Correspondence

EDITED BY LOUISE HOWARD

Effectiveness of community psychiatry

Sir: The Editor is to be applauded for devoting an almost complete issue of the *British Journal of Psychiatry* to the PRiSM study (November 1998). This important study properly addresses the issue of effectiveness at a stage when the number of relevant efficacy studies is increasing.

Tyrer (1998), in his editorial raises several important issues but finishes on the relatively prosaic conclusion that we need to examine what makes a team function well (or badly). The PRiSM study will be widely debated and quoted and will enter the annals of community psychiatric research. Unfortunately, it is likely to be over-quoted and misrepresented as the final statement on community-based care (as is the fate of such studies). It is now timely to examine the implications of the study for future research.

The limitations of the study have been highlighted by the authors and important among these is generalisability. The study examines two services in a deprived area of south London, but do its results apply to other urban, sub-urban and rural districts? This emphasises the importance of repeating the study in a range of districts, preferably selected to cover a representative cross-section of the UK population. Replication studies could be used to examine process variables to allow identification of key positive (and toxic) ingredients of provision that could then possibly be used to test their effectiveness in further pilot sites. The key issues are to identify what service elements are best utilised under what conditions, thus giving empirical verification to Tyrer's proposition, among others. Such studies would not replace efficacy studies that are desperately needed in a wide range of areas related to those with severe mental illness (e.g. early intervention for psychosis, prophylaxis for bipolar disorder).

Repetition of the PRiSM study will require sufficient funding, but where will such grants come from? Current National Health Service research and development funding promotes the use of randomised controlled trials, but effectiveness studies such as the PRiSM evaluation adopt a quasi-experimental design. In view of this it is likely that under the current funding environment, support for such replications will not be forthcoming (note that the PRiSM study was funded by the Bethlam and Maudsley Trust). It is important that research and development funding is re-examined and that a source of grants is made available to continue the trajectory set by the PRiSM study, possible in the form of a national research programme. In this way not will only the potential of the PRiSM study be realised, but the community-based care of people with severe mental illness will get the evaluation that it deserves.

Tyrer, P. (1998) Whither community care? *British Journal of Psychiatry*, **173**, 359–360.

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Clinical outcome measurement

Sir: Professor Marks (1998) outlines the use of the clinical outcome and resource measure (CORM), a clinical information system for outcome measurement. I fully endorse his general approach to routine clinical outcome measurement, although I believe access to such information lies at the basis of good clinical management and should not just become the focus of clinical audit. Professor Marks states that data are rarely entered completely cleanly into a computer.

SafetyNet Millennium, a detailed mental health information system targeted at those with severe mental illness (SMI), which is in use on single PCs as well as local and area-wide networks, incorporates serial Health of the Nation Outcome Scales (HoNOS) SMI ratings and longitudinal graphing of HoNOS scores (similar to CORM) and has overcome this obstacle through the use of optical mark reader forms for admission and discharge data, Körmer returns and HoNOS SMI data. Such an approach negates the need for keyboard-literate staff and results in rapid data input and very few errors for relatively little additional cost. SafetyNet Millennium is a fully scaleable system and is available to interested parties at minimal cost on CD-ROM.

Routine capture of the clinically based HoNOS ratings as outcome measures is the likely way forward and the challenge is surely to develop clinical information systems that are inexpensive, enable easy data capture and also incorporate wide-ranging relevant clinical information, such as ICD–10 diagnoses, care planning, risk assessment, legal status, medication, discharge summary information, etc.

It is astonishing that in this 'information age' so few psychiatrists have access to a computer-based list of their case load, who a patient's keyworker (or care co-ordinator) is and when a patient was last seen by any mental health worker. The SafetyNet Millennium development is supported as a registered charity and anyone interested in employing the system can contact me for a trial CD-ROM.

Marks, I. (1998) Overcoming obstacles to routine outcome measurement. The nuts and bolts of implementing clinical audit. *British Journal of Psychiatry*, **173**, 281–286.

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Developing theoretically relevant measures of psychoanalytic constructs

Sir: We were interested in the report by Hobson *et al* (1998) because of parallels with our own research. Since the early 1980s, our team has refined a clinical interview measure of quality of object relations, or QOR (Piper & Duncan, 1998). In line with Hobson *et al*, our work has indicated

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that judges can "agree in rating psychoanalytical aspects of interpersonal relatedness, and that such judgements have clinical relevance".

