of how well the patient presents at the Tribunal. Clearly, psychiatric patients can be mentally ill, and potentially disturbed and violent, but conduct themselves normally at a hearing.

When a Tribunal has reached an apparently wrong decision, this prompts the question of whether all the facts have been put before it. Sometimes there are inconsistencies between reports from the consultant, nurse and social worker. Often reports are undated. It is disconcerting for Tribunal members if they are faced with staff standing in for the professionals directly responsible for the care of the patient, and who are answering to reports compiled by others. Junior members of staff might feel intimidated and not do their case justice.

A form of standard questionnaire to cover points especially relevant to the Tribunal's decision-making might be a useful adjunct to complement psychiatric, nursing and social reports. Perhaps, when a Tribunal does decide to discharge, the responsible medical officer could be called back to discuss the implications of discharging the patient. It would be helpful if consultants could inform their Tribunal office of any cases where a Tribunal's decision has gone wrong.

DOUGLAS A. SPENCER

Meanwood Park Hospital
Leeds LS6 4QB

Involvement in patient care by managerial staff

DEAR SIRS

NHS non-clinical management staff are often considered remote from day to day problems of patient care dealt with by the clinical multidisciplinary team. The following case provides an example of direct involvement in patient care by the Mental Health Service Manager at a South Wales hospital.

A shy and anxious 20-year-old woman had been attending a psychiatric day hospital for two years. Referred by her GP for sub-clinical anorexia nervosa, she also had great difficulty in social relationships. She was a highly talented artist and had been runner-up in a nationwide competition for book illustrations. During her stay she gradually built up good relationships with staff and her psychiatric problems improved. Her enthusiasm and skill in painting and sculpting were encouraged and she expressed an interest in going to the local art college. After meeting with a tutor there, she was advised to apply, put together a portfolio of her work, and attend for interview. She became extremely anxious at the prospect of an interview and the staff felt she needed interview training.

The Mental Health Service Manager was approached for advice and offered to perform mock interviews with the patient. Three were held over one month, lasting 30–45 minutes, during which a dramatic improvement was noted in her presentation, confidence, and response to questioning. She successfully completed the real interview and was offered a place at the Art College.

This seems to be the first example where a member of NHS managerial staff has been directly involved in patient care. We would be interested to know whether there are other examples.

IMAD M. ALI

East Glamorgan Hospital
Church Village
South Wales

ANNETTE EVANS

Day Hospital
East Glamorgan Hospital
South Wales

Definition of nearest relative, Section 3, Mental Health Act

DEAR SIRS

When a patient is to be admitted under Section 3 of the Mental Health Act, on the application of an Approved Social Worker, the nearest relative is required to given consent. If that relative objects to the application being made then the Section 3 cannot proceed.

I report a recent occurrence where the definition of the nearest relative was misunderstood.

The occurrence concerned a patient in the manic phase of a long standing unstable bipolar disorder. The responsible consultant decided, on a Bank Holiday Sunday, to proceed with compulsory ECT. Two medical recommendations were provided for admission under Section 3. The Approved Social Worker was informed that the patient had no living relative in the United Kingdom but had nominated a friend to act as the nearest relative. This friend refused to agree to the Section 3 and the Approved Social Worker decided that he could not proceed with an application.

The Act defines who should be regarded as a relative and in the absence of such a person makes provision for the appointment by the County Court of a person to exercise the functions of the nearest relative. If it is not possible for the Approved Social Worker to ascertain who is the patient's nearest relative within the meaning of the Act or if he believes that the patient has no nearest relative then he can make an application under Section 3 without consultation taking place. An application to the County

Court for the nomination of a nearest relative should then be considered.

B. BARRACLOUGH

Royal South Hants Hospital
Southampton SQ9 4PE

I am grateful to Ms Carol Thomas for advice about the Mental Health Act.

Central monitoring of clozapine

DEAR SIRS

McGilt & Anderson (*Psychiatric Bulletin*, July 1992, **16**, 450) wonder if patients established on clozapine might eventually move to having their blood monitored by the local haematological service. In fact the Germans already do this as each clinician takes responsibility for his/her own monitoring. However, many Germans do not believe that clozapine is more risky than normal psychotropic drugs with regard to neutropenia and also that they use, in general, lower doses of clozapine and mix clozapine with conventional psychotropics.

I feel, as we have now nearly 50 patients who have commenced clozapine and two red alerts, that central monitoring is essential. One reason is to keep track of red alerts and ban the transient patient from being re-exposed, which could prove fatal. A second reason is that the Clozaril Patient Monitoring System (CPMS) has all the registered cases on computer analysis to enable early warning signs to be picked up. This may lead to more false positive neutropenias and increase the number of red alerts, but I think that the UK service is probably the safest in operation.

M. A. LAUNER

Burnley General Hospital
Burnley BB10 2PQ

Telemedicine child psychiatric consultations to under-serviced areas

DEAR SIRS

I would like to offer a brief report of a Canadian experience using telemedicine to offer child psychiatric and family assessments between the University of Western Ontario, London, and Woodstock General Hospital, Department of Psychiatry, using an interactive television link.

Weekly psychiatric consultations took place via the interactive television link between November 1984 and August 1985. This involved a child psychiatric team of a psychologist, social worker, psychiatric nurse and child psychotherapist, and myself acting as a consultant. New case assessments often combined with crisis interviews and follow-up reviews took place on a weekly basis. Approximately every fourth week, an on-site visit allowed me to conduct an assessment with the team in person. While no patients or families refused involvement, there was a consensus between both patients and staff that live interviews are superior.

What was lost? While technically feasible to interview individuals or families, valuable diagnostic information was lost, e.g. unavailability of split-screen techniques prevented simultaneous views of the individual and family. Secondly, significantly less hypothesis generating took place among team members than during an on-site assessment. Thirdly, team members and patients experienced an "emotional distance" with the consultant in comparison to face to face contact. Thus while on-site visits were important in establishing rapport and developing team cohesion, they also appeared to contribute towards a negative attitude within team members towards the television link.

What was gained? The link provided adequate clinical assessments of a routine and crisis nature with a 50% reduction in the consultant's time because of reduced travelling when compared to on-site consultations. Patient acceptability was generally high.

In Ontario, and throughout Canada, there remains a severe shortage of specialist psychiatric consultation for the northern regions of the province. The use of telemedicine links with established psychiatric teams could allow the regular input of specialist psychiatric consultation without the need for the extensive travelling time. These services might combine with the presence of an on-site psychiatric resident, supervised by the psychiatric consultant via telemedicine link, who would become a member of the on-site team. This would also serve the function of exposing consultants-in-training to a first-hand experience of rural conditions while providing them with adequate consultant supervision. Hopefully, some of them would become interested in making a more permanent commitment to rural practice.

LAURENCE JEROME

Childrens' Psychiatric Research Institute
London, Ontario N6A 4G6
Canada

Reactions to pregnancy: exacerbated by sexual abuse?

DEAR SIRS

I read with interest Dr Neilsons' account of her pregnancy (*Psychiatric Bulletin*, July 1992, **16**, 442–443). For four of my patients, with bulimia nervosa and a history of childhood sexual abuse (CSA), news of my pregnancy had marked repercussions.