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correspondence

Understanding of the term 'schizophrenia' by the British public

There have been significant milestones in the detection and treatment of most psychiatric disorders, especially in the past two decades. However, there are some concerns about media misrepresentation of severe mental disorders such as schizophrenia. A postal survey of the UK public was conducted in order to examine their understanding of the term 'schizophrenia'.

We distributed 500 questionnaires to a representative panel of the UK general population recruited for a previous study (Luty *et al*, 2006) and received 402 completed replies (81% response rate). Participants were asked the open-ended question 'What do you understand by the term "schizophrenia"?' and 42% described at least one Schneiderian first-rank symptom or gave a description that reasonably matched one of the diagnostic features in ICD–10. This included 26% who described auditory hallucinations; 40% mentioned 'split' or 'multiple' personality, which is not a diagnostic feature. Only 6% mentioned violence or aggression. In comparison, 73.6% of participants correctly identified the symptoms of schizophrenia from a series of vignettes in a Swiss study (Lauber *et al*, 2003). Our survey reveals some wide gaps between the professional and public understanding of the term 'schizophrenia'.

LAUBER, C., NORDT, C., FALCATO, L., *et al* (2003) Do people recognise mental illness? Factors influencing mental health literacy. *European Archives of Psychiatry and Clinical Neuroscience*, **253**, 248–251.

LUTY, J., FEKADU, D., UMOH, O., *et al* (2006) Validation of a short instrument to measure stigmatised attitudes towards mental illness. *Psychiatric Bulletin*, **30**, 257–260.

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Smoking ban in psychiatric services

O'Gara & McIvor (*Psychiatric Bulletin*, July 2006, **30**, 241–242) raise concerns about the introduction of a smoke-free health service in England and Wales by December 2006. In March 2004, Ireland became the first country in the world to introduce a complete prohibition on smoking in the workplace to protect people from the harmful effects of second-hand smoke. Psychiatric hospitals, including the Central Mental Hospital and Prisons, were granted an exemption from the ban. However, it was decided by the management team at the Central Mental Hospital (Ireland's only forensic psychiatric hospital) that the hospital would not avail of this exemption. Other psychiatric hospitals in Ireland did avail of the exemption.

Six months before the commencement of the ban, a smoke cessation counsellor was employed to organise individual and group work for staff and patients. Nicotine clinics and awareness groups were set up.

Upon commencement of the ban, patients who wished to smoke were taken to designated outdoor areas, five to six times during the day for an average of 20 min and for longer periods during the summer. They have no access to these facilities at night.

Initially, not everybody was supportive of the policy. Some patients wrote letters of protest demanding that smoking rooms be provided. Surprisingly, there were more complaints from staff than from patients. The rights of both smokers and non-smokers were highlighted. Resistance lessened within weeks of commencement of the ban.

Following the implementation of the ban, the wards became noticeably cleaner and smoke-filled air disappeared. Our experience at the Central Mental Hospital has demonstrated that it is feasible to implement a total smoking ban in a psychiatric hospital.

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Boundaries for psychotherapists

The recent articles on the Kerr/Haslam Inquiry (*Psychiatric Bulletin*, June 2006, **30**, 204–206, 207–209) raise important issues. The experience of sexual feelings during psychotherapy and the potentially abusive nature of dual relationships are described in the literature (Pope *et al*, 1993; Syme, 2003). Breach of boundaries by doctors and therapists working in the field of human sexuality is relatively rare, with 98.7% of 814 UK clinicians responding to a survey having rarely or never been tempted to have sexual relations with a client (with no difference between physicians and non-physicians and no clear gender bias) (Wylie & Oakley, 2005).

Sexual and relationship psychotherapists, as members of the British Association for Sexual and Relationship Therapy, adhere to a clear code of ethics and practice, which should be openly disclosed and available to all patients under the clinicians' care. Integrative care involving physical and psychological therapies requires clear protocols and patient guidance, including overt statements with regard to chaperone policy (Carr, 2003).

CARR, S.V. (2003) The intimate examination: time for a name change. *Journal of Family Planning and Reproductive Health Care*, **29**, 156–159.

POPE, K. S., SONNE, J. L. & HOLROYD, J. (1993) *Sexual Feelings in Psychotherapy*. New York: American Psychiatric Association.

SYME, G. (2003) *Dual Relationships in Counselling and Psychotherapy*. London: Sage.

WYLIE, K. R. & OAKLEY, K. (2005) Sexual boundaries in the relationship between clients and clinicians practising sexology in the UK. *Sexual and Relationship Therapy*, **20**, 453–456.

