correct such assumptions. These therapeutic methods could be learnt by other therapists, and evaluated scientifically in follow-up studies.

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Mental health legislation and the practice of psychiatry

DEAR SIRS

The letter from Dr McNicholas (*Psychiatric Bulletin*, 1992, **16**, 568–569) makes compelling reading. Her focus appears to be on the cost factors as primary predictors of treatment within the mental health arena, and indeed in some cases this is certainly the case. However, one factor which she failed to mention is the influence of mental health legislation upon the practice of psychiatry. Although not working in the United States, I can speak from a Canadian perspective. The changes that are occurring in mental health legislation here are primarily directed towards the rights of the individual. This is an excellent premise in many areas as it allows greater patient autonomy and a sense of involvement in the treatment process. However, psychotic patients may have very little insight into their disabilities, and they are in danger of avoiding the treatment they sorely need. This most vulnerable and disadvantaged section of the psychiatric population may actually be harmed by their own autonomy in such an instance, and it behoves physicians to advocate on behalf of such patients in an attempt to assure their right to treatment.

Dr McNicholas is correct in her suggestion that all patients should have appropriate care irrespective of cost. We must also attempt to insure that mental legislation is directed toward those most in need.

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Psychiatry of mental handicap – its future

DEAR SIRS

Psychiatrists who work predominantly in mental handicap services are concerned about the development of services for those of their patients who also develop mental and emotional illness. The minority with joint contractual arrangements with general psychiatry and child psychiatric services may not feel anxious about this issue, but the majority of psychiatrists working in mental handicap do not seem to have a clear role or function in the new services. With the reorganisation of the NHS, particularly with the emergence of independent trusts of hospitals and community services, the confusion will, I am sure, turn into chaos.

Already in some areas, in order to get more 'business and finance", general psychiatric colleagues are willing to provide services for mentally handicapped patients with mental illness. If money can be saved by these means, such practices may be encouraged and the integration of psychiatric mental handicap services with general psychiatric services, child psychiatric services, etc, will accelerate.

The principles of normalisation could be manipulated to support such 'integration'. Local authority social services, who have the major responsibility for the provision of services for mentally handicapped people, may also use such cost-saving tactics. Conflict between psychiatric subspecialties arising from the change of policy by trusts will be detrimental to both specialist and general provision for mentally handicapped people and their families.

Does the psychiatry of mental handicap as a distinct subspecialty have a future? Will there be a gradual merger with general psychiatry and other subspecialties? This would certainly adversely affect the training and educational needs of the psychiatrists and ultimately the service for this vulnerable section of society. However, if there is going to be integration of specialised services within the core of general psychiatric services or other specialised services, then there is an urgent need to clarify the role, function and division of the expertise, that is, specialists, psychiatrists, specialist nurses, etc, within these emerging and developing integrated services.

The Royal College of Psychiatrists, particularly the mental handicap, general psychiatry, community psychiatry and child psychiatry sections, should urgently look at this issue and provide guidelines to the profession as well as service providers, and the government.

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MRI on adolescents presenting with schizophrenia

DEAR SIRS

It can now be considered standard practice to undertake brain scanning of adolescents presenting with schizophrenia. Magnetic Resonance Imaging (MRI) offers the best available resolution and the least invasive method.

The chances of a brain scan producing results of immediate clinical relevance to the management of an individual patient are not high. However, we can expect quantitative differences between the brains of adolescents with schizophrenia and those of control

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subjects. It is important to carry out scans in such a way that maximum use can be made of data collected for research purposes ultimately aimed at benefiting the group of those with schizophrenia as a whole.

Currently at Oxford we are carrying out MRI on adolescents presenting with schizophrenia. This group is a good one for testing the neurodevelopmental hypothesis of the aetiology of schizophrenia. The research has been approved by our local Research Ethics Committee.

I would be grateful to be informed of subjects who might be suitable for this study. Only DSM-III R criteria are required. I have obtained a grant sufficient to cover the costs of research scans and travelling expenses. We have scanned 19 subjects so far and aim to carry out two further Saturday morning sessions scanning eight adolescents each time within the next few months.

Please write to me at the address below or telephone 0227 462733.

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An MP questioning clinical judgement

DEAR SIRS

A curious incident happened while I was a senior house officer in old age psychiatry. An 87-year-old lady had been admitted informally to the assessment ward from a residential home. She had been increasingly aggressive and restless, and had threatened to jump out of a window. She had biological features of depression, was not eating or sleeping, had lost a lot of weight, and expressed a wish to end her life.

After admission she remained retarded and there was concern about her fluid intake, amounting to less than a litre over three days. A course of ECT was arranged, and her legal next-of-kin, her daughter, was informed. Subsequently I received two threatening phone calls from her son-in-law, who was a consultant in one of the London teaching hospitals, saying that if we gave his mother-in-law ECT he would institute legal proceedings against myself, my consultant and the health authority.

At this time, the patient's daughter, to the best of my knowledge, had not expressed any reservations about our proposed course of action. When contacted, all she would say was that she needed time to discuss the matter with her husband. That evening I received a phone call from their Member of Parliament stating that he had been informed of his constituents' concern and associating himself with the threat of legal action.

In my two years in psychiatry, I have had instances of relatives being concerned about proposed courses of treatment, but to the best of my knowledge neither I nor any of my colleagues have ever received a phone call from an MP questioning our clinical judgement. I wondered if other readers have had any similar experience.

The patient died from an intestinal obstruction; she had had one session of ECT.

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Involvement in patient care by managerial staff

DEAR SIRS

I read the letter from Ali & Evans (*Psychiatric Bulletin*, 1992, **16**, 661) several times, with some bemusement, and then decided it must be a rather clever and amusing spoof on trends in 'community' psychiatry. That this is so can be seen by substituting *day surgery centre* for day hospital and *wart* for references to anxiety at interviews; the absurdity of the clinical arrangements described can then be clearly seen. However, perhaps I have missed something, or worse, the letter is not a spoof, and there is a real need to be more explicit – with the question, should not interview training of the type described be part of any psychiatric day hospital service when required?

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Reply

DEAR SIRS

Dr Bowker's analogy of a patient with a wart attending a surgical day hospital is inappropriate. Anxiety at a forthcoming interview was not our patient's presenting complaint; subclinical anorexia nervosa and social phobia were the reasons for referral. The other flaw in the analogy is to assume that a hospital administrator would possess the skills to treat his patient's wart. In fact, our administrator's training and experience in interviewing was the skill employed as an adjunct to treatment.

Our patient's problems were treated over two years with relaxation therapy and anxiety management, supportive psychotherapy aimed at raising self-esteem and assertiveness, as well as art therapy. Only recently during her attendance at our day hospital did the offer of an interview arise, bringing with it associated anxiety. It was due to the initiative shown by the Sister of the psychiatric day hospital who was aware of the administrator's experience, that the mock interviews were arranged.

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