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correspondence

Conspiracy of silence?

Sir: The finding of Clafferty *et al* (*Psychiatric Bulletin*, September 2001, **25**, 336–339) that only 59% of consultant psychiatrists told people their diagnosis of schizophrenia at the time of the first “established episode” raises a number of interesting issues that deserve further discussion and debate. The conclusion that failure to disclose such a diagnosis constitutes a “conspiracy of silence”, contributing to the stigma of mental illness, is highly questionable. Even with operationalised diagnostic criteria, the diagnosis of schizophrenia is often highly unreliable and premature diagnosis may lead to considerable negative effects for the individual concerned and his/her family (McGory, 1995).

The finding that large numbers of consultant psychiatrists use the term psychosis may reflect an increasing trend away from the use of a diagnosis of schizophrenia that has low reliability and questionable validity. There is a growing voice of opinion in favour of the use of the term psychosis, which seems to be meaningful and acceptable to patients (Spencer *et al*, 2001).

Perhaps there is a need for greater consensus between psychiatrists about how best to give helpful and honest diagnostic information to patients and their families.

McGORY, P. D. (1995) Psychoeducation in first episode psychosis: a therapeutic process. *Psychiatry*, **58**, 313–328.

SPENCER, E., BIRCHWOOD, M., McGOVERN, D. (2001) Management of first-episode psychosis. *Advances in Psychiatric Treatment*, **7**, 133–142.

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Sir: Clafferty *et al* (*Psychiatric Bulletin*, September 2001, **25**, 336–339) report some very interesting findings. Some of their conclusions urging increased disclosure of the diagnosis of schizophrenia are, however, problematic.

In the course of studying the social correlates of insight in 150 people with schizophrenia (White *et al*, 2000), we found that individuals with poor insight reported, strikingly, that they were

rarely able to trust or confide in health professionals.

There is no evidence that telling this surprisingly large group of patients their diagnosis will impact on their poor insight. It is more likely that it will antagonise them, and further damage an already fragile therapeutic relationship.

It would seem much more important in this instance to recommend that doctor and patient develop an understanding of the patient’s experiences that is shared by them both, and that can subsequently form the basis of mutually acceptable therapeutic interventions. This principle, which is collaborative rather than didactic, egalitarian rather than authoritarian, underpins much cognitive–behavioural therapy for psychosis and requires the clinician to work more with the patient’s existing beliefs. Seen in this light, blanket recommendations regarding the disclosure of diagnosis for the sake of reducing the stigma of schizophrenia lack subtlety, and indeed seem misplaced.

WHITE, R., BEBBINGTON, P., PEARSON, J., *et al* (2000) The social context of insight in schizophrenia. *Social Psychiatry and Psychiatric Epidemiology*, **35**, 500–507.

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Women patients in medium secure psychiatric units

Sir: The development of separate secure services for women (Hassell & Bartlett, *Psychiatric Bulletin*, September 2001, **25**, 340–342) is essential. However, in my experience the campaign to develop such services is brushing aside the limitations of both our phenomenological understanding of a particular group of patients, and the evidence base for interventions for this group. These patients, who I anticipate will be instantly recognisable to clinicians, present with many features of borderline personality disorder and some “are subject to episodic descent into psychosis”. I do not want to revisit the failings of the personality disorder/mental illness dichotomy. However, even when our current pharmacopoeia is exhausted,

many of these patients continue to manifest evidence of severe psychological vulnerabilities, which have been present from an early age, and for which long-term psychological interventions are recommended. Forensic psychiatrists have become increasingly cautious about admitting male patients who present with problems primarily attributable to their personality. Disproportionately more women than men with a primary diagnosis of personality disorder are admitted to secure services (Coid *et al*, 2000). Does this gender bias reflect a particular therapeutic optimism or medical paternalism?

COID, J., KAHTAN, N., GAULT, S., *et al* (2000) Women admitted to secure forensic services: I: Comparison of women and men. *The Journal of Forensic Psychiatry*, **11**, 275–295.

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Sir: Hassell and Bartlett (*Psychiatric Bulletin*, September 2001, **25**, 340–342) provide a welcome snapshot of women in medium security. They report large increases in numbers of women in such conditions, of whom almost all those detained in NHS facilities are in mixed gender units. They find that women are more often in private sector units than men, and comment that some units no longer accept women because the environment is considered unsuitable.

Service planners have woken up to the fact that mixed gender wards do not work. This is not a surprise, given the historical lessons that prison development has taught us. In the early 19th century women comprised around 20% of the prison population. High profile campaigning led to formal recognition of the problems they faced when regularly outnumbered by men in gaols. The Gaol Act, passed in 1823, led to gradual separation of penal facilities and presently there are 10 establishments in England (none in Wales) that care for women only (Home Office, 1997).

The National Service Framework (Department of Health, 1999) gives a clear commitment to ending mixed gender hospital accommodation, and makes it clear that “as part of the strategy to provide safe services NHS trusts need to . . . recognise that the needs of male



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and female patients may be different". The experience of the prison service (Moulden, 2000) makes a bold case for small, locally determined units that could clearly meet the required objectives, with the added benefit of minimum disruption to local services and social networks.

