A verdict of accidental death was recorded in 31 of the 150 paracetamol deaths where an overdose was taken but death was not thought to be the intention. The most effective way of preventing these deaths would be to convince people never to exceed the manufacturers' dosage recommendations. To achieve the same objective by the addition of methionine to all paracetamol products would be difficult because of formulation difficulties involving a very large number of products and different manufacturers. Furthermore, is it certain that the consumption of more than the daily requirement of methionine in this combination would be safe for all the more than 20 million adults in the United Kingdom who currently consume paracetamol each year without harm?

Certainly it will be disappointing if the number of deaths due to paracetamol overdosage continues at the current level, but it would be wise to recognise that in 1990 in England and Wales there were a further 1593 deaths due to overdosage of medicines other than paracetamol and that the prevention of such deaths should receive at least equal attention.

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1 Bray GP. Liver failure induced by paracetamol. *BMJ* 1993;**306**: 157-8. (16 January.)

Treating mentally ill people in the community

EDITOR,—Robert Bluglass suggests that brief readmission to hospital to extend leave of absence, a practice declared unlawful in England, persists "under Scots law."[1] Unfortunately, the situation is far from clear. The only reported appeal in Scotland against liability to detention while on leave of absence concerned a patient who was spending three or four days at home each week.[2] The sheriff (a judge in Scotland) dismissed the appeal on the ground that at least some inpatient treatment was actually, and not merely potentially, required at the time the appeal was heard. He went on to say that this was an essential requirement to justify continued detention under the Mental Health (Scotland) Act 1984.

No reported appeal by a patient in Scotland has exactly mirrored the circumstances of the case in England to which Bluglass refers. I suspect that any such appeal would be successful. The statutory form that a responsible medical officer must complete to extend detention (whether or not the patient is on leave of absence at the time) refers unambiguously to the need for treatment in hospital. Any legal reform on this matter introduced in England will equally be necessary in Scotland.

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1 Bluglass R. Maintaining the treatment of mentally ill people in the community. *BMJ* 1993;**306**:159-60. (16 January.)
2 Blackie J, Patrick H. *Mental health: a guide to the law in Scotland.* Edinburgh: Butterworths Scottish Legal Education Trust, 1990.

EDITOR,—Robert Bluglass sets out the views endorsed by the Royal College of Psychiatrists concerning community mental health legislation.[1] These proposals add little to existing, though rarely used, provisions for guardianship under the Mental Health Act 1983.

The purpose of community intervention is not simply to observe but to ensure that treatment is sustained for those whose illness, in terms of either severity or nature, warrants this. A supervision order allows for close observation but requires evidence of deterioration before action can be taken in the form of recall to hospital to restart treatment. This may well be appropriate for some patients but falls short of securing treatment for others whose relapses may be abrupt and catastrophic.

The current use of restriction orders (section 41) circumvents this problem and has not led to abuse. Many patients who thereby benefit from continuation of treatment as a condition of discharge from hospital are able to resume relationships and activities that would be hazardous without such treatment. Since the order can be made only by a crown court after prosecution for a serious offence, a considerable number of patients, who are equally dangerous or vulnerable, are denied this provision. So too are their families, who are then subject to a greater burden of care, stress, and risk.

A commitment to statutory provision of treatment in the community would represent a considerable advance in health care. A commitment to statutory provision alone fails those most at risk.

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1 Bluglass R. Maintaining the treatment of mentally ill people in the community. *BMJ* 1993;**306**:159-60. (16 January.)

EDITOR,—Robert Bluglass seems to bypass the essential problem in community care of mentally ill people—namely, chronic schizophrenia in which insight is lost.[1] This loss of insight—part of the intrinsic schizophrenic defect state—causes such loss of judgment that the sufferers, given the choice of non-compliance, will refuse to comply with treatment simply to assert their freedom. If they could but appreciate it there is ample evidence from their repeated admissions of the deterioration, often with antisocial consequences, that results from stopping drug treatment.

