In defence of the long case

Benning & Broadhurst (Psychiatric Bulletin, December 2007, 31, 441–442) argued that the abandonment of the long case from the Member of the Royal College of Psychiatrists (MRCPsych) exam threatens the holistic approach in psychiatry and ignores the importance of the subjective dimension of the experience/behaviour and the role of the patient’s biography in aiding understanding. We share their concern.

An online survey of trainee psychiatrists working in the North Trent Rotation Scheme with a response rate of 46% (n=43, ST1–3 and trust grade doctors n=26, ST4 and specialist registrars n=17) showed that the majority of trainees (62.8%) did not agree with abandoning the long case. Those who have passed the MRCPsych (i.e. ST4 grade and specialist registrars) opposed it more strongly than junior trainees (94% v. 42%, P=0.01). Similarly, senior trainees were more likely to disagree that Observed Standardised Clinical Examination (OSCE) is a fair alternative than junior trainees (76.5% v. 34.6%, P=0.01), but is not capable of testing from the bio-psychosocial perspective (82% v. 50%, P=0.05). Unsurprisingly, more senior trainees (58.8%) than junior trainees (30.8%) felt that the exam would be easier.

The majority of responders were concerned that passing the long case depends largely on one encounter. This could be addressed by incorporating one or two long cases per year as part of workplace-based assessments, which would ensure the appropriate choice of patients and possibly more time allocated for each case, as it has been shown to increase reliability from 0.60 to 0.90 (Waas & Jolly, 2001). Finally, although we agree that OSCE could test different specific competencies, we should not forget that ‘the whole is more than the sum of its parts’ as one of our responders commented.


Lekshmi Premkumar ST1 Doctor in Psychiatry, Sheffield Care Trust, *Mohammed Abbas Specialist Registrar in Psychiatry, Rotherham General Hospital, Mental Health Unit, Moorgate Road, Rotherham S60 2UD, email: mohdguot@hotmail.com

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How and why the long case should be kept: a view from the antipodes

The commentary by Tyrer (Psychiatric Bulletin, December 2007, 31, 447–449) summarises the reasons why the Royal College of Psychiatrists has decided to abandon the long case as a summative assessment in the MRCPsych examination. The Royal Australian and New Zealand College of Psychiatrists (FRANZCP) examination. We agree with Tyrer that the main question is not whether the skills tested in a long case are important and need to be assessed, but whether they need to be assessed using a summative examination. A major value of a summative assessment is that the examiners have no possible conflict of interest or even awareness of the prior training and examination history of the candidate. Making the long case part of training as a formative assessment does not get around any problems of reliability and may make the reliability worse as assessors do not have the same degree of examination training. There may also be a significant conflict of interest with local supervisors keen to get their trainees through training.

Finally, there is the wider issue of the change in culture in medicine. Increasingly there are moves to reduce medicine to a set of procedures which are laid out by guidelines, encouraged by incentive payments and evaluated by audit or other performance measures. Relying solely on OSCEs encourages this tick-box procedural approach to healthcare. We believe that what patients need when they visit a specialist is someone who can make sense of complexity, knows what procedures to use and what to do when they do not work. Dropping the long case in the examination is not good for consumers and risks reducing psychiatry to a set of simplistic procedures.

*Simon Hatcher Senior Lecturer in Psychiatry, University of Auckland, Auckland Hospital Support Building, Level 12, Private Bag 92019, Auckland, New Zealand
An elegy to essay writing

Benning & Broadhurst (Psychiatric Bulletin, December 2007, 31, 441–442) raise an important issue with regard to the change in the MRCPsych exam format. In addition to the loss of a long case, the new exam discards essays and critical appraisal in theory assessment. The loss of essay, in my opinion, deserves significant mourning.

Essays have traditionally been the only mode of testing logical arguing skills. This is an essential skill for any clinician in psychiatry given the intangible nature of certain domains of our clinical work. In the absence of a well-constructed arguing ability, team working and teaching cannot flourish.

Essays tested contemporary contents, unlike multiple choice questions which were obtained from a bank of questions. The creativity and reasoning abilities of a candidate are largely tested in the new format exam. This means we might get many qualified specialists in the future who read the specified syllabus and managed their time well at Clinical Assessment of Skills and Competencies (CASCs, formerly OSCE exams), though they never had a chance to prove that they are up-to-date with the developments in psychiatry or that they could think critically about a controversial issue in the field. This is a great loss as the aforementioned are important and distinguishing skills for any psychiatrist.

