the columns

correspondence

The limits of responsibility

Sir: In his haste to point out more pressing issues than the stigmatisation of people with severe mental illness (*Psychiatric Bulletin*, November 2001, **25**, 412–413), Bristow seems to have overlooked just how psychiatry came to be in this state in the first place.

Ever since its inception as a recognised speciality our profession has been hamstrung by a sense of inferiority whenever we compare ourselves to our more physically inclined colleagues. How many of us have never heard, or used, the quip that we are 'not real doctors', or experienced that small moment of deflation when we reveal our speciality to an interested enquirer? For decades we have dealt with this professional cringe in several ways. In our rush to embrace biological legitimacy, we seem to have forgotten the other two corners of the biopsychosocial triangle, or at least left them to others. We have also been happy to pick up whatever responsibility was going; in the 1960s and 1970s, when this responsibility concerned a group of people that few cared or even knew about, we were happy to hold onto it as a way of vouchsafing some sort of status. Now that the black pigeons of the asylum have come home to roost, it seems that Bristow is no longer a bird fancier.

Our profession would not have committed itself to the current status quo were it not for the poor regard in which it still holds itself. This regard derives from the unpleasant fact that psychiatrists are almost as stigmatised within the medical profession as our patients have been within society as a whole.

Just who should take responsibility for the behaviour of the mentally ill is a question for which no one yet has an answer, Howlett included (*Psychiatric Bulletin*, November 2001, **25**, 414–415). In the meantime, might psychiatrists not be in a better position than most to carry on making the best of a difficult job, one that they have in any case been doing for decades? Our professional liability will only decrease if we are seen to be confronting these issues rather than running away from them.

Mark Salter Consultant Psychiatrist, Nelson Hospital, Nelson, New Zealand

Home treatment service

Sir: I would like to respond to the concerns raised by Sandor (*Psychiatric Bulletin*, December 2001, **25**, 486–487) regarding home treatment. He is correct to highlight the lack of a 'strong evidenced-based rationale'. However, his focus on 'model fidelity' is, in my view, misplaced.

It is tempting to fault models of service delivery on this basis, but surely this ignores more important issues? Instead we should focus on the important factors like patients' clinical and social outcomes. Other factors like service retention, adherence and satisfaction levels should also be borne in mind.

To suggest that an identikit model can be used in vastly different settings seems unrealistic. This creates a problem insofar as it acknowledges that model fidelity is an improbable goal. None the less, I would refer Sandor to the editorial by Slade & Priebe (2001), 'the challenge is to make the important measurable'. We could see this as following the lead of naturalistic pharmacological research (i.e. examining real-life scenarios).

Therefore, I would suggest that those assessing the impact of home treatment should acknowledge the deficiencies as outlined by Sandor. But it is imperative that we embrace the challenge to measure what is important.

SLADE, M. & PRIEBE, S. (2001) Are randomised controlled trials the only gold that glitters? *British Journal of Psychiatry*, **179**, 286–287.

MacDara McCauley Registrar in Psychiatry, Cavan/Monaghan Psychiatric Services

Mirror-image studies

Sir: I was pleased to find the data from my 1979 study of mirror-image studies of depot neuroleptics included in the meta-analysis by O'Ceallaigh and Fahy (*Psychiatric Bulletin*, December 2001, **25**, 481–484). These studies are rarely mentioned today, but they had two principal advantages when they were carried out, and these tend to be overlooked. First, the limited data they collected were as 'hard' as it was possible to get. Whether a particular patient is in or out of hospital on a particular day is a fact that even a vestigial record system can generally supply, while there is a legal requirement to record medication that is given.

Second, in a disorder where individual outcome and need for medication vary so widely, each subject is being compared with his/her own previous experience, and not with a theoretical average.

Of course, being in or out of hospital is not always directly equivalent to greater or less morbidity. However, in the circumstances of the NHS or similar services, this equivalent is broadly acceptable. Furthermore, in the real-life world of clinical research, there is simply no alternative to using this measure (Johnson & Freeman, 1972, 1973).

More fundamental, though, is the historical dimension. Mirror-image studies could only be done when there was a population of patients who had been on oral antipsychotics for a reasonable length of time and who could then be switched to depot treatment. This was possible in the late 1960s and 1970s, but hardly at all after that in Europe. It avoided any ethical problems.

Introducing depot drugs also had the effect of focusing attention on the need for continuity of care in schizophrenia and for setting up registers or information systems to prevent patients being overlooked by services (Freeman *et al*, 1979; Wooff *et al*, 1983). Historically, this coincided with the birth of community psychiatric nursing, which was able to reach a hard core of people who could not be persuaded to attend clinics regularly. This may be old hat now, but in the early 1970s it was revolutionary.

In Britain, depot treatment was developed by a small number of enthusiasts in provincial non-teaching hospitals. Early research efforts, including my own, were greatly encouraged by modest help from the E.R. Squibb company of the UK and its Medical Director, the late Dr Gerry Daniel. Without them, the effective development of essential maintenance medication – and of research into it – would have been much delayed.

FREEMAN, H., CHEADLE, A. J. & KORER, J. A. (1979) A method for monitoring the treatment of schizophrenics in the community. *British Journal of Psychiatry*, **134**, 412–416.

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columns

JOHNSON, D. A. & FREEMAN, H. (1972) Long-acting tranquillizers. *The Practitioner*, **208**, 395–400.

— & FREEMAN, H. (1973) Drug defaulting by patients on long-acting phenothiazines. *Psychological Medicine*, **3**, 115–119.

