moved to psychiatry after previously spending 2 years training in emergency medicine, I read Dr Gordon’s article with interest.1 The survey clearly highlighted a need for mental health training of new doctors working in the emergency department. During one of my training posts in emergency medicine, I completed an audit which showed that 75% of patients presenting to the department with self-harm were being seen by junior medical staff and highlighted the need for increased training and supervision of junior emergency department doctors. In addition, many such patients present out of hours when access to senior support and psychiatric services may be more limited.

I think that it is also important to consider the knowledge, skills and attitudes of senior doctors working in the emergency department. Assessment and treatment of the patient presenting with self-harm and behavioural disturbance does form part of the College of Emergency Medicine curriculum. However, in my experience, many senior doctors working in emergency medicine – with some exceptions – have little interest in assessing and treating patients who present with self-harm or other mental health problems. As my audit showed, many such patients are left to junior doctors to see. When asked for advice about such patients, a common response from senior doctors is to advise that the patient should be referred to ‘psych’, without any meaningful discussion or assessment of the patient; this is in contrast to patients presenting with other problems such as trauma or minor injuries, when a senior doctor may show more interest in seeing the patient and teaching their junior staff.

It would be beneficial for patients if links between emergency departments and psychiatric liaison services were improved and if increasing the amount of mental health training available for all grades of doctors working in emergency departments was considered.

This issue has potential effects on patient safety, which is substantiated by a third of foundation year 1 respondents in the British Medical Association’s study reporting that they had been asked ‘to undertake tasks which they felt were beyond their capabilities’ during their placements.2

In our own work, we expressly aimed to target this situation, consequently designing and implementing a simulation-based programme as part of the induction process of our trust. Simulation-based training has been recommended as a risk-free and efficient way of improving the quality of junior doctors’ training.3 Junior doctors new to psychiatry participated in a range of complex, clinical, out-of-hours simulated scenarios under the observation of experienced consultants and patient representatives. Timely focused feedback was given by the observers, and the doctors had an opportunity to discuss their performance within clinical supervision sessions using recorded video. We received positive feedback from the participants, including a self-reported increase in their confidence when this was measured in follow-up sessions. They also felt that this would have an impact on their performance with real patients. The patient representatives gave a unique viewpoint and they felt that there were clear improvements in trainees’ performance following the first session.

We recently presented our small-scale pilot in a London Deanery ‘Quality and innovation’ conference, where it was well received. It generated interest from other trusts that were keen to potentially implement similar programmes locally.

We ultimately hope that our project will be used to increase and focus supervision in out-of-hours work, while also improving patient safety using engaging and interactive learning through simulation.

1 Gordon JT. Emergency department junior medical staff’s knowledge, skills and confidence with psychiatric patients: a survey. Psychiatr 2012; 36: 186–8.

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Simulation training: a tool to improve junior doctors’ confidence

We read Dr Gordon’s paper1 with great interest as it echoes our own work while surveying the confidence of junior doctors new to psychiatry. Like Dr Gordon, we felt there was a specific need to combat their self-perceived lack of confidence, particularly in the out-of-hours environment, as often more senior supervision is based off site. However, we do feel that Dr Gordon’s recommendations for ‘mental health training of new doctors working in the emergency department’ should perhaps be expanded to all those new to psychiatry, as the identified difficulties are not unique to the liaison service.

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1 Gordon JT. Emergency department junior medical staff’s knowledge, skills and confidence with psychiatric patients: a survey. Psychiatr 2012; 36: 186–8.

2 British Medical Association. Cohort Study 2006: Medical Graduates (Third Report). BMA, 2009.

3 Temple J. Time for Training: A Review of the Impact of the European Working Time Directive on the Quality of Training. Medical Education England, 2010.

