## ECT UNDER COMPULSION

In answer to an enquiry from the College Public Policy Committee about the giving of treatment to patients detained under a Section 25 order, Dr E. F. Carr, of the Department of Health and Social Security writes:

Our legal advisers consider that the inference from Section 25, supported by the plain indication of Section 29 that admission under Section 25 may be a matter of 'urgent necessity' justifying an abridged emergency procedure, is that *some* treatment may properly be given without his consent to a patient detained for observation. Their view is that treatment so authorized cannot exceed what is reasonably required by way of observation (i.e. for the purpose of diagnosis and the determination of what future care and treatment may be appropriate) or is immediately necessary in the interests of the patient's own health or safety or with a view to the protection of other persons. It is, of course, for the doctor concerned to judge, in the light of the facts of each case and these rather restricted criteria, whether he could properly administer ECT to a particular patient without the patient's consent. It seems to us that the advice given in the College guidelines on the use of ECT, about the seeking of consent of patients who are able to understand the nature and purpose of the treatment and the seeking of the approval of relatives in other cases, was wise. As indeed were the recommendations that, except in an emergency, two consultants' opinions should be sought and that a defence organization should be consulted in cases of doubt.

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## TEACHING PSYCHOTHERAPY

DEAR SIR,

In their paper, Teaching Psychotherapy in Mental Hospitals, Dr S. Lieberman *et al* (*Journal*, April 1978, **132**, 398–402) stated, under the heading of Group *vs* Individual Supervision, 'Nearly all trainees preferred individual to group supervision of their psychotherapy. Generally, our attempts at group supervision were unsatisfactory. This was reflected mainly in poor attendance, and was a problem we shared with the two specialist psychotherapists already in the Region'. This does not accord with my experience of carrying out both types of supervision. I have not found one type of supervision to be superior to the other, but rather that each type involves different experiences of supervision.

In individual supervision, there is usually a more detailed dissection and discussion of sessions, and the ventilation of aspects of the countertransference and its possible relationship to personal problems in the trainee will certainly be more open than in the setting of a group.

However, in group supervision trainees have the opportunity, not only to present their own cases, but also to listen to their colleagues' cases, and all members can put forward their own ideas about the sessional material presented. This means a fair degree of exposure of the supervisee presenting to his colleagues, and necessitates his being able to tolerate some criticism of his work, which can only occur if there is a feeling of trust in the group between the supervisees themselves and, of course, between them and the supervisor.

The supervisor's role is crucial here and I think that two important ingredients in achieving this are (a) by maintaining a non-competitive relationship towards, and among, the trainees, and (b) by taking all contributions to the discussion as worthy of serious consideration in understanding the material. This trust takes a while to develop, but has been worth working for.

I am writing this to combat the notion that if individual supervision is not available group supervision is unsatisfactory. I should add that my supervisees at this Centre agree with the view expressed here.

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## NURSE THERAPISTS

DEAR SIR,

I must thank the authors of the Monograph I reviewed (*Journal*, September 1977, **131**, 320) on Nurse Therapy for their good humoured response to my review (*Journal*, April 1978, **132**, 416). Since I do not wish to exchange puerile insults with Dr Harding, and as my old friend Dr Marks is in firm possession of the wrong end of the stick, I will content myself with commenting on their disingenuous suggestion that nurse therapists might be responsible to that old work horse, the 'multidisciplinary team'.

In a primary care setting, such a team is headed by the general practitioner, and contains social workers and receptionists, as well as an array of specialized nurses. Should one of Dr Marks' specialized nurses require advice concerning a problem arising in therapy, he or she would need to refer the patient—

presumably with the consent of the G.P.—to the district clinical psychology service or even to the more familiar, hospital-based 'multidisciplinary team'.

Your readers may wonder why Dr Marks and the authors of the Monograph have been so reticent about debating these issues in public. Could it be because the nurses are already arguing to the Whitley Council that 'if they do the work of a psychiatrist they should receive large incomes' (*On Call*, 13 April 1978, page 13)—and they therefore do not wish anyone to think they need to be responsible to anyone? Or have they had difficulty persuading clinical psychologists to supervise treatment programmes for patients they have not seen?

I would not like to rest my case without referring once more to the number of highly intelligent young unemployed psychology graduates in this country. We have recently advertised a post for a research psychologist and received twenty-two applications. More than ten of these have good honours degrees in Psychology, yet have had to work since graduation as barmen, bricklayers and in labouring jobs.

Since Dr Harding saw fit to write—and you, Sir, saw fit to print—reference to my attitude towards midwives, my wife and I wish to inform readers of the *Journal* that we were happy when our last baby was delivered by a midwife. The midwife was, after all, directly responsible to an obstetrician.

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## A CORRECTION

In the article 'A Controlled Evaluation of the Therapeutic Effectiveness of a Psychiatric Day Centre for Pre-School Children' by S. Wollacott, P. Graham and J. Stevenson (*Journal*, April 1978, **132**, 349–55) Table I, first line, the mean age of the community group should be 36.0 months and not 26.0 months.

## INTER-PROFESSIONAL COOPERATION

DEAR SIR,

Two ideas which could be useful in tackling the problem of institutions which are set up for short-term assessment and become clogged by long-term cases, as clearly presented by Dr Jean Harris in her Paper 'Child Observation and Assessment Centres: Psychiatrists' and Social Workers' Difficulties' (*Journal*, February 1978, **132**, 195–9) are: (1) putting more of the total resources (including residential staff) into pre-admission work (Bruggen, Byng-Hall and Pitt-Aitkens, 1973) and (2) doing much of the assessment work in the home (Campbell, 1975).

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### References

BRUGGEN, PETER, BYNG-HALL, JOHN & PITT-AITKENS, TOM (1973) The reason for admission as a focus of work for an adolescent unit. *British Journal of Psychiatry*, **122**, 319–29.

CAMPBELL, DAVID (1975) Adolescents in care. *Social Work Today*, **6** (9), 265–9.

## LIST OF BOOKS SUITABLE FOR A PSYCHIATRIC LIBRARY

DEAR SIR,

Later this year the Library Books Sub-Committee will start compiling a Supplement to the List recently published and welcomes suggestions from members of the College of books that might be included. The titles proposed in the letter from Dr Merritt (*Journal*, May 1978, **132**, 527) and his colleagues will, of course, be considered.

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