supplementary reports containing confidential and potentially controversial information for tribunals in the future.

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Cannabis psychosis

DEAR SIRS

Dr Cembrowicz (*Psychiatric Bulletin*, May 1991, **15**, 303) states that psychiatrists responding to his questionnaire, as in Dr Littlewood's study (Littlewood, 1988) "felt that major tranquillisers were the best treatment" for cannabis psychosis. Cannabis and alcohol have been the commonest causes of major psychosis in young adults admitted to my ward for some time (Cohen & Johnson, 1988) and the psychosis with cannabis may either be of a manic type (Rottanburg *et al*, 1982) or it may be schizophreniform; organic features can often be detected in the mental state if the examiner looks beyond the obvious psychotic features. In all cases the disorder subsides very rapidly when the cannabis is stopped but you have to make absolutely certain that its use is not continuing clandestinely. If cannabis continues to be used then major tranquillisers are not effective and if it ceases they are not necessary. The 'best treatment', indeed the *only* treatment, is to stop the cannabis; the use of other drugs except temporarily for the control of very disturbed behaviour is both illogical and inappropriate.

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Section 5(2) Audit

DEAR SIRS

Drs Joyce, Morris and Palia wrote detailing results of a Section 5(2) Audit at the Glanrhyd Hospital, Glamorgan (*Psychiatric Bulletin*, April 1991, **15**, 224–225, letter). I felt it would be worthwhile to submit the findings of a similar procedure undergone at Hollymoor Hospital, Birmingham.

This hospital provides in-patient psychiatric care for a catchment population of approximately 250,000. I studied all Section 5(2) applications over the 15 months to 31 December 1990. Our policy is that Section 5(2)s should be signed by the patient's Responsible Medical Officer. If he or she is not in the hospital, the junior doctor on call is designated as the nominated deputy. He or she may complete Section 5(2) after discussion of the case with the RMO or other acting consultant. The total number of admissions in 1990 was 850. Thus, extrapolating for the 15 month period, there were just over 1,000 admissions. During this time, 34 Section 5(2)s were applied. Data were collected on 33 of the cases and notes were not available for the 34th.

There were 16 males and 17 females. Eight patients were married, 19 single, four widowed and two were separated or divorced. One patient was aged under 17, 16 were 18–35, 12, 36–64, and four were over 65. For eight patients this was their first admission to hospital; in 25 cases there had been one or more previous admissions; in 11 cases the application of Section 5 was within one day of admission. In a further eight cases, the application was within five days of admission, in four cases, 5–14 days, and in ten cases more than 14 days.

The time of application was between 0900 and 1700 hours in 18 cases, although four of these were at weekends; in 12 cases, the application was between 1700 hours and midnight; in three cases between midnight and 0900 hours. The Section was applied by a member of the home team, consultant or junior, in 20 cases, and by the hospital duty doctor in 13 cases. Discussion with, or involvement of, the RMO occurred in 18 cases, and with the duty consultant in a further eight cases. In seven cases the application appeared not to have been discussed with any consultant.

There was an immediate change in observation level in 11 patients but not in 22. During the period of Section 5(2) the patient was assessed by a member of medical staff in 32 cases but not in one case. The assessment for further detention involved the junior doctor in six cases (these junior doctors were in some instances Section 12 Approved), the senior registrar or associate specialist in four cases, and the patient's consultant in 26 cases. In some instances there was a combination of staff involved as judged by scrutiny of the notes.

After the Section 5(2), 21 patients were detained under another Section of the Mental Health Act, 12 were not. The time to discharge was less than one day in no cases, 1–7 days in one case (who took his own discharge), 7–28 days in 12 cases and over 28 days in 20 cases. The final diagnoses recorded in the case notes were schizophrenia on 10 occasions, affective disorder on 18 occasions, personality disorder once and other diagnoses, mainly organic conditions, on four occasions.

