Brit. J. Psychiat. (1970), 116, 457–63

Correspondence

THE SEEBOHM REPORT

DEAR SIR,

The negative reception given by the R.M.P.A., in its Memoranda in the May issue of your *Journal* (pages 605–11), to the Seebohm Report's proposals concerning social workers in local authority mental health departments is disturbing. As a psychiatric social worker and mental welfare officer I find the shortcomings of the social work services in the community very serious indeed. The fragmentation of social work between local authority departments is inefficient, resulting in gaps, neglect, and an absence of overall planning, policy, and accountability. The psychiatric patient in particular is the loser. The lack of community support for the mentally ill mother, the young schizophrenic, and the elderly person is grave. There are insufficient day nursery places, home helps, domiciliary services and suitable housing for the elderly, and hostels and workshops for the young mentally ill are often entirely absent. Cause and effect are masked—so that the fate of the young mother and her children, or of the elderly man or woman left in hospital does not immediately repercuss on the local authority departments which have failed to give adequate help.

If doctors want vigorous social policy for their patients they must have comprehensive planning and an active seeking out of need; and they are not going to get this until social workers can work together in one department. Training and standards (which have been hard fought for) are a vital concern to us, and I am glad that the R.M.P.A. shares our concern. It is doubtful that in a rush towards togetherness we will become interchangeable and lose all specialized function. But there is a lot that can be shared. While agreeing that the Report deals with Child Guidance Clinics in an ambiguous, controversial and at times sweeping fashion, it is difficult to envisage the new department functioning without C.G.C. social workers.

In establishing their social work identity, workers in the mental health services are not seeking to weaken their links with psychiatry and with the medical profession at large, but on the contrary to build on them and to improve their service to the mentally ill.

ANNE TANNER.

8 Portland Place,
Bath

DEAR SIR,

In reply to the letter from Miss Anne Tanner, the point at issue is, in fact, largely the question of specialization—whether the work within the psychiatric and mental health services is so specialized as to require a separate identity within these services; or whether generally trained social workers from a different department could develop this function to an effective professional level. The grounds for the Association's support of the first alternative are set out in the two Memoranda in some detail, and are incontrovertible in the context of the future of the psychiatric services. Merely to state the opposing view is not enough. This is an age of specialization, and it is unrealistic for social workers to believe that a generally trained worker responsible to a different department would be able to provide the special approach and wide medically-orientated erudition that the mental health social worker is already beginning to achieve.

Perhaps the most important feature, recommended by the Seebohm Committee and fully supported by the Association, is the overall review of the psychiatric services which is now being organized by the R.M.P.A. in association with the B.M.A. and the S.M.O.H. This must necessarily include a review of the whole medico-social field involved in mental health and hospital services, and will undoubtedly consider the many existing shortcomings of the present services to which Miss Tanner draws attention. But until this Working Party has been able to report, and until the new organization of the Medical Services is definitely settled, it would be most unwise to support the removal of the Social Work element from the medical services as they at present exist.

Whatever the final pattern proves to be, nothing can diminish the need for effective co-ordination of all the personal services, and no re-organization can magically produce all the buildings, the personnel and the money needed to meet existing mental health needs. The facilities are steadily expanding within the difficult conditions of the tripartite service. It is to be hoped that in any future deliberations, the Psychiatric Social Workers will reconsider their position, not merely by attempting to envisage a new Social Services Department, but rather by studying the manner in which comprehensive and integrated

psychiatric services ought to be developed in the future.

FRANCIS PILKINGTON.

Moorhaven Hospital,
Bittaford,
Ivybridge,
S. Devon

COMPARISONS OF HYPNOTIC DRUGS

DEAR SIR,

Drs. Andersen and Lingjaerde (*Journal*, December 1969, pp. 1393–7) describe a comparison of nitrazepam and phenobarbitone which prompts comments of a kind I have made before (Oswald, 1968), and will now repeat, because I want to urge that phenobarbitone should not be used as an hypnotic.

They write of phenobarbitone promoting, in their patients, 'a better *quality* of sleep'. We know so little about the nature of sleep that any remarks about its quality are hazardous, even more so when based upon the reports patients made in the morning when they would still be under the influence of ninety per cent of the bed-time dose of phenobarbitone. Phenobarbitone is very slowly excreted, and blood levels fall only 23 per cent or less in 24 hours (Butler *et al.*, 1954). Judgements about oneself made under the influence of barbiturates can be unrealistically self-satisfied (Smith and Beecher, 1960). Comments about the night's sleep may be presumed to be influenced by the drugged state at the time the judgement is made.

I hope that before deciding to prescribe phenobarbitone as an hypnotic a doctor would reflect that a patient's claim to have slept well after morphine would not constitute a reason for its routine nightly employment. I hope, too, he would reflect upon the fact that trials, such as the one referred to, tell us nothing about the drug-induced impairment of skill in, for example, driving during the following afternoon (especially if alcohol is taken at lunch time). I hope especially that he would remember the contemporary epidemic of self-poisoning. An overdose of nitrazepam very rarely causes coma. Coma after phenobarbitone overdose, because of the slow excretion, is liable to last several days; assuming the patient does not die, tolerance develops during the coma, leading to eventual drug-withdrawal features. These features, such as broken sleep, may not reach a peak until three weeks later, at the time the drug is finally cleared from the body (Haider and Oswald, 1970).

Drs. Andersen and Lingjaerde term the night nurse's report an *objective* measure. We may assume the night nurse gave the sleeping pills, and we are told that the placebos looked different. Consequently the difference between placebo and active tablets on 'objective' assessment loses validity. I have yet to encounter identical-looking hypnotic and dummy tablets where the bitter taste of the active tablets was not immediately recognizable, so I wonder whether the patients really were much more often 'blind' than the night nurse.

The authors also make the usual error of assuming that one night is independent of the next. Phenobarbitone is so slowly excreted that obviously nights could not be independent in this trial. There is, moreover, ample evidence from published all-night electrophysiological studies, conducted in this department and in various centres in the U.S.A., that after the distortion of sleep caused by such hypnotics as barbiturates or nitrazepam a 'rebound' occurs when the drugs cease (e.g. Oswald and Priest, 1965). The rebound is in a direction opposite to the drug's effect and includes restless sleep, shortened sleep and vivid, anxious dreams. If therefore a patient gets an hypnotic on night 1 and placebo on night 2 he may be expected to say he slept badly on night 2 *because he had the drug the night before*.

The rebound effects persist for days, in fact, weeks. Consider, therefore, a trial like that of Drs. Andersen and Lingjaerde where there is a sequence—placebo, drug, A, drug A, drug A, placebo, placebo, drug B, drug B, drug B. We may expect (we were not told) that most patients would have been on hypnotic drugs on prior nights. If we were to assume that the prior drug was potent and that drug A and drug B are both inert, then, in the above design, where, overall, placebo precedes drugs A and B, sleep will be less disturbed on drugs A and B nights, providing withdrawal 'rebound' is maximal on the first (placebo) night and declines appreciably over a nine-day period. In this way drugs A and B could appear superior to placebo even though inert.

If all patients were equally accustomed to prior hypnotic drugs, and if drug A and drug B were switched equally among the patients, so that for half of the patients drug B preceded drug A, then A and B should appear equal. On the other hand if this switching procedure were imperfect or failed to match patients for age (to take but one factor into account) then one of these two possibly inert drugs could appear not only superior to placebo but also superior to the other.

If, alternatively, we were to assume that in a study of this nature no patients had received prior drugs for a couple of months, and if drug A were potent and drug B inert, drug B could still appear superior to placebo because two of the placebo nights im-