I am a candidate who sat the last of old pattern MRCPsych part 2 exams and, like most of my peers, I spent a substantial amount of time researching the British Journal of Psychiatry, Advances in Psychiatric Treatment and Psychiatric Bulletin, as well as other journals, when preparing for my exams. Journal reading habit was cultivated strongly by essay papers in MRCPsych. This is not the case with multiple choice questions. Factual recall is tested equivalently by both multiple choice questions and essays (Palmer & Devitt, 2007), but higher order cognitive skills including problem-solving cannot be easily tested by a set of questions (Schuwirth et al, 1996). It is, moreover, everyone’s secret that the College uses a bank of questions with a high repetition rate for subsequent exams.

One argument against essay writing is standard of assessment, which could vary widely when an essay is evaluated. Standardisation of assessment could be attempted by structured essay evaluation tools. Removing essay writing completely and replacing it with multiple choice questions is a costly trade-off between assessment standards and abilities tested. Multiple choice questions may be an easy option if one considers online delivery of exam modules in the future, but whether we need to give up on essay papers is a matter of serious debate. Fast food may be easy and appealing, but cannot solve all nutritional requirements!!

Declaration of interest
L.P. was awarded Laughlin prize for outstanding performance in old format MRCPsych exam, Autumn 2007. He is also involved in writing a multiple choice questions’ book for the new format MRCPsych.


Lena Palaniyappan Academic Clinical Fellow, Division of Psychiatry, Institute of Neuroscience, Newcastle University, Leazes Wing, Royal Victoria Infirmary, Newcastle upon Tyne NE1 4LP, email: Lena_palaniyappan@ncl.ac.uk

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The art of psychiatry

I read with interest the article by Benning & Broadhurst (Psychiatric Bulletin, December 2007, 31, 441–442). Holism has become such a cliché in psychiatry. It is sad that at a time when other specialties are embracing the humanities, psychiatry seems to have started to neglect it.

Psychiatry has made a list of progress over the last few decades. Paging through psychiatric journals filled with imaging studies and genetic breakthroughs showing remarkable discoveries, one can fully appreciate the changes that have been made. In response to these advances in psychiatry Dr. David J. Hellerstein argues that, ‘In exploring these new universes, we need not be only technicians and scientists, but also artists!’ (Hellerstein, 2007).

The pressures on seeing patients within specified targets and this affair with all things biological has an impact on our patient care. This reductionist psychiatry with quick consultations and quick fixes fits in with the consumer society of ‘Just add water and stir’. It is unfair to expect a pill to fix complex psychosocial problems.

It is all well and good to have holistic training, but you also need the support and resources to implement the techniques you have learned. In the proposed New Ways of Working we are expected as doctors to only see the most complicated cases. Hopefully, in this new scheme, there will be more time allocated to spend with patients and provide them with a more holistic treatment. Teaching will give the foundation to build from, but without the resources to implement holism they will become forgotten poems.


Jon van Niekerk Specialist Registrar in General Adult Psychiatry, Ravenley Building, Manchester Royal Infirmary, Oxford Road, Manchester M13 9WL, email: vzvanniejkerk@hotmail.com

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Utility of the electroencephalogram

While the electroencephalogram (EEG) has been available to psychiatrists for over 30 years, its usefulness in psychiatry remains unclear. One study shows that the yield appears low in psychiatry, particularly for epileptic disorder which is fundamentally a clinical diagnosis (Stone & Moran, 2003). However, this contrasts with Fenton & Standage’s (1993) finding that 92% of EEGs were useful in a psychiatric series.

We compared the requests from psychiatrists for EEGs with the corresponding report in 186 tests (patient group aged 16 years and above, trial over a 28-month period, target population 924 000). This information is held electronically, but we also inspected the original written request in a quarter of cases.

Clear abnormalities suggesting epilepsy or cerebral dysfunction were found in 15% of the study cohort (9% of <65 years old, 39% of ≥65 years old). We defined a test as being useful if it was either clearly abnormal or clearly normal and was likely to add diagnostic weighting in the context of the information on the request form; this usefulness was found in 37% of tests (32% in <65 years old, 35% in ≥65 years old). The apparent usefulness was reduced if suspected cases of epilepsy were excluded, which happened in 19% of tests (16% in <65 years old, 35% in ≥65 years old).