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CASC candidates need better preparation

Kashyap & Sule are right to express outrage at the low pass rates for the Royal College of Psychiatrists Clinical Assessment of Skills and Competencies (CASC), and concern over the difference between UK-trained candidates and those trained elsewhere.1 They offer good suggestions for improvement. However, by focusing on the examination itself rather than the quality of CASC preparation in UK postgraduate training programmes, their outrage may be misdirected.
The validity and reliability of multitrait Objective Structured Clinical Examinations (OSCEs) has been tentatively established. Despite the appeal of the long-case examination, it has poor interrater and test–retest reliability when systematically evaluated; its continued use in high-stakes professional examinations is difficult to justify. However, it is very concerning that many candidates are surprised when failing a supposedly objective examination after 3 years of practicing psychiatry. Can it be that so many intelligent and diligent psychiatry residents have a severe lack of insight into their own abilities? This seems implausible. It is more likely that postgraduate training programmes are failing to equip residents with the skills they need to pass the CASC. Given that these are predominantly consultation and interpersonal skills, it is difficult to escape the conclusion that residents receive inadequate feedback on clinical skills in their initial years of practice, even before commencing formal preparation for the CASC.

The College dropping the Part 1 OSCE shifted responsibility for evaluating first-year residents’ core clinical skills to postgraduate training programmes by means of the workplace-based assessment (WPBA) system. This approach is not effective: there are multiple flaws in the current WPBA system and its suitability for assessing and developing core clinical skills is even more questionable than the long-case examination. These observations are supported by our own experience of delivering CASC training: many candidates are surprised to receive in-depth feedback on difficulties in interpersonal and consultation style. After 3 years of practising psychiatry to their best of their ability with little criticism or coaching, it is no wonder that they are disappointed when the first piece of negative feedback they receive is failing the CASC. This affects UK-trained and non-UK-trained residents alike and to focus on discrepancies detracts from the issue that the current pass rate is too low for all candidates.

This leads us to the conclusion that a substantial share of responsibility for low CASC pass rates lies not with the Royal College of Psychiatrists, but with the postgraduate training programmes. It is of course important that the CASC is continuously evaluated and improved, but there are more pressing issues. First, we suggest that training programme directors collect and publish data on CASC pass rates and urgently improve support and training for residents at risk of failing. Second, preparation for the CASC must start in the first year of psychiatric practice, in the form of in-depth consultation skills training beyond the WPBA system. Finally, we recommend that current and prospective psychiatry residents use all available information regarding the quality of clinical skills and CASC training when choosing a postgraduate training programme.

Declaration of interest
A.T. and D.H. deliver CASC revision training although do not profit from it. D.H. is author of Deconstructing the OSCE, due to be published in 2013 by Oxford University Press.

1 Kashyap G, Sule A. MRCPsych CASC exam: is there a better choice? Psychiatrist 2012; 36: 197.
2 Hodges BD, Regehr G, Hanson M. Validation of an objective structured clinical examination in psychiatry. Acad Med 1998; 73: 910–2.
3 Leichner P, Sisler GC, Harper D. A study of the reliability of the clinical oral examination in psychiatry. Can J Psychiatry 1984; 29: 394–7.
4 Menon S, Winston M, Sullivan G. Workplace-based assessment: attitudes and perceptions among consultant trainers and comparison with those of trainees. Psychiatrist 2012; 36: 16–24.
5 Kahn MJ, Merrill WW, Anderson DS, Sz尔sz MP. Residency program director evaluations do not correlate with performance on a required 4th-year objective structured clinical examination. Teach Learn Med 2001; 13: 9–12.

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The need for age-appropriate forensic services

Dr Connolly has rightly pointed out that planning for the development of mental health services requires an understanding of the changing demographics in the country. We feel that the complex needs of elderly mentally health services. In addition, they may have visual impairment, auditory impairment, mobility problems and cognitive impairment. Currently, forensic mental health units with long-term rehabilitation wards provide care for elderly individuals. This longer-term admission is usually due to ongoing risks combined with difficulties in rehabilitating this patient group because of ‘institutionalism’ or ongoing mental health issues. We wondered whether such units were equipped to be able to deliver care for older individuals with increasing physical comorbidities or those who develop certain organic conditions such as dementia. Another issue that needs consideration is the use of risk assessment tools such as Historical Clinical Risk Management 20 (HCR-20) in the older age group in forensic units that are generally used for working-age individuals. It is our view that the current psychological treatment programmes such as the sexual offending treatment programme will need modifications for this client group.

We feel that the complex needs of elderly mentally disordered offenders appear to fall within the domains of geriatric psychiatry services and forensic psychiatry services, but they may not be met by either service alone. Consideration should be given to setting up specialist tertiary forensic geriatric psychiatry. There has been some initiative in the independent sector in this matter.

