Correspondence

Getting rid of 'Section' jargon

DEAR SIRS

We have new Mental Health Acts. Their provisions need to be discussed and communicated. Reports we write need to be intelligible to colleagues in other countries (especially other countries within the UK) and in other times (e.g. after the introduction of yet another new Act). It has been clear for many years that the use of numerical shorthand (i.e. referring to Section 25, 60, etc) is useful only to those closely involved with the legislation during the life time of that legislation; to others and in other times it is confusing and opaque. Would it not be wise for us to all resolve to use intelligible verbal shorthand instead? The Act itself usefully provides subheadings in its margins on which such shorthand could be based. In this way we could develop the following jargon:

Section 2—assessment order; Section 3—treatment order; Section 4—emergency assessment order; Section 5—in-patient detention order; Section 7—guardianship order; Section 13—social worker application; Section 35—remand for reports; Section 36—remand for treatment; Section 37—hospital (or court guardianship) order; Section 78—interim hospital order; Section 41—restriction order; Section 47—convicted prisoner transfer; Section 48—unconvicted prisoner transfer; Section 49—prisoners restriction order; Section 57—treatment *and* second opinion certificate; Section 58—treatment *or* second opinion certificate; Section 136—police order.

This list embraces some of the important powers in the Act that tend to get referred to by number. The principle can be applied to any section. Most of the labels are three words or less and could become readily comprehensible if they came into common use. To state that 'in 1974 the patient was admitted under Section 26 of the Mental Health Act 1959 and is now detained under Section 37 of the new Mental Health Act' may be technically true, but is an undesirable form of mumbo-jumbo that is a barrier to clear communication. The sentence could read, 'in 1974 the patient was detained under a Mental Health Act civil treatment order, but is now under a hospital order'; or, 'the patient has twice been subject to compulsory detention under mental health legislation, in 1974 he was detained by his psychiatrist, in 1983 he was sent to hospital by a court'. The first sentence requires detailed familiarity with two Acts and tells the uninitiated nothing, the second is fully intelligible to the initiated and partially intelligible to most interested people; the third sentence would make some sense to a wide audience although it might not be exact enough for a medical report.

JOHN GUNN

Institute of Psychiatry
London

Interpreting the Mental Health Act

DEAR SIRS

Dr Maragakis (*Bulletin*, January 1984, **8**, 9) proposes that junior medical staff should be delegated under Section 5(3) of the Mental Health Act 1983 to detain patients already in hospital voluntarily.

The compulsory detention of a patient admitted voluntarily to hospital is a serious decision which should be taken by the most experienced person available. The most experienced people in a psychiatric unit are the senior medical staff and senior nurses. Delegation of this responsibility to senior house officers might arguably conform to the letter of the new Act, but would appear to run contrary to its spirit. Restricting signatories of Section 5(2) to consultants and other appropriate senior doctors does not require that two consultants be on call: it is surely a poor unit which cannot find a consultant within the six hours that a senior nurse is permitted to detain a patient. This will result in consultants being called at inconvenient times such as during the night or at weekends, but surely we should accept this when the question of the personal liberty of one of our patients is under discussion. There is little doubt that the proper operation of such a system would reduce the number of the patients detained, since the extra skills of the consultant should ensure that some patients, who would otherwise have been detained, will be regarded as fit to leave the hospital, and that others will be persuaded to stay voluntarily.

The fact that psychiatrically inexperienced GPs and policemen have some statutory powers under the Act is not an argument in favour of extending this power to inexperienced junior hospital doctors, but would more rationally lead to the suggestion that these powers be removed from psychiatrically inexperienced GPs and the police.

M. PEET

Walton Hospital,
Chesterfield, Derbyshire

The Approval Exercise—constipated chaos?

DEAR SIRS

I have noticed with dismay an increasing trend within the College which can only be termed obsessional behaviour. Unfortunately this habit seems to have filtered through to the convenors and even higher levels, as Approval visitors seem to be slavishly sticking to their sheets of College rules for accreditation. Most important, there is no proven correlation between the College rules for accreditation and a good working unit.

At a recent meeting of clinical tutors at my hospital, following an Approval visit by the College team, my medical and surgical colleagues were incredulous at the trivial and

nit-picking way the team had searched for reasons to downgrade us. If history is to teach us anything, it shows that any institution that is riddled with obsessionals given free rein is destined to end in constipated chaos.

