columns

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 to 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 adhere 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.

SCOTTISH EXECUTIVE (2005) *Mental Health (Care and Treatment) (Scotland) Act 2003: Code of Practice, Volume 1*. (http://www.scotland.gov.uk/Resource/Doc/57346/0017038.pdf).

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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.

MARCH, J., SILVA, S., PETRYCKI, S., *et al* (2004) Fluoxetine, cognitive–behavioral therapy, and their combination for adolescents with depression: Treatment for Adolescents with Depression Study (TADS) Team. *JAMA*, **292**, 807–820.

PERERA, A., GUPTA, P., SAMUEL, R., *et al* (2007) A survey of anti-depressant prescribing practice and the provision of psychological therapies in a south London CAMHS from 2003–2006. *Child and Adolescent Mental Health*, **12**, 70–72.

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