# Book reviews

**Acute Problems: A Survey of the Quality of Care in Acute Psychiatric Wards.**
By Sainsbury Centre for Mental Health.
London: The Sainsbury Centre for Mental Health. 1998. 56 pp.

In this second, more intensive report on acute in-patient care from the Sainsbury Centre, 215 patients on nine different acute wards were studied soon after admission, during admission and after discharge. The picture that emerges is extremely disquieting, although unlikely to surprise those who work on similar wards. The authors find that there is little evidence of individualised treatment plans while on the ward, and that patients often feel unsafe and spend much time doing nothing. They note the absence of the multi-disciplinary team, and record that in-patient care is often confined to interviews with psychiatrists and care from nurses. Care from occupational therapists, social workers and psychologists is unusual, and often late in coming. Despite this, the patients improve, with symptoms on the Brief Psychiatric Rating Scale (Overall & Gorham, 1962) falling from an average 12.7 on admission, to only 6.4 on discharge. The authors appear bemused by this finding, saying it is "against the odds", but it should cause them no surprise: if patients are admitted at a time of acute crisis, and most of them receive chemotherapy, a reduction of this magnitude is to be expected. They state that "nearly a fifth of patients receive no medication *whatsoever*" (emphasis added); but this should not surprise them either, as on an earlier page they state that 15% had no diagnosis or that of personality disorder, while 10% were social or respite care admissions. They make no comments on the fact that many more patients receive major tranquillisers than receive diagnoses of psychotic illness, and that one-fifth of the patients in one unit had been in seclusion, while staff in five of the nine wards managed perfectly well without seclusion rooms. The authors draw 10 major conclusions from their survey, when taken together with other published work on acute care. Addressing themselves to the Department of Health and commissioners, they state that "patient-centred care should be the fundamental principle underpinning . . . acute care"; and this seems likely to be adopted by the Department of Health, and to form yet another exhortation to the providers of care. The authors do not suggest that resources for mental health services should be improved, to allow more staff to be employed to deliver the sort of care that they advocate. After all, the present staff are not sitting on their hands: in my view there are not enough of them in many areas. Having exhaustively documented the deficiencies of the buildings in which acute care takes place, they rightly conclude that commissioners and providers should take steps to improve the hospital environment. Addressing providers, they urge that a range of therapeutic activities should be made available, and that recreational activities should be "considered as therapy", and made available throughout weekdays and at weekends. This, they assert bravely, will make in-patient care "optimally effective".

The authors describe alternatives to hospital admission as "lamps in a dark landscape", and make recommendations for implementing "a range of crisis services". It is certainly correct that much pressure could be taken off acute units if alternative facilities were available for people who do not need acute care, but it is unlikely that all the patients whose histories are given in detail could be cared for in such facilities – unless, of course, they were acute units that happened to be housed in non-institutional settings. Overall, this is a generally helpful report both for the mentally ill and for those who care for them, and it is to be hoped that useful action will flow from it.

## Reference

OVERALL, J. E. & GORHAM, D. R. (1962) The Brief Psychiatric Rating Scale. *Psychological Reports*, **10**, 799–812.

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**Mount Misery.** By Samuel Shem.
London: Black Swann. 1999. 570 pp. £7.99 (pb), ISBN 0-552-99813-3.

Samuel Shem's novel charts the first year of an American young doctor in the fictional psychiatric hospital Mount Misery. Dr Roy Basch, the hero, chose a psychiatric career after becoming disillusioned with medicine. It is the sequel of *The House of God* (Shem, 1985), his first novel,

which follows his first year as a doctor. The *House of God* has achieved cult status with junior doctors on both sides of the Atlantic. *Mount Misery* looks set to follow in its footsteps as essential reading for anyone interested in a psychiatric career.

Shem paints a nightmarish view of American psychiatry. Mount Misery is populated by psychiatrists obsessed with sex, money and their own theories. The only likeable psychiatrist, the clinical tutor, commits suicide early on in the novel. Very little of Mount Misery reminded me of my first senior house officer post. This can only be a positive sign for British psychiatry.

There is more to this novel than negative views on psychiatry. The characters and plot are bizarre and vivid – but hugely entertaining. There is an enormous amount of rather black medical humour in this novel and it is worth reading just for that. Shem wickedly parodies Freudian psychoanalysis while at the same time attacking purely drug-based psychiatry. Very few authors could write an entertaining novel on the state of modern psychiatry. Shem is probably the most talented doctor/author writing at the moment and he deserves to be read.

## Reference

SHEM, S. (1985) *The House of God*. London: Black Swann.

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**Hard to Swallow: Compulsory Treatment in Eating Disorders.** By Janet Treasure and Rosalind Ramsay. Maudsley Discussion Paper No. 3. London: The Maudsley. 20 pp. £2.95.

This is an interesting little book which brings together legal and psychiatric arguments about the justification for compulsory treatment of severe anorexia nervosa. It comes out clearly in favour of such treatment in principle but is critical of how it is sometimes done in practice. This is not surprising since the authors are notable advocates, researchers and practitioners in the field.

Psychiatrists are likely to find the legal arguments of interest because they are less familiar and more decisive. Perhaps surprisingly while psychiatrists still debate the phenomenological status of anorectic beliefs and anguish about consent and curability, the law seems to have made up its mind. Anorexia nervosa is a mental illness, compulsion can be justified and food and feeding may be considered as treatment. A simple message is emerging out of the legal discussions – if the person is in danger, get on and do something. But what? And how?

Personally, I have no objections in principle to the compulsory treatment of anorexia nervosa. In practice, I avoid it like the plague. It seems to me that too often the characteristic and understandably mixed feelings of the anorexia sufferer are transformed into simple opposition by pushy treatment attempts driven by the worries of those around him or her including clinicians. Then the interaction can come to resemble a poker game in which the ante is repeatedly upped. It is a game that can be played out to the death. It seems to me almost always better to try to help the sufferer himself or herself to experience his or her own dilemma. He or she needs to confront the enormity of both options – staying as he or she is, or changing. Given space to do so, almost all sufferers appreciate the nature of their situation only too well. Most dither but eventually decide to have a go at change. The clinician should not fudge the issues or compromise about what recovery would involve but equally should not take over what is the responsibility of the patient to try to decide and to decide to try.

Playing the long game in this way feels right to me. However, such management can be a worrying business for the clinician. Furthermore, I am willing to acknowledge that some patients may present at a point where more direct action may seem inevitable. But they are, or should be, very few. Either way, the management of very severe anorexia nervosa is a specialist business. This is not a matter of esoteric knowledge, but more that clinicians dealing with such patients need to have the confidence that comes with experience if they are to make their patients feel safe enough to change. The authors of this book are critical of the compulsory admission of patients with anorexia to non-specialist centres. I agree. Indeed, I would suggest that in some cases, the Mental Health Act 1983 is invoked in order to help the worried clinical team feel that something is being done. The more confident and competent are those around the patient with anorexia, the less often will he or she need to be sectioned. Arguably, there will always be a need for a few centres like Dr Treasure's where skilled and humane compulsory treatment is available. Paradoxically, the more such centres are available the less often they would be needed in that role. Undoubtedly, the first recourse for the generalist confronted with a worrying patient should be to the telephone for advice rather than to the pink paper for false reassurance.

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