



# the columns

## correspondence

### Recovering a meaningful life is possible

Sir: David Whitwell discusses what may become one of the most important concepts in mental health over the coming decade; recovery (*Psychiatric Bulletin*, October 1999, **23**, 621–622). However, his view of recovery as a myth is based on a medical understanding of the word, equating recovery with cure, or with returning to how you were before the illness started. In the growing literature on this issue in the USA and elsewhere, most service users put forward the concept of recovering a meaningful and fulfilling life. It may well be a quite different life to the one envisaged before the onset of mental illness, but it is none the less a valuable and valued life.

The analogy used by many people is that of suffering a permanent physical disability as the result of an accident. You may well need medical care, but it will not cure you. You may equally need social care, but are unlikely to want to be seen as a dependent service user for the rest of your life. The aim is to find ways around the problems which the disability may cause, to recover a life of purpose and meaning. That may well include searching out the strengths which the disability has brought, for example an understanding which may equip you to help others.

Many of the best mental health services and user groups in the UK already strive towards this approach. From open employment schemes to self-management training, they span a wide and growing group. The question is not so much over the approach, as over the word. Recovery can so easily be interpreted as cure. Will a word which seems to strike the right chord in other countries work here, or will we need to find an alternative?

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### A bureaucratic short-cut to consultant posts in the UK

Sir: Many European doctors training in the UK during the past years have complained about the new Certificate of Completion of Specialist Training (CCST) system

(Cervilla & Warner, 1996). The time required to become a psychiatrist is still so much longer in the UK than in the continent. Complaints have resulted in the Specialist Training Authority issuing the so called 'Official Confirmation of UK Training'. This confirms that the trainee has spent four years in UK-recognised training posts (regardless of training level), thus fulfilling EU regulations and leading to accreditation in Europe. Ironically, with this European accreditation, the doctor can come back to the UK and register on the GMC Specialist Register being eligible for appointment as consultant psychiatrists, after as little as four years of senior house officer level training, even if they had failed their MRCPsych (Cervilla, 1996). Moreover, psychiatrists trained in Europe for just four years can also enter GMC Specialist Register straight away. This is in contrast to those British, or indeed European, doctors who stayed in the UK till the end of their psychiatric training and who spent at least six years as psychiatric trainees, including passing the MRCPsych Examination, before entering the Specialist Register. This scenario is unfair to those that spend many years of hard training work at lower pay. In addition, it might give a bad image in Europe of British standards of psychiatric training. More importantly, the quality of care provided by doctors partially trained, but yet fully accredited is likely to be poor and potentially dangerous. Changes in the current regulations are, therefore, needed.

### References

CERVILLA, J. (1996) Spanish psychiatric training: is there a need for change? *Psychiatric Bulletin*, **20**, 738–740.

— & WARNER, J. (1996) Certificate of Completion of Specialist Training (CCST): implications for higher training in psychiatry. *Psychiatric Bulletin*, **20**, 372–373.

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### Value of advocacy

Sir: As the managers of the advocacy scheme in the area where Dr Gamble is based, we were dismayed, and not a little

angry, to read his letter (*Psychiatric Bulletin*, September 1999, **23**, 569–570). We have requested details of the evidence on which Dr Gamble has based his specific allegations, and we await his reply. In the meantime, we feel it is important to respond to his criticisms of independent advocacy, in the public setting in which he made them.

First, it should not come as a surprise if advocates and doctors sometimes give patients different information: survey after survey has shown that psychiatric patients frequently feel they have not been told enough about their medication, for example, and advocates have a legitimate role to play in enabling patients to make decisions about their options on the basis of information from a range of sources – not only clinical. If different pieces of information are at times 'in conflict', does that not merely reflect the often uncertain knowledge base of treatment in mental health? In our view, the only cause for alarm would be if anyone was giving patients information which was clearly false.

Second, the argument that because advocates see patients alone, it follows that they are "giving advice in private which others may not be aware of" (our emphasis) is logically flawed – and wrong. Mental health advocates adhere to a code of practice which states that they should not give advice to patients, nor offer their own opinion.

Third, Dr Gamble expresses concern about the "anti-medical establishment political agenda" and "destructive ideology-driven power" of "some advocacy movements" – including, apparently, our own service. Dr Gamble's use of terms such as political and ideology-driven we can forgive (and would be interested to debate further, in the context of mental health advocacy and the psychiatric system), but we take strong exception to the other labels he puts upon us. Our advocacy service operates in accordance with a policy drafted painstakingly over a period of some months, more than seven years ago, by a group which consisted of several representatives working in the local mental health service (including a consultant psychiatrist), as well as Mind staff and users. Underpinning the notion of independent advocacy described in this