

could achieve, and that some patients needed further discussion before referral was made.

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Mental Health Review Tribunals in practice

DEAR SIR

It has been drawn to my attention that the references for my paper (*Psychiatric Bulletin*, June 1993, 17, 331–336) contain two errors and an omission.

- (a) There is a third edition of Richard Jones' *Mental Health Act Manual* published in 1991.
- (b) The reference to the 'Mental Health Act Manual', DOH, should read 'Mental Health Act 1983, Memorandum on Parts I to VI, VIII and X', Department of Health. London: HMSO.
- (c) *Mental Health: Tribunal Procedure* (1992) L. Gostin & P. Fennell, Longmans.

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DEAR SIR

Gordon Langley has provided a valuable service to Tribunal members and non-members alike in his paper on 'Mental Health Review Tribunal practice' (*Psychiatric Bulletin*, June 1993, 17, 331–336). In addition to the references he quotes, new Tribunal members are provided (among other material) with *A Guide For Members* produced by a small group of us in 1988. In addition, both new and experienced members will find Larry Gostin's and Phil Fennell's *Mental Health: Tribunal Procedure* (second ed, Longman, 1992) a most useful aid to practice. (See David Tidmarsh's review of it in the June issue of the *Journal*, p. 860).

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Clozapine withdrawal syndrome

DEAR SIR

I was interested to read Palia & Clarke's description of a possible clozapine withdrawal syndrome (*Psychiatric Bulletin*, June 1993, 17, 374–375). My own experience of treating 20 patients with this

drug confirms that the inevitable rebound that one witnesses on stopping it suddenly is worsened by a confusional state which varies in severity from patient to patient. Because of my awareness of this, the last time I took a patient off the drug (for reasons other than a red alert), I weaned the patient off a dose of 375 mgs daily over three weeks (the latest Clozaril data sheet suggesting gradual reduction over one to two weeks). Despite this, the confusional state that accompanied the rebound psychosis was most marked, and led to the patient having to be nursed in pyjamas for one week. This patient had been taking clozapine for over two years, and I wonder whether the weaning off period should be extended to a month or more if the patient is well established on the drug (say a minimum of 18 weeks, which is the time that blood testing changes from weekly to fortnightly).

I look forward to reading or hearing of others' experience in this area.

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Hypnosis in psychiatry

DEAR SIR

Dr Mathew on 'Hypnosis in Psychiatry' (*Psychiatric Bulletin*, April 1993, 17, 202–204) concludes that "Hypnotherapy should be considered as a supportive and supplementary therapy and not as a substitute form of therapy to treat the untreatable." What exactly does he mean? A "substitute" for what? And, how can the "untreatable" be "treated"?

There are numerous examples of hypnosis as a treatment in its own right as distinct from being merely "supportive" or "supplementary", as in severe refractory irritable bowel syndrome (Whorwell *et al*, 1984, 1987) and infertility without any organic basis (Mackett, 1985). I recently treated two cases in which AID had been attempted unsuccessfully over a prolonged period. The patients were referred by a consultant in infertility. Both became pregnant within months.

I agree with the author that psychiatric patients should not consult those with no medical qualifications and no formal training in psychiatry. But why pick on the practice of hypnosis in this connection? For similar reasons, I have never been in favour of the direct referral of psychiatric problems to clinical psychologists.

Mathew concludes that hypnosis is valuable in liaison psychiatry where specialists have not discovered any organic abnormality. This may or may not be true, but diagnosis (and therefore therapy) should be based on positive grounds, not merely on

the absence of physical factors. This applies – as in any other branch of medicine – to the decision whether or not to treat by hypnosis.

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- MACKETT, J. (1985) Hypnotherapy for subfertility: report of two cases. *Proceedings of the British Society of Medical and Dental Hypnosis*, 6, 20–21.
- WHORWELL, P. J., PRIOR, A. & FARAGHER, E. B. (1984) Control trial of hypnotherapy in the treatment of severe refractory irritable bowel syndrome. *Lancet*, ii, 1232–1234.
- , — & COLGAM, S. M. (1987) Hypnotherapy in severe irritable bowel syndrome: further experience. *Gut*, 28, 423–435.

Reply

The main aim of my article was to outline the current situation of hypnosis and its possible application in psychiatry, not to discuss details of case reports and possible further application in general practice.

I am sad that Dr Silverman misunderstood my statement of “substitute to treat the untreatable”. Hypnotherapy has always been misused and has unfortunately been applied as a main therapy for malignant disorders and even HIV infection which currently cannot be treated by any known conventional methods. Hypnotherapy has also been misused to treat disorders which may be treated by surgery. Therefore, hypnotherapy must not be considered as an alternative or “substitute” or second-line therapy for any disorder which is currently untreatable by conventional or known methods.

I am surprised that Dr Silverman thinks that organic abnormality should not be taken into account as he states in his final paragraph “this may or may not be true”. To elaborate the point further Dr Silverman quotes the paper by Mackett (1985) “the use of hypnosis in infertility without any organic basis”. How and who decided about the organic basis and why did they not use people with “organic basis”?

I have tried to keep the paper as brief as possible with a view to encouraging psychiatrists in my venture to establish a ‘Hypnotherapy Special Interest Group’ within the Royal College of Psychiatrists, about which I have already written to the President.

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User satisfaction with a psychiatric day hospital

DEAR SIRS

The Mental Illness Key Area Handbook from the Department of Health emphasises that central to the creation of “appropriate and responsive services” is involvement of users “with the most severe mental illnesses and the most longstanding health and social problems”. We wish to report our recent study which examined the pattern of need of patients attending a psychiatric day hospital in an inner city area of high social deprivation.

We used a structured interview on a comprehensive patient sample recruited across all hospital working days and opening hours: the sample (23) was representative of all 96 patients on the attendance register. Day patients tended to be single, middle-aged, isolated, with mainly psychotic illness, had an approximately equal sex distribution and ethnic minorities composition similar to the general population. In-patient admissions were about three times the length of other catchment area patients, and social disabilities were severe according to World Health Organisation criteria.

Twenty-one (91%) of the patient sample named their key worker. High levels of satisfaction were reported for professionals that patients had most access to and contact with: 74% of patients rated nurses as “helpful” or “very helpful”, while similar ratings for occupational therapists were 96%. Psychiatrists’ ratings were lower (consultants: 30%, registrars: 52%). The reported helpfulness of psychologists and social workers depended on their accessibility. Average group attendance was ten patients (range 4 to 15); regression analysis showed a consistent level of satisfaction of 71% across self-selecting groups ($n = 15$, $P < 0.0001$) of all sizes. Most patients (74%) believed their mental health was benefitting from attendance, and over half (52%) said their care was strengthened by sharing it with others.

Our initial, anonymous, self-completed questionnaire (a widely used method) failed to obtain any useful information from this patient population. However, using our structured interview we identified specific areas in which care was subsequently improved. We would stress that in-depth interviewing requires many manhours, including negotiation and consultation with, and feedback to, staff and users. In our opinion, all staff should be involved in planning the audit, and interpretation of the implications for change.

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