

Correspondence

A hazardous and irreversible treatment

DEAR SIR

The new Mental Health Act requires psychiatrists to take special consultative steps before they use hazardous and irreversible treatments to help their patients. It seems to require them, at least until a circular or research appears concerning a particular treatment, to determine whether the treatment is or is not hazardous or irreversible. The responsibility lies with the individual consultant concerned. The present test most people seem to propose has to do with statistically and scientifically proven effects of specific treatments. Such criteria seem to me to exclude all but a tiny minority of treatments—e.g. sterilization, leucotomy, lobotomy for epilepsy.

Was this the intention of the authors of the Act? I suspect it was that of the psychiatrist authors. More important, will the public, and especially those amongst them interested in mental health, allow such an interpretation? Let us discuss three treatments in the light of such public scrutiny.

There is no evidence that properly applied ECT is either hazardous or irreversible, apart, of course, from the quite trivial anaesthetic risk and the remote possibility that the transformer has been wired up the wrong way. Many of our patients, even those who know that ECT restores them to a normal mood state, approach it with fear. Our hospitals are peopled with patients who had ECT on an off-chance that their inadequacy—schizophrenia, personality disorder, or some such—might turn out to be a depressive illness, or even just that ECT might help. Indeed, I imagine most of us still do this occasionally when really up against it. The problems of diagnosis are not what I wish to discuss; the purpose of mentioning them is simply to remind us that they exist. All of us have patients who feel they were irreversibly damaged by ECT. Such beliefs range from: 'My memory has never been any good since . . .' through 'Since the electric treatment I have never had any energy', to 'I have to smoke all the time to compensate for the Redeptin you have to give me to repair the damage the ECT did'—to quote three of my patients. In some particularly articulate patients there even seems to be real evidence of the nature of the disaster that befell them. Their problem, now much more clearly expressed and therefore possible to locate and identify, was not understood, in spite of the best of intentions and reasonably competent endeavour. A solution they knew to be irrelevant was applied, after consent was refused, or sought at a time when they did not know what they were letting themselves in for. From the beginning they knew an irrelevant, active treatment was being applied to the wrong part of their being. Is it remarkable that they then found the event a turning point, developed delusions about it, went into somatic disability and/or lost faith in themselves and humanity? Are we sure this experience is not hazardous or

irreversible? Was it really the intention that such treatment could be applied against the patients' will without the most searching enquiries and consultation?

Phenothiazines are the treatment of choice in schizophrenia. Phenothiazines are amazingly safe. Tardive Dyskinesia is fortunately rare. Irreversible Parkinsonian side effects are fortunately rarer. The three-month rule does protect us to some extent. Liver damage seems to have disappeared and agranulocytosis hardly ever happens and usually clears. Patients return to health in droves on phenothiazines. The anergic syndrome following recovery generally clears. The place of 'depression' after treatment with phenothiazines has been removed, at least in statistical terms.

When discussing Russian psychiatry, even psychiatrists are able to regard phenothiazines as harmful and destructive when applied to dissidents. Quite right too, but do we not indulge in a double think when we discuss ourselves and our patients? The relatives are very struck by the Parkinsonian side effects of these drugs. Fortunately they see them come and go almost immediately because when they develop we treat them. For some of the public this transient state is 'zombie like' and worse than the illness the patient had. They look iller, and they spend more time in a day looking ill than while their psychotic state was in full bloom. What about the paranoid old lady with a paraphrenic-like state we have all admitted in the hope that the admission would lead of itself, or with phenothiazines, to recovery, and whom we have had to release again, uncured, because there is no continuing evidence that she is a danger to anyone, or because the in-hospital state is actually worse than the out of hospital one? The relatives are never forgiven, they can never forgive themselves, the GP is more firmly 'one of them', and the patient is left more alienated.

