remained the predominant feeling there was a move towards indifference and a change in some to relief and security.

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Junior psychiatrists and ECT practice

DEAR SIRS

I read with interest the article by Henderson *et al*, 'Administration of electroconvulsive therapy: training, practice and attitudes' (*Psychiatric Bulletin*, March 1993, **17**, 154–155).

This paper addresses some important issues and is a welcome contribution to the important debate which is emerging about the administration of ECT and junior psychiatrists. It is reassuring that 93% of junior psychiatrists were "confident" about their ECT practice. However, despite being a deceptively simple procedure, ECT administration requires a high level of skill and knowledge. My own confidence has decreased over the past two years as my understanding of ECT has increased.

Clinical outcome in patients receiving ECT may be influenced by a diverse range of variables including patient age and sex, electrode placement, stimulus frequency, duration and energy, wave form (sinusoidal or square) and whether bi- or unidirectional (Abrams, 1992). Most of these factors can now be manipulated by the clinician (usually the SHO/registrar) using a variety of commercially available machines. A thorough examination of ECT practice in relation to these factors is now long overdue.

It has been my personal experience over the past couple of years that the relationship between these variables and response to ECT are very poorly understood by junior psychiatrists, as well as by a considerable proportion of senior colleagues. Since junior psychiatrists are in the "front line" in relation to the administration of ECT, much greater emphasis on training and understanding of ECT is needed. Greater knowledge of the ECT process will enable ECT to be tailored to the needs of the individual patient. This will help to minimise side effects and foster optimal conditions for clinical efficacy.

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The museum at Wakefield

DEAR SIRS

Dr Spencer (*Psychiatric Bulletin*, March 1993, **17**, 177) draws attention to the museum at Wakefield. A book which throws a very particular light on the history of mental hospitals in this country is that written by the curator of the museum, Mr A. L. Ashworth and the late Dr John Todd, **The House: Wakefield Asylum, 1818*. It is of special interest since the chapters are based on successive medical Directors from the opening of the Hospital in 1818 to the termination of the Directorship system of management in 1933. The book therefore describes the ideas and work of these luminaries, from William (later Sir William) Charles Ellis to Professor Joseph Shaw Bolton. The backdrop to these descriptions is the development and life of the hospital, with vignettes of staff, patients, treatments and entertainments.

The West Riding Pauper Lunatic Asylum, later called Stanley Royd Hospital, was the sixth asylum to open in Britain following the County Asylums Act of 1808. Samuel Tuke, of The Retreat at York, played the major role in the planning of the hospital and, in *Practical Hints on the Construction and Economy of Pauper Lunatic Asylums. The House*, provides vivid descriptions of the humane William Ellis and the influential Sir James Crichton-Brown (the 'orator of medicine') who invited such men as J. Clifford Allbutt and Hughlings Jackson to contribute, as well as instituting teaching for medical students from Leeds. Crichton-Browne produced and edited the famous West Riding Lunatic Asylum Medical Reports. Sir David Ferrier pioneered research into the localisation of cerebral function in mental illness. The reclusive Dr William Bevan-Lewis wrote an early British text on psychiatric disorder. Joseph Shaw Bolton became one of the earliest (if not the first) professor of psychiatry and continued the tradition of education about mental illness. Henry Maudsley gained his introduction to treatment of the mentally ill at Wakefield before going South to found

**The book is in limited circulation. It is obtainable on direct application to: The Administrative Department, Stanley Royd Hospital, Aberford Road, Wakefield, West Yorks WF1 4DQ. Cost: £15 (£16.50 inc. postage).*

the Hospital which perpetuates his name. Charles Darwin studied patients at the Hospital and sought advice from Crichton-Browne for his work *Expression of Emotion in Man and the Animals*.

Those taught to think that the history of the mental hospitals is a 'bad thing' will be reoriented by this illuminating account of clinical, scientific, managerial and humane endeavour. The reading of the book may prompt a visit to the museum at Stanley Royd Hospital: open Wednesdays 10 a.m.–1 p.m. and 1.30–4 p.m. Mr Ashworth may be contacted by phone: 0924 201688.

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Section 5(4) of Mental Health Act, 1983

DEAR SIRS

Drs Bowler and Cooper's paper about the use of Section 5(4) of the 1983 Mental Health Act (*Psychiatric Bulletin*, March, 1993, **17**, 147–149) is an important contribution to the limited literature on this subject. An inner-related, and arguably just as important, issue is the number of patients who are detained by nurses without using the provisions of the Act.

In our study (Allen & Johnstone, 1992), we found that out of 98 nurses who were eligible to detain patients, 22 admitted to having detained them by use of restraint without using Section 5(4). Interestingly, an earlier survey of the same cohort by us revealed just 12 nurses who were willing to admit this; we postulated that this was due to the feedback given in our second survey which enabled nurses to be more open about this rather difficult question.

A potentially worrying finding was the apparent lack of correlation between the decision to prevent patients leaving and their potential 'detainability'; out of 22 patients detained by restraint without using Section 5(4) only 12 were deemed by nurses to have a 'serious mental illness' so, by their own definition, would not have been detainable under the Act.

Restraint was only for a few minutes in 20 cases but for up to an hour in two cases, and over an hour in another; the latter three being 'seriously mentally ill'. We concluded that there may well be grounds for restraining people under common law for their own protection but that this did not normally include detaining them in hospital against their will and we questioned whether nurses were making reasoned judgements when deciding whether to exercise the provisions of the Act.

It was particularly interesting that during the period of our survey, which lasted for six months, Section 5(4) was used on ten occasions, compared with its previous use: ten times in the four and a half years since the implementation of the Act. We suggested that raising staff awareness and confirming the acceptability of the Section influenced their behaviour.

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Reference

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Questioning clinical judgement

DEAR SIRS

If Dr Akinkunmi (*Psychiatric Bulletin*, March 1993, **17**, 175) continues in old age psychiatry, he will soon become accustomed to having his clinical judgement queried by all sorts of people, not just Members of Parliament – although I admit it is not usual for MPs to get over-involved in person, choosing usually to write to Chairmen of Health Authorities or to the Health Services Commissioner.

One of the worst examples in my experience (some years ago now) was with a County Councillor who, hearing that an elderly depressed man was to be allowed home, went to the ward and bullied the nursing staff into letting her make a full "examination" of the patient, which included testing his ability to walk and climb stairs; in due course I was telephoned and given her opinion that my patient was not ready for discharge. This was conveyed to the family who resisted discharge so effectively that it could not take place; the patient just "gave up" and died a few months later.

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Training in liaison psychiatry

DEAR SIRS

I am delighted to see liaison psychiatry having a higher profile but have to say that the recommendations from the Liaison Psychiatry Group Executive Committee do not go far enough. What is missing is an explicit recognition of the essential quality of liaison psychiatry, which is the relationship between the psychiatrist and the hospital department where he or she works. Trainees who are simply supervised on clinical work will fail to understand what is happening to them, and to their colleagues if this is not addressed in supervision. As we all know, regular doctors mistrust psychiatrists, and a major part of the liaison task is joining the department or ward being served. This is comparable to an anthropological exercise, and requires some discussion between