The present rigid inspection system is bringing units all over the country to their knees, usually to the advantage of over-staffed academic units and leading to real suffering amongst patients.

I am convinced that this is morally wrong, and that our non-psychiatric colleagues are correct to laugh at us for being so petty.

As an elected member of the Executive of the North Western Division, I am finding it increasingly hypocritical serving my term and supposedly supporting this inspection system, which is undermining patients' rights to care and treatment wherever they reside.

May I suggest a College meeting to bring these matters into open debate?

M. A. LAUNER

Burnley General Hospital
Burnley, Lancs.

Psychotherapy supervision—A contemporary view

DEAR SIRS

Drs Lieberman and Cobb's survey concerned with psychotherapy supervision in the South West Thames Region (*Bulletin*, June 1983, **7**, 102–3) stimulated me to circulate a questionnaire of my own. I sent this to all senior registrars, registrars and SHOs in the St George's rotational training schemes and the consultants for whom the junior doctors were working. The total number circulated was 32 consultants, 17 senior registrars, 26 registrars and SHOs. Questionnaires were returned by 28 consultants, 17 senior registrars and 21 registrars and SHOs—giving a respondence rate of 88 per cent.

The results of the survey are listed below:

1. Asked about preference for the kind of psychotherapy supervision, 71 per cent of consultants and 81 per cent of junior doctors preferred specialist psychotherapists to be giving this; a further 10 per cent overall indicating that a mix of specialist psychotherapists and consultants with a special interest would be optimal, and 11 per cent of consultants and 13 per cent of juniors making the special interest consultant their first choice.
2. Of registrars and SHOs, 33 per cent felt their supervision needs were being fully met. Overall, 71 per cent of juniors felt their needs were met (either 'very much so' or 'adequately') compared with 82 per cent of consultants.
3. 86 per cent of consultants and 87 per cent of juniors felt that the current provision of about one hour for individual psychotherapy supervision per week and one hour for group psychotherapy supervision per week was 'about right'. (A small number at all grades felt this was either too much or too little.)
4. I asked colleagues to define themselves as either 'organically minded', 'psychotherapeutically minded', or 'drawing equally on both aspects of treatment'. Of the consultants, 10 per cent replied 'organic', 50 per cent 'psychotherapeutic' and 40 per cent answered 'both'. This compared with total scores for the juniors of 13 per cent 'organic', 42 per cent 'psychotherapeutic', 45 per cent 'both'. There was no bias demonstrated towards the kind of psychotherapy supervision preferred in terms of these three kinds of orientation. (In fact, the three consultants identifying themselves as 'organic' opted for specialist psychotherapists.)
5. Asked about in-fighting and jealousy between the specialist psychotherapist and the general psychiatrist, 93 per cent of the consultants and 79 per cent of the juniors did not hold the view that such in-fighting and jealousy had to happen, as against 7 per cent of consultants and 18 per cent of juniors who saw it as inevitable. (A number of respondents made the point that a certain amount of tension and competitiveness was generally to be found among consultant colleagues, but this in itself was no more than human nature.)
6. I asked whether such in-fighting and jealousy had personally been observed—18 per cent of consultants and 21 per cent of juniors said they had noticed it, as against 78 per cent of consultants and 74 per cent of juniors who had not.
7. Asked if it had 'been the impression that specialist psychotherapists hold the view that no one but a specialist psychotherapist is skilled enough both to supervise juniors in psychotherapy and to do psychotherapy of a proper kind', 46 per cent of consultants and 66 per cent of juniors answered in the negative; 43 per cent of consultants and 28 per cent of juniors confirmed this. Regarding the corollary that 'the attitude of general psychiatrists is seen as being that if only psychotherapists can train our junior doctors, then perhaps only psychotherapists can do psychotherapy', 71 per cent of consultants and 76 per cent of juniors answered that this was not their view, as against 25 per cent of consultants and 18 per cent of juniors who said 'yes'. A number of respondents also drew attention to the distinction between supervision and the practice of psychotherapy, regarding the former as the special responsibility of psychotherapists and the latter as properly being one of a general psychiatrist's skills.
8. Finally, I asked whether or not the consultants involved in the rotational training schemes at St George's were in general felt to support an integration of physical and psychotherapeutic treatments. 82 per cent of the consultants and 76 per cent of the juniors said they thought this was true, as against 6 per cent of consultants and 8 per cent of juniors who thought not.