

creative solutions for recruiting a higher proportion of both male and female graduates into psychiatry.

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Internet peer review

Sir: I was interested to read Dr Mortimer's letter in this month's *Psychiatric Bulletin*. She puts the case for Internet peer review very strongly. Internet peer review is a very successful idea and has been used in the International Journal of Psychiatry, *Psychiatry On-Line*. We have been publishing entirely Internet peer reviewed papers and articles since 1994. Your readers can find us on the following URL:
<http://www.priory.co.uk/journals/psych.htm>

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Disulfiram implantation

Sir: We describe the results of disulfiram implantation over a five year period within clinical practice at an alcohol service at a district general hospital.

The pharmacological basis of usage of disulfiram lies in its action on alcohol dehydrogenase preventing breakdown of acetaldehyde in the metabolism of ethanol. Early uncontrolled studies of disulfiram implantation showed significant improvement in abstinence and social functioning (Malcolm & Maddens, 1973; Whyte & O'Brien, 1974). More recent placebo-controlled studies have consistently shown no differences between placebo and active treatment groups with regard to a wide set of alcohol-related variables (Borg *et al*, 1985; Johnson & Morland, 1991).

We reviewed the case notes of all patients ($n=12$) treated with disulfiram implants at Princess Alexandra Hospital between 1989 and 1994. All patients were seen by one psychiatrist (OJD), and implantation under one surgeon (MWM). Patients were encouraged to take oral disulfiram for 8 to 12 weeks prior to implantation. They were given an explanation of the mode of action of disulfiram before the medication was prescribed and gave informed consent. The 'challenge' approach was not used. Implantation took place under local anaesthetic, placing 6 tablets of disulfiram 100mg into each iliac fossa using a trochar and cannula via a sub-umbilical incision.

Baseline data showed that the number of previous alcohol-related admissions ranged from 0-20 with median value 3.5. The patients with implants were at the more severe end of

alcohol dependence considering the length of drinking prior to implantation (range 5-32 years, median 19), brief lengths of abstinence (range 0-24 months, median 6), amount (range 50-560, median 155 units/week) and frequency (range 3-7 days per week, median 7) of consumption.

Comparison, prior to and post-implant, showed reduced consumption and increased abstinence within the post-implant group. The liver indices also showed improvement. Analysis using Wilcoxon signed ranks tests showed significant decrease in units being drunk per week ($P<0.02$) and in number of days spent drinking per week ($P<0.03$). The outcome, to date, of this sample revealed six patients abstinent, four still drinking with little change in consumption, one had medical complications and one dead of an accidental overdose.

This sample has apparently benefited from disulfiram implantation, with half the patients having a good outcome. There were no skin complications noted. The criteria for selection for implantation were not constant, as seven patients requested implantation and it had been offered to the remainder when compliance with oral Antabuse was difficult. There is little doubt that implantation has a powerful placebo effect which is extinguished if patients are aware of a chance of receiving placebo (Johnson & Morland, 1991). The question remains whether it is ethically appropriate to use minimal amounts of disulfiram within an inert carrier to achieve similar results, if so then this should be offered to those requesting this treatment.

- BORG, S., HALLDIN, J., KYHLHORN, E., *et al* (1985) Results from a placebo controlled multicentre trial. In *Pharmacological Treatments in Alcoholism: Withdrawal and Aversion Therapy*, pp. 56-88. Uppsala, Sweden: National Board of Health and Welfare.
- JOHNSON, J. & MORLAND, J. (1991) Disulfiram implant: A double-blind placebo controlled follow-up on treatment outcome. *Alcoholism: Clinical and Experimental Research*, **15**, 532-536.
- MALCOLM, M. & MADDENS, J. (1973) The use of disulfiram implantation in alcoholism. *British Journal of Psychiatry*, **123**, 41-45.
- WHYTE, C. & O'BRIEN, P. (1974) Disulfiram implant: A controlled trial. *British Journal of Psychiatry*, **124**, 42-44.

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Terminology

Sir: Can I invite you to withdraw your apology in relation to the word "dement". Although it is always more politically correct to preface a group of patients by the phrase "patients suffering from

XXX" the word dement to describe a patient suffering from dementia is no different from the terms arthritic, cardiac, schizophrenic, and depressive, and bears no comparison with abusive descriptions like "schizos" and "psychos" as suggested by Dr Manchip. The use of a term to describe a group of patients should not be taken as "dehumanising and derogatory" but tells us much more about the attitudes of those who object.

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GMSC guidance to GPs

Sir: The General Medical Services Committee (GMSC) has recently issued guidance to general practitioners (GPs) in respect of their responsibilities for the assessment and continuing care of patients with mental disorders (*British Medical Journal*, 1996). The guidance implies that GPs have fulfilled their obligations after having assessed and referred a patient to specialist psychiatric services. The latter are then expected to assume responsibility for prescribing and administering of any psychiatric medication, with the GP remaining responsible for prescribing for conditions unrelated to mental illness.

We agree that, in most cases, it is not appropriate for a GP to act as a keyworker under the care programme approach, but their involvement in such cases is nonetheless invaluable. This has traditionally included not only monitoring the patients' mental state and prescribing drugs but also, for example, providing emotional support to their families and administering depot neuroleptics. The removal of prescribing responsibility would inevitably lead to an eventual withdrawal of these "psychiatric primary care services", to the detriment of a particularly vulnerable group of patients.

GPs prescribe on FP10s on the recommendation of consultants from other disciplines. They may disagree with the specialist advice received but presumably, in most cases, are content to comply with it, whilst retaining some overall clinical responsibility for the patient. GPs would also expect to monitor their patients' progress between hospital appointments. We question why psychiatry has been singled out to be the exception; psychiatric management should be no different in this respect and the fact that the GP would not be the key worker is surely irrelevant.

We believe that the GMSC guidance is potentially divisive. It does nothing to encourage the notion of shared care between primary and specialist care and has significant resource

implications for over-stretched hospital or community trusts. An increase of referrals to specialist care may be expected as fund-holding practices seek to transfer the financial burden of prescribing. In response, psychiatrists may feel compelled to discharge patients prematurely back to their GP.

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BMJ, 312, 583.

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The Patient's Charter for Mental Health Services

Sir: The Patient's Charter for Mental Health Services is currently a draft edition for consultation. It is a 22 page booklet, informing patients how "the rights and standards in the Patient's Charter apply to people using NHS adult mental health services".

We have serious concerns about the Charter. We understand that it was written in consultation with users of the service. We see little evidence of consultation with mental health professionals in its preparation.

There appears to be a great disparity between what the Charter offers and what, in our experience, is currently available. One striking example is the expectation that a mental health nurse will visit within four hours if a patient is referred as urgent, and within two working days if the referral is non-urgent. The description of a referral as urgent is not clarified, raising the question of what is urgent – a panic attack or florid psychotic episode? Moreover, who will identify a referral as urgent? This will be a source of potential conflict between the patient, the GP and the mental health team. Further conflict may stem from exploitation of the Charter. In the hands of a manipulative patient it could jeopardise genuine therapeutic strategies such as boundary setting.

We find the document inconsistent in both its attention to detail and its philosophy. Some standards are specific, some are vague. We quote from the draft edition of the Charter by way of example: "You can expect a home visit within a two-hour time band" yet "You can expect to be told what treatments are available other than medication". Turning to the philosophy of the Charter, there is a curious mix of paternalism and user empowerment. Again, quoting from the Charter: "Prior to discharge . . . you will be told what to do, and who to contact in the event of problems" whereas "You have the right to be referred to a consultant acceptable to you". Statements such as these have far reaching implications.