In terms of abnormal positive results for epilepsy, there were no tests supporting unsuspected epilepsy; however, 7 out of 96 in the younger group and 2 out of 26 in the older group did support suspected cases of epilepsy. For cerebral dysfunction, there were 5 out of 45 suspected...
and 2 out of 103 unsuspected instances in the younger group, and 2 out of 9 suspected and 11 out of 29 unsuspected in the older group. The division between suspected and unsuspected cases was dependent on the quality of the referral, which was often limited.

Our findings suggest that the EEG gives useful diagnostic information in a little over a third of cases. However, in practice the effect is likely to be reduced by such factors as the primacy of a clear clinical diagnosis in suspected epilepsy, the nature of the EEG report being usually suggestive rather than indicative, and the superiority of other investigations (e.g., neuroimaging) in certain situations. The EEG test remains important in the differential diagnosis of both possible cerebral dysfunction (encephalopathy) and seizures, as well as the monitoring of epilepsy. In order to keep the rate of uninformative tests to a minimum, clinicians should carefully describe the presenting signs and symptoms, considering whether these are consistent with epilepsy and whether other investigations are preferable. This information should be included in the EEG referral to improve the utility of the subsequent report.


Shweta Gangavati Senior House Officer, Leicestershire Partnership NHS Trust,

*Chris Meakin Consultant Psychiatrist, Bradgate Mental Health Unit, Groby Road, Leicester LE3 9EJ, email: christopher.meakin@leicestp.nhs.uk
doi: 10.1192/pb.32.4.152b

The Bournewood gap is not as wide as it sometimes seems

In response to Singhal et al (Psychiatric Bulletin, January 2008, 32, 17–20), I would like to point out a common misunderstanding with regards to the European Court of Justice judgement on the Bournewood case [H.L. v. UK, 2005]. The authors give a good description of the case itself, but they then confuse its specifics with the details of the so-called ‘Bournewood gap’. This, however, fails to take account of the actual judgement, which concludes that the reason why the court ruled against the Bournewood Trust in that particular case was because of the specific circumstances that amounted to a deprivation of liberty under Article 5 of the Human Rights Act 1998. They listed a number of points regarding complete control over the patient’s movements and choices including not allowing visitors and home visits to his carers. It was the completeness of control exercised by the treating team that was the issue at hand rather than the more general point of H.L. lacking capacity to consent to his stay in hospital. The court specifically pointed out that this case should not be considered as a precedent but should be considered on its merits alone. While appreciating that one English judge in particular has given the meaning of de facto detention a broader interpretation in his particular judgement, the original European Court of Justice ruling should not be ignored.

When the Ministry of Justice introduced the deprivation of liberty safeguards in the Mental Health Act 2007 (thus amending the Mental Capacity Act 2005) they failed to give any reasonable explanation why the safeguards were necessary. Their official argument that the amendment will bridge the so-called Bournewood gap has to be viewed with some scepticism. This is because the definition of people who fall within the deprivation of liberty safeguards goes much beyond the original case brought to the European Court of Justice. An easier interpretation would have been to use the Mental Capacity Act 2005 to make decisions in the best interests of a patient and thus bridge the Bournewood gap. There was no specific need for additional legislation in this area but it falls in line with a number of local and national decisions taken with anticipatory obedience in order not to fall foul of some perceived legal obligation.

This anticipatory obedience or defensiveness has certainly contributed to giving the Human Rights Act a bad name and the same is potentially possible with the Mental Capacity Act if people get the impression that they have to do unreasonable and additional paperwork in order to comply with the Act. Acting in anticipatory obedience therefore has negative consequences for the perception of perfectly reasonable legislation on top of creating a lot of additional administrative work and costs for the respective authorities who are charged with the execution of the new amendments. As clinicians we ought to contribute to a sensitive interpretation of the new legislation and prevent a situation where staff on the ground consider far too many people to be in danger of potential Human Rights Act breaches.

