the advantages of a larger regional centre, with fostering of interest and maintaining some expertise locally. All patients to be notified to the regional centre. Other recommendations are made concerning staff for the regional centres and it is suggested that this can be achieved by redeployment. It is also suggested that an adult physician, probably one with an interest in respiratory disease, should be identified to work with the cystic fibrosis paediatrician and joint adolescent clinics set up. Finally, the regional centres should pool data for research.

Overall, this is a very sensible compromise, but one wonders how it will work in practice. It always needs an enthusiast to deal with long term handicap and they are not always neatly arranged as hoped in these recommendations.

The report is perhaps particularly interesting for the Child and Adolescent Psychiatry Specialist Section as it illustrates a general problem of who will care for the adult long term handicapped and how will this be done.

March 1986

Correspondence

British psychiatrists in Canada

DEAR SIRS

Further to G. M. Green's article about British psychiatrists in Canada, (*Bulletin*, April 1985, **9**, 77–78) I would like to add to the comments of other correspondents on this subject.

In the Province of Ontario psychiatrists in mental hospitals have been in dispute with the Government for almost a year over working conditions and staffing levels among other things.

Because of this dispute we recommend that anyone applying for an appointment in the Ontario Psychiatric Hospital system should get information on the present status of this dispute. Contact Dr John C. Deadman, Ontario Psychiatric Hospitals & Hospital Schools Medical Staff Association, c/o Hamilton Psychiatric Hospital, Box 585, Hamilton, Ontario, Canada L8N 3K7.

JOHN C. DEADMAN

The Mental Health Act

DEAR SIRS

Dr L. D. Culliford (*Bulletin*, February 1986, **10**, 38) has pointed out one area of dispute where the Mental Health Act is less than clear and entrusts eventual clinical responsibility and interpretation to the attending physician's judgement. Recently we encountered another situation when the Act proved unclear.

A severely depressed middle-aged lady on a Section 2, who was refusing food and drink, was felt to require a course of ECT. As she was unable to consent, the relevant office of the MHA Commission was contacted and a second opinion (Section 58) was obtained. A course of 12 ECT was recommended. This would normally involve a time span of six weeks giving ECT biweekly.

Though the patient's condition improved somewhat, the Section 2 expired before an adequate course of ECT could be administered. The patient became informal and did not consent to further ECT which were felt necessary.

Under the circumstances, should a Section 3 be invoked and the ECT continued though there may not be enough grounds clinically to justify this decision? Or should ECT, as recommended by the approved doctor from the MHA Commission under Section 58, be continued even though the patient was now informal and clearly did not consent to ECT but was still in need of it?

The MHA 1983[1] recommends that 'A course of treatment or plan of treatment may be continued if the patient has withdrawn consent, if the RMO considers that the discontinuation of the treatment or plan of treatment would cause serious suffering to the patient. In all such cases treatment must cease as soon as its cessation will no longer cause serious suffering'.

The implications of some of the terms are debatable. In this case the patient, though clinically less depressed, was well enough to commit suicide. Does the authority of the treatment (12 ECTs) recommended under Section 58 extend till the course is completed or does this authority get invalidated once the other Section (in this case Section 2) expires?

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REFERENCE

[1]MENTAL HEALTH ACT (1983). *Memorandum on Parts I to VI, VIII and X*. London: Department of Health and Social Security.

Alcoholism and the Mental Health Act

DEAR SIRS

In an earlier issue of the *Bulletin* (February 1986, **10**, 38), Mr G. K. Roberts, an official of the Medical Defence Union, while responding to Dr Culliford's query on the above subject, appears to be suggesting that although alcoholism *per se* does not justify detention under the provisions of the Mental Health Act 1983, delirium tremens may justify detention under the provisions of

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