# the columns

# correspondence

## Conditions for detained patients

Sir: I have recently retired from the mental health review tribunal, previously visiting about 25–30 different psychiatric units each year. I am first concerned that over recent years the percentage of admissions formally detained has risen to about 20%, having previously, through my entire career, remained steady at about 10%. This is now common knowledge, but has been tolerated rather than arouse the concern it merits. For the whole of the 20th century each new Mental Health Act was welcomed as promoting improvement in treatment, and a more humane attitude to patient care. The present Act followed this trend and was welcomed as such. It is only in recent years that the style of treatment of detained patients has, in my view, regressed to the point where the treatment is more harsh and restrictive than was the practice 30, even 40 years ago.

Following admission the detained patient, even the best behaved, is likely to be confined to the ward. There is often an unreasonable delay in allowing privileges. Access to the hospital grounds away from the ward may start at, say, 15 minutes twice a day perhaps for a few weeks before extended slowly by small increments. The onus is on the patient to demonstrate or prove the absence of risk.

Often there are no suitable grounds or garden in which a patient may enjoy fresh air, especially where the unit occupies wards within a large district general hospital. In some units there are no grounds at all separating the unit from a busy street or main road. In such circumstances there is no opportunity to grant any leave short of Section 17 leave – to leave the hospital premises, with all its legal formality, with no possibility for staff to sensibly take the lesser risk first.

Another phenomenon, which I consider bizarre, is the use of a sentry, this being a nurse stationed near the ward door to prevent unauthorised exit by a detained patient. The suggestion that a lock is more sensible than wasting the time of a highly trained nurse will be met with one of a variety of arguments presented with the conviction that all is well. Of course there are units where a more sensible practice may prevail. I am impressed by the unit that has a locked door and provides door keys on loan to patients allowed out from the ward.

Another example of institutional practice is the practice of visiting hours and the unquestioning attitude of the staff to it. By about 1960 or so many of the large old psychiatric hospitals, overcoming conservative objection, had abolished formal visiting hours, deciding that there was no reason why their patients could not enjoy the visiting privileges always available to private patients. Today almost every psychiatric unit will have a notice on or near its entrance announcing the hours: visiting from 4.15–6 p.m.; 5–7.30 p.m.; or visiting from 3–5 p.m., every unit different but each passionately defended as the only sensible hours. However, on enquiry, there is nobody in the unit, be it ward domestic to consultant, who can say who actually decided on the visiting hours, and an astonishing variety of guesswork results from such enquiry.

It was always a special treat to enter the one London unit that has on its entrance door "visitors are welcome at all reasonable times". This unit is just as busy and hard-working, with apparently as difficult case-load as any other similar unit. The generally restrictive treatment inevitably produces, in a number of patients, resentment, hostility and a great temptation to break rules considered unfair, or even absurd. The patients' breaking of rules is often recorded as psychiatric pathology, and 'lack of progress' or 'lack of insight'. Rarely, if ever, is there consideration of the possibility that the patient may be more reasonable than the institution.

**Charles Finn**

## Atypical antipsychotics

Sir: Bebbington's conclusion that the new atypical antipsychotics are no more effective in reducing psychotic symptoms than their older counterparts (*Psychiatric Bulletin*, August 2001, **25**, 284–286) may not apply to one of these drugs, clozapine.

Clozapine was re-introduced in 1989 on the basis of repeated indications of therapeutic superiority, which culminated in the Kane *et al* trial (McKenna & Bailey, 1993), not, as Bebbington suggests, as part of a strategy to develop drugs without extrapyramidal side-effects. Supporting this, the meta-analysis of Geddes *et al* (2000) found the effect size for clozapine's effectiveness over conventional neuroleptics to be 0.68, which falls between the values of 0.5 and 0.8 proposed by Cohen for 'moderate' and 'large', respectively. This is difficult to reconcile with Bebbington's statement that "the meta-analysis indicated that some of the atypical antipsychotics had slightly better efficacy". Geddes *et al* (2000) argued that the apparent superiority of atypical neuroleptics was owing to the high dose of comparison drug used in many of the studies. However, clozapine was the atypical neuroleptic in only 12 of the 30 studies included in their two meta-regressions. When the Cochrane Collaboration (Wahlbeck *et al*, 1999) compared clozapine trials using low doses and standard doses of the comparison drug, no difference in clinical improvement, relapse rate or drop-outs was found.

