officers, prison officers, non-statutory agency workers, and parents. Their education will, however, require time and skill and cannot be left to good will.

The legal response to drug abuse seems as confused as the medical one. It is sometimes argued that if the authorities were more successful in reducing imports of drugs their efforts might be counterproductive. The purity of drugs available on "the street" would fall, and medical complications would become more frequent. The numbers of drug related crimes might rise with street prices. Against that, the number of new cases would decrease only in the long term. Problems have already been seen from the response by the courts to drug dealers—giving them long sentences. Wrangles in court have become familiar, with forensic specialists arguing how much drug in a person's possession merits the label "pusher" and a long prison sentence. The main sufferers are the "user pushers," who may or may not deserve imprisonment depending on the commentator's views.

The Social Services Committee recommended that each regional health authority should have at least one fully staffed specialist facility—and that means input from a consultant psychiatrist, a clinical psychologist, social workers, and community psychiatric nurses. Their prime aim should be rehabilitation and that implies establishing and maintaining good relations with all the available long term care facilities, most of which are non-statutory.

Local differences in the pattern of drug abuse create local demands. In the east of Scotland, for example, the predominant route of drug abuse is intravenous, while in Merseyside it is by inhalation, and as a result the complications seen in the two regions are different. Virologists have found a higher prevalence of antibodies to the human T cell lymphotropic type III virus in the Scottish drug abusers than in those elsewhere.

The voluntary agencies are already making a vital contribution. In those parts of the country with no established team of specialists they may offer the only care available. Multidisciplinary teams (both regional and district) trying to organise and coordinate drug abuse services must incorporate these agencies as full partners. Where there is only an embryonic statutory service the professionals may have to overcome their traditional suspicion of volunteers. In this context government policies on funding have not been helpful. Three year funding is good neither for the service nor for the morale of the staff. A year may be needed to develop a team and over two years to establish its credibility with other professionals and clients. No government would be happy with a three year term to prove itself.

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Acute pancreatitis

In Britain, as in North America, acute pancreatitis affects one in every 10 000 of the population each year.[1] Patients usually present with sudden severe abdominal pain and are admitted as emergencies to surgical wards.[2] The overall mortality is 8-10%, and the death rate has not been altered by the use of many different types of treatment.

The diagnosis is usually confirmed by finding the serum amylase activity twice or more the upper limit of normal, though patients with acute pancreatitis may have completely normal values. The hyperamylasaemia may be transient, and the serum lipase activity is said to be more specific, to show a more prolonged rise in acute pancreatitis than the serum amylase, and to be raised more often. Measurement of the serum lipase activity is, however, more difficult than that of the serum amylase, and laboratories are often reluctant to perform this assay. Another possibility is measurement of the immune reactive trypsin activity in the serum, but this has no diagnostic advantages over the serum amylase. Anatomical studies—such as ultrasonography and computed tomography—may show enlargement of the pancreas in about a third of cases but are not part of the routine diagnostic procedure. About 5% of patients are diagnosed at laparotomy—not a desirable approach, since the postoperative course is often stormy.

The two indisputable principles of management in acute pancreatitis are to give adequate analgesia and to set up an intravenous infusion to compensate for the hypovolaemia caused by exudation of large amounts of fluid round the inflamed pancreas. Nasogastric suction has no specific effect on the disease and should be reserved for those patients who are vomiting. A urinary catheter should be passed if renal failure is suspected so that the flow of urine can be measured accurately. Oxygen and intravenous feeding have their advocates. If the patient is critically ill then treatment with an H_2 receptor antagonist such as intravenous ranitidine 50 mg three times daily should help prevent the development of haemorrhagic erosions. These agents will not alter the outlook in established gastrointestinal haemorrhage, however, and do nothing to compensate for the haemorrhagic tendencies of diffuse intravascular coagulation which may occur after acute pancreatitis. Many drugs have been tested for a specific effect in acute pancreatitis; all have proved to be useless—or at least of unconvincing benefit. These include aprotinin, glucagon, somatostatin, calcitonin, fresh frozen plasma, and anticholinergics.