1 Connolly M. Futurology and mental health services: are we ready for the demographic transition? Psychiatrist 2012; 36: 161–4.
The psychiatrist and the interpreter

I am glad to see such a positive response to the editorial on interpreting practice. Psychiatry and speech and language therapy are two of the most challenging areas of practice for interpreters.

Australia has an honourable tradition in the field of language support for its diverse population, as I experienced in New South Wales a few years ago. Andrew Firestone’s description of using a triangular seating arrangement but having changed to sitting the interpreter next to him is interesting. I have found that if I sit next to either the clinician or the patient, problems in the doctor–patient relationship can still occur. If closer to the patient, it is more likely that they will address questions directly to me, trying to draw me in ‘on their side’, such as ‘Are you married?’ or ‘Do you have children?’ If closer to the clinician, my impartiality can seem to the patient to be compromised.

In the UK almost all interpreters in the public sector are independent freelance workers. Being seen by the service user as directly employed by a state institution, whichever it is, can cause them to distrust our interpretation, especially if they have arrived from a totalitarian state. Seating the interpreter at the apex of an isosceles triangle, in which the clinician and patient are closest together and directly facing one another, allows eye contact to be maintained between them, and keeps the interpreter out of direct line of sight. Interpreters who are still occur. If closer to the patient, it is more likely that they will address questions directly to me, trying to draw me in ‘on their side’, such as ‘Are you married?’ or ‘Do you have children?’ If closer to the clinician, my impartiality can seem to the patient to be compromised.

In the UK almost all interpreters in the public sector are independent freelance workers. Being seen by the service user as directly employed by a state institution, whichever it is, can cause them to distrust our interpretation, especially if they have arrived from a totalitarian state. Seating the interpreter at the apex of an isosceles triangle, in which the clinician and patient are closest together and directly facing one another, allows eye contact to be maintained between them, and keeps the interpreter out of direct line of sight. Interpreters who are taking notes will be busy with their notebooks and not available for eye contact. They still need to be able to see the speakers’ faces, of course.

It would be interesting to know whether interpreters and clinicians maintain direct speech during clinic sessions, such as ‘How are you feeling?’ rather than ‘Ask her how she feels’. This is another way of keeping the interpreter out of a direct relationship with either party during the interview. It is very important that the interpreter introduces themselves and briefly explains how they work, at the beginning of the session. This, and everything else that is said, should be done in both languages. If the patient is reminded at the outset that ‘I will interpret everything I hear’ and ‘I will speak to you as the doctor does, with “I” and “you”,’ they are his words’, ownership of what is said remains with the primary interlocutors, not the interpreter.

Death and risk in adolescent anorexia nervosa

Responding to Robinson’s article on avoiding hospital deaths from anorexia nervosa, the most helpful context to consider this in relation to teenage patients is to place it within a broader concern about risk. Robinson states that a ‘very unwell’ patient should be admitted, but crucially, the definition of that is still not sufficiently clear. How risk is perceived, including what is severely disabling as well as what may be ‘life-threatening’, is a key issue.

Using death certificate data provided by the Office for National Statistics about 18 years ago, I observed 112 certified deaths in England and Wales over a 5-year period; however, only 7 of these individuals had been below their 18th birthday. Notwithstanding the uncertainty of death certificate methodology, in this instance, suggested by the observation that a third of the 112 deaths had occurred after the person’s 65th birthday, these 7 deaths approximate to only around 1 in 5000 adolescents with anorexia — an important finding to set in context fears about these young patients.

That death-data enquiry had been to establish a better empirical understanding about risk following our team’s decision (which I supported) to recommend the de-commissioning of a psychiatric in-patient unit that had often provided long-term treatment for teenagers with anorexia. It had previously participated in the UK’s first prospective multicentre study of adolescent psychiatric admissions, which demonstrated disappointing treatment effects for those with anorexia nervosa. But without such a facility, might there be a local increased risk of fatal outcomes for this condition? Reassured that the probability of death was unlikely to be significantly increased by closing the unit, a substantial change in practice was possible, relocating therapeutic skills to enhance outpatient treatment capacity. Gower et al’s subsequent treatment study confirmed our view that without hospitalisation the disorder should not usually be regarded as hard to treat, untreatable or life-threatening.

