it may have been their first contact with a psychiatric hospital. However, it was seen that virtually all patients fell firmly within the category of mental illness and most, whether they were subsequently detained further under the Mental Health Act or not, stayed in hospital for a period of treatment so it did not appear that Section 5(2) was being abused as an expedient measure merely to detain disturbed persons. Rather it seemed to have been used appropriately upon those suffering with mental illness.

It was felt though that there was a need to improve the documentation at the time of application of Section 5(2) and this documentation should include details of discussion with the RMO or duty consultant and instructions as to the observations required for the patient. It was also felt that the documentation of subsequent assessment, including the specific assessments for the purpose of the Mental Health Act, could be clarified and that such assessment should contain within it a clearly stated treatment plan. With reference to those detained within a day of admission, it was thought that some of these patients may have been served by better preparation or assessment at home before admission. Thus, it is hoped to liaise with colleagues in primary care and provide regular sessions on assessment and treatment of psychiatric emergencies. All these measures will be subject for further scrutiny in future audit meetings.

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Family psychiatry and family therapy

Dear Sirs

I am not much further forward after John Howell's clarification of the differences between family psychiatry and family therapy (*Psychiatric Bulletin*, March 1991, **15**, 171). The debate seems to be partly over "who discovered it first", along with misunderstood and/or different terminology for similar and fast developing ideas in both fields. I still suspect that the essential contents of both fields are compatible to a large extent. But I think it is important for psychiatrists that this issue is not allowed to rest with John Howell's iatro-centric views. The only cure seems to be for each camp to read the others' literature more thoroughly.

But, speaking of cures, one difference is clear. Over the last decade – apart from the word "therapy" in its own name, with which it is now unfortunately stuck – the active trend within family therapy has been systematically to question the language we use. Words which are plainly related to medical ways of thinking – such as psychiatry, patient, pathology – would not be as uncritically used in the family therapy field as John Howells and (presumably) family psychiatry does. The reason is that a "systems" way of thinking sees such terms themselves as potentially part of a cycle of labelling that may play a part in sustaining the process we are presuming to understand and alter. In other words, psychiatric terminology may be iatrogenic as well as iatrocentric. However, no-one would go back to the anti-psychiatric idea that the self-fulfilling cycle of labelling is always the *whole* story.

Lastly, in quoting an American who blithely considers family therapy to be a mere branch of family psychiatry, John Howells had better watch out for retribution from the active, multi-disciplinary and multi-agency majority in the field of family therapy practice and research on all continents. They would be rightly furious to be so ignorantly colonised by the psychiatric empire! If he apologises forthwith, I won't show them what he wrote!

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Dear Sirs

It is possible to agree with Dr Child that confusion will subside if care is taken to read the literature with an open mind and this would include reading the early literature on family psychiatry. But he raises other issues of critical concern to psychiatry.

Dr Child is right to point to the possible destructive effects of labelling. The problem in psychopathology is teasing out a discrete element in a complex field so that it can be encompassed by a word. The field is rendered more complex by able and ingenious speculators who invent concepts that have no basis in reality. An iatro-centric view is helpful in that the organic part of medicine has gone through the process of clarification already. To adopt its rigorous scientific approach, discipline, and emphasis in reality is no disadvantage in the clarification of psychopathology – the other part of medicine.

No apology is required for practising medicine in the medical field, encompassing as it does somatic and psychological pathology. Disorders of the psyche should not have less well trained medical practitioners than in the disorders of the soma. To open medical treatment and practice to all and sundry is no service to the afflicted. The highest standards of practice by the most able medical practitioners is the aim.

Teams are not new in medicine. Consider an obvious clinical team of surgeon in the operating theatre with the immediate help of anaesthetist, theatre nursing sister, porter and with a radiologist and histologist on immediate call. This team is characterised by co-operation between a number of independent experts but each functioning in their

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special field alone. The operating is a matter for the surgeon, anaesthetics for the anaesthetist, etc. But a team concept that has built up in psychiatry calls for the whole team operating at the operating site with collective decision-making, etc. We can picture the end result for the patient! A curious element also in the psychiatric team is that the psychiatrist, while apparently no more expert than the rest of the team, claims a medical salary usually considerably higher than that of the other team members. He may claim, "I can give drugs". But this function, in some circumstances, is being claimed also by the nurse and the clinical psychologist.

The term "psychiatrist" is unashamedly iatrogenic and Dr Child, as such, may share the claim to be a "healer of the psyche". If psychiatrists feel their expertise in psychopathology needs improvement then they should concentrate on research and training for medical colleagues leading to increasingly high standards of practice. But to indulge in cosy popularity from less well trained practitioners at the price of exposing patients to lower standards of care is unethical. Patients pay dearly for the multidiscipline, multi-agency practice on all the continents. The Royal College of Psychiatrists has a duty to protect its members and it will neglect these issues at its peril.

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Who cares for the adult brain-damaged

Dear Sirs

Shawcross (1990) described Hamble Ward – a unit for adult brain-damaged indviduals with behavioural problems in Southampton. A similar unit, Heddiw (Welsh for today) Ward, was set up in Whitchurch Hospital, Cardiff in 1988, and has received 40 referrals (20 admissions). Causes for the brain injuries of the admissions include: traumatic head injury (5), cerebrovascular disease (6), Huntington's chorea (4), presenile dementia of Alzheimer type (3), Herpes Simplex Encephalitis Amnestic syndrome (1) and hypoxic brain damage (1).

Thirteen admissions were male and seven female; the age range was 29–70 years (mean for males 54.9, for females 56.3). The time interval from onset of the brain insult/diagnosis to admission ranged from two months to ten years (mean 3.3 years). Referrals were from general psychiatric wards (4), the district rehabilitation unit (2), medical wards (4), and the community (5). A wide range of behavioural problems were seen – depressed mood (5), aggression (6), wandering (5), sexual disinhibition (2), emotional lability (2). Before 1988, the ward was a 16 bedded male ward for the physically frail and offered a homely but custodial environment for patients 51–71 years. This group was an uneasy mixture of long-stay graduates of the hospital and patients with organic brain syndromes from the admission wards. Nursing morale was low as they felt that they were the "dumping ground" of the hospital and, at their request, a planning team was set up and the orientation of the ward changed to a neuropsychiatric rehabilitation unit for people under 65. The aim of Heddiw is a multidisciplinary, problem-orientated approach to treatment (Livingstone, 1990).

Eleven of the first 20 admissions to the unit have now been discharged: fostering (4), home + respite care (6), nursing home (1). The average length of admission is nine months. The bedding accommodation is divided into seven assessment and five respite beds.

Nursing morale has improved greatly since 1988 and, in addition to the in-patient service, the staff act in a consultative capacity to the local rehabilitation hospital. Heddiw fulfils an important need – the neuropsychiatric rehabilitation of young brain damaged individuals showing challenging behaviour – and currently has seven patients on its waiting list for admission.

Should a similar service be provided in every district?

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Do we ride a paper tiger?

Dear Sirs

I would invite readers to go through the agenda and minutes of the meetings of their Division of Psychiatry over the past 60 months, note the topics brought to discussion, and the decisions reached. Note also the actions taken in response to the decisions, and the time intervals between decisions and actions.

Did you notice a certain pattern? That perhaps the same issues were raised, with little variation and even less action, year after year. Does the monthly

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