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.