Correspondence

Section 35—Remand to Hospital for a Report

DEAR SIRS

We write to describe some of the problems that can arise from the use of Section 35 of the Mental Health Act, 'Remand to Hospital for a Report'. The Report of the Committee on Mentally Abnormal Offenders (Butler Committee) published in 1976, recommended that legislative provision should be made for the compulsory detention of patients in NHS hospitals whilst on remand, for the preparation of reports from the Court. During the drafting of the 1983 Mental Health Act, this recommendation was supported by the Royal College of Psychiatrists and resulted in Section 35. However, the College also recommended that this Section should, under certain circumstances, allow for compulsory treatment. This latter proposal was considered inappropriate by the Home Office, and by Parliament, and thus Section 56 of the 1983 Act specifically excludes Section 35 from the provisions for compulsory treatment contained under Part IV of the Act. One can only treat a patient detained under Section 35, therefore, if he or she consents, and under no other circumstances, except those dictated by Common Law.

We recently saw a patient remanded in custody following a charge of arson with intent to endanger life. He had a long history of psychotic illnesses, frequently involving aggressive conflict with the law. However, no clear diagnoses had been made and his compliance with medication had been poor. The history suggested that the offence had been committed as a consequence of psychotic thinking, but the position was unclear and it was apparent that obtaining adequate documentation of his previous history was going to prove time consuming. As a consequence we felt it appropriate to admit him to the Mersey Regional Secure Unit on Section 35.

Following admission he refused to consent to any medication, became increasingly irritable and aggressive and ultimately quite severely assaulted a member of staff, making repeated threats of further assault and fire raising. The diagnosis by this time appeared to be recurrent hypomania in a paranoid personality. We were forced to treat him with major tranquillizers for the protection of others under Common Law.

Regrettably the crisis arose on a Friday and the nearest possible Court Hearing date was seven days after. Our dilemma, therefore, was that he required regular treatment for the period up until the Hearing, but refused his consent. Neither he, nor we, were afforded the protection of Part IV of the Act.

A discussion with the staff at the Mental Health Act Commission Office concerning a concurrent Section 2 or Section 3 was inconclusive, and it was considered that there was no precedent for either. However a medical member of the Commission pointed out that precedent was implied in the fact that it was possible to detain under Section 2 a relapsed patient on Section 37/41 to prevent the problems associated with recall. Accordingly we went ahead and implemented Section 2 in order that we might treat him under the three months provision. His response to medication was gratifying.

Unfortunately the opportunity to raise the issue in Court did not arise; he pleaded guilty to a reduced charge and the Hearing was very brief.

If such a case can arise and cause significant problems in a highly staffed Regional Secure Unit with a locked assessment ward, we wonder what the implications would be for a less secure setting. Unless the Commission formally sanctions such a course, or takes steps to make provision for treatment under Section 35, we feel that the apparent usefulness of the Section will be diminished by the impossibility of regular compulsory medication in similar circumstances.

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The adolescent services

DEAR SIRS

Dr Parry Jones' personal view of adolescent psychiatry (*Bulletin*, December 1984, **8**, 230–233) touches on important issues for the future of the Adolescent Services. He comments on the inadequacy of the overlap between adolescent and adult psychiatry, expresses doubts about the total integration of child and adolescent psychiatry and suggests that adolescent psychiatry should be a 'unique blend of the two'. Having been in the frontline of adolescent psychiatry for 17 years, I would like to argue that adolescent psychiatry is 'a blend between the three': child, adolescent, and adult psychiatry, placing each of them as separate specialties.

The integration of child and adolescent psychiatry, arguably desirable from the theoretical angle, has for the last several years been a clinical and practical anachronism and anomaly. Training in child psychiatry (or child psychotherapy) with a smattering of adolescence, in no way prepares one for dealing with disturbed adolescents of today. Moreover, the in-service experience that would enable child psychiatrists to develop expertise in adolescence is not available to them—most work is in the setting of the Child Guidance Clinic. Even those who work in in-patient children's units, which admit early and mid-adolescents, pass on the youngsters to a specialist Adolescent Unit if and when their behaviour fits into a matrix predicted as 'requiring specialist adolescent treatment'. Many child psychiatrists are embarrassed at being called specialists in the field. Yet all of them are counted as specialists in adolescence, giving an entirely erroneous impression of the specialty being well endowed, whilst the appalling neglect of appropriate training in adolescence continues.