GEDDES, J., FREEMANTLE, N., HARRISON, P., *et al* (2000) Atypical antipsychotics in the treatment of schizophrenia: systematic overview and meta-regression analysis. *BMJ*, **321**, 1371–1376.

McKENNA, P. J. & BAILEY, P. E. (1993) The strange story of clozapine. *British Journal of Psychiatry*, **162**, 32–37.

WAHLBECK, K., CHEINE, M., ESSALI, A., *et al* (1999) Evidence of clozapine's effectiveness in schizophrenia: a systematic review and meta-analysis of randomized trials. *American Journal of Psychiatry*, **156**, 990–999.

**P. J. McKenna**, Consultant Psychiatrist, Fulbourn Hospital, Cambridge CB1 5EF

**Authors' reply**: McKenna criticises the basis on which Bebbington included clozapine in his conclusion that the newer neuroleptics had little therapeutic advantage over their older counterparts. While he may be right to conclude that clozapine is especially effective, our meta-regression (Geddes *et al*, 2000) did appear to apply equally to all atypicals.

Part of the problem with a correct evaluation of the effectiveness of



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clozapine is that it is largely based on studies involving patients known to be resistant to treatment with conventional neuroleptics. Greater effectiveness in this context may merely be a reflection of effectiveness in a different client group. Equally, conventional neuroleptics would be almost bound to do better in a group of patients unresponsive to clozapine. Furthermore, there is now evidence that clozapine has no advantage over conventional neuroleptics in unselected patients with first episodes (Lieberman *et al*, 2001).

This is not to say that the clozapine lacks utility in people unresponsive to other medication, but it does bear on the claim that it should be a first-use drug.

LIEBERMAN, J. A., PHILLIPS, M., KONG, I. *et al* (2001) Efficacy and safety of clozapine versus chlorpromazine in first episode psychosis: results of a 52-week randomized double-blind trial. Abstracts of the VIIIth International Congress on Schizophrenia Research, April 2001. *Schizophrenia Research*, **49**, special issue.

**Paul Bebbington & John Geddes**

## Mind Odyssey Indeed

Sir: Wednesday 25 July was an unusual day with such a series of coincidences (or was it what Jungians would call synchronicity?), that I thought readers of the *Bulletin* might also find it of interest. The day certainly illustrated aspects of my College work, linked to 'Science and Caring', the 'Mind Odyssey' and to the 'Changing Minds' combat stigma campaign.

I had had lunch with Nicholas Kenyon, the Director of the BBC 'Proms', at a small restaurant behind the Albert Hall. The meeting was arranged at short notice, although I had written perhaps 6 months before to search for links between the 2001 Mind Odyssey and this particular cultural event.

During the abbreviated lunch and prior to a special meeting of the Court of Electors to discuss "who regulates?", I searched for overlap interests between the purpose of the Mind Odyssey and the organisation and themes of the promenade concerts.

We discussed around the subject of music and musicians and creativity and mental disorder, and some interesting ideas emerged. Who would write an introduction to the Proms programme for next year, making these links? Those composers who had psychiatric disorder, how would they now be treated in a community mental health service? Could there be a Mind Odyssey Prom? (Answer: probably not.) Was there a possibility that Guy Woolfenden's piece commissioned by the College and performed at the Annual Meeting might be included in a Prom concert next year? (Answer: unlikely.)