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Pharmaceutical sponsorship of educational events

Vassilas & Matthews (*Psychiatric Bulletin*, May 2006, **30**, 189–191) reinforced the reasons that led me to totally change my approach to pharmaceutical sponsorship.

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Pharmaceutical companies may have a genuine interest in education, but should that allow them to influence prescribing? Research has shown that although they believe their own prescribing is unaffected, many doctors believe that their colleagues are influenced (Halperin *et al*, 2004). Vassilas & Matthews call for trusts to develop guidelines and this is essential. I believe we also need to take individual responsibility. In particular, we need to look at our education and how we fund it. We can all buy lunch and pens for ourselves, but realistically how many of us could attend big international symposia if not sponsored? Clearly that should not be the case. I have read suggestions that pharmaceutical companies with a real interest in education could contribute anonymously to a general fund for education without any payback. This is something to consider. For myself I have found I can access excellent local and online education within the scope of a National Health Service consultant budget and will continue not to see representatives of pharmaceutical companies or accept their gifts.

HALPERIN, E. C., HUTCHISON, P. & BARRIER, R. C. jR (2004) A population-based study of the prevalence and influence of gifts to radiation oncologists from pharmaceutical companies and medical equipment manufacturers. *International Journal of Radiation Oncology and Physics*, **59**, 1477–1483.

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Functionalised community mental health teams and in-patient care

Commander & Disanyake (*Psychiatric Bulletin*, **30**, 213–215) reported that the number of psychiatric in-patients in west Birmingham fell by one-third between 1992 and 2003 and attributed this change to functionalised community mental health teams. They have not discussed several other factors which I think are also relevant.

In 1992 there were about 5 consultant (adult) psychiatrists supported by about 10 junior doctors and a small number of nurses and social workers in the community, serving an inner-city population of about 250 000. By 2003 the number of mental health professionals, including doctors, had greatly increased (probably tripled) and west Birmingham had become part of the Birmingham and Solihull Mental Health Trust, covering a population of about 1.2 million. The large psychiatric hospital in west Birmingham had closed and was replaced by fewer admission wards and fewer continuing care wards. Several 'respite hostels' were set up by the trust for patients who would have been admitted to hospital in the past, and residents may not have been counted as admissions. Beds were often full, and patients were sometimes moved to other psychiatric hospitals and occasionally to the private hospital in Birmingham.

With fewer beds, patients with depression and other psychiatric illnesses with less challenging behaviour who did not require admission under the Mental Health Act 1983 received out-patient care. This may explain the increase in the proportion of compulsorily detained patients. Wards were often full, with occupancy rates in excess of 100% most of the time.

I wonder if the fall in the number of people in hospital was not only due to the functionalised teams but also because there were fewer beds, more staff working in the community and other places for patient admission.

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Risk assessment in self-harm

Lepping *et al* (*Psychiatric Bulletin*, May 2006, **30**, 169–172) report an increase in the number of psychosocial assessments following the introduction of a self-harm pathway. Questions remain about patients who abscond from the accident and emergency department (A&E). Factors that may lead to qualitative improvement in assessments should be given further consideration.

An integrated care pathway between the local university hospital and the mental health trust was set up in Middlesbrough in February 2004. Doctors in A&E use a modified SAD PERSONS scale for triage (Hockberger & Rothstein, 1998). Patients scoring <5 are offered home visits by the self-harm team and those scoring $\geqslant 5$ are admitted to the medical assessment unit for daytime assessments the following day. Six-month data for comparable months in 2003 and 2004 have shown a 24% increase in referrals, a 17.8% ($P<0.0001$) increase in assessments and a reduction in the number of absconsions/self-discharges by 81.5% ($P<0.0001$). Admissions to the medical assessment unit have increased by 33%; 42% of planned home visits were cancelled by patients. These were from a group who had a low-risk score in triage.

The modified SAD PERSONS scale is easy to use by non-psychiatrists and allows reliable risk assessment of self-harm to be carried out at an early stage, which guides professionals if patients refuse treatment or abscond. We consider that daytime assessments after patients have had time to recover from the effects of drugs, alcohol or overdose, which allow access to collateral information, are of further benefit.

HOCKBERGER, R. S. & ROTHSTEIN, R. J. J. (1988) Assessment of suicide potential by nonpsychiatrists using the SAD PERSONS score. *Journal of Emergency Medicine*, **6**, 99–107.

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