Correspondence

Relationships with patients

Sir: As Dr Harry Kennedy's article (*Psychiatric Bulletin*, April 1999, **23** 193–194) makes clear, the current statutory provision for the supervision and treatment of patients in the community is in need of reform. Many of the remedies which Dr Kennedy asks us to consider seem sensible enough. I am sure he has earned himself a respectable place in that steadily accumulating genre: Mental Health Act; sub-category 'What is to be done?'. Yet am I alone in thinking that much of this copy misses the point.

Dr Kennedy talks about psychiatrists being caught in a "gap between freedom and responsibility", but perhaps the real gap lies elsewhere and has more to do with the discrepancy between the Hippocratic clinical ideal and the practice of psychiatry today – in the community and elsewhere. Historically speaking, more than most medical specialities, psychiatry has shown itself willing to court the state rather than the patient, to replace care with control, and to prefer obedience over gratitude. Of course the public knows this and is understandably suspicious. Naturally, a public which fears psychiatry will fear mental illness that much more, and, paradoxically, demand more fearsome powers for psychiatrists; hence the escalating public anxiety, and hence the tremendous public relief, excitement and blame when someone else – always someone else – goes publicly and dangerously 'mad'.

At a time when the College is seeking to change minds and campaign against stigma, surely, we would be engaging in a much wider debate about the nature, conditions and consequences of the kind of social relationship we as a profession can and do establish with our patients.

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The value of advocacy: putting ethics in to practice

Sir: I can not agree more with Thomas & Bracken (*Psychiatric Bulletin*, June 1999, **23**, 327–329) on the need to strongly support advocacy for individuals with mental health problems. It is however untrue that representation of patient's interest will 'inevitably' cause conflicts with psychiatrists.

On the contrary, the advocacy services need to be more transparent in order to improve their image and reputation with the treatment team. 'Transparent advocacy', should entail an open, logical and justifiable representation of patients' wishes, needs and interests in order to promote their autonomy and welfare. It should not just be a pseudo-political stance of 'protecting patients' rights'.

Drawing particular instance from advocacy in learning disability services, I often do not understand how advocate workers reach their conclusion about what is in the best interest of the patients. In my opinion, they should share and explain the basis of decisions made on patients' behalf, with multi-disciplinary team members. Otherwise they will continue to portray themselves as fundamental sentimentalists, opportunists or, indeed, anti-psychiatrists. Unless and until advocacy is seen to be transparent and reasonably substantiated, it will be viewed by some, with scepticism.

OLADIMEJI KAREEM, *Senior House Officer in Learning Disability Psychiatry, Oxford Deanery Rotational Training Scheme, Northampton Healthcare Trust, Postgraduate Centre, Princess Marina Hospital, Upton, Northampton NN5 6UH*

Sir: In their review, Thomas & Bracken (*Psychiatric Bulletin*, June, 1999, **23**, 327–329) point out the potential benefits of advocacy in psychiatry and the importance of junior doctors being exposed to advocates during their training. As a junior doctor in training, I have been exposed to advocates, with a mixed experience of their usefulness for patients.

On ward rounds, patients sometimes ask advocates to attend in order to help to express their views and ask questions about treatment. I have witnessed conflicts with consultants over whether advocates should be permitted to attend. Advocates have the advantage that they can concentrate on particular patients, while the doctor sees all the patients as well as performing other duties. At times I have found the information which I have given to be in conflict with that given by the advocates. In one case, a patient with mania which had proved resistant to treatment with conventional agents was being treated with gabapentin, an anticonvulsant for which there is evidence in open studies for

effectiveness in mania (Ferrier, 1998). After talking to an advocate at a day centre who told her that it was an 'experimental' treatment, the patient became anxious and asked to discontinue treatment. Her mania subsequently worsened.

While junior doctors sometimes see patients with a nurse or other doctor on the ward, and are thus fairly open in their interactions, advocates usually see patients alone either on or off the ward (sometimes in day centres). There is thus a feeling that advocates are giving advice in private which others may not be aware of.

The title of Thomas & Bracken's article was "Putting ethics into practice". I am concerned that the ethics of some advocacy movements are not those of doctors but that they may be using their access to vulnerable people (psychiatric patients), to promote their own anti-medical establishment political agenda. It would be mistaken to 'dismiss' them as being 'anti-psychiatry' as Thomas & Bracken state. To dismiss them would be to ignore their destructive ideology-driven power. Local advocates have told ward patients that nurses are unable to fight back if attacked, a tacit encouragement of violence against staff.

My experience of advocacy has suggested that while the concept is a good one, in practice there are problems.

Reference

FERRIER, I. N. (1998) Lamotrigine and gabapentin. Alternative in the treatment of bipolar disorder. *Neuropsychobiology*, **38**, 192–197.

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Guidelines for the police and psychiatric services

Sir: Your special article 'Police training for the management of dangerous patients' (*Psychiatric Bulletin* January 1999, **23**, 46–48) drew attention to an important aspect of the relationship between the police and psychiatric services.

Another area of police practice impinging on psychiatry needs to be highlighted, as it is a cause for concern. This is the widespread practice of the police bringing people from the community to be 'assessed' at psychiatric hospitals, without placing them on Section 136 of the Mental Health Act 1983.

The usual scenario is that the police attempt to arrest an individual, but on becoming aware of a psychiatric history, decide to divert the person to hospital.

This practice is worrying for a number of reasons: it results in a large number of patients being escorted/detained by the police outside of the protection of Section 136 of the Act. It may encourage people to escape justice by hiding behind a psychiatric label. Also the person may be coerced unwillingly to go to hospital, which subsequently may leave trusts open to litigation by patients claiming they were taken to hospital and detained on wards illegally.

It appears imperative that this practice is monitored on a local basis, and guidelines drawn up between the police and psychiatric services regarding best practice in this grey area.

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Healthy debate about the fragmentation of services

Sir: I am pleased to see that my article (*Psychiatric Bulletin*, January 1999, **23**, 31–33) has generated questions and debate from medical colleagues, National Health Service Management and the media. They all had specific and valid questions and concerns on the feasibility and difficulties of single gender wards.

The most frequent question was about problems which may arise in all male wards once single gender wards are established universally in a district. Most colleagues fear that single gender male wards may become extremely difficult to deal with and may turn into unofficial intensive care units.

The concern around fragmentation of services and difficulties in coordination has been brought forward by a senior practitioner with a special interest in services. I have to admit that the coordination of continuity of care in our specialist service has taken an enormous effort. It has been through personal endeavour, universal good will and collaboration that the difficulties in working with four sectors and six adult general psychiatry consultants have been, only partly, overcome. Being served by several different community teams, organising Care Programme Approach meetings, keyworking systems, outpatient follow-up by each one of them has been a daunting task. We still are in the process of reorganising the follow-up system.

Questions around length of stay in hospital have come from different sources including Department of Health officials. The problems of aggregating difficult to treat female patients with complex needs has not been overcome in our