specification of disorders and also in obtaining a consensus on the optimum array of factors constituting the management process for defined conditions. Variations in ideology; the widespread use of multidisciplinary team approaches to diagnosis and treatment; the need to assess both clinical and social 'outcomes' of treatment: all these would complicate audit in psychiatry.

However, at a less sophisticated level much could be done to heighten self-scrutiny and to promote constructive feedback. The case conference may be an admirable forum for audit. A cogwheel division may decide to take a hard look at patient turnover in different firms; at out-patient waiting lists; at the use of Section 29 of the Mental Health Act; at prescribing costs in hospital.

The medical profession in Britain is ambivalent in its attitude to audit. There are fears that imposition of elaborate auditing procedures would be divisive, anxiety-provoking and productive only of a new bureaucratic apparatus. Nevertheless, audit of a kind is already extant, and the College has been involved since it was founded. Discussion and debate among members will no doubt take place in a variety of settings, and gradually the future role of the College in this large area will be fashioned.

Parliamentary News

(March to August, 1980)

The Mental Health Services

Figures were given on 25 March and 31 March for the numbers of consultants in the various specialties. For England and Wales the numbers are: Mental illness 1,055; Child and adolescent psychiatry 271; Mental handicap 149; for Scotland; Psychiatry 181; Child psychiatry 29; Forensic psychiatry 5; Mental deficiency 14.

The number of in-patients in psychiatric hospitals for mental illness in England and Wales has dropped from 143,000 in 1954 to 78,000 at the end of 1978. Of the 175,000 'or so' people admitted each year, only about 9,000 remain for over a year.

Figures were given on 23 May for the number of admissions to all psychiatric hospitals in England under the various compulsory procedure sections of the Mental Health Act. Admissions under Section 25 dropped from 6,713 in 1976 to 6,137 in 1978, and under Section 29 from 11,057 in 1976 to 8,299. On the other hand, Section 26 admissions rose from 756 to 962. It is not clear whether these last figures refer only to initial admissions under Section 26 or include those detained under Section 26 after having originally been admitted under Sections 25 or 29.

Asked about procedure for the investigation of complaints in mental hospitals, Mr Jenkin (2 July) replied that the findings of the Brookwood Inquiry did not suggest inadequacy in the present arrangements. Staff who felt concerned about aspects of patient care should know of the avenues open to them and be assured of management support.

On 3 July Dr Vaughan announced that the proposal to close the Henderson Hospital had been rejected and the hospital would be kept open and funded for the time being from 'secure units' allocations.

On 1 May particulars were given of local authorities which had reached the Guideline figure for residential and day care for the mentally ill. Thirty-two authorities were on target for residential provision, but only three for day care. On the other hand six authorities provided no residential accommodation, and there was a long list of others that had not yet provided day care. However, taken overall, it appears (15 May) that the level of 0.12 places per 1,000 population precisely matches the projection in 'The Way Forward'.

Treatment

In replying to a question on the use of psychosurgery on 5 June, Sir George Young said that in regard to detained patients the DHSS's view was that the Mental Health Act gave implicit authority to administer recognized forms of treatment for mental disorder without the patients consent where necessary, but that it was good practice to explain and seek consent from patients and agreement from relatives. Sixty-six psychosurgery operations were reported during 1979.

A similar reply was given on 1 May to Mr Stevens who was advocating a ban on the use of ECT. In both these replies when referring to the position of non-detained patients, the expression used was 'informal (voluntary) patients'. This equating of the present 'informal' with the former 'voluntary' patient appears to diverge widely from the original principles of the Mental Health Act according to which 'non-volitional' patients were to be admitted informally.

Questions were asked on two dates about the instruction of general practitioners in psychiatry and particularly in the correct use of psychotropic drugs, and it was alleged that in some cases a 'Big Mix' of antidepressants, anxiolytics and beta-blockers had caused deaths.

In the last weeks of the session a number of questions related to the loan by the Director of Public Prosecutions of pornographic material for the use of psychiatric hospitals in the assessment and treatment of certain patients. The

questions appeared to seek safeguards rather than to attack the practice itself.