Declining death rates observed for anorexia nervosa over the past two decades have been attributed to its more effective and earlier introduced treatment, but not necessarily because the treatment was hospital based. A careful review of the literature provides two less prone to grab media headlines than premature deaths. First, in adolescence at least, chronicity rather than death is by far the more likely adverse outcome of failing to effectively treat the condition. In comparison with adults, in whom medical complications are not uncommon and excess mortality rates have been observed compared with the normal population, the only significant medical complication (as opposed to biological adaptation to starvation) during adolescence is progressive loss of bone mineralisation. Yet published studies on adolescent admission imply that hospitalisation was most often considered essential.
to avoid a youngster’s possible death, not to divert them from a pathway into chronicity. The COSI-CAPS multicentre study of adolescent psychiatric hospitalisation is particularly instructive in throwing light on how risk in these patients is constructed.\textsuperscript{5} Anorexia nervosa was the single most frequent diagnosis at admission (108/403 patients); only a sixth of those patients were detained but two-thirds nevertheless were considered at risk to themselves. The cohort was disproportionately White, female, aged 15–17, living at home, and with an over-representation of single parents. The body mass index (BMI) of all patients with anorexia on admission was within the ICD-10 diagnostic threshold (of 16, for adults), but most were not far below it (14.8; s.d. = 1.8, n = 108, 95% CI 14.3–15.4). Since the normal range of BMI for adolescents aged 15–17 is also less than for adults, it seemed that a relatively low threshold for admission was occurring.

This study had usefully included a number of independently provided units (private hospitals), accounting for a third of their non-eating disorder cases. Such youngsters were significantly less likely to have been receiving any psychiatric treatment before admission (P < 0.001), emphasising the part community concerns play in hastening hospitalisation. In short, the second lesson taught me that risk often seems to have been ‘socially constructed’ rather than medically evidenced, a concept developed by Mary Douglas, the distinguished anthropologist who died last year. This concept has also been important for the support I provide to clinical practice in remote and rural communities.

Robinson posed questions for further research, for example: (1) how to manage severely physically ill patients who resist nutritional treatment; and (2) what is the best model of cooperative care between medical and specialist psychiatric services. In my experience, any request for medical care of these patients must be very carefully defined, usually circumscribed to stabilising metabolic problems. Nasogastric feeding is not required for that, however self-evident the case might seem for rapidly improving poor nutritional state (it does not directly stabilise a patient’s illness and might instead produce other medical problems, as I have observed and Robinson has indicated, as well as to adversely affect the therapeutic alliance).

Addressing his question on ‘how to manage severely physically ill patients who resist nutritional treatment’, my experience suggests that it is important to distinguish between what is being ‘resisted’: normalising metabolism, restoration of metabolic rate in particular (since this directly affects cognition, mood and exercise intolerance), or the additional caloric requirement to improve absolute weight gain or BMI, which frighten these patients. Teenagers often develop anorexia nervosa in response to otherwise unaddressed, perhaps previously unrecognised, psychological distress (problems that might have first resulted in compensatory overeating and excessive weight gain). So nutritional treatment addressing metabolic rate, and thus general well-being, is a far more readily agreed first treatment goal between the patient and their professional carer. Securing collaborative care is an unarguable vital step towards eventual recovery.

1 Robinson P. Avoiding deaths in hospital from anorexia nervosa: the MARSIPAN project. Psychiatrist 2012; 36: 109–13.

2 Gowers SG, Clark A, Roberts C, Griffiths A, Edwards V, Bryan C, et al. Clinical effectiveness of treatments for anorexia nervosa in adolescents. Randomised controlled trial. Br J Psychiatry 2007; 191: 427–35.

3 Rothery DJ, Wrate RM, McCabe R, Aspin J, Bryce G. Treatment goal-planning: outcome findings of a British prospective multi-centre study of adolescent inpatient units. Eur Child Adolesc Psychiatry 1995; 4: 209–21.

4 Reas DL, Kjelsås E, Heggestad T, Eriksen L, Nielsen S, Gjertsen F, et al. Characteristics of anorexia nervosa-related deaths in Norway (1992–2000): data from the National Patient Register and Causes of Death Register. Int J Eat Disord 2005; 37: 181–7.

5 Tulloch P, Lelliott P, Bannister D, Andiappan M, O’Herlihy A, Beecham J, et al. The Costs, Outcomes and Satisfaction for Inpatient Child and Adolescent Psychiatric Services (COSI-CAPS) Study. NCCSD, 2008.