It was a nice lunch and friendly conversation. I said that I was planning to come to the Prom that evening to hear the European premier of a new piece, *Seeing*, by Christopher Rouse. The concert was a sell out but Nicholas Kenyon found a place for me in his private party overlooking the orchestra! In the socialising before the concert I was introduced to the composer. He explained that the source of his inspiration came from reflecting on Robert Schumann's short life, who spent his final years in an asylum with untreated depression, and a well-known rock guitarist who had schizophrenia. The programme note said that Rouse's music was acclaimed as "among the most intriguing orchestral music now being written".

Christopher Rouse himself wrote "How do people with mental illness 'see' – not in the purely ocular sense, but rather in the psychological and spiritual sense? How do they interpret what they see? And how can a representation of those images be translated into sound? Seeing does not 'take a stand' upon mental illness as a social cause; rather, I wish to concern myself with the tragic toll such afflictions can take upon individual persons and those who care for them."

The music, the man and the commentary had said it all. The 'Proms' and the College had come momentarily together, albeit briefly.

**John Cox**, President, Royal College of Psychiatrists

## Conspiracy of silence? Telling patients with schizophrenia their diagnosis

Sir: We were interested to read the report by Clafferty *et al* (*Psychiatric Bulletin*, September 2001, **25**, 336–339). Although some psychiatrists avoid giving an accurate diagnosis of schizophrenia, we would disagree with their main conclusion that psychiatrists collude with a conspiracy of silence. They found 89% of psychiatrists disclose a diagnosis of schizophrenia if it is a recurrent episode, compared to 59% for a first episode. As 20% of patients only have a single episode of psychosis this discrepancy may reflect concern about misleading patients. The diagnosis of schizophrenia implies a long-standing disability, with marked implications for the patient's sense of identity, employment and relationships. With this in mind, we can understand why some psychiatrists would only use the term schizophrenia when the prognosis is clearer.

A striking finding in this paper was that less than half of psychiatrists would tell their patients about a diagnosis of dementia (significantly lower than for other mental illnesses). This is in contrast to the consistent finding that most patients with dementia wish to know their diagnosis (Holroyd *et al*, 1996; Erde *et al*, 1988; Jha *et al*, 2001). This is the only survey published since the National Institute for Clinical Excellence approval of cholinesterase inhibitors for Alzheimer's disease. If the findings are applicable to Alzheimer's disease as well as to dementia as a whole, this would imply that patients are denied treatment for their condition purely because of reticence among psychiatrists to tell them their diagnosis. It seems the main conspiracy of silence is not in schizophrenia but in dementia.

ERDE, E., NADAL, E. & SCHOLL, T. (1988) On truth telling and the diagnosis of Alzheimer's disease. *Journal of Family Practice*, **26**, 401–406.

HOLROYD, S., SNUSTAD, D. & CHALIFOUX, Z. (1996) Attitudes of older adults on being told the diagnosis of Alzheimer's disease. *Journal of the American Geriatric Society*, **44**, 400–403.

JHA, A., TABET, N. & ORRELL, M. (2001) To tell or not to tell – comparison of older patients' reaction to their diagnosis of dementia and depression. *International Journal of Geriatric Psychiatry*, **16**, 879–885.

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## Special interest sessions in public health

Sir: Specialist registrars in psychiatry should consider spending their special interest sessions doing a placement in a public health department. I have just completed a placement, 1 day per week for 6 months, and found it a very valuable addition to my training.

Although particularly useful for those training in substance misuse, there are benefits to be gained in the broader remits of training. My placement was based around the writing of a formal report, which taught me a great deal about data sources, needs assessment and service organisation. The necessary literature searches and liaison with colleagues increased my knowledge of my own speciality.

I also gained good management experience, and enhanced my IT skills. It was useful to appreciate a different and wider viewpoint on the health service and appreciate the positive impact that public health has to offer on mental health service planning.

I am happy to give further details of my experience to interested colleagues, who may wish to arrange their own placement.

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