# the columns

# correspondence

## Institutional racism in British psychiatry?

The president of the College was recently reported (*BMA News*, 28 September 2002) to have expressed the opinion that there is an element of institutional racism in (presumably British) psychiatry. He gave as evidence of this: 'You are six times as likely to be sectioned [sic] under the 1983 Mental Health Act if you are black, young and male.'

No doubt some psychiatrists hold racist attitudes, as do many other people. However, the president's suggestion that psychiatrists in this country allow any racial views they may privately hold to influence their professsional practice is unjustified and offensive. His view that the fact, if it be one, that young black males are admitted to hospital under the provisions of the Mental Health Act 1983 more frequently than are others, is evidence of improper practice, based on racial attitudes, is self-evidently absurd. That the president of a medical royal college should hold such an opinion must be a matter for concern.

I would suggest that a retraction of the reported remarks, accompanied by an apology on the part of the president to the College membership, would be appropriate.

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## Reply to Ian Bronks' letter for the *Bulletin*: Mike Shooter

First things first, I did indeed talk about the possibility of institutional racism in both the practice of psychiatry and the structures of our psychiatric profession (the two may not be unconnected). I did so as part of a speech to the inaugural meeting of the British Association of Pakistani Psychiatrists in Birmingham about the challenges facing the College in the next few years.

Institutional racism was defined in the MacPherson Report as 'The collective failure of an organization to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviours which amount to discrimination, through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantages minority ethnic people'.

The key words here, I think, are 'collective', 'service' and 'unthinking'. By this definition, I believe that the implementation of any legislation that results in young black males who live in inner city areas being six times more likely to be caught by it, must contain an element of institutional racism – and one can see why.

Young black males tell us that they are wary of psychiatric services that do not seem sympathetic to them; they feel, with some justification, that they are more likely to be perceived as dangerous than their white counterparts. They are loath, therefore, to come forward early when treatment might be most effective and the consequences complete the vicious circle. I think that is a collective failure that we all need to address, including a government whose current proposals for Mental Health Act reform would compound the problem with their emphasis on dangerousness and their loose criteria for compulsion.

I make no apology for this view, or for the fact that the College has commissioned a three-year external audit of all its processes and structures for evidence of institutional racism. I am not sure that we can expect to eradicate it from practice if it is there in the College to which we belong – unwitting though that may be.

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## Assertive community treatment

We are grateful to T. Burns and J Catty for calling attention to the importance of 'Defining the comparator and identifying active ingredients' of the conditions being studied (*Psychiatric Bulletin*, September 2002, **26**, 324–327). We agree on the importance of the accurate use of the terms used to describe treatment models when making comparisons. We applaud their call to be more rigorous in this regard and want to point out an example of how difficult this seems to be. In their paper, they assert that the impressive advantages of assertive community treatment (ACT) reported in earlier studies are not being repeated in later studies. To support their assertion, they then reference two UK studies (Thornicroft *et al*, 1998; UK 700 group, 1999). Unfortunately neither of these are studies of ACT.

This error is particularly egregious because it has been pointed out previously in the literature that these are not studies of ACT (Marshall *et al*, 2000; Rosen & Teesson, 2001). It is clearly misleading to label these as ACT studies, and yet they continue to perpetuate this misrepresentation. By mis-labelling studies as ACT, even though clear criteria have been developed to identify and measure ACT's essential elements (Teague *et al*, 1998), the authors demonstrate that it is difficult for them to practise what they so rightly preach. As they point out, these kinds of errors cloud rather than clarify our understanding of the role various models could play in a system of care.

MARSHALL, M., BOND, G., STEIN, L. I., *et al* (1999) PRiSM Psychosis Study. Design limitations, questionable conclusions. *British Journal of Psychiatry*, **175**, 501–503.

ROSEN, A. & TEESSON, M. Does case management work? The evidence and the abuse of evidence based medicine. *Australian and New Zealand Journal of Psychiatry*, **35**, 731–746.

TEAGUE, G. B., BOND, G. R. & DRAKE, R. E. (1998) Program fidelity in assertive community treatment. *American Journal of Orthopsychiatry*, **68**, 216–232.

THORNICROFT, G., WYKES, T., HOLLOWAY, F., *et al* (1998) From efficacy to effectiveness in community mental health services. PRiSM psychosis study, 10. *British Journal of Psychiatry*, **173**, 423–427.

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We are delighted that our work is read by such influential figures in the ACT world and that they appreciate our attempt to bring scientific rigour to



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the area. However, we stand by our conclusions.

It is preceisely because we wished to understand the heterogeneity of results from good services and good studies that we undertook our work. We examined 20 components of home-based care in experimental and control services of published studies. These included, but were not restricted to, ACT studies. Our results (Burns *et al*, 2001; Catty *et al*, 2002) show that the clear distinction between ACT and other forms of intensive home-based care that Professor Stein and colleagues insist on, and which Marshall and colleagues (Marshall *et al*, 1997; Marshall & Lockwood, 1998) used, simply will not withstand scrutiny. Many of the ACT teams did not have all the 'ACT' characteristics and many of the 'non-ACT' teams had more of them. In short, the groups overlap. It is for this reason that we conducted our regression analysis to determine which components are associated with outcome. Many of these 'effective ingredients' were present in later study control services. We would argue that this is why big differences are no longer being found in US or European studies.

None of this is to take away from the epoch-making impact of Stein and Test's original study. If we are to progress in our understanding of community care, however, we must be prepared to test more sharply-focused questions with increasingly well-designed studies.

