well as intractable problems of communication between consultants, and misunderstanding of the different impacts of symptoms and behaviour in the hospital and home settings.

Most fundamentally, a return to the earlier psychiatric pessimism about long-term illnesses is likely on the part of hospital consultants who deal only with those who relapse.

1 Burns T. The dog that failed to bark. *Psychiatrist* 2010; **34**: 361–3.

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The dog didn't bark because it was usefully occupied

An instinctive medical conservatism compromising the ability of psychiatry to adapt for the future has perhaps been inadvertently exposed by Professor Burns.[1] Very little of his article really stands up. The focus is on the in-patient/community 'split'. He assumes that the split has or is likely to remain at the ward door. Dysfunctional relations between egocentric psychiatrists reminiscent of the most troubled splitting and projection associated with 'psychopathology' sound like a 'mess', and would be, if they were to become established or even desired practice. No doubt there are some examples of fractured systems like this. Burns may know of hard-bitten consultant psychiatrists favouring community treatment orders (CTOs) without proper clinical consensus between colleagues; but it is not logical to condemn a movement, a 'silent revolution' or otherwise, by reference to its worst exemplars. His reasoning is reminiscent of the Dangerous Dogs Act.

Why is the role of the in-patient consultant 'obvious nonsense'? It is no such thing. The task of the in-patient consultant is to think clearly about the best interests of the patient in context: doctors should not be in-patient consultant psychiatrists unless they possess the skills to communicate with their community colleagues and hold their confidence. Burns is pessimistic about human nature and consultants in particular. He fears that they will not work well together, and culturally never have. Consider surgeons and anaesthetists. I can recall some examples of pretty odd behaviour; but out of necessity, either would accept or cope with the consequences of decisions taken by the other. Burns' attachment to sustaining individual medical autonomy across the whole process of patient care is just not helpful or necessary. He refers to the Oxford Community Treatment Order Evaluation Trial (OCTET) study highlighting the need for psychiatrists to demonstrate tolerance and collaboration as if this were an unreasonable suggestion. These are characteristics that should be developed in all doctors, but especially psychiatrists. Is that a problem?

A further misunderstanding concerns bed numbers and pressure. I would contend that acute bed numbers have reduced for a variety of reasons in recent years, one being that the introduction of crisis teams has reduced the admission rate by managing the route into acute beds and offering a preferred alternative to admission for many, thereby of necessity setting a different threshold. The in-patient mix has consequently changed. Is this an argument for re-expanding in-patient care? Surely not, the idea that we take people into hospital to dilute the experience of others is absurd. There has been pressure on beds for as long as I can recall it first hand, since 1986, long before the changes Burns contests. He rightly dislikes confusing multiple ward rounds. It is hard to fathom why this is his experience in contemporary systems, other than through eccentric implementation of change. Is something strange happening in Oxford? If there is one in-patient consultant, there will be one ward meeting, or at least if there are more, they will feature the same consultant. This contrasts with old-style sector ward rounds, several per week, each to do with a small number of patients managed in contrasting ways quite arbitrarily by disconnected consultants interacting at times only to argue about what sector someone lives in. I recollect strong views being expressed about a patient moving over the road. That particular problem should be consigned to history.

Burns alludes to a continental professional and service model. The reason for the arguable historical success of the British approach, in so far as it has been a success, is not in the location or otherwise of splits in the system. It is in the existence of a social healthcare system in the NHS and a now strained sense of collectivism. It is in Anglo-Saxon empiricism, sceptical of medical obscurantist elitism feared by Burns, and an excellent and ever-necessary defence against pomposity and hierarchy building.

Finally, it is invidious to infer increased suicide rates from studies of discharge from examples of private sector units with no interest in supported discharge, or indeed follow-up. Considering NHS in-patient services, what is the evidence that suicides have become more prevalent, let alone that there is a causal link?

Burns may overestimate the importance that individual psychiatrists should attach to their role. The flipside of 'continuity' is the patient who is shackled to a disliked consultant for years without fresh thinking and no automatic second opinion. Burns concedes potential advantages rather gamely. He acknowledges that we may all need a rest from each other, doctors and patients included. In past years this happened unofficially – let us recall without nostalgia the patients who revolved from one trainee to another for years on end without a shred of consultant continuity. They taught me a lot, but such practice is now hopefully extinct. The care programme approach (CPA) involving continuity with nurses or social workers as an alternative strand to the discussion bears mentioning. Indeed, CPA is probably the key to consultants having a consultant role rather than acting as a kind of parallel, ghettoised general practitioner for people with enduring psychosis.