WOOFF, K., FREEMAN, H. L. & FRYERS, T. (1983) Psychiatric service use in Salford. A comparison of point-prevalence ratios 1968 and 1978. *British Journal of Psychiatry*, **142**, 588–597.

Hugh L. Freeman Professor, 21 Montagu Square, London W1H 2LF

Changing Minds campaign

Sir: Professor Crisp (*Psychiatric Bulletin*, November 2001, **25**, 444–446) gave an update on the Changing Minds campaign, and concluded by urging all areas of the College to participate actively in this campaign. As someone who has helped to run one of the Stigma Alert educational roadshows aimed at general practitioners (GPs), I would like to add further encouragement to any College members thinking of offering their support.

The difficulty in finding someone to speak at the event on behalf of service users gave strong evidence as to the continuing impact of stigma on the lives of our patients. The speaker I eventually found spoke eloquently about the experience of rejection by her former employers, and the fact that some mental health professionals are still wary of accepting her in her recovered role as a support worker because they remember the time when she was an in-patient.

It is hard to say if the meeting changed the minds of the handful of GPs who attended. It certainly was a very useful bridge-building occasion, bringing together local health professionals and patients, and carers groups. Moreover, I can confirm that participating in the campaign has changed my mind. My awareness of stigmatising attitudes has been so heightened that I find myself moved to respond actively where I see psychiatry maligned, and possibly more invidiously, ignored.

Another round of these meetings is planned for the spring throughout the UK, and Liz Cowan at the campaign office (Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG) would be pleased to hear from interested College Members.

Liz Hare Specialist Registrar, Community Rehabilitation Service, Rehabilitation Service, West Brig Tweed Road, Galashiels TD1 3EB

Nurses' uniforms

Sir: In July 2001 the psychiatric nursing staff in the mental health unit in Leigh Infirmary, Leigh, Lancashire, balloted to go back to wearing their nursing uniforms in all the in-patient psychiatric wards, including the psychiatric intensive care unit, acute male and female wards, and rehabilitation wards. Within the previous 3 years there were multiple requests independent of each other to return to wearing uniforms, coming mainly from relatives, service users and in-patient staff. Reasons given for the request were in relation to clearer identification of staff, better boundaries with patients and a more professional rapport, which would lead to a better established alliance.

The decision was taken following long discussions with consultants, medical and nursing staff, and service management, and a ballot of the nurses, which reflected unanimous interest in wearing nursing uniforms.

Five months later all involved seem to be happy with the decision and wish to continue to wear uniforms. Patients, relatives and staff express satisfaction with the process. There has been a great reduction in aggression, violence and the number of untoward incidents on the wards. In-patients have been more collaborative and understanding of the alliance with the professionals.

Since this is an unusual practice in mental health services today, I wish to share this experience with colleagues.

Dora Kohen Professor of Psychiatry, Lancashire Postgraduate School of Medicine and Health, Department of Psychiatry, Leigh Infirmary, Leigh, Lancaster WN7 1HS

Driving and substance misuse

Sir: Further to the paper by Bradbeer *et al* (*Psychiatric Bulletin*, July 2001, **25**, 252–254) and the letter of Kirk *et al* (*Psychiatric Bulletin*, November 2001, **25**, 452), please see Box 1 below, which is available at our in-patient alcohol treatment facilities. The leaflets are taken away and at least sometimes read, judging by the questions that patients ask us. We agree with the difficulties noted by Kirk *et al* in bringing up the issue in the clinical interview in some instances where patients are ambivalent about their attendance at the clinic.

J. D. Chick Consultant Psychiatrist, **E. B. Ritson** Consultant Psychiatrist, Out-patient Department, Lothian Primary Care NHS Trust, 35 Morningside Park, Edinburgh EH10 5HD

Box 1. Alcohol, driving and the law (Chick & Ritson correspondence)

Most people know that it is unwise to drink then drive, and against the law to drive with more than 80 mg per cent of alcohol in the blood. A breath test or a blood test can be used by the police. You can also have this level first thing in the morning after drinking heavily the night before. Many people who have alcohol problems are careful to avoid driving when they have been drinking. If you are addicted to alcohol you find it very difficult to stop drinking, and in these circumstances you must not drive.

Notifying the Driver and Vehicle Licensing Agency (DVLA)
According to the Road Traffic Act, there are certain medical conditions where an individual is required by law to notify the DVLA. Most people know that epilepsy and diabetes are included. Few people know that dependence on alcohol or misuse of alcohol are also medical conditions requiring notification. This is also listed in a European Union Directive to which the UK is a signatory.

What will happen if I notify the DVLA?
If you notify the DVLA that you have an alcohol problem, the Drivers' Medical Group may ask for a report from your doctor. You may well be allowed to continue to hold your licence, but a further report may be needed in future, or they may withhold your licence until a medical report gives evidence that you are recovering from your alcohol problems. The medical report might involve your doctor taking a blood sample.

What about my insurance?
Insurance companies may vary in their approach to this and we can give no fixed guidance. Voluntarily notifying of the DVLA of your alcohol problem would be very unlikely to affect the cost of your car insurance. On the other hand, in theory, claims by a driver with an alcohol problem who had not declared his/her condition to the DVLA might not be met by the insurer. To date, we have not heard of this happening.

Recommendations
People with alcohol problems who are drivers should write to DVLA Medical Group at D6/03 Longview Road, Swansea SA99 1TU to ask for advice. It is a very busy office and they do not recommend telephoning for advice.

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