Reply

DEAR SIRS

I am grateful to Dr Weich for the comments he raises about the important issue of supervision which I did not have the space to address in the article. However, as it has rightly been raised, I would like to make a few comments.

It was sensitive of Dr Weich to pick up the sense of feeling somewhat alone in trying to struggle with the dynamics in out-patient work. In the unit where I worked at the time (an average NHS psychiatric hospital in Surrey) dynamic supervision was available, but dealt with patients undergoing formal psychotherapy. Out-patient work was supervised, but limited by time constraints and a medical model orientation. I was fortunate in that a weekly psychotherapy interest group was held where broader clinical issues were examined, including out-patient work. The group provided me with much support and opportunity to reflect with others, but was autonomous to my training programme. I agree with Dr Weich that unsupervised work can lead to dangerous and pathological acting out, although to ignore events occurring within the doctor patient relationship can also lead to disastrous results.

The issue of how to integrate our work with different models kept separate in clinical practice remains unresolved within the current general psychiatric set up, and within trainees' training programmes. I hope that bringing attention to these difficulties can further stimulate thought and action aimed at resolving them.

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Patients repeatedly admitted to psychiatric wards

DEAR SIRS

Drs Evans, Rice and Routh (Psychiatric Bulletin, June 1992, **16**, 327–328) make the same clinical error that I have had cause to write about twice in the past six months (Cohen 1991, 1992). In the patients they describe it is not possible to make a diagnosis until some days *after* the alcohol and/or drug has been stopped and in the vast majority of such patients the diagnosis is not schizophrenia or manic depressive psychosis. All too often the diagnosis is made and treatment begun by junior doctors on admission when the history of the taking of alcohol/drugs should have compelled a waiting policy; attention to organic features in the mental state at this stage, quite apart form the history, would sometimes give a clear indication of the true nature of mental disturbance and this part of the mental state examination in such patients is often inadequately recorded.

Such patients need to be confronted with the fact that they have a choice – if they stop taking their substance their very unpleasant experiences will cease, if they don't they won't. Neuroleptic drugs do not work in these circumstances as the authors discovered and to give them is to pretend that the patients have an "illness" for which "treatment" can be given instead of symptoms caused by the substances that they are taking. This is a recipe for failure of management as the authors describe, as it *prevents* correct management. Neuroleptic drugs should not be prescribed and after-care should be appropriate to alcohol/drug abuse. Where the latter is refused the only thing that can or should be offered is first aid to protect the patient and others. Why, for instance, did one of their patients have to discharge himself on four occasions against medical advice when he is said have used alcohol and drugs on the ward and should probably have been discharged forthwith?

The problem described is sadly common and represents an enormous waste of resources. Perhaps it is time the College tackled it on a national basis.

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References

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Reply

DEAR SIRS

Professor Cohen makes a valid point about the difficulties in differentiating between drug induced and functional psychoses. However this does not apply to two of the three revolving door patients described, nor do I agree with his suggested treatment for the third.

Patient 1 was diagnosed as schizophrenic in his middle teens and as a chronic schizophrenic with persistent auditory hallucinations and paranoid delusions in his late teens. Initial compliance with medication did not help his symptoms, nor did psychological treatment. It is not therefore surprising that, in common with his peer group of unemployed young men in "bedsit land" he uses illicit drugs. The exacerbations in his mental state probably are caused by his drug abuse, but I do not think he should be rejected by health services for refusing to comply with a partially effective treatment with, to him, worse side effects than his symptoms.