What, then, can be done to improve the overall mortality in acute pancreatitis? Various systems have been used to identify patients with severe disease who might be particularly suitable for additional management. First attacks of acute pancreatitis and acute pancreatitis associated with gall stones both carry a poorer prognosis. In addition, low serum concentrations of calcium and albumin and a low Pa_{O_2}; a raised serum concentration of urea, raised aspartate transferase and lactic dehydrogenase activities, and a raised white cell count; and age over 55 all suggest a poor outlook.[3] Peritoneal lavage may be used to assess the severity of the attack and to predict outcome[4] but has no specific therapeutic value.[5] A combination of clinical, laboratory, and lavage

findings will identify around 80% of the patients with severe disease who have a poor prognosis and are candidates for a trial of energetic measures.[6 7]

Traditionally surgery has been reserved for those patients who have complications such as pseudocyst or abscess formation. To this may now be added the immediate surgical management of associated gall stone disease, particularly if there are stones in the common bile ducts; it helps to prevent early relapses of acute pancreatitis.[6] Total or subtotal resection of the pancreas has been tried; it carries a mortality of around 25% and clearly must be reserved for severe cases—indeed, it has not been shown to confer any clear benefits.[8] In one recent series of 40 resections carried out between 1973 and 1978, 11 patients died in the postoperative period and there were four later deaths.[9] When 24 of the 25 survivors were reviewed five to 11 years after surgery no fewer than 10 had developed polyneuropathy, and in five of these the complaint had been disabling. All but two of the survivors had diabetes mellitus.

Specific treatment in acute pancreatitis is likely to help only a few patients, and the numbers are likely to be too small for clinical trials to produce convincing evidence of benefit. For the present the surgeon considering pancreatic resection is well counselled to reach rather slowly for his scalpel.

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The Mental Health Act Commission

The publication of the first biennial report of the Mental Health Act Commission provides an opportunity to take stock.[1] Its predecessors date from 1774, since which time there had been one form or another of inspectorate to ensure compliance with mental health legislation until 1960, when the Board of Control was disbanded—leaving no independent body with a statutory duty to visit psychiatric hospitals and to safeguard the interests of patients.[2] Probably as a result the 1960s and 1970s saw a succession of scandals about conditions in mental hospitals—Ely, Farleigh, Whittingham, South Ockendon, Normansfield, Rampton. Allegations of neglect, ill treatment, cruelty, and inadequate medical and nursing care were repeatedly substantiated.

In 1969 the Hospital Advisory Service was set up to encourage and disseminate good practice and to advise the Secretary of State on standards of care and management practices in hospitals. The Department of Health and Social Security was, however, not keen to reinstitute a commission, and in 1978 it proposed instead to try some experimental schemes of patients' advisers.[3] The re-establishment of a commission had frequently been advocated by the Royal College of Psychiatrists, and in 1981 the government changed heart after the publication of the report of the review of Rampton Hospital, which made a strong case for an appointed body to inspect and monitor all institutions housing detained patients.[4]

The Mental Health (Amendment) Bill required the Secretary of State to set up a special health authority to exercise a general protective function and to be "a real safeguard" for detained patients.[5] When the Bill was introduced in the House of Lords the government spokesman said he believed the authority would build up a body of knowledge and experience which would "throw light on the whole field of mental health." Attempts were made in both Houses of Parliament to extend the remit of the commission to informal patients, but this was rejected by the government—partly on the grounds that they already benefited from other bodies such as the Health Service Commission, the Health Advisory Service, and the Court of Protection, and partly on the grounds that the commission might need to be 20 times as large, diluting its work in relation to detained patients.[6 7]

The commission was set up on 1 September 1983 and has cost the taxpayer about one million pounds a year. As a special health authority it is responsible to the Secretary of State, but it is an independent body with a chairman and 91 other part time members from medicine, nursing, law, social work, psychology, lay public, and academics. The commission's functions are to protect the interests of detained patients by visiting and interviewing them in hospitals, investigating complaints by and about detained patients, and keeping under review the way in which the powers and duties are specified in the Mental Health Act. It also provides second opinions by appointed doctors on consent to treatment and is required to prepare for the Secretary of State a code of practice for the guidance of doctors and the staff of hospitals in relation to the admission and treatment of patients suffering from mental disorder. A draft code of practice was, indeed, sent out for consultation to professional bodies by the Secretary of State in December 1985.

In its first two years the members of the commission have paid nearly 1000 visits to some 500 hospitals, and its report records their admiration for the unsparing dedication shown by so many members of staff whom they met. The commission says it has aimed at being "a catalyst of good practice, to observe and detect both the good and the bad policies and to disseminate the good."

The Act requires the commission to investigate any complaint made by a detained patient which he considers has not been satisfactorily dealt with by the hospital managers. This is the normal route, which the commission initially recommends, but a primary investigative function is not ruled out in some cases. The biennial report gives some details