Detained patients

DEAR SIRS

Before completing Form 39, a second opinion approved doctor must consult with two persons professionally concerned with the patient, one of whom must be a nurse and the other neither nurse nor a doctor.

It is evidently assumed that *all* detained patients have had involvement with another professional, but in my experience there is a small but significant number of detained patients where this is not the case. This particularly applies to the most severely mentally ill patients—for example, those suffering from severe depressive psychosis. The patient has been too ill to have been referred to the Occupational Therapy Department, and the hospital Social Work department has not been involved. In some cases the only other professional involved is the community-based social worker who made the application for admission, but if one consulted this social worker he or she would only be able to give an account of the patient's mental state before admission, whereas the SOAD may be seeing the patient several weeks later.

I have not encountered this problem in teaching hospital psychiatric units, presumably because of the better level of staffing.

To ensure that another professional is available it would be necessary to involve a hospital social worker routinely with every detained patient from the time of admission, although this might be difficult where staffing levels are low.

The only other course would be to modify Form 39 by inserting a section where the SOAD could certify that no other professional has been involved with the patient, if this is in fact the case.

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See page 300

Community groups continued

DEAR SIRS

In my original critique of Dr Novosel's paper on a Community Group in a State Hospital (*Bulletin*, December 1986, **10**, 360) I emphasised the need for objectivity in assessing improvement in patients treated by such groups. I am gratified that in a subsequent comment (*Bulletin*, April 1987, **11**, 135) Dr Whyte agreed with many of my remarks.

Dr Whyte does, however, unfortunately stray into the same trap as did Dr Novosel. I did indeed say (albeit partly tongue in cheek) that a depression rating scale when applied to the participants of the group—who had begun talking of a nuclear war . . . "Armageddon . . . hopelessness . . . no cure for mental illness . . . psychiatrists knew nothing . . . (and) . . . a sense of panic and confusion" would have registered a "profound increase in depressive symptoms". I did not say that this was evidence of failure of the group. However, Dr Whyte cites this as evidence of "success". Psychotherapy may indeed produce a transient aggravation of symptoms prior to their decreasing. However, if a worsening of symptoms is to be presented as evidence of improvement, what would be indicative of deterioration? Surely not the amelioration of symptoms? Outcome must be measured at the end of treatment, not part way through. Psychotherapy must recognise this fact and use criteria of improvement that are acceptable to the man in the street—at the end of the day is the patient better off? Failure to do so will relegate psychotherapy to the realms of pseudo mysticism.

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Autism research

DEAR SIRS

The Department of Health and Social Security and the Department of Education and Science are jointly funding a two year research project to look at the current education, treatment and handling of autistic children and adults. The project is based at the Child Development Research Unit at the University of Nottingham and will be directed by Dr Elizabeth Newson.

During the first stage of the project, information will be collected on the type of help and services available to autistic children and adults. In the second stage, a more detailed study of some of the units, centres, schools and groups identified will be undertaken.

If any of your readers are currently working with autistic children or adults or know of any facility or service that caters specifically for their needs, I would be very grateful if they could send details to me.

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Effects of the 1983 Mental Health Act on compulsory admissions

DEAR SIRS

Winterson & Barraclough[1,2] reported on the effects of legislation on compulsory admissions to the District General Hospital Unit in Southampton. They found a reduction in the use of sections for admission since the 1983 Mental Health Act came into force. There was an increased preference for the 28 day order with marked reductions in the use of emergency and 6 month orders. Darvill & White[3] produced figures for Barrow Hospital in Bristol and reported no significant change in practice since the new act.

TABLE I

Impact of 1983 Mental Health legislation on admissions under Section to Coney Hill Hospital

	Under 1959 Legislation			*Under 1983 Legislation*		
Section*	1980–81	1981–82	1982–83	1983–84	1984–85	1985–86
28 day: 2 (25)	54 (38%)	69 (44%)	73 (47%)	69 (61%)	77 (63%)	80 (61%)
6 month: 3 (26)	6 (4%)	14 (9%)	9 (6%)	18 (16%)	18 (15%)	17 (13%)
Emergency: 4 (29)	72 (50%)	68 (44%)	69 (44%)	19 (17%)	20 (16%)	28 (21%)
Other	11 (8%)	4 (3%)	4 (3%)	7 (6%)	7 (6%)	6 (5%)
Total (and % of all admissions)	143 (8·3%)	155 (8·0%)	155 (7·9%)	113 (5·6%)	122 (5·5%)	131 (6·8%)

*Sections of 1959 Mental Health Act in parentheses.
Years in this table run 1 October to 20 September.

I report on compulsory admissions to Coney Hill Hospital which is a psychiatric hospital serving Gloucestershire with a population of 505,894.[4] Acute admissions include those suffering from alcoholism and drug addiction and psychogeriatric admissions. About 65% of its catchment area is rural, comprising Forest, Cotswold, Tewkesbury and Stroud districts; the 35% urban population reside in Gloucester or Cheltenham districts. Admissions under section to this hospital for the three years following the introduction of the new Mental Health Act have been compared with admissions for the three years preceding it. (See Table I).