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Author’s response: I am grateful to Dr Wrate for raising the issues he has. I would point out, first, that the Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN) report\textsuperscript{1} was intended for clinicians caring for adult patients over 18 with severe anorexia nervosa. It was clear during the preparation of MARSIPAN that a further document for children and adolescents was required. The work was done and the junior MARSIPAN report\textsuperscript{2} is the result. I think that the main issue raised by Dr Wrate, namely the appropriateness or otherwise of specialist hospital care for children and adolescents with anorexia nervosa, needs to be addressed by a child and adolescent psychiatrist such as those involved in the junior MARSIPAN report. However, I should be grateful if I could comment on some of the other issues discussed in the letter.

Assessing whether a person is at a risk high enough to warrant hospital treatment is one such problem. In adults, current opinion suggests that a body mass index (BMI) of <13 kg/m\textsuperscript{2}, electrocardiographic abnormalities, low potassium (especially <3.0 mmol) and severe anorexic myopathy constitute a serious threat to life. In one study, the patients who died from malnutrition had BMI between 9.1 and 12.9.\textsuperscript{3} In adolescents, junior MARSIPAN recommends that a BMI <0.4th percentile indicates high (‘red’) risk. This turns out to be more conservative, as a BMI at the 0.4th percentile in a 15-year-old is 15. I hope that my child and adolescent psychiatrist or physician colleagues will take the opportunity to give a view on this. From my practice, the most reliable sign that a patient requires admission is when I feel my own heart sinking. This usually accords with the high-risk parameters in the patient, quoted in the MARSIPAN report.

Dr Wrate correctly notes that the past two decades saw a decline in death rates for anorexia nervosa, but argues that this is due to the fact that treatment is now more effective and introduced earlier, not necessarily because it is hospital based. It is uncertain whether patients presenting with very high risk would have similar survival rates outside hospital with community care. The Scottish Anorexia Nervosa Intensive Treatment Team (ANITT; www.anitt.org.uk) provides community care for adults of very low weight, but no evaluation of that or any other similar service has been published, nor are there randomised trials of care in this very high-risk group of (adult) patients.

On the question of chronicity, Dr Wrate identifies progressive loss of bone mineralisation as the only significant
medical complication of adolescent anorexia nervosa. However, I am aware of many reports of serious complications such as irreversible failure of linear growth, irreversible failure of breast development, and cardiac abnormalities in this patient group.4 Again, the views of my colleagues treating younger patients would be appreciated.

Another interesting point raised by Dr Wrate is that with regard to young people with anorexia nervosa, risk may be ‘socially constructed’. The implication is that if a risk is socially constructed rather than medically evidenced, it is related to the needs of individuals and systems such as the family and hospitals rather than a real risk of death. This may be true in many cases, especially if the usual risk factors are not too seriously impaired. However, I think it would be dangerous to apply it to the most seriously ill, for example a patient with a BMI of 10.

Finally, there is the issue of patients resisting nasogastric feeding as opposed to treatment as such. This is a complicated matter. The act of admitting a patient to a specialist eating disorders unit may well engender fury in the patient and a determination not to gain weight. On the other hand, the admission may have been appropriate because of their dire physical state. In adult eating disorder services there is varying opinion about whether a seriously ill patient ever requires nasogastric feeding. If a patient resists eating, as may be the case, the option is to provide nutrition against their wishes, often under the Mental Health Act 1983. This might involve forcing the patient to eat by restraining them and pushing food into their mouth. This may be ineffective, or so aversive to staff that nasogastric feeding may be preferred. Some have said that skilled nursing can always result in a patient accepting food, thereby avoiding nasogastric feeding. I suspect that the situation in which a patient’s life would be lost if forced feeding were not done is more commonly encountered in adults, as suggested by Dr Wrate. However, when it does occur, clinicians may be forced into more and more coercive treatment.

Occasionally, such treatment may not be short lived and there are, at present, several adult patients in units around the UK receiving forced nutrition, under the Mental Health Act, by nasogastric or percutaneous endoscopic gastrostomy (PEG) feeds for periods which can run to several years. This may be aversive to patients, staff and relatives, not to mention the enormous cost to the National Health Service (£1000 per day is not unusual in this situation), and merits audit and research.