Under the Mental Health Act 1959 patients maintained on guardianship orders knew that drug treatment could be enforced and therefore appeared regularly for depot injection on the right day and at the right time without pressure or demur. They retained their status, and often jobs, in the community, and tension among relatives was relieved.

The essential weakness of the guardianship provisions under the 1983 act (sections 7 and 8) is that the guardian has the power to enforce attendance for treatment but not treatment itself. All that is needed is two alterations to sections 7 and 8 of the current act. Guardianship should be either to social services as now or to hospital managers. Section 7(5) of the act should be strengthened to put the hospital managers on a par with the local social services authority. The clause "and receive such medical treatment" added to section 8(1)(b) would then make medical treatment compulsory in the community. Those who believe that such insistence would "infringe civil liberties"[1] should appreciate that this liberty is valueless if wise judgment is so impaired by lack of insight that sufferers from the underlying illness can use this liberty only to their detriment.

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1 Bluglass R. Maintaining the treatment of mentally ill people in the community. *BMJ* 1993;**306**:159-60. (16 January.)

EDITOR,—The renewed enthusiasm shown by the secretary of state, and now the Royal College of Psychiatrists,[1] for extending the coercive powers of psychiatry in dealing with the problems consequent on chronic underfunding of community care and the shortcomings of institutional psychiatric practice is regrettable. The argument that, with compulsory supervision, mentally ill people in the community may be offered better service is dubious.

Instead of advocating greater restrictions and sanctions on "mentally ill" people, perhaps the current debate should address the fundamental contradiction that has become all too apparent in contemporary psychiatric practice: the contradiction between care and control, cure and coercion. Professional views of mental illness, especially when manifested in the public realm, continue to be based on nineteenth century ideas about madness as something that should be brought under control and removed from the public gaze. When madness cannot be contained, or attempts to control it fail repetedly in spite of various changes in mental health policies, the answer is sought in greater powers of control and surveillance, now extended into people's homes and the community at large.

Institutional psychiatry with its reliance on hospital treatment has clearly failed and this predates the advent of community care in this country. The notion that hospital care must remain an essential part of mental health provisions is therefore open to challenge. Our work in Ladywood in Birmingham has shown that in the acute care of severely mentally ill people through home treatment, hospital admission can be avoided in four out of five cases. The key to our success is the recognition by users and their families that we avoid notions of coercion and forcible treatment, that psychiatric practice involves more than ensuring compliance with medication. Similar research elsewhere leads to better overall outcome in the long term than does hospital admission.[2] These new beginnings within community care would be seriously compromised if institutional models, with their emphasis on compulsion and surveillance, are simply relocated in a different guise in the community as the power base of psychiatry, namely the asylums, is run down.

The use of compulsion in psychiatric care is not just a procedural, professional matter. There is good evidence to show that the Mental Health Act is used disproportionately against black people and other disadvantaged groups, and this element of social control that is invested in psychiatric practice is likely to be further strengthened and made more pervasive by the introduction of community supervision orders. Such a mental health "sus law," invoked on the basis of unreliable predictions of dangerousness, will bring psychiatric practice closer to policing and will undermine the attempts to achieve cure or care, both in hospitals and in community settings. Sadly, these arguments do not seem to be uppermost in the current discussions at Whitehall or in the Royal College of Psychiatrists.

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1 Bluglass R. Maintaining the treatment of mentally ill people in the community. *BMJ* 1993;**306**:159-60. (16 January.)
2 Hoult J. Community care of the acutely mentally ill. *B J Psychiatry* 1986;**149**:137-44.

Preoperative autologous blood transfusion programme

EDITOR,—Martin R Howard and colleagues report their experience of preoperative provision of autologous blood in the Northern region between December 1989 and November 1991.[1] Their project was preceded by a two year pilot study, also funded by Northern Regional Health Authority, from 1987 to 1989. The pilot study was based in Sunderland District General Hospital, and its results have been published[2,3] and presented at numerous international meetings. Howard and colleagues do not compare their results with those of the pilot study, to whose success they owe their funding.