The formal association of child and adolescence as a single specialty apart from general psychiatry has had far reaching

effects on the general psychiatric services. It has removed from general psychiatrists any motivation to direct interest towards a specialty so remote as child psychiatry, and with it adolescent psychiatry, creating an ever increasing gap between the two. Yet they have much in common—syndromes, dosage of medication and treatment methods using the verbal mode of communication, as opposed to play therapy used with children.

In practice, adolescent psychiatrists need the adult services; often for the continuation of treatment, sometimes for the sharing of in-patient facilities and expertise. Similarly, general psychiatrists need the adolescent services. There is a two-way relatedness between the two as opposed to a simple undirectional relationship between child and adolescent psychiatry. Having trained and talked with many general psychiatrists, I have no doubt that the adult services will be richly influenced by their understanding of adolescence. It seems as if an artificial barrier has been imposed between the two; as if the child has come between the adolescent and the adult.

Were adolescent psychiatry to be placed where it rightfully belongs—as a specialty in its own right—then formal recognition will be given to links that are realistically appropriate; early adolescence with child psychiatry and mid and late adolescence with adult psychiatry; the need for appropriate training in adolescence will be recognized, and much that is wrong with the existing confused and confusing adolescent service will begin to change.*

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* Psychiatrists working predominatly with adolescents in the London Region's (the Front-Liners) have formed a Group in order to discuss and understand matters pertaining to their work in adolescence. We have had three meetings, and hope to continue our discussions in the future. Anybody wishing to get in touch with us should contact one of the joint conveners: Dr J. E. Thomas, Consultant Psychiatrist, Tavistock Clinic, 120 Belsize Lane, London, NW3 5BA; or Dr K. S. Perinpanayagam, Consultant Psychiatrist, Brookside Young People's Unit, 107a Barley Lane, Goodmayes, Ilford, Essex, IG3 8XJ. The views expressed in this letter are those of the author and not necessarily those of the Group that has been formed.

The psychiatrist's role in treating patients with chronic pain

DEAR SIRS

Dr Stephen Tyrer's gloomy view of the psychiatrist's role in treating patients in chronic pain (*Bulletin*, July 1985, **9**, 135–136) may be explained by the following: it is inappropriate for patients with unexplained chronic pains to be treated in 'pain clinics' directed by anaesthetists, such clinics tend to create 'pain patients' who are prescribed a number of different treatments by the various specialists associated with the clinic. Better results are obtained when the patients are treated either by a psychiatrist or psychologist working in the clinic to which the patient presents.[1,2] I have been closely associated for six years with a Department of Oral and Maxillo-Facial Surgery and have had considerable success in managing patients with chronic facial pain with a combination of brief psychotherapy and tricyclic antidepressant therapy. We have also shown that tricyclic antidepressants have analgesic properties independent of any antidepressant effect.[2]

Furthermore, Dr Tyrer recommends the use of questionnaires such as the General Health Questionnaire and Anxiety and Depression inventories which may not be relevant to the study of patients with unexplained pain, as these case finding instruments and symptom rating scales do not adequately reflect the clinical picture shown by patients with chronic unexplained pain.[3] Psychiatric illness amounting to caseness may not always be detected in these patients, despite evidence of emotional problems such as an increased incidence of events.[2] Thus the limited role for the psychiatrist defined by Dr Tyrer is probably the result of the combination of inappropriate diagnostic criteria being used in inappropriate settings.

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Pre-registration house officer posts in psychiatry

DEAR SIRS

I read with interest the letter by Professor C. P. Seager (*Bulletin*, July 1985, **9**, 141–142), and congratulate him on the innovative attempt to improve early postgraduate training. It would seem an excellent means to offer experience in psychiatry which otherwise might not be gained, and no doubt it will attract a number of able candidates into our profession.

However, I would argue that four months each in medicine and surgery is wholly inadequate to gain skills necessary to last an entire professional life time. As a junior psychiatrist one has virtually sole responsibility for the physical well being of psychiatric in-patients, and the high incidence of either concurrent or causative organic disorder in patients presenting with psychiatric problems is well recognized.

Even after six months medicine and surgery, I myself feel poorly equipped—and judging by the fact that two out of four of Professor Seager's graduates intending to enter psychiatry have sought further medical experience, they also seem to feel on uncertain ground.

Further experience would remedy the lack of knowledge, but for many it is all too easy to be swept on in the post-registration single specialty stream; or worse, simply to remain blissfully unaware of one's ignorance.

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