Psychotherapy works wonders sometimes. Linked with social manipulation, social therapy, family interventions, and behavioural techniques it will, at times, resolve appalling problems. Evidence for its efficacy is sparse, but for most of us it is convincing. Kindness and understanding do heal. Psychotherapy is always given to the consenting patient—or is it? Try to get informal consent that does not involve an extraordinary leap into the realms of trust for the analysis of the transference, or family systems examination from all the parties or for involvement in a psychodrama. Just try to explain these techniques! *One Flew Over the Cuckoo's Nest* illustrated the abuse of a kind of psychotherapy, and is for those of us involved in that sort of psychiatry a disturbing lesson. The truth is that detained patients are given psychotherapies, and that there is little chance of really explaining to them what they are letting themselves in for. How many psychotherapists cannot think of anyone they wish they had never tampered with because the patient graduated from

neurotic to incapable?

These three example treatments illustrate the complexities of our responsibilities. The readership may hope for early classification outside the Law Courts. To do our best and be wrong is bad enough, but to do our best to a patient who is sure we are wrong, and be wrong, is worse, and in such circumstances it is even more difficult to be right. On the other hand we are presented with the problems in such circumstances, and we have to handle them.

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Sorting out the confusion in psychiatric day care

DEAR SIR

Philip Vaughan, in his recent article (*Bulletin*, October 1983, 7, 184–5), rightly highlights the current confusion over the functions of psychiatric day care in this country. However, there is, in fact, evidence in the literature which could dispel the confusion.

There are numerous studies demonstrating the value of day hospital care as an alternative to in-patient admission,^{1,2,3} although none is as impressive as the study Vaughan cites.⁴

Family burden has been specifically investigated in an important controlled study by Herz and colleagues in the United States, in which day care was used in conjunction with a policy of brief hospital admission for acutely ill patients.⁵ Burden was lower for the families of patients offered a combination of brief in-patient admission and transitional day care than for families of those offered standard (prolonged) in-patient treatment. Similar findings are reported by Hirsch in the UK.⁶ Turning to day care for the chronic (psychiatric) patient, there is abundant evidence as to its utility in both improving the quality of life and preventing relapse in schizophrenic patients.⁷ Interestingly, the most effective units are those concentrating on 'recreational' rather than 'therapeutic' activities.

Much less researched is the use of day care for neurotic illnesses. However, one controlled study showed no advantage of day care as opposed to out-patient treatment for newly-presenting neurotic patients.⁸ Its authors concluded that out-patient treatment was to be preferred. (There is, however, evidence that for chronic neurotic disorders a community psychiatric nursing service may be preferable to psychiatric out-patient care.⁹)

One reason for the difficulty in rationally planning psychiatric day care within a district is the artificial distinction between hospital and social service provision. There needs to be close communication between day hospitals and day centres, with the opportunity for interchange of both patients and skills between units. The need for communication also applies to residential facilities, as local authorities take on responsibility for many who, in the past, would have

occupied a long-stay hospital bed.

Perhaps the future lies in a Mental Illness Service, distinct from both Health and Local Authorities.

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DEAR SIR

Phillip J. Vaughan (*Bulletin*, October 1983, 7, 184–5) rightly draws attention to the confusion surrounding day care. He points to the enormous variety of kinds of day hospital serving almost every kind of patient, and observes that day hospitals frequently offer treatment that is hardly different from that offered in nearby in-patient units. The style often reflects the ideas and personality of the consultant in charge rather than 'a systematized part of a complete whole'. However, exactly the same comments can be made about in-patient care.

There is very little research of an adequate standard addressing the questions that Mr Vaughan raises, so units are bound to evolve according to hunch and habit. Braun *et al.*¹ reviewed controlled outcome studies of alternatives to hospital admission, modifications of conventional hospitalization, and alternatives to long-term hospitalization for the period 1966 to 1978. They found only two studies of day care, seven studies of other alternatives to hospital admission, and six studies of modifications of hospital admission.