H. L. v. UK [2005] ECHR.

Peter Lepping Consultant Psychiatrist/ Honorary Senior Lecturer, University of Wales, Central/Wrexham Community Mental Health Team, North East/Wales NHS Trust, 16 Grosvenor Road, Wrexham LL11 1BU, Wales, email: peter.lepping@new-tr.wales.nhs.uk
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Blood-borne virus testing and Hepatitis B immunisation in specialist alcohol and drugs service

In the UK, which has among the highest rates of recorded illegal substance misuse in the Western world, 34% of people diagnosed with Hepatitis B, over 90% diagnosed with Hepatitis C and 5.6% diagnosed with HIV were associated with injecting drug use.

In our cross-sectional survey on 150 individuals under active management by the Trust Alcohol and Drug Services based at Great Yarmouth, 3% were diagnosed positive for Hepatitis B, 19% for Hepatitis C and 2% for HIV. About half had no documentation regarding blood-borne viruses; 36 had at least one dose of Hepatitis B vaccine, but only 18 had three doses. Those who showed a trend towards completing Hepatitis B immunisation were in the age group above 30 years old, known to the services for more than 2 years, injectors, those who accepted the offer of immunisation and those positive for Hepatitis C. This is of concern as studies show an emergence of increasing incidence of blood-borne viruses among new, young and vulnerable drug users.

At the time of our study, 22% individuals shared injecting equipment. Injecting is not only a key factor in the transmission of blood-borne viruses, but also plays a significant role in deaths from overdose, accounting for more than 7% of all the deaths among those aged 15–39 years old in 2004 (European Monitoring Centre for Drugs and Drug Addiction, 2006). We recommend the following: (1) clinicians need to collect, keep, analyse and make effective use of patient data including sexual health and injecting practice; (2) drug and alcohol services should increase awareness of harm from injecting drug use, with particular regard to blood-borne viruses and overdose; and (3) effective treatment goals should include testing, immunisation and treating of blood-borne viruses for all service users.


*Vellingiri Raja Badarakalimuthu Specialty Registrar, Northumberland, Tyne and Wear NHS Trust, Northgate Hospital, Great Yarmouth NR30 2NZ, email: dr_vellingiraj@yahoo.co.uk

Daphne Rumball Consultant Psychiatrist, Drug and Alcohol Services, Norfolk and Waveney Mental Health Partnership NHS Trust
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Evidence base and economic impact of community treatment orders

The recent article by Owino (Psychiatric Bulletin, July 2007, 31, 241–243) highlights that community treatment orders are not greatly different from the current provisions of section 17 leave. I believe that the evidence base and economic impact of the new orders require further consideration.

A well-resourced, systematic and independent review of community treatment orders was conducted by Churchill (2007). This large review considered the findings of 72 studies conducted in 6 different countries over the last 30 years and concluded that there is very little evidence to suggest that they are associated with any positive outcomes. Furthermore, there is some evidence, and widespread agreement, that they cannot work as intended without adequate resources, and it is widely acknowledged that they will not work without the general support of mental healthcare providers.

The Cochrane review by Kisely et al. (2005), which only includes two trials of community treatment orders, concludes that compulsory community treatment results in no significant difference in service use, social functioning or quality of life compared with standard care. Regarding economic impact of the community treatment, the Kings Fund report by Lawton-Smith (2005) provides a detailed economic forecast. The report suggests that, over a period of 10–15 years, the number of people subjected to community treatment orders in England and Wales might rise to between 7800 and 13 000 at any one time. The financial cost predictions in England and Wales will be £3.4 million in the first year, later increasing to £21.2 million in 2014/15. This is to be considered against savings related to reduced use of hospital beds, of which it estimates saving £8.7 million in the first year, increasing to £47.7 million in 2014/15 (Department of Health, 2006).

Given the lack of credible evidence to support community treatment orders and the indication by Owino that they are not greatly dissimilar to the current provisions of section 17 leave, it is difficult to understand why the government has pursued their implementation. Arguments that they have been more convinced by the political notion that the orders will help improve public safety must also be considered against the evidence that they may also lead to cost savings through closure of in-patient beds.