1 Royal College of Psychiatrists, Royal College of Physicians. MARSIPAN: Management of Really Sick Patients with Anorexia Nervosa: Report from the MARSIPAN Group (College Report CR162). Royal College of Psychiatrists, 2010.

2 Royal College of Psychiatrists. Junior MARSIPAN: Management of Really Sick Patients under 18 with Anorexia Nervosa: Report from the Junior MARSIPAN Group (College Report CR168). Royal College of Psychiatrists, 2012.

3 Rosling AM, Sparén P, Norring C, von Knorring A-L. Mortality of eating disorders: a follow up study of treatment in a specialist unit 1974–2000. Int J Eat Disord 2011; 44: 304–10.

4 Katzman DK. Medical complications in adolescents with anorexia nervosa: a review of the literature. Int J Eat Disord 2005; 37 (Suppl): SS2–9; S87–9.

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From Rabone to reality

Large et al1 draw valuable attention to the flawed information on which the Supreme Court based its decision to uphold the appeal of Rabone against the Pennine Care NHS Foundation Trust,2 identifying a number of well-recognised biases that prompted the judges to overvalue the risk of suicide by a factor of 40.

Another significant bias that is often overlooked in post-hoc analyses of serious untoward events concerns the value framework of the assessor, described with precision by Kahneman & Tversky.3 Expert witnesses, although owing a primary duty to provide valid information to the court, are nevertheless instructed by legal professionals who are obliged to adopt either a defensive or offensive stance given the inherently adversarial nature of the legal system. The differing value frameworks that this provides are evident in the discrepancy in the evaluations of the ‘immediate risk’ posed by Ms Rabone of between 70% (as estimated by the claimants) and 20% (as estimated by the defendants). That such a spectacular discrepancy might point to the meaninglessness of a numerical approach seems to have escaped consideration.

Instead, deferring to the expert status of the witnesses, the Court appears to have dealt with this variance by taking the most conservative figure as the valid baseline for their consideration.

The judgments derived from such flawed considerations do little to help those who daily face the difficult task of attempting to ‘second guess’ (i.e. to anticipate) the intentions and behaviours of a mind disturbed by what the Court termed ‘a recurrent depressive disorder’.

Most mental health professionals appear to agree that a sincere wish to die is one of the less common reasons for the issue of a suicidal threat.4 Unless such considerations are taken into account by those who define the laws by which our best practices are shaped and defined, misinformed legalism will continue to exert an increasingly demoralising effect on those who do their best in a very difficult situation.

The present judgment will, in all likelihood, lead to an increase in the detention of individuals with depression against their wishes in services that, especially in the current social and economic climate, may not be as well equipped to reduce risk (in either the short or long term) as either judges or the general public may like to think. Practical measures derived from ethics and common sense may be of more help here than actuarial procedures.

Ms Rabone appeared to had given a clear commitment not to self-harm at the time of her departure. It is unclear how much weight was given to this fact by the Court, but it presumably carried considerable weight in the mind of the unfortunate psychiatrist who granted her informal leave. A useful standard by which to judge the wisdom of such a decision might involve contemporary recording of unequivocal evidence of future orientation. At its simplest, this could comprise clear recording of the patient’s agreement not to act on impulses of self-harm, accepted as valid regardless of the private discomfort of those involved, alongside an equally clear recording of the patient’s agreement to return to care at a clearly agreed place and point in time. All individuals failing these tests should be subject to consideration for legal detention.
To this, a prudent psychiatrist might add a written note setting out the grounds for his or her decision, relating the individual circumstances of the case at hand. Such an entry in the case notes made at every significant point during the patient’s progress would be time consuming and might read, in effect, as an open letter to a future court, but its use would seem to be the most appropriate response to the judgment handed down by the Supreme Court on this occasion.

1 Large M, Ryan CJ, Callaghan S. Hindsight bias and the overestimation of suicide risk in expert testimony. Psychiatrist 2012; 36: 236–7.

2 Rabone v. Pennine Care NHS Foundation Trust [2012] UKSC 2.

3 Kahneman D, Tversky A. Choices, values and frames. Am Psychol 1984; 39: 341–50.

4 Salter M, Turner T. Community Mental Health Care: A Practical Guide to Outdoor Psychiatry; 203–24. Churchill Livingstone, 2008.

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