



# the columns

## correspondence

### Recovering a meaningful life is possible

Sir: David Whitwell discusses what may become one of the most important concepts in mental health over the coming decade; recovery (*Psychiatric Bulletin*, October 1999, **23**, 621–622). However, his view of recovery as a myth is based on a medical understanding of the word, equating recovery with cure, or with returning to how you were before the illness started. In the growing literature on this issue in the USA and elsewhere, most service users put forward the concept of recovering a meaningful and fulfilling life. It may well be a quite different life to the one envisaged before the onset of mental illness, but it is none the less a valuable and valued life.

The analogy used by many people is that of suffering a permanent physical disability as the result of an accident. You may well need medical care, but it will not cure you. You may equally need social care, but are unlikely to want to be seen as a dependent service user for the rest of your life. The aim is to find ways around the problems which the disability may cause, to recover a life of purpose and meaning. That may well include searching out the strengths which the disability has brought, for example an understanding which may equip you to help others.

Many of the best mental health services and user groups in the UK already strive towards this approach. From open employment schemes to self-management training, they span a wide and growing group. The question is not so much over the approach, as over the word. Recovery can so easily be interpreted as cure. Will a word which seems to strike the right chord in other countries work here, or will we need to find an alternative?

**Cliff Prior**, Chief Executive, National Schizophrenia Fellowship, 30 Tabernacle Street, London EC2A 4DD

### A bureaucratic short-cut to consultant posts in the UK

Sir: Many European doctors training in the UK during the past years have complained about the new Certificate of Completion of Specialist Training (CCST) system

(Cervilla & Warner, 1996). The time required to become a psychiatrist is still so much longer in the UK than in the continent. Complaints have resulted in the Specialist Training Authority issuing the so called 'Official Confirmation of UK Training'. This confirms that the trainee has spent four years in UK-recognised training posts (regardless of training level), thus fulfilling EU regulations and leading to accreditation in Europe. Ironically, with this European accreditation, the doctor can come back to the UK and register on the GMC Specialist Register being eligible for appointment as consultant psychiatrists, after as little as four years of senior house officer level training, even if they had failed their MRCPsych (Cervilla, 1996). Moreover, psychiatrists trained in Europe for just four years can also enter GMC Specialist Register straight away. This is in contrast to those British, or indeed European, doctors who stayed in the UK till the end of their psychiatric training and who spent at least six years as psychiatric trainees, including passing the MRCPsych Examination, before entering the Specialist Register. This scenario is unfair to those that spend many years of hard training work at lower pay. In addition, it might give a bad image in Europe of British standards of psychiatric training. More importantly, the quality of care provided by doctors partially trained, but yet fully accredited is likely to be poor and potentially dangerous. Changes in the current regulations are, therefore, needed.

### References

CERVILLA, J. (1996) Spanish psychiatric training: is there a need for change? *Psychiatric Bulletin*, **20**, 738–740.

— & WARNER, J. (1996) Certificate of Completion of Specialist Training (CCST): implications for higher training in psychiatry. *Psychiatric Bulletin*, **20**, 372–373.

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### Value of advocacy

Sir: As the managers of the advocacy scheme in the area where Dr Gamble is based, we were dismayed, and not a little

angry, to read his letter (*Psychiatric Bulletin*, September 1999, **23**, 569–570). We have requested details of the evidence on which Dr Gamble has based his specific allegations, and we await his reply. In the meantime, we feel it is important to respond to his criticisms of independent advocacy, in the public setting in which he made them.

First, it should not come as a surprise if advocates and doctors sometimes give patients different information: survey after survey has shown that psychiatric patients frequently feel they have not been told enough about their medication, for example, and advocates have a legitimate role to play in enabling patients to make decisions about their options on the basis of information from a range of sources – not only clinical. If different pieces of information are at times 'in conflict', does that not merely reflect the often uncertain knowledge base of treatment in mental health? In our view, the only cause for alarm would be if anyone was giving patients information which was clearly false.

Second, the argument that because advocates see patients alone, it follows that they are "giving advice in private which others may not be aware of" (our emphasis) is logically flawed – and wrong. Mental health advocates adhere to a code of practice which states that they should not give advice to patients, nor offer their own opinion.

Third, Dr Gamble expresses concern about the "anti-medical establishment political agenda" and "destructive ideology-driven power" of "some advocacy movements" – including, apparently, our own service. Dr Gamble's use of terms such as political and ideology-driven we can forgive (and would be interested to debate further, in the context of mental health advocacy and the psychiatric system), but we take strong exception to the other labels he puts upon us. Our advocacy service operates in accordance with a policy drafted painstakingly over a period of some months, more than seven years ago, by a group which consisted of several representatives working in the local mental health service (including a consultant psychiatrist), as well as Mind staff and users. Underpinning the notion of independent advocacy described in this



policy is a set of principles which affirm the legal and human rights of users of mental health services – principles which are to be found in many a patients' charter, in the Mental Health Act code of practice and even, increasingly, in the operational policies of NHS trust services. It is very worrying that such principles could be deemed anti-medical establishment and, worse, destructive.

Dr Gamble leaves his most outrageous accusation – of local advocates' "tacit encouragement of violence against staff" – till last. We are mystified as to why, if there have been genuine concerns of such a serious nature about employees in our service, no one has brought them directly to our attention.