Nuwan Galappathie Specialist Registrar in Forensic Psychiatry, Forensic Clinic, Blackberry Hill, Bristol BS16 1ED, email: ngalappathie@doctors.org.uk
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‘Forensic’ – yet another form of stigma

I read with interest the recent article by Turner & Salter (Psychiatric Bulletin, January 2008, 32, 2–6) and O’Grady’s commentary thereof (Psychiatric Bulletin, January 2008, 32, 6–7) on the borderline between forensic and general adult psychiatry, and I have to disagree with authors. I think it would be more healthy to concentrate on the actual patient rather than various artificial classifications that have been cooked up over the past years.

Prior to returning to forensic psychiatry I was mainly involved with the seriously mentally ill and their treatment. I have noticed that in fact the patients have changed very little, it is just the surroundings and legal paraphernalia, etc. that have. We still see people with severe psychosis who have not responded to treatment for a variety of reasons, some of them having personality disorder alongside psychotic illnesses and some with personality disorder per se. Our role as psychiatrists with such patients is key to achieving the maximum stabilisation to enable them to live as normal a life as possible within a setting that is suitable for them. I regard the rest of the paraphernalia and surrounding status as largely irrelevant, from a purely psychiatric point of view.

It would appear that there are many people who seek to interfere with the treatment and care of these patients, in particular members of the legal profession who have on occasion given me detailed instructions on what medical treatment to deliver to their client. Clearly they are no more qualified in that, than I am in giving them legal advice for my patients. It would seem that the cause of the increased number of ‘forensic’ patients is merely due to a breakdown in the quality of care given to these people in the community. I think the current political idea that one system fits all has been an abject failure, as indeed are all generalised solutions to the needs of individual patients. Obviously most people with severe mental illness will be able to live in some capacity in the community without any problems with violence or suicide, but there still remains a significant number who will never be able to do this, however much politicians seek to deny this. I have met many of such people and I can recognise their mental pain as they struggle to come to terms with a rigid system into which they will never fit.

In addition to these problems, of course, millions of pounds have as its contents appear to be very relevant to low-income countries as well.

Recruitment and retention of psychiatrists in low-income countries

I have read the article Brown et al (Psychiatric Bulletin, November 2007, 31, 431–413) with great enthusiasm as its contents appear to be very relevant to low-income countries as well.

Recruitment into psychiatry seems to be a global issue. In addition to problems in recruitment, many psychiatrists and psychiatric trainees leave low-income countries in order to find more lucrative jobs in high-income countries. For instance, the Postgraduate Institute of Medicine, University of Colombo, Sri Lanka, has trained a reasonable number of psychiatrists over the past few decades. However, there are about 35 psychiatrists working in the country at present (about 2 psychiatrists per 1 million people). Obviously, this figure is grossly inadequate. Shortage of other professionals in the multidisciplinary team adds to the problem further. As a result of concentration of most of the psychiatrists in the cities, peripheries are poorly served.

In the Doctor of Medicine (MD; psychiatry) training programme in Sri Lanka there is a component of overseas training after completion of MD (Psychiatry) part 2 examinations. A survey among the trainees revealed that the majority preferred the UK centres for their overseas training and all indicated that they would like to return to Sri Lanka after their overseas training (details are available from the author upon request). However, it seems that once exposed to the overseas training and the Western
lifestyle, many are reluctant to return. These issues were discussed at length at the recently held South Asian Federation of Psychiatric Association’s Annual Academic Sessions in Katulata, Sri Lanka.

We believe that there are a few options to reduce this crisis, for instance enhancing the recruitment of more doctors into psychiatry or improving the knowledge of psychiatry among primary care doctors. Already some medical schools in Sri Lanka (e.g. University of Kelaniya and University of Colombo) have addressed this issue and increased the psychiatry training component in their undergraduate curricula. One of them is Colombo Medical School where psychiatry is assessed as a separate subject in the final Bachelor of Medicine and Bachelor of Surgery (MBBS) examination. Soon psychiatry will be incorporated as a separate subject at the final year assessment at the Faculty of Medicine, University of Kelaniya.

The importance of improving the quality of undergraduate teaching in order to enhance the recruitment of medical graduates to the field of psychiatry has been emphasised (Sierles et al, 2003). When medical students are more knowledgeable, fear and stigma associated with psychiatry, which seems to be more prevalent in low-income countries such as Sri Lanka, become less prominent.