The reduction in compulsory admissions closely mirrors that at Southampton. There was a dramatic reduction in the use of emergency sections to Coney Hill Hospital as well as an increased preference for 28 day orders. However, the use of six month orders does not show the same pattern as at Southampton. Before the 1983 Act they were used far less frequently than at Southampton where they were as popular as the 28 day order. Since the new legislation, at Coney Hill Hospital, their use has actually increased.

Winterson & Barraclough[1] suggested that their 6 month sections declined because of new confidence that treatment could be given on a 28 day order. At Coney Hill Hospital most consultants interpreted the 1959 Act as allowing them to treat on the 28 day order so this does not apply. The trend towards more 6 month orders at Coney Hill Hospital may reflect a reluctance to use Section 2 because of the new right

TABLE II

Admissions under Section to Barrow, Royal South Hants and Coney Hill Hospitals

	Coney Hill Hospital		*Barrow Hospital*		*Royal South Hants Hospital*	
Section	1981–83	1983–85	1981–83	1983–85	1981–83	1983–85
28 day: 2 (25)	142 (46%)	146 (62%)	162 (68%)	188 (70%)	123 (38%)	171 (66%)
6 month: 3 (26)	23 (7%)	36 (15%)	67 (28%)	69 (26%)	125 (39%)	43 (17%)
Emergency: 4 (29)	137 (44%)	39 (16%)	6 (3%)	1 (1%)	67 (21%)	33 (13%)
Other	8	14	2	10	12	11
Total (and % of all admissions)	310 (8·0%)	235 (5·6%)	237 (10·3%)	268 (9·7%)	327 (16·4%)	258 (12·2%)

of appeal. On Section 2 an appeal will be heard within a month whereas on Section 3 an appeal is not heard in practice until the fifth or sixth month. Thus in some cases a 6 month order may be preferred because it allows the psychiatrist more time to treat the patient before his/her actions are called into question, particularly where a patient has previously appealed successfully against an order.

I also note that our overall section rate as a percentage of all admissions has been consistently lower than that of Southampton and Barrow. (See Table II). It is speculated that this might be a reflection of the predominantly rural nature of Coney Hill's catchment area. It is known that urban areas collect greater numbers of mentally ill patients; perhaps it could be argued that urban regions therefore have more disturbed or dangerous mentally ill patients that require compulsory admissions than rural regions. Clearly more research is needed to answer this question.

Our more frequent use of emergency sections than either Southampton or Barrow may be attributable to rural areas in Coney Hill's catchment area that are relatively inaccessible to the approved doctor at night. Their use has been greatly discouraged with the new act but in the light of Barrow's figures, additional measures to reduce emergency sections might be sought at Coney Hill Hospital.

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Neglect of the long-term severely mentally ill

DEAR SIRS

Dingwall's survey of some Scottish mental hospitals seemed to indicate a lack of direction in rehabilitation services (*Bulletin*, May 1987, **11**, 158–160). There are many possible factors which may be contributing to this, but an interesting hypothesis concerning the role of staff attitudes has been put forward by Lamb.[1] He commented on the general tendency to neglect the long-term severely mentally ill and attributes this in part to the following:

(a) a basic moral disapproval of dependency and passivity within society which mental health professionals share

(b) professionals' own needs remaining unfulfilled by the care of these patients as degrees of improvement are small

(c) an initial overenthusiasm for rehabilitation with correspondingly unrealistic expectations leading to disillusionment.

Perhaps further examination of staff attitudes towards the most disabled group of patients might contribute towards the improvement of rehabilitation techniques and help the sub-specialty find its direction.

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Rehabilitation teams

DEAR SIRS

I was particularly interested in Dr Dingwalls's article 'Psychiatric Rehabilitation—a lack of direction' (*Bulletin*, May, 1987, **11**, 158–160). In it, he referred to the formation of a Scottish multi-disciplinary body of rehabilitation workers.

In Northern Ireland, we formed such a group two years ago (CHART: acronym for Community/Hospital Association of Rehabilitation Teams). Its main strength has been its multi-disciplinary membership and its provision of an arena for sharing of problem solving and academic interests. Above all, we have utilised the group to exert pressure and express protest in a formal manner with more efficacy achieved than with the individual/unit approach.

Although we could not claim, as our name suggests, to have found a direction, we may have glimpsed a few signposts!

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Community psychiatry

DEAR SIRS

Reading the recommendations for training in community psychiatry (*Bulletin*, June 1987, **11**, 213), I was struck by the statement that the recommendations do not for the most part represent new departures. New departures are precisely what is needed if we are to have a good service a few decades from now.

I believe we now have a large and growing population of people with severe psychiatric handicap who are in minimal or no contact with psychiatric services. How can we remedy this by sticking to what we are doing?

One deficiency that is evident to me is lack of insistence upon experience of long-term follow up. This is undermined by six-monthly rotation, although it need not preclude long-term involvement.

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