DEPARTMENT OF HEALTH (1999) *National Service Framework for Mental Health, Modern Standards and Service Models*. London: Stationery Office.

HOME OFFICE (1997) *Women in Prisons: A Thematic Review by HM Chief Inspector of Prisons*. London: The Home Office.

MOULDEN, M. (2000) Women prisoners with mental health problems. *Prison Service Journal*, **126**, 11–12.

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Mental Health Act reform: treatment of dangerous and severe personality disorder

Sir: Chiswick (*Psychiatric Bulletin*, August 2001, **25**, 282–283) has captured the essence of the proposed Mental Health Act reforms with regard to dangerous and severe personality disorder (DSPD).

The existing Mental Health Act always gave clinicians the power to detain patients with psychopathic disorder in a hospital for treatment if the patient was thought to present risks to others. Treatment of patients with psychopathic disorder is stressful because of the difficulties in treating them, the resources they take up, the strong countertransference reactions these patients evoke and the staff burnout that they cause. Therefore, understandably, clinicians resort to a narrow interpretation of the 'treatability test'.

In the proposed reforms, the emphasis is on the fact that this group of patients needs treatment and that the interpretation of the treatability test needs to be a broad one.

The main arguments put forward by clinicians against the proposals are that (a) patients who are not treatable should not be detained and (b) it is unethical to detain patients for public protection alone.

Taking the first argument about treatability of psychopathy, there is a lot of evidence in the literature that psychopathy can be a difficult condition to treat, but not entirely untreatable.

As to whether it is unethical to detain patients when they pose a risk to others, it can be argued that because of the high probability of their offending, patients with DSPD run a high risk of being imprisoned and being the victims of retaliation by others and therefore detention in hospital prevents offending behaviour and

protects them from the consequences thereof.

If we as clinicians refuse to treat people who are clearly unwell and distressed, we would be failing in our duty of care and pushing these vulnerable patients into the criminal justice system.

Since it seems inevitable that the proposals will become law, we should be fighting for more resources to be able to deliver the services this group of patients need.

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Impoverished services for poor people – perceived racism in psychiatric services

Sir: Sashidharan's article on institutional racism in British psychiatry (*Psychiatric Bulletin*, July 2001, **25**, 244–247) failed to mention a major issue that in my experience is crucial to this debate. Black and other ethnic minorities are more likely than the general population to be poor and socially disadvantaged and live in areas that generate high psychiatric morbidity, but where mental health services are likely to be similarly impoverished and deprived. This alone may account for much that is objectionable and countertherapeutic in the experience of Black psychiatric patients.

We recently demonstrated the importance of inequality in a randomised controlled trial of community care for recently discharged patients in Brent and Westminster (Tyrer *et al*, 1998). This study showed that although community care reduced admissions to hospital compared to hospital-based care, this only made a worthwhile impact where there were adequate numbers of hospital beds.

As Sashidharan points out, it is undeniable that many Black people experience psychiatric services as noxious and alienating. However, he is selective in focusing almost exclusively on the providers of psychiatric services in searching for the causes and remedies.

TYRER, P., EVANS, K., GANDHI, N., *et al* (1998) Randomised controlled trial of two models of care for discharged psychiatric patients. *BMJ*, **316**, 106–109.

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Driving and mental illness

Sir: Wise and Watson's survey of psychiatrists' knowledge and attitude towards driving and mental illness (*Psychiatric Bulletin*, September 2001, **25**, 345–349)

importantly describes the prevalent lack of knowledge and/or willingness to apply the existing Driver and Vehicle Licensing Agency (DVLA) regulations.

They omit to mention patients with dementia who are probably the largest and potentially the most at-risk group of drivers with mental illness.

Driving while suffering from relatively mild dementia (of Alzheimer's or vascular aetiology) can pose a significant risk to other road users and occasionally result in incidents leading to newspaper headlines such as 'pensioner drives wrong way along motorway'.

The majority of patients with dementia are cared for by their general practitioners and it is primarily their responsibility to be aware of DVLA regulations and to apply them rigorously. This will almost inevitably cause friction in the doctor–patient relationship as many elderly car owners view their right to drive as their only means of continuing to lead an independent life.

Suggestions to patients that they should cease driving are frequently countered by responses such as 'I only go to the shops twice a week on the same route' or 'I've driven for 50 years without problems'.

Allowing a patient to drive while being aware that he/she has a progressive dementing illness could expose the doctor to serious medico-legal consequences.

As the prevalence of dementia rises rapidly in the 8th decade, I suggest there should be more frequent testing of driving ability, possibly including brief tasks of cognitive function for all drivers over the age of 70.

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Home treatment service

Sir: I read with interest the study by Harrison *et al* (*Psychiatric Bulletin*, August 2001, **25**, 310–313) about which patients are suitable for a home treatment service. The authors are right to comment that little has been written about the type of patient suitable for this approach. However, this question may be premature, in that there is little agreement about what 'the approach' actually involves. Their own particular model is described as a hybrid between day hospital and home treatment, which is rather an unusual configuration for home treatment services.

The authors write as if there is a strong evidence-based rationale for the development of acute home treatment services. Despite their incorporation in the National Service Framework for Mental Health, there is not. Their referral to "key components of the model" is highly