We are very sorry that Dr Gamble's 'exposure' to advocacy during his training has made such a negative impact on him, but we also believe that the conclusions he draws from his limited experience are unwarranted. Of course there are sometimes problems in the practice of advocacy (just as there are sometimes problems in the practice of psychiatry), but we would expect any important concerns about our service to be discussed with us frankly and respectfully. We sincerely hope that other psychiatrists are more inclined to share the stand of Thomas & Bracken (*Psychiatric Bulletin*, June 1999, **23**, 329) that psychiatry needs to move 'away from a negative anti-psychiatry view of advocacy to a more constructive engagement'.

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Sir: We are grateful to Dr Gamble for his letter (*Psychiatric Bulletin*, September 1999, **23**, 569–570) which simply helps to reinforce the purpose of our original article (Thomas & Bracken, *Psychiatric Bulletin*, June 1999, **23**, 327–329). Dr Gamble's attitudes towards advocacy demonstrate how important it is that the College makes exposure to local advocates and advocacy services a mandatory requirement for all training schemes for the Membership Examination.

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## Consent of 16- and 17-year olds to admission and treatment

Sir: Parkin (*Psychiatric Bulletin*, October 1999, **23**, 587–589) is correct in stating that current guidance on consent to treatment as set out in the 1999 Code of Practice "remains potentially confusing

and is inconsistent with good practice". Although the Mental Health Act 1983 (MHA) has built into it greater protection for patients' rights regarding consent to treatment, if the child is not under a section of the MHA, the compulsory regulations of the MHA do not apply. For the child in the community or admitted 'informally', that is, not under the MHA, the new Code of Practice (Department of Health & Welsh Office, 1999) seems to be undermining the competent child's rights regarding consent to treatment. In doing so it is following the judicial paternalism of recent case law, which seems to subordinate one of the Code's guiding principles, that is, that people to whom the MHA applies should "be treated and cared for in such a way as to promote to the greatest practicable degree their self-determination and personal responsibility, consistent with their own needs and wishes", in favour of other 'best interests', which may be assumed to be a professional (whether judicial or medical) understanding of their physical or mental well-being. This makes the new Code internally inconsistent as well as "inconsistent with good practice". I echo Parkin's call to the Mental Health Act Commission to investigate such inconsistencies.

## Reference

DEPARTMENT OF HEALTH & WELSH OFFICE (1999) *Code of Practice to the Mental Health Act 1983 (Pursuant to Section 118 of the Act)*. London: The Stationary Office.

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## Use of the Mental Health Act to treat compliant mentally incapacitated patients with electroconvulsive therapy

Sir: Having recently been involved in a difficult clinical dilemma, we have had it brought to our attention that our usual practice and what we believed to be the common practice of psychiatrists throughout the country is in fact contrary to the Code of Practice.

The dilemma involved the need to resort to the use of the Mental Health Act 1983 (MHA) when wanting to treat a compliant mentally incapacitated patient (due to mutism secondary to severe psychotic depression) with electroconvulsive therapy (ECT). Nobody would dispute the need to detain a mentally ill patient who verbalises refusal to consent to treatment. The difficulty comes when deciding to treat a patient who is uncommunicative from a functional or organic mental illness, with medication or ECT. Our common practice is to use the MHA

in these patients, even though they have not actually refused treatment.

Having carried out a postal survey of all the consultants in elderly mental illness and their senior registrars in south and west Wales (20 responded out of 22), all agreed with this course of action.

It was brought to our attention by Richard Jones, a leading specialist in Mental Health law, that the criteria for admission under Sections 2 or 3 of the Act cannot be satisfied in respect of a compliant mentally incapacitated patient (i.e. one who is not "persistently and/or purposely" attempting to leave the hospital (see paragraph 19.27 of the Code of Practice; Department of Health & Welsh Office, 1999, and paragraphs 1–626A of the sixth edition of the Mental Health Act Manual; Jones, 1999). Hence, ECT (being a medical treatment for mental disorder) can and should be given to a mentally incapacitated patient under common law as long as the requirements for "treatment of those without capacity to consent" (see paragraph 15.19 of Code of Practice; Department of Health, 1993, and paragraph 15.21 Code of Practice, published 1999) are satisfied.

Perhaps it is significant that this has come to our attention following the Bournewood judgement which clarified our position in treating, under common law, those patients who are compliant but mentally incapacitated. Most would agree that this refers to individuals with learning difficulties or dementia or who are temporarily incapacitated from delirium, and these are indeed specified in paragraph 15.20 of the newly published Code of Practice. It unfortunately does not include such cases as mutism secondary to severe psychotic depression.

We are uncertain how such a widely held practice, which appears to contradict the Code of Practice, originated. We would be interested to hear from anyone who feels they can shed light on this interesting clinical conundrum.

## References

DEPARTMENT OF HEALTH AND WELSH OFFICE (1993) *Code of Practice, Mental Health Act 1983*. London: HMSO.

— & — (1999) *Code of Practice, Mental Health Act 1999*. London: The Stationery Office.

JONES, R. M. (1999) *Mental Health Act Manual* (6th edn). London: Sweet & Maxwell.

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## Alternatives to methohexitone

When the ECT anaesthetic methohexitone was unexpectedly withdrawn earlier this