Reviews

ECT Pros, Cons and Consequences: A MIND Special Report. 1988. Obtainable from: MIND Publications Mail Order Service, 4th Floor, 24–32 Stephenson Way London NW1 2HD. 25p each, £2 for 10, £18 for 100 (prices include postage).

News of a MIND special report on ECT is sufficient to generate an air of gloom in any psychiatric gathering. Is there no end to the remorseless assault on psychiatry?

In this case the gloom can be dispersed, for this is not a MINDless regurgitation of data free prejudice but a genuine attempt to present a balanced account for patients and their relatives. As such it is to be warmly welcomed, even though it is not as most of us would have written it.

This six-sided pamphlet presents the essence of the controversy, gives an accurate account of how patients will experience treatment, then reviews the College guidelines and the extent of their implementation. It goes on to consider what ECT is used for, considers issues of consent and weighs the risks and benefits.

Among the concerns addressed by the pamphlet are the manner in which ECT is given and the wide variations in practice between districts, hospitals and clinical teams. The Pippard & Ellam report in 1980[1] revealed the wide variations in use and in standards of practice. Latey & Fahy[2] have demonstrated some of the associations of these variations.

The need for proper training and supervision of doctors administering ECT should be constantly reiterated. A variety of studies including Freeman *et al*[3] and Hughes *et al*[4] have identified simple measures which can make ECT more acceptable and less distressing to patients and their relatives.

In trying to be helpful, the authors assert "ECT does have a proven capacity for abuse but this also applies to psychiatric drugs". The big difference of course is that self abuse of ECT is scarcely a problem whereas non-compliance and abuse may occur with drugs.

ECT abuse, real or alleged, is laid at the door of the psychiatrist and many are deeply wounded by these allegations. In the past, doctors may have condoned the use by institutional staff of treatment as a means of control or punishment but this certainly should not occur to-day.

Under the heading 'current usage', two statements from the College guidelines are given perjorative italics "many psychiatrists feel that for severe depression bilateral ECT is preferable" and "the therapeutic effect of ECT is probably dependent on producing a generalised fit".

From the literature, it is possible to make more categorical statements which avoid the implication that gut instinct or emotion determine our actions and the word probably is best avoided. These are reminders that College statements designed for internal consumption are widely read and liable to be critically dissected.

This is an independent document produced at a time when there are rumblings of parliamentary lobby groups opposing the use of ECT. As such it deserves to be welcomed as a contribution to the continuing debate and a useful source of information for patients and families.

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References

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[3] FREEMAN, C. P. & KENDELL, R. E. (1980) ECT patients' experiences and attitudes. *British Journal of Psychiatry*, **137**, 8–16.

[4] HUGHES, J., BARRACLOUGH, B. M. & REEVE, W. (1981) Are patients shocked by ECT? *Journal of the Royal Society of Medicine*, **74**, 283–285.

Focus on Restraint: Guidelines on the Use of Restraint in the Care of the Elderly. The Royal College of Nursing, 20 Cavendish Square, London W1M 0AB. 1987. Pp 9. No price stated.

The Section for the Psychiatry of Old Age discussed the restraint of elderly patients in hospitals and homes within the last year. Now this document from the Royal College of Nursing appears as a welcome contribution to a continuing debate.

On the second page it states "In broad terms restraint means restricting someone's liberty, preventing him from doing something he wants". (Anyone who is restrained, whatever his mental or

physical condition, is suffering from a denial of this basic human right). "This means that anyone who applies any form of restraint should be prepared to justify the reason". "There are a number of circumstances in which nurses are empowered by law to use restraint. Certain Sections of the Mental Health Act 1983 allow the use of restraint for specific purposes, and nurses have the same rights as other citizens in using the minimum restraint necessary to prevent a crime occurring. The middle ground, as always, is a no man's land of muddy confusion. While expecting the nurse to use restraint in the event of a perceived danger... in the interests of providing a reasonable degree of freedom some degree of risk must be considered to be acceptable."

After this promising beginning there is, disappointingly, no information about how frequently restraint is used, possibly because such information is not available. If so, then it should be, and some of the recommendations in the paper may facilitate its collection. Two excellent papers in the *Journal of American Geriatrics Society*[1,2] set a standard which is to be hoped will be matched by the British literature before long.

The paper does not state why restraint should be a particular issue now. The likelihood is that it reflects difficulties in coping with the increasing numbers of the demented elderly in an ageing population. The 20% of the demented elderly who are in institutional care obviously include those whom it is most difficult to look after at home, yet very few are formally detained.

Under the heading 'Nurses and the Duty to Care', there is a statement that nurses are likely to be the major professional group involved in decisions about restraint, though there are increasingly frequent situations where a multidisciplinary approach is used. There is no recognition that the consultant is the legally responsible medical officer; indeed, the word 'doctor' does not appear in the paper, though in practice it is most unlikely that any decisions about whether or how to restrain patients will not sooner or later be referred to a doctor. The penultimate paragraph of this section states "the more incapable or infirm the patient the greater responsibility of the nurse to ensure that what he or she does satisfies the multiple expectations of relatives, colleagues, society and the Law". Of course, these expectations cannot always be reconciled. On the next page under 'Commonly Used Methods of Restraint' it is not made clear enough that one of the most frequent methods of restraints is to lock the ward. This means of course that everyone is locked in, not just the patient who is deemed to need restraint. This important issue is not discussed anywhere in the paper.