Mental Handicap

On 22 July Mr Jenkin stated the Government's conclusions on the Jay Report. Since the shift to community care would be gradual and since severely handicapped people would always need NHS care it would not be right to make fundamental changes in present training arrangements. However, the GNC and the Central Council for Social Work Training were being asked to look into ways of introducing common elements within the separate forms of training and the feasibility of eventual joint training.

On 14 May Mr Clement Freud initiated an Adjournment Debate on Down's syndrome. His speech was mainly a plea for better communications with affected children's parents and for more support for specialized clinics, particularly that of Mr Brinkworth in Birmingham. In his reply Sir G. Young promised to consider the latter request sympathetically, but emphasized that, in general, help should be given within the comprehensive assessment and other services for the mentally handicapped.

There has been a further fall in the population of mental handicap hospitals since 1974—from 51,000 to under 47,000.

A written answer on 8 May stated that adult training centre places in England had increased from 25,000 in 1970 to 42,000 in 1979. The highest rate per 100,000 population was 136.7 in Salford, and the lowest 10.2 in the London Borough of Sutton—this latter is quite exceptional, very few areas having less than 50 places.

Other questions on mental handicap were either of a general nature, eliciting a restatement of well-known Government policy, or else of local interest only.

Mentally Abnormal Offenders and Security

Various sums have been allocated to RHA's in England for the provision of secure psychiatric units, ranging from £370,000 for East Anglia to £1,050,000 for the West Midlands.

Sixty-four psychiatric hospitals in England and Wales provide secure accommodation by way of either interim secure units or closed or highly staffed wards.

Questions about mentally subnormal prisoners produced different replies for England and Wales and for Scotland. In the former there were at the end of last year 38 such prisoners suitable for transfer. In Scotland there appeared to be no problem: such patients were accommodated at Carstairs or in closed (if necessary) wards and there were no plans for providing 'secure units'. However, on 13 May, Mr E. Ross expressed some concern about security arrangements in Scottish mental hospitals.

Obstruction to transfers

On 1 July Mr Kilroy-Silk again questioned the Secretary of State about the continued obstruction to hospital care for mentally abnormal offenders, and stigmatized as disgraceful and indefensible that NHS hospitals should refuse admission to the 446 mentally disordered prisoners. In his reply Mr Jenkin said that Mr Kilroy-Silk deserved thanks from the whole House for his campaign. He pointed out that the NHS did accept almost 1,000 such persons each year, and the number of prisoners who were the main problem was about 150. He had recently had a discussion with one of the unions involved—but he was still considering the best way of overcoming misunderstandings. He added, however, that where clinicians had decided that admission was right, it was intolerable that others should take it upon themselves to deny the patient the treatment recommended.

Previously Mr Kilroy-Silk had named six hospitals as ones that refused to accept transferred patients, but Sir G. Young said that these hospitals were currently prepared to consider transfers.

The Special Hospitals

A number of questions were asked about the state of affairs at *Rampton*, and on 21 May Mr Kilroy-Silk presented a petition from 'citizens of the United Kingdom' praying for action to improve conditions there and investigate allegations of ill-treatment. As is customary, the petition was ordered 'to lie upon the Table'. On 18 June Mr Kilroy-Silk alleged delay on the part of the Director of Public Prosecutions in dealing with the cases submitted by the police, but it appeared that most of these had only very recently been reported to him.

The case of Ronald Sailes who was originally admitted to *Broadmoor* in 1962 after a conviction for rape, and this year committed murder while residing in a hostel in Plymouth, was the subject of a statement by Mr Jenkin on 4 June. This case has had sufficient publicity in the national press.

Figures were given on 13 June for discharges from and readmissions to Broadmoor in the five years 1975-9; there were in that period 391 discharges and 52 readmissions from various sources.

[I apologize for an error in the last 'Parliamentary News' (*Bulletin*, May 1980, p. 73). The term 'trainees' refers to persons sentenced to Borstal training. A.W.]

Addiction and Alcoholism

Figures have been given for admissions (including readmissions) to hospitals for alcoholism and alcoholic psychosis for each of the three years 1976-78.