A recent survey carried out among undergraduates in medical schools in the Western Province of Sri Lanka demonstrated that the career choice in psychiatry is about 2%, which is less than in the Western world (details are available from the author). A study in Spain has shown that the career choice for psychiatry was 6%, compared with 4.5% in the USA (Pailhez et al, 2005).

Psychiatry seems to be a less attractive medical field globally. Overworked psychiatrists with minimum rewards for their work tend to lose their interest in the profession, which can adversely influence the quality of care and teaching. Psychiatrists should be aware of factors that will help them prevent that.

As medical teachers and practising psychiatrists we should also be aware of the problems encountered in psychiatry to enhance the recruitment and retention of psychiatrists.

**New Ways of Working: implications for patients in adult psychiatry**

We read with interest the article by Mehta et al (Psychiatric Bulletin, December 2007, 31, 381–384). Community mental health teams’ case-loads comprise a variety of service users such as stable patients requiring ‘routine follow-ups’, long-term patients caught in the system, ‘revolving door’ patients (who tend to slip through the net), patients requiring social care and newly referred individuals. There is a tendency for the ‘status quo’ service users on standard Care Programme Approach to remain in the mental health system for routine out-patients.

It is difficult to define a ‘complex patient’ as their and the carer’s opinions may differ from the objective. However, we think the authors’ parameter of defining a ‘complex patient’ based on time elapsed since the last appointment, level of Care Programme Approach and lack of objective clinical activity are a good measure of complexity.

The New Ways of Working emphasises the role of a consultant psychiatrist in complex cases. However, after more than 2 years from its introduction the actual initiative is still patchily distributed within organisations and all its main principles are not fully accepted. We agree with the authors that once the New Ways of Working is implemented, routine follow-ups would be expected to be eliminated from consultant’s care.

The consultants and the multidisciplinary teams should change the current practice, laying more emphasis on the brief short-term interventions, promoting recovery, self-dependence and timely discharge to primary care. Stable patients can be effectively managed in primary care and an initiative to improve liaison with general practitioners can facilitate such people to be followed-up.

However, it would be interesting to see how the new breed of consultants who start their career under New Ways of Working would function in the long-term. In trying to use the skills of a consultant psychiatrist more effectively to deliver their expertise more ‘timely’ than ‘routinely’, there is a danger that they may end up in dealing with ‘complex patients’ only. Consultants may also lose the skills to manage ‘routine patients’, who are far more common than ‘complex patients’ in a psychiatric practice.

**Child and adolescent in-patient units – room for expansion**

We read with interest the concerns expressed in a recent article by Cotgrove et al (Psychiatric Bulletin, December 2007, 31, 457–459). The Ashfield Unit is an adolescent unit able to accept emergency admissions that opened in 2003 in recognition of a lack of emergency provision leading to delayed admissions and inappropriate use of paediatric or adult psychiatric wards. Our experience since opening has been in contrast to the concerns expressed by Cotgrove et al. We have not had inappropriate admissions and there have been no difficulties with recruitment and retention of staff.

What has been unexpected is the high level of violence, aggression and risk to others in some young people. This may be similar to the experience in adult psychiatry in recent years, with only the most disturbed patients being referred for admission into in-patient psychiatric units. There has been a higher than expected need for intensive nursing care in a low-stimulus environment – a third of our young people presenting with psychosis required the use of the intensive nursing area at some point in their admission (Cullen et al, 2006).

Although O’Herlihy et al in their paper (2007) demonstrate a dramatic increase in forensic provision, we would recommend an increase in provision of a spectrum of psychiatric intensive care units for adolescents alongside general and acute adolescent in-patient units, which could be used flexibly to allow the young person to be rehabilitated back onto an open ward as soon as possible.

**References**


*Nicole Karen Fung* Specialist Registrar in Child and Adolescent Psychiatry, Ashfield Unit, Parkview Clinic, 60 Queensbridge Road, Moseley, Birmingham B13 8QE, email: nkf@doctors.org.uk, Linda Cullen Consultant Child and Adolescent Psychiatrist, Ashfield Unit

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Right to independent advocacy

There has been debate over the advantages, if any, of the Mental Health (Scotland) Act 2003 compared with the Mental Health (Scotland) Act 1984. One of its introductions has been the right for any patient with a mental disorder to access an independent advocate, a person who enables the patient to express their views about the decisions being made about their care and treatment by being a voice for the patient and encouraging them to speak out for themselves’ (Scottish Executive, 2005). It is noteworthy that this definition of the remit of the advocacy workers precludes the peddling of an anti-psychiatry agenda independent of the wishes of the patient. However, as advocacy workers are employed by organisations not directly funded or run by the Health Board or local authority, their activities are not open to the scrutiny of the Mental Welfare Commission for Scotland which refers complaints to the commissioning agency.

