clinical time available for fulfilling health service contracts and income generation. It may also have an impact on the quality of care received by service consumers.

As such, the time devoted to audit should also be subject to cost benefit analysis. In other words audit must itself be audited. I should be very interested to hear from the Working Group how this might be done.

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DEAR SIRS

Dr Halstead has rightly drawn attention to an important point. In the College's response to the White Paper *Working for Patients* with a reference to the *Bulletin*, we have recommended one session per week but did point out the resource implications of this.

However, it is important to emphasise that the mere collection of data is *not* audit. Audit must be a continuous cycle of setting standards, evaluating practice and then putting the recommendations into action. Its sole purpose is to improve the quality of care. A recent leader in the *British Medical Journal* of 13 January 1990, refers to this process as "the closing of the feedback loop", without which "audit may be little more than a pious exercise in self congratulation".

I am grateful to Dr Halstead for drawing attention to the problem of time. Particular difficulties may arise when doctors hoping to get together for a lunch-time meeting, are in an institution which is divided into several sites, separated by horrendous traffic jams and inadequate public transport.

There is no single solution but we hope to publish some examples of good practice in psychiatric audit after the next series of meetings of the working group.

Dr ANN GATH
Registrar

Clinical audit in mental handicap

DEAR SIRS

The clinical audit for the psychiatry of mental handicap is difficult to measure as, in this particular branch, the multidisciplinary approach is crucial and the overlap of socio-economic and cultural factors, combined with the verbal communication problems of the patients, requires time to identify the diagnostic problems and to assess, treat, manage and support the patient and his family in or out of the hospital environment, in community facilities etc.

Over the past ten years we have developed the following procedure for mentally handicapped patients referred to the consultant psychiatrist in mental handicap for assessment and treatment and we are using this procedure in order to standardise the criteria for clinical audit in mental handicap.

We are interested in the views of colleagues about this issue and their methods of measuring clinical audit in mental handicap.

Clinical Audit Procedure

(1) *Prior to admission*
  (a) Written referral from GP.
  (b) Visit by community nurse for information on circumstances and background.
  (c) Visit by social worker for information on social background.
  (d) Out-patient appointment and/or admission to unit if acute psychosis or behavioural problems presented.

(2) *On admission*
  (a) Examination by GP (local GPs cover admission), physical examination and relevant investigations, e.g. FBC, LFT
  (b) Examination by psychiatrist or registrar for assessment, observation, any special investigation, e.g. EEG, thyroid function, blood, glucose, serum anticonvulsant levels monitoring, scanning, specialist referral eg, neurologist.

    GPs carry out physical examination and make referrals for medical or surgical opinions
  (c) Review and follow-up by consultant psychiatrist/registrar once or twice a week as necessary.
  (d) Nursing staff and multidisciplinary team observation and assessment. Individual patient plans (IPPs).
  (e) Clinical psychologist assessment, tests and advice, help in behavioural modification programmes.
  (f) Physiotherapist, occupational therapist, speech therapist, social worker, nursing staff, care assistants, community nurses, relatives whenever possible, and other relevant staff.

(3) *On discharge*
  Clinical meeting and review of progress with community nurse, social worker involvement in regular follow-up: day-care, ATC etc.

(4) Discharge letter to GP; copy to community nurse.

(5) Follow-up: out-patient appointment arranged.

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Benzodiazepines and ECT

DEAR SIRS

While it is accepted that benzodiazepines have anticonvulsant activity, most psychiatrists would not prescribe them and administer ECT at the same time in the belief that seizure is the necessary requirement for the patient to get better, the reality of the interactions seem to be more complicated than that.

Firstly, it is known that there are depressed patients who seem to have adequate seizures during ECT treatment, but still remain equally depressed. Secondly, there are patients who are on small doses of benzodiazepines, get ECT, have seizures and improve. Thirdly, there are patients who are in the process of withdrawal from benzodiazepines and develop depression as a result (Lader *et al*, 1981) that seems to be difficult to treat with antidepressants and most likely ECT too. During withdrawal, patients experience among many other symptoms those of depression, and major convulsions or temporal lobe seizures sometimes occur on abrupt withdrawal (Ashton, 1986). As these symptoms can occur together I would suggest that for several weeks following the withdrawal of benzodiazepines patients would show altered responses to ECT and antidepressants. My concern is that clinicians might misunderstand this to indicate that in future ECT should not be given on the grounds that: "s/he does not respond to ECT". It would be interesting to hear from other psychiatrists if they have found altered response to ECT as a result of benzodiazepine withdrawal.

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LADER, M. H. & PETURSSON, H. (1981) Benzodiazepine derivatives – side effects and dangers. *Biological Psychiatry*, **16**, 1195–1221.

The double negatives and the Mental Health Review Tribunal

DEAR SIRS

We would like to express through your correspondence columns some difficulties we have experienced in conveying the reports of the Mental Health Review Tribunal to our patients who had appealed against their detention under the Mental Health Act 1983. Here are two examples of the Tribunal's decision on two patients detained under Section 2 (extracted from form 7);

(1) "The Tribunal is *not satisfied that . . . . is not now* suffering from mental disorder of a nature and degree which warrants his/her detention in a hospital for assessment. The Tribunal is *not satisfied that it is not necessary in the* interests of the patient's health and safety that she should be detained. . . ."

(2) "They are *not satisfied that he/she is not suffering from* mental disorder. . . . They are also *not satisfied that his/her* detention as aforesaid is *not justified in the interests of* his/her own health. . . ."

In both cases the Tribunal accepted the medical and social worker's opinion and since the Tribunal had no objection to the reasons for their decision being "fully disclosed" to the patient they were conveyed to the patients and in both cases the patients insisted on seeing the reports for themselves. After reading the report both patients refused to believe that they had lost their appeal and had great difficulty in interpreting the double negatives. One patient's appeal against her subsequent detention under Section 3 was, we believe, related to her inability to understand the Tribunal's report on her initial appeal against Section 2.

Until the 17th century the use of double or multiple negatives was permitted in educated English as a form of emphasis (*International English Usage*, Croom Helm): "Nor go neither; but you'll lie like dogs, and yet say nothing neither" (Shakespeare, *The Tempest*, Act 3, Scene 2). This form is now only used in dialects, e.g. "He didn't say nothing".

The use of double negatives is still legitimate in educated English when they combine to express a positive (*Longman Guide to English Usage*). In the example "a not unhappy choice" or "not infrequently" the word "not" negates the negative word to produce a "weak positive". While in "You cannot not admire her pluck" and "None of us have no friends" a "strong positive" effect is produced. The above two examples from the Tribunal reports are similar to the later examples of "strong positive" and yet they caused consternation and confusion in our patients.

The capacity to understand such linguistic points will depend, of course, upon the level of sophistication that the patient possesses. Only a few patients are highly literate and though the disorder of mood and thinking can cause problems in understanding the written word, we believe that our patients were stymied by the style of the language used. There is no denying(!) the fact that the use of multiple negatives makes the sentence difficult to understand even for normal people, and the less said the better for terms like 'aforesaid', 'heretofore' and 'notwithstanding'.