It was worrying that a number of patients were detained within a day of admission, particularly so as

it may have been their first contact with a psychiatric hospital. However, it was seen that virtually all patients fell firmly within the category of mental illness and most, whether they were subsequently detained further under the Mental Health Act or not, stayed in hospital for a period of treatment so it did not appear that Section 5(2) was being abused as an expedient measure merely to detain disturbed persons. Rather it seemed to have been used appropriately upon those suffering with mental illness.

It was felt though that there was a need to improve the documentation at the time of application of Section 5(2) and this documentation should include details of discussion with the RMO or duty consultant and instructions as to the observations required for the patient. It was also felt that the documentation of subsequent assessment, including the specific assessments for the purpose of the Mental Health Act, could be clarified and that such assessment should contain within it a clearly stated treatment plan. With reference to those detained within a day of admission, it was thought that some of these patients may have been served by better preparation or assessment at home before admission. Thus, it is hoped to liaise with colleagues in primary care and provide regular sessions on assessment and treatment of psychiatric emergencies. All these measures will be subject for further scrutiny in future audit meetings.

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Family psychiatry and family therapy

DEAR SIRS

I am not much further forward after John Howell's clarification of the differences between family psychiatry and family therapy (*Psychiatric Bulletin*, March 1991, **15**, 171). The debate seems to be partly over "who discovered it first", along with misunderstood and/or different terminology for similar and fast developing ideas in both fields. I still suspect that the essential contents of both fields are compatible to a large extent. But I think it is important for psychiatrists that this issue is not allowed to rest with John Howell's iatro-centric views. The only cure seems to be for each camp to read the others' literature more thoroughly.

But, speaking of cures, one difference is clear. Over the last decade – apart from the word "therapy" in its own name, with which it is now unfortunately stuck – the active trend within family therapy has been systematically to question the language we use. Words which are plainly related to medical ways of thinking – such as psychiatry, patient, pathology – would not be as uncritically used in the family therapy field as John Howells and (presumably) family psychiatry does. The reason is that a "systems" way of thinking sees such terms themselves as potentially part of a cycle of labelling that may play a part in sustaining the process we are presuming to understand and alter. In other words, psychiatric terminology may be iatrogenic as well as iatrocentric. However, no-one would go back to the anti-psychiatric idea that the self-fulfilling cycle of labelling is always the *whole* story.

Lastly, in quoting an American who blithely considers family therapy to be a mere branch of family psychiatry, John Howells had better watch out for retribution from the active, multi-disciplinary and multi-agency majority in the field of family therapy practice and research on all continents. They would be rightly furious to be so ignorantly colonised by the psychiatric empire! If he apologises forthwith, I won't show them what he wrote!

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DEAR SIRS

It is possible to agree with Dr Child that confusion will subside if care is taken to read the literature with an open mind and this would include reading the early literature on family psychiatry. But he raises other issues of critical concern to psychiatry.

Dr Child is right to point to the possible destructive effects of labelling. The problem in psychopathology is teasing out a discrete element in a complex field so that it can be encompassed by a word. The field is rendered more complex by able and ingenious speculators who invent concepts that have no basis in reality. An iatro-centric view is helpful in that the organic part of medicine has gone through the process of clarification already. To adopt its rigorous scientific approach, discipline, and emphasis in reality is no disadvantage in the clarification of psychopathology – the other part of medicine.

No apology is required for practising medicine in the medical field, encompassing as it does somatic and psychological pathology. Disorders of the psyche should not have less well trained medical practitioners than in the disorders of the soma. To open medical treatment and practice to all and sundry is no service to the afflicted. The highest standards of practice by the most able medical practitioners is the aim.

Teams are not new in medicine. Consider an obvious clinical team of surgeon in the operating theatre with the immediate help of anaesthetist, theatre nursing sister, porter and with a radiologist and histologist on immediate call. This team is characterised by co-operation between a number of independent experts but each functioning in their