Quality of object relations is defined as a person's enduring tendency to establish certain types of relationships that range along an overall dimension from primitive to mature. In a semi-structured interview, the patient's life-long pattern of relationships is explored in reference to criteria that characterise five levels of object relations. An overlap with Hobson *et al*'s interview and Personal Relatedness Profile (PRP) is suggested. Of the 30 items from the PRP, we judge 22 to have clear parallels with the QOR criteria.

Hobson *et al* report satisfactory reliabilities for most items of the PRP. The QOR scale has been refined through its use in five clinical trial studies of time-limited dynamic therapy, with progressive improvements in inter-judge reliability. In a current comparative trial of short-term group therapy, two reliability studies have each returned intraclass correlation (ICC(2,2)) values of 0.81.

Hobson *et al* also report that the PRP successfully discriminated between patient groups defined by diagnoses of borderline personality and dysthymic disorder. In our work, we have examined subgroups defined by low and high QOR scores. Low-QOR patients tend to show more pathology on pre-therapy measures of outcome, notably those indices addressing interpersonal functioning. Quality of object relations has been found to be a direct predictor of the therapeutic alliance (Piper *et al*, 1991) and outcome in brief individual therapy (Piper *et al*, 1998), and of remaining and benefiting in a day treatment programme (Piper *et al*, 1996). Quality of object relations also appears to be a moderator of the impact of transference-focused technique in brief individual therapy. In short, QOR has provided important indications regarding the selection of patients for psychodynamic therapy and for the use of particular techniques with particular patients.

We encourage Hobson *et al* and others to continue the development of theoretically relevant measures of psychoanalytic constructs and examination of their clinical utility.

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'Patient *v.* client'

Sir: A patient is someone I attend to, treat and work with. Webster's (1987) *Dictionary* defines patient as "One that suffers, endures or is victimized". The word is derived from the Latin *pati* (to suffer). It saddens me to see some colleagues referring to patients as 'clients'. Webster's defines client as "A person who engages the professional advice or services of another". It is derived from the Latin *clinare* (to lean). Prostitutes and lawyers may have clients. Psychiatrists have patients.

Clinical social workers prefer to use 'client' (Lieberman, 1987), as do psychologists. Occupational therapists lean towards the use of 'client' and psychiatric nurses use both. Social workers brought 'client' from the field of social welfare, where its use attempted to avoid imposing a sick role. Its use in the field of psychotherapy was geared towards avoiding the medical model. Its use by nurses and occupational therapists seems curious. It is inaccurate to claim that a 'client' *engages* their professional services.

Words have meanings and significance. The use of 'client' reflects an assumed equality in the relationship. However, the inherent inequality between psychiatrists and patients is recognised in the ethical and legislative restrictions placed on relationships between psychiatrist and patient. Sharrott & Yerxa (1985) quoted Pellegrino, "There is . . . a special dimension of anguish in illness. That is why healing cannot be classified as a commodity, or a service on a par with going to a mechanic . . . to a lawyer . . .".

Use of 'client' to describe a patient ignores the ethical and moral bond between psychiatrist and patient, one which is based on non-maleficence and beneficence while still respecting patient autonomy.

I urge all mental health professionals to abandon the cold, inappropriate 'client' to describe the individuals who entrust us with their care.

Lieberman, F. (1987) Psychotherapy and the clinical social worker. *American Journal of Psychotherapy*, **41**, 369–383.

Sharrott, G. W. & Yerxa, E. J. (1985) Promises to keep: implications of the referent "patient" versus "client" for those served by occupational therapy. *American Journal of Occupational Therapy*, **39**, 401–405.

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Schizophrenia and diabetes mellitus

Sir: It is reported that patients treated with clozapine are more often classified as having type 2 diabetes mellitus or impaired glucose tolerance compared with patients in a control group (Hagg *et al*, 1998). Clozapine increases the risk of diabetes if there is a history of pre-existing diabetes, a family history of diabetes or if the patient is Black. Such patients may need close blood sugar monitoring during initiation of clozapine treatment (Popli *et al*, 1997).

We report the case of a 30-year-old Black male, diagnosed with schizophrenia 10 years ago. He has no history of pre-existing diabetes or a family history of diabetes. He was detained in a medium secure unit. Resistant to traditional depot antipsychotic medication, he was commenced on clozapine. The dose was gradually increased to 325 mg daily. After three months, he developed a sore throat, felt lethargic and unwell. His speech became slurred and he was thirsty. Blood sugar was 19 mmol/l. Clozapine was stopped and he was admitted to casualty in a hyperglycaemic ketoacidotic state. He made a good recovery and his diabetes resolved completely. Clozapine was discontinued.