The comments under 'The Use of Restraint' about staff shortages and learner nurses and nursing auxillaries often being unprepared for the decisions they have to make, and being placed in impossible situations, may be true but sound rather plaintive and not very constructive. The suggestion that relatives demand that their mother or father is stopped from wandering in the misguided belief that this will make the patient happier is probably incorrect; their chief worries about wandering are that patients will escape, get lost or come home.

There are some good points under the heading 'The Implications of Using Restraint'. "Restraining a patient for a whole day because he was aggressive when being dressed is obviously bad practice". "Restraint, if applied consistently, can produce dependence on its use... (and) eventually results in institutionalisation of the worst kind. There are, as well, real practical dangers in the use of restraint". However, the evidence that restraint exacerbates dementia or "death wish" is dubious.

Under 'What are the Alternatives?' "Reorienting to reality" will not help a wandering patient who does not want to be in hospital. Also, under 'Controlling the Environment', advising the nurse to be aware of becoming irritated by the patient's disturbed behaviour is a counsel of perfection. Insufficient attention is given to the role of design in reducing the need for restraint, e.g. access to a garden, a 'race track' round a patio, or a centre of interest (e.g. a bar!) away from the entrance to the ward. Cramped wards and the mixture of restless with infirm patients are likely to increase the use of restraint. Avoiding unnecessary admission or misplacement of ambulant demented patients in, say, medical wards, will also reduce the need for restraint. The mention of the use of medication omits the inevitable involvement of a doctor. The inclusion of warmth with thirst and hunger as a cause of restlessness at night is surprising: cold is far more important.

A section on 'Restraint in the Community', while advocating practical solutions, suggests none. On the other hand, the check list to control restraint and the guidelines for good practice are excellent. A 'restraint watchers' group is directed to review the type and frequency of restraint used, identify where its use is excessive, to coordinate and develop alternatives to restraint, to devise locally-agreed guidelines for nurses on its use, to note where restraint is used for lack of nurses or other resources, and notify the Health Authority accordingly, and to ensure that the evaluation of the use of restraint is ongoing and systematic. If restraint is used the nurse must assess and record (a) the problem behaviour (b) why it is a problem (c) the proposed solutions (including restraint) and the reason why that is the method of choice. Restraint should be strictly time-limited and under no circumstances last for more than eight hours.

On balance, this is a useful pamphlet, but a clearer statement of the goals of restraint and for whose sake, and how to balance rights against risk would

have improved it. So would emphasis on the need for support, in particular by the nursing hierarchy, and for training in the management of disturbed old people. Unfortunately, many RGNs lack this because they get little or no experience on psychogeriatric wards.

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References

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'Goodbye to All That?': Re-thinking the Politics of Mental Health. Report from the Socialist Health Association, 195 Walworth London SE17 1RP. Pp 20. Price £2.00 (includes postage).

These political thinkers seem to regard psychiatrists, even in Britain, as instruments of the established order, offering palliatives for the effects of an unjust society. Unemployment, poor housing, ethnic and sex discrimination, they argue, are the causes of most distress which we psychiatrists identify as mental illness. They say we have an undue preoccupation with unproven biological theories to justify our proclivity for ECT and drugs rather than psychotherapy. Even psychotherapy in our hands is a little suspect, because too often our methods emphasise individual responsibility rather than social pathology.

In support of their thesis they refer to sources including Hollingshead and Redlich, Brown and Harris, Goldberg and the Black Report: it just shows once again that you can take out of great works whatever you wish.

Besides a change of Government, remedies suggested in this small booklet, produced with the help of ASTMS and NUPE, include re-orientating the professionals by making them more sensitive to consumer views. There, I think, they have a point, and 'the professionals' will certainly agree that community care needs more cash and the planning process needs to be better organised and responsive to consumer preferences. They favour the Nottingham initiative to set up patients' councils.

One is a little reassured that psychiatrists may still have an important part to play in mental health services. But I must say that if I thought the views expressed about us in this booklet were widely held among the general public I would be proposing that we set up a fund to employ Saatchi & Saatchi to do something about our image.

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Elsie – a Person of No Importance?

A delightful and moving booklet has been privately printed by Joyce Wilkins, a retired speech therapist who used to teach in the Education Department here in Nottingham. All psychiatrists will enjoy reading it – buy it; I will tell you why.

Elsie Bigge spent the first 52 years of her life in a variety of institutions which included a children's home, then Cane Hill Hospital and finally St Lawrence's Hospital, Caterham. In 1951 Joyce Wilkins with her sister and parents, who were friends of the superintendent, went to collect Elsie; she was to be released 'on licence' as a servant in their home. How she came to be a patient in St Lawrence's you will learn from this account of Elsie's life, pieced together from her own reminiscences. You will read too an account of the 35 years that were the rest of Elsie's life, when she lived happily, enjoying, observing and remarking on the world around her, first as a servant, then in retirement as a family member in the Wilkins' home.

You will wonder why she was in hospital in the first place, and in a sense the story will explain, but in another sense it won't, because there was no good reason. The heroic adaptability with which this woman was able to start a new life in her sixth decade makes this, in jargon, a "success story of community care". In clichés (which this account singularly lacks) it is a period piece, and a little gem. Don't be put off by my clichés, I use them as a brief way to describe this little book, so pleasantly produced and with a delightful cover picture, and to entice you to read it. You can get it by writing to Joyce Wilkins at 6 Davenport Park, Station Road, Heathfield, Sussex TN21 8DR, and sending her £2, which includes postage.

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