the columns

correspondence

Conditions for detained patients

Sir: I have recently retired from the mental health review tribunal, previously visiting about 25–30 different psychiatric units each year. I am first concerned that over recent years the percentage of admissions formally detained has risen to about 20%, having previously, through my entire career, remained steady at about 10%. This is now common knowledge, but has been tolerated rather than arouse the concern it merits. For the whole of the 20th century each new Mental Health Act was welcomed as promoting improvement in treatment, and a more humane attitude to patient care. The present Act followed this trend and was welcomed as such. It is only in recent years that the style of treatment of detained patients has, in my view, regressed to the point where the treatment is more harsh and restrictive than was the practice 30, even 40 years ago.

Following admission the detained patient, even the best behaved, is likely to be confined to the ward. There is often an unreasonable delay in allowing privileges. Access to the hospital grounds away from the ward may start at, say, 15 minutes twice a day perhaps for a few weeks before extended slowly by small increments. The onus is on the patient to demonstrate or prove the absence of risk.

Often there are no suitable grounds or garden in which a patient may enjoy fresh air, especially where the unit occupies wards within a large district general hospital. In some units there are no grounds at all separating the unit from a busy street or main road. In such circumstances there is no opportunity to grant any leave short of Section 17 leave – to leave the hospital premises, with all its legal formality, with no possibility for staff to sensibly take the lesser risk first.

Another phenomenon, which I consider bizarre, is the use of a sentry, this being a nurse stationed near the ward door to prevent unauthorised exit by a detained patient. The suggestion that a lock is more sensible than wasting the time of a highly trained nurse will be met with one of a variety of arguments presented with the conviction that all is well. Of course there are units where a more sensible practice may prevail. I am impressed by the unit that has a locked door and provides door keys on loan to patients allowed out from the ward.

Another example of institutional practice is the practice of visiting hours and the unquestioning attitude of the staff to it. By about 1960 or so many of the large old psychiatric hospitals, overcoming conservative objection, had abolished formal visiting hours, deciding that there was no reason why their patients could not enjoy the visiting privileges always available to private patients. Today almost every psychiatric unit will have a notice on or near its entrance announcing the hours: visiting from 4.15–6 p.m.; 5–7.30 p.m.; or visiting from 3–5 p.m., every unit different but each passionately defended as the only sensible hours. However, on enquiry, there is nobody in the unit, be it ward domestic to consultant, who can say who actually decided on the visiting hours, and an astonishing variety of guesswork results from such enquiry.

It was always a special treat to enter the one London unit that has on its entrance door "visitors are welcome at all reasonable times". This unit is just as busy and hard-working, with apparently as difficult case-load as any other similar unit. The generally restrictive treatment inevitably produces, in a number of patients, resentment, hostility and a great temptation to break rules considered unfair, or even absurd. The patients' breaking of rules is often recorded as psychiatric pathology, and 'lack of progress' or 'lack of insight'. Rarely, if ever, is there consideration of the possibility that the patient may be more reasonable than the institution.

Charles Finn

Atypical antipsychotics

Sir: Bebbington's conclusion that the new atypical antipsychotics are no more effective in reducing psychotic symptoms than their older counterparts (*Psychiatric Bulletin*, August 2001, **25**, 284–286) may not apply to one of these drugs, clozapine.

Clozapine was re-introduced in 1989 on the basis of repeated indications of therapeutic superiority, which culminated in the Kane *et al* trial (McKenna & Bailey, 1993), not, as Bebbington suggests, as part of a strategy to develop drugs without extrapyramidal side-effects. Supporting this, the meta-analysis of Geddes *et al* (2000) found the effect size for clozapine's effectiveness over conventional neuroleptics to be 0.68, which falls between the values of 0.5 and 0.8 proposed by Cohen for 'moderate' and 'large', respectively. This is difficult to reconcile with Bebbington's statement that "the meta-analysis indicated that some of the atypical antipsychotics had slightly better efficacy". Geddes *et al* (2000) argued that the apparent superiority of atypical neuroleptics was owing to the high dose of comparison drug used in many of the studies. However, clozapine was the atypical neuroleptic in only 12 of the 30 studies included in their two meta-regressions. When the Cochrane Collaboration (Wahlbeck *et al*, 1999) compared clozapine trials using low doses and standard doses of the comparison drug, no difference in clinical improvement, relapse rate or drop-outs was found.

GEDDES, J., FREEMANTLE, N., HARRISON, P., *et al* (2000) Atypical antipsychotics in the treatment of schizophrenia: systematic overview and meta-regression analysis. *BMJ*, **321**, 1371–1376.

McKENNA, P. J. & BAILEY, P. E. (1993) The strange story of clozapine. *British Journal of Psychiatry*, **162**, 32–37.

WAHLBECK, K., CHEINE, M., ESSALI, A., *et al* (1999) Evidence of clozapine's effectiveness in schizophrenia: a systematic review and meta-analysis of randomized trials. *American Journal of Psychiatry*, **156**, 990–999.

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Authors' reply: McKenna criticises the basis on which Bebbington included clozapine in his conclusion that the newer neuroleptics had little therapeutic advantage over their older counterparts. While he may be right to conclude that clozapine is especially effective, our meta-regression (Geddes *et al*, 2000) did appear to apply equally to all atypicals.

Part of the problem with a correct evaluation of the effectiveness of

https://doi.org/10.1192/pb.26.1.36 Published online by Cambridge University Press