People do, of course, need stability in their key relationships. I am not at all sure that psychiatrists should appropriate a role, which properly lies 'out there'; our difficult job is to try to help make that a reality and then quietly withdraw. Good psychiatrists are quite capable of sharing thoughts and plans, do not unilaterally and thoughtlessly impose directives on their colleagues, are considerate of their own limitations and ultimately the very conditional nature of the impact that we personally should aim to have on peoples' lives. When the water closes over us as if we were never there, we succeed. We have to see ourselves as less linear and more systemic, less unique and more integrated, and act humanely mindful of all,

which may involve a healthy modesty and ability to share and even to let go.

1 Burns T. The dog that failed to bark. *Psychiatrist* 2010; **34**: 361–3.

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Two heads are better than one

An article starting with a quote from Sherlock Holmes always grabs my attention and Burns' article is no exception.[1]

We made the in-patient/out-patient split in Greenwich in 2006, which resulted in my relinquishing my in-patient work. Initially, I was not at all keen on the idea, for the very reasons laid out by Burns. As time has gone on, however, I have completely changed my mind.

The main positive feature for me is that one has the benefit of a very experienced consultant colleague reviewing the case, including the diagnosis and the management plan. When there is agreement, I feel reassured and move on with improved confidence. When there is a difference of views, I have the opportunity to examine what is being said and to learn from it.

I thought many patients would hate it, but in the 4 years that have elapsed since the change, only one or two have complained to me about it. It has been a helpful change.

1 Burns T. The dog that failed to bark. *Psychiatrist* 2010; **34**: 361–3.

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Towards integrated care in Europe

The split responsibility for in-patient and out-patient care is one of the most serious problems facing mental healthcare in Europe. It is a major obstacle in the continuity of care, particularly with severely mentally ill patients.

I have been involved in mental health services research for 30 years. During that time, I have observed increasing efforts to overcome this split responsibility. There are several ongoing evaluations of 'integrated care' all over Europe, which have been developed to overcome this divide. Britain has always set a good example in integrated care and it would be a great pity if the NHS were to abandon this well-accredited approach.

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Do we stand by the values upon which the College was founded?

The association between the non-restraint movement and the formation of the Royal College of Psychiatrists has never been formally acknowledged in either current or past literature. This movement was a significant step in the humane treatment of patients within the psychiatric system and a focus point for the development of other forms of treatment for aggression and mental disorder.

The movement originated in York Asylum in the early 1800s, started by Pinel and Tuke, and was then taken up by Lincoln Asylum's lead physician, Edward Charlesworth. From 1828, also the time of Parliament attempts at passing legislation to improve monitoring of madhouses, Lincoln Asylum had gradually reduced the use of mechanical restraints, until their complete abolition in 1838.[1] By 1839, interest had been generated, and Dr John Connolly visited from Hanwell Asylum in Middlesex. After witnessing Lincoln's progress, Connolly set about abolishing the use of mechanical restraints in Hanwell.[2] By 1841, Lincoln was not the only asylum to abolish the use of restraints: Hanwell, Montrose and Northampton (now St Andrews Hospital) had joined the non-restraint movement.[3]

In early 1841, Samuel Hitch, resident superintendent of the Gloucestershire General Lunatic Asylum, proposed the establishing of an association of 'Medical Gentlemen connected with Lunatic Asylums'.[4] He sent a circular to 88 resident medical superintendents and visiting physicians in 44 asylums in June 1841, requesting their participation in his proposed association. The first annual meeting of the Association of Medical Officers of Asylums and Hospitals for the Insane took place on 4 November 1841, where it was announced: 'The members here present have the greatest satisfaction in recording their appreciation of, and in proposing a vote of thanks to those gentlemen who are now engaged in endeavouring to abolish [mechanical restraint] in all cases.'[4]

This association later became the Royal College of Psychiatrists (1971) and this clear statement supporting the abolishment of the use of mechanical restraints heralded a new era.

The use of mechanical restraints remains current given the specific references in both the Mental Health Act Code of Practice and National Institute for Health and Clinical Excellence guidance, despite the extremely limited evidence base. It is helpful to be reminded that the College began with such benevolent principles: challenging the *status quo* and striving for the very best for our patients.

1 Walk A. Lincoln and non-restraint. *Br J Psychiatry* 1970; **117**: 481–95.

2 Suzuki A. The politics and ideology of non-restraint: the case of the Hanwell Asylum. *Med Hist* 1995; **39**: 1–17.

3 Smith L. 'The Great Experiment': the place of Lincoln in the history of psychiatry. *Lincolnshire Hist Archaeol* 1995; **30**: 55–62.

4 Bewley T. *Madness to Mental Illness: A History of the Royal College of Psychiatrists*. RCPsych Publications, 2008.

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Defining coercion

To define coercion as a subjective response to a particular intervention that is an unfortunate but necessary part of the care of people with psychiatric illness is astonishing![1] This Orwellian definition cannot go unchallenged.