I have rated the change in mental state according to the scale 1 worse, 2 no change, 3 marginally improved, 4 clear improvement, 5 marked improvement. Seven were ranked at 5, four were ranked at 4, one was ranked at 3 and one was ranked at 1.

Thirteen patients were started on clozapine after long intractible schizophrenic conditions. There were no problems with the white cell counts sufficient to cause the drug to be stopped and such side effects as there were settled, except for one severe extrapyramidal reaction. Most of the patients improved either clearly or markedy with regard to level of disturbance and emotional warmth. Seven of these patients now spend most of their time out of hospital and only return for the white cell counts and dispensing of the clozapine. Six of the patients had actually requested clozapine, and all of the patients and relatives were fully counselled on the side-effects before the drug was considered.

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Benzodiazepines as night sedation

DEAR SIRS

Various studies have shown that pharmacological dependence and tolerance to benzodiazepines occur with therapeutic dosages. Alternative ways of dealing with insomnia exist and it can be asked if benzodiazepines should ever be used to manage these conditions. The *British National Formulary* (1990) (BNF) states that "routine use of benzodiazepines as hypnotics, especially in hospitals, is undesirable and ideally they should be reserved for short treatment in acute distress". The Royal College of Psychiatrists (1988) statement on benzodiazepine prescribing for insomnia states that their use should be limited to cases where the condition is severe, disabling, or subjecting the individual to extreme distress.

Little is known about the prescribing habits or knowledge of new medical graduates on this topic. We surveyed 97 graduates of a single medical school in pre-registration house jobs, using a telephone questionnaire; 93 responded.

In the month prior to the study 92 of the doctors prescribed night sedation, 82 (92.5%) prescribing only benzodiazepines. One-third estimated that more than 50% of their patients received night sedation and 12 stated that more than 80% received it. One-half of the doctors stated that they prescribed night sedation in response to nursing requests or pressure, but 14 said they commenced patients on benzodiazepines routinely. The first choice of sedative for almost all of the respondents was temazepam. Just over 10% did not know that tolerance developed to benzodiazepines with the same number being unsure. Less than 5% did not know that the patient can become dependent on benzodiazepines and 2% were not sure. Approximately 9% of the doctors would discharge patients on benzodiazepines even if the patient was not taking these prior to admission.

The majority of the doctors surveyed were aware of the occurrence of tolerance and dependence with benzodiazepines, but this did not seem to influence their prescribing practice. Our figures highlight a need for more teaching about safe prescribing of benzodiazepines as night sedation to medical and nursing staff. Formal prescribing policies may protect inexperienced doctors from undue pressure to commence patients on night sedation. On a more optimistic note, only 9% of the doctors surveyed would continue benzodiazepines after discharge if the patient was not on them on admission. Although not strictly comparable, this contrasts well with 72.2% of patients on benzodiazepines after discharge from psychiatric hospital (Fry, 1989). This group of graduates are taught to use the BNF as a source of reference for drug dosages but its guidelines on prescribing practices do not seem to be followed. Of those surveyed, 10% asked our advice on prescribing benzodiazepines, possibly indicating a need for more direct guidance from senior doctors.

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A full list of references is available on request to the authors.

Section 5(2) audit

DEAR SIRS

The visiting Mental Health Act Commissioners in August 1990 commented that Section 5(2) was

being used too often in our hospital. We wish to report the results of a Section 5(2) audit at Glanrhyd Hospital, Bridgend, Mid-Glamorgan which provides in-patient psychiatric care for the catchment area population of 160,000. We studied all the Section 5(2) applications from 1 January until 31 December 1989. According to our local *Hospital Doctors' Handbook*, the Section 5(2) should if possible be signed by the patient's Responsible Medical Officer (RMO). If he/she is not in the hospital, the junior doctor, who sees the patient, should contact the RMO or other acting consultant. The junior doctor can then complete Form 12 after discussion of the case.

Section 5(2) was implemented 42 times; [on three of these occasions the person was already detained on Section 5(4)]. These implementations refer to 37 persons, as one person was detained three times and three others were each detained twice during the year. Friday was the single most common day for implementation of Section 5(2) with 12 occurring. Twenty-one Section 5(2) (one half of the total) were implemented between 16.00 and 20.00 hours. More than half the patients were under 45 years old but seven were over 65. The primary diagnosis of the patients (ICD-9) was a psychotic condition (290–299) in 29 cases, personality disorder (301) in five cases, and other (302–311 and 345) in eight cases. The time interval between admission to hospital, and placement on Section 5(2) varied from 10 minutes to 7.5 years with 16 in the first 24 hours and another 18 within 10 days. Five Section 5(2) were applied by consultants, one by a senior registrar, and the remaining 36 by junior doctors. In 16 cases the junior doctor did not discuss the case with the consultant. Most patients were assessed by the RMO within 72 hours but in three cases there was no evidence of assessment until the seventh, eleventh and twelfth day after implementation. Twenty of the 42 Section 5(2) applications were converted to Section 2 or Section 3. Three patients were allowed home within 72 hours and six were made informal within 72 hours but stayed on in hospital; 13 became informal at the expiry of the 72 hours for which they were detained.

A worrying trend is that eight patients were placed on Section 5(2) within two hours of arriving on a ward (four within one hour). Most Section 5(2) are implemented by junior doctors, sometimes without discussion with the consultant, while the Code of Practice recommends that junior doctors should always discuss these cases with the consultant. Outside normal working hours it is usual practice for the nominated deputy to be the junior doctor on call but from 09.00 until 17.00 it is unclear who this is. We feel it would clarify the position if consultants nominate one junior doctor as their nominated deputy during working hours. Thirteen patients became informal after 72 hours. As three were not assessed by the RMO within 72 hours, that leaves ten who were assessed but were left on Section 5(2) for its duration. This is contrary to the Code of Practice. We recommend that all staff be aware of the admission procedures required before a patient is deemed to be informally admitted, that junior doctors always discuss these cases with consultants, that there be one nominated deputy during normal working hours as well as outside normal working hours, and that the RMO assess all patients placed on Section 5(2) within 72 hours.

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Appeals against Section 2 of the Mental Health Act 1983

DEAR SIRS

Since the introduction of the 1983 Mental Health Act there have been changes in the pattern of admission to psychiatric hospitals. In particular, there has been a general trend towards more informal admissions (Winterton & Barraclough, 1985; Sackett, 1987; Durani & Ford, 1989). There has been an increase in admissions under Section 2 with a decrease in Section 4 when compared to those admitted under the corresponding sections of the Mental Health Act of 1959. Webster & Dean (1989) have pointed out problems in patients knowing about rights of appeal. We wish to give a summary of our findings in a large district health authority.*

The records of all patients admitted under Section 2 to Leicester Psychiatric Hospitals over two years were studied retrospectively. Leicester has a population of 885,000 and has three mental illness units, one in a district general hospital and the other two in traditional psychiatric hospitals. Four hundred patients were admitted in this period; 47% were men. The district general unit admitted 35% of patients, and the two other hospitals 39% and 26%; 15.5% were of Asian origin. The total number of appeals was 36 (9%) with an equal sex ratio. Their average age was 37.5 years ranging from 20–69 years. Two-thirds of these patients were from the district general

**Fuller information can be obtained from the authors.*

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