For England and Wales the annual number is in the region of 12,000-13,000 and has been rising; for Scotland about 5,000 falling; and for Northern Ireland about 2,000 rising.

There were the usual questions about facilities for treatment, and an interesting debate (16 May) on the pros and cons of attempting further discouragement of alcohol (and tobacco) abuse by taxation.

The only question and answer of interest relating to drug

abuse referred to figures for drug offences and the number of Iranian nationals involved. In 1978 there were 83 prosecutions concerning the supply of heroin, and a total of over 14,463 prosecutions for all drug offences, but very few Iranians were involved.

Patients' voting rights

On 2 July Mr Barry Shurman sought and obtained leave to bring in a Bill to amend the law disenfranchising patients resident in psychiatric hospitals. He pointed out the anomalies in the present law—patients with the same mental condition were granted or refused the vote according to whether or not they still possessed a home address, or according to whether they were being treated in a unit of a general hospital or in a psychiatric hospital. He hoped the Bill would receive the Government's favour.

Miscellaneous

On 25 March Sir G. Young replied to questions from Mrs Renée Short on the subject of *Huntington's Chorea*. Mrs Short had suggested screening tests for pregnant women at risk, but Sir George pointed out that no such tests existed.

On 1 July Mr van Straubenzee questioned Mr Jenkin about the Government's grant to MIND, and brought out the fact that Mr Tony Smythe had apologized for the way he had prosecuted his accusations against the staff of Broadmoor. Mr Jenkin said that bodies that accepted public money should act responsibly and not fling wild charges, but that the Government would not use the power of the purse to muzzle critics.

The Government will not ban the use of *hypnosis* by unqualified persons, nor undertake to study the dangers of hyperventilation and hypnosis as practised at meetings of the 'Exegesis Programme'. The ban on the entry of foreign scientologists entering the country has now been revoked.

Addenda

Sir George Young stated on 31 July that savings resulting from the restructuring of the Health Service would be available for redeployment on patient care.

Concern about the use of pornographic films was again shown in the form of questions about the qualifications of staff in the psychology department of two of the Special Hospitals (6 August).

A series of nine questions by Mr J. Ashley on the prevention and treatment of *Huntington's Chorea* appears in Hansard for 7 August, but the reply was being sent privately.

ALEXANDER WALK

A Symposium on Psychiatric Research

By JAMES CRAIG, Western General Hospital, Edinburgh

A Symposium on Research Methods was held under the auspices of the Research and Clinical Section of the Scottish Division of the College at Gartnavel Royal Hospital, Glasgow, on 30 and 31 May. Dr A. M. Shenkin opened the proceedings with a short, moving tribute to our late Chairman, Dr Astor Sclare, who did so much to stimulate ideas for research in Scotland.

'Selecting and Starting a Research Topic' by Dr Norman Kreitman provided useful advice to beginners in research and those in a position to guide them. He pointed out the value of traditional clinical research and believed common sense was more important than statistics. 'What are the clinical problems?' is a good question to ask before premature immersion in the literature. These and other principles were outlined with many illuminating illustrations.

'Ethical Aspects of Research' were pursued by Professor R. E. Kendell who, after a review of the history of medical ethics, elaborated on two basic ethical principles in psychiatry, namely (a) the subject must understand the implication of the research and give 'free and informed consent' and (b) the subject must not be exposed to hazard. The constitution and function of Ethics Committees were outlined. They help prevent enthusiasts acting unethically mainly by their presence and the climate of opinion which has produced them rather than by their actual decisions. In conclusion Professor Kendell suggested a useful rule of thumb in assessing the ethical acceptability of a research proposal: to ask the question 'would I allow this to be carried out on my parent, spouse or child?'

'Single Case Study Methods' were broached by Dr Alistair E. Philip. He likened drug trials to the formal post-renaissance garden, beautiful in their perfect symmetry but not having much in common with every-day life, unlike single case study methods which enable many more data to be included. He gave the example of his own paper published in 1969. 'A Method for Analysing Assessments of Symptom Change', in which he made the basic assumption that the items in a rating scale such as the Hamilton were