In principle, independent advocacy for vulnerable people who may have communication difficulties is an excellent idea but in practice it can give people with no health service training the opportunity to pursue a mission to find fault with services regardless of the welfare of the patients. Some advocacy workers misrepresent themselves as working for the benefit of the patient when their stated purpose is to assist them in expressing views about care and treatment decisions, however harmful or self-destructive these views may be. In contrast, all professionals who make up the multidisciplinary team are employed for the health and welfare of the patient, and are bound by codes of ethics and ever-increasing demands for evidence, accountability and governance.

Unnecessary interference with the patient’s confidence in the service being provided undermines the trust which is so often crucial in a therapeutic relationship, whereas cultivation of suspicion and mistrust can lead to an increase in aggressive and threatening behaviour towards psychiatric staff. When de-escalation efforts by staff are then impeded by advocacy workers, either because they are enjoying the spectacle or because they see it as part of the patient’s right to be freely abusive and threatening to staff, their presence moves from being unhelpful and time-consuming to being dangerous. Do other organisations employ skilled professional staff to perform a function and then employ unskilled, untrained staff with a remit to undermine that function and foster hostility and mistrust? I suspect that businesses interested in profit would not seek to damage consumer confidence and satisfaction by provoking complaints and creating an atmosphere in which morale and productivity will decline.

When time has been spent with someone who has severe communication difficulties to ensure that their views are properly represented it is occasionally possible to see why independent advocacy is considered in principle to be beneficial and why some of the individual practitioners of the function are an asset to the service, usually when they do not interfere too closely to their stated remit. Unfortunately, the damage to therapeutic relationships and interactions, and to the planning and implementation of treatment programmes means that any benefits are greatly outweighed. Until there is a major revision of the Act with significant input from clinicians, it is to be hoped that the aims and methods of advocacy services are redefined to minimise the damage to the health and welfare of the people for whom they are supposed to speak.


Frank Corrigan Consultant Psychiatrist, Argyll and Bute Hospital, Lochgilphead, Argyll PA31 8LD, email: frank.corrigan@ NHS.net

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Perplexed trainees – what do you follow: the NICE guidelines or clinical wisdom?

We certainly agree with authors Hodes & Garralda (Psychiatric Bulletin October 2007, 31, 361–362) who observe that there are flaws in the National Institute for Health and Clinical Excellence (NICE) guidelines and a lack of available evidence for the treatment of depression in children and young people. During basic training in psychiatry, a trainee is encouraged to follow the NICE guidelines, Maudsley guidelines and others when initiating any intervention.

The same principle applies to the speciality of child and adolescent psychiatry. However, as a trainee in this speciality we have noticed that there are different factors that contribute to the use of pharmacological interventions.

As the authors mention, these trials demonstrated the benefit of fluoxetine over and above that of cognitive–behavioural therapy (CBT). This is supported by the TADS study (March et al., 2004) and by the ADAPT trial (www.iop. kcl.ac.uk/projects/?id=10095).

Another concern is the low availability of CBT as a first line treatment for adolescents with moderate to severe depression (Perera et al., 2007).

Consider the teenager presenting in crisis after an intentional overdose, or serious deliberate self-harm, following traumatic life events and family disruption. Thought must be given to the family’s ability, resources and motivation to support the young person through CBT.

It is clear that the authors are not advocating indiscriminate prescribing of antidepressant medications, but it also seems that the NICE guidelines for depression do not fully appraise the ‘real world’ situation with respect to resources and patient choice.

We trust that NICE recognises this and plans a timely review of its recommendations. We continue to exercise our clinical acumen and review the available evidence when treating the young people that we see.


*Vimutha Pemmaraju, Oaklands Centre, Raddlebarn Road, Selly Oak, Birmingham B29 6JB, email: Vimutha@doctors.org.uk, Sasha Riddlebasten Ems Centre, Halesowen, West Midlands

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