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Correspondence

Letters for publication in the Correspondence columns should be addressed to:
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'BOUND FOR BROADMOOR'

DEAR SIR,

My attention has been drawn to the following paragraph in the review of Peter Thompson's book, *Bound for Broadmoor* (this issue, pp. 333–4):

'The harshest indictment to the psychiatric process comes at the end of the book. After four years in Broadmoor Thompson appeals to the Mental Health Review Tribunal and wins. Within 24 hours he finds himself outside the gate with £10 given by a charity for discharged prisoners, and boxes and boxes of personal effects. He received no after-care and no follow-up arrangements were made and he presumed this was because he "had the audacity to achieve discharge through a Tribunal".'

Your readers, of course, realize that I am not able to discuss any patient who has been under my care; but they may like to know the usual procedure. The necessarily short-notice discharge by Mental Health Review Tribunals has attracted public concern (Estimates Committee, 1968).* We in the Special Hospitals are legally precluded from admitting informal patients, or retaining any on an informal basis, even for the time-consuming completion of after-care arrangements: Section 97 of the Mental Health Act 1959 lays down that Special Hospitals are '. . . for persons *subject to detention*'. That being said, when the Tribunal decides to discharge a patient it gives us as much warning as is legally possible. With—and only with—the consent and co-operation of the patient, we use this short period in a crash programme to try to set up after-care. We get in touch with friends and relatives, we arrange, if necessary and possible, hostel accommodation, and interviews with a DRO and community support agencies, whether local authority or probation service. We try to ensure provision of social security benefits as quickly as possible. The patient is kitted out and given working clothes and tools as appropriate, and to tide him over till wages or Supplementary Benefits are forthcoming a sum of money from a small charitable fund at my disposal is provided. Travel warrants, transport to railway station, etc., are also arranged when necessary. Medical after-care, GP and psychiatric, is, of course, central in the arrangements.

* Second Report from The Estimates Committee, H.M.S.O. 1967–68, para. 53 at page xxi.

In short, we try to do all that is possible in the time allowed.

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MIGRAINE, ANOREXIA NERVOSA AND SCHIZOPHRENIA

DEAR SIR,

In reference to Dr. Paula Gosling's letter (*Journal*, **119**, 228–9, August 1971), whilst still appreciating many of the points she raises and confessing the use of oral contraceptives with symptomatic relief administered by myself to female patients with various psychiatric states, I would like to make a few more comments.

It is quite generally accepted by neurologists that migraine can be influenced by the 'pill' in various ways. Those cases whose pattern changes from a generalized attack of migraine to a focal type may be in danger of occasionally later developing a vascular occlusive lesion.

Vascular occlusion as opposed to thromboembolism is rare in pregnancy, but it has occurred in quite a large number of women on the 'pill'. This number has lessened since the Scowen scare. (There are numerous variables here such as age, weight and hormone levels in the puerperium.) Coronary thrombosis in men is, after all, at a very different site and has other variables.

A more detailed reference to the various neurological complications is written up by Dr. E. R. Bickerstaff, Consultant Neurologist to the Midland Centre for Neurology and Neurosurgery, Smethwick, in *G.P.*, 24 March 1972, 9. He is also preparing an intensive monograph on the subject.

Biochemical changes in women taking the pill are present, but relating these changes to vascular events is difficult. The neurological disorders are inadequately understood, but they remain a problem which cannot be denied in the present state of knowledge.

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