BURNS, T., KNAPP, K., CATTY, J., *et al* (2001) Home treatment for mental health problems: a systematic review. *Health Technology Assessment*, **5**, 1–139.

CATTY, J., BURNS, T., KNAPP, K., *et al* (2002) Home treatment for mental health problems: a systematic review. *Psychological Medicine*, **32**, 383–401.

MARSHALL, M. & LOCKWOOD, A. (1998) *Assertive Community Treatment for People with Severe Mental Disorders*. Oxford: The Cochrane Library.

—, GRAY, A., LOCKWOOD, A., *et al* (1997) *Case Management for People with Severe Mental Disorder*. Oxford: The Cochrane Library.

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## Good practice of ECT administration

The audit cycle described by MacEwan (*Psychiatric Bulletin*, September 2002, **26**, 337–339) demonstrates a common error in the practice of electroconvulsive therapy (ECT) administration.

Patients who had brief or absent seizures were re-stimulated with higher charges in the practice described by MacEwan. What has not been taken into account is that duration of convulsions also depends on the individual's response to the muscle relaxant and therefore may not accurately reflect the duration of seizure activity in the brain.

Using motor seizures as a measure of effectiveness of the ECT was an excellent idea in the days of unmodified ECT. It must not be forgotten that muscle relaxants are used precisely to stop the convulsions, and therefore it would be erroneous to use the absence of motor seizures as evidence of inadequate stimulation.

Either electroencephalogram (EEG) monitoring, or if resources do not allow this, use of the simple cuff method would be the best way of monitoring the duration of seizures. The fact the re-stimulation resulted in induction of adequate seizures in only 25% of cases demonstrates that it may not always be the best course of action.

Lalla & Milroy (1996) have published a comprehensive review of the literature about seizure duration in the practice of ECT. Their inference from the review is that there is a lack of good evidence to support the contention that longer ECT seizures are more efficacious.

LALLA, F. R. & MILROY, T. (1996) The current status of seizure duration in the practice of electroconvulsive therapy. *Canadian Journal of Psychiatry*, **41**, 299–304.

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Dr Mahapatra is correct in his assertion that the method of ECT administration in the audit described was common practice at that time. Indeed in one survey (Robertson *et al*, 1997), 58% of clinics in Scotland did not use the cuff technique.

One of the purposes of audit was to examine the effects of a different ECT machine and further training on rates of missed fits. A significant reduction in missed fits was observed.

As discussed in my paper, stimulus titration and EEG monitoring could be considered in future practice and further audit could be carried out.

ROBERTSON, C., FREEMAN, C. P. L. & FERGUSON, G. (1997) ECT in Scotland. *Psychiatric Bulletin*, **21**, 699–702.

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## Audit of antipsychotic and anticholinergic prescribing: Leeds CMHT 2000–1

We read with interest the paper by Harrington *et al* (*Psychiatric Bulletin*, November 2002, **26**, 414–418). It mirrored the results of a recent audit we did on atypical, high dose and co-prescribing of antipsychotics, as well as concurrent anticholinergic prescribing. Drug card information on all general adult inpatients, aged 18–65, prescribed an antipsychotic on a regular basis was collected during a single visit in April 2000. Re-audit occurred in June 2001, and on this occasion adult day hospital patients were included.

Overall, 231 inpatients received a regular prescription for an antipsychotic drug in 2000 and 321 patients in 2001 (213 in-patients and 99 day hospital patients). There were high levels of atypical antipsychotic prescribing (49%, 95% confidence interval [CI] 42–55 in 2000 and 52%, 95% CI 46–57 in 2001), co-prescribing (20%, 95% CI 15–26 in 2000 and 25, 95% CI 20–30 in 2001) and above *British National Formulary* (2002) limits prescribing (15%, 95% CI 11–20 in 2000 and 17%, 95% CI 12–21 in 2001) when compared to total antipsychotic prescribing. Furthermore, there were high levels of anticholinergic prescribing with atypical antipsychotics alone (21, 95% CI 13–31 in 2000 and 18%, 95% CI 12–26 in 2001).

These prescribing patterns increase the risk of side-effects and negate the cost benefits of atypical antipsychotics. They also run counter to 1993 Royal College of Psychiatrists guidelines on antipsychotic prescribing and World Health Organization anticholinergic prescribing guidelines (World Health Organization, 1990; Barnes, 1990). This audit appears to indicate problems in dissemination and a lack of widespread knowledge of current guidelines.

BARNES, T. R. (1990) Comment on the WHO consensus statement: prophylactic use of anticholinergics in patients on long-term neuroleptic treatment. *British Journal of Psychiatry*, **156**, 412.

BRITISH NATIONAL FORMULARY (2002) BNF 43, March. London: British Medical Association & Royal Pharmaceutical Society.

ROYAL COLLEGE OF PSYCHIATRISTS (1993) *Consensus Statement on the Use of High Dose Antipsychotic Medication*. Council Report CR26. London: Royal College of Psychiatrists.

WORLD HEALTH ORGANIZATION (1990) *Prophylactic Use of Anticholinergics in Patients on Long-term Neuroleptic Treatment. A Consensus Statement*. Geneva: World Health Organization.

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## From couch to coach

The Football Association (FA) launched its strategy "Psychology for Football" at the Pride Park Stadium, Derby, on



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7 November 2002. The meeting was a call to football professionals to endorse the use of sports psychologists.

Psychologists have received a cautious reception from sports professionals (Martin *et al*, 1997). Countries like Australia and the USA have been using psychologists in sports for decades. In the UK, developments have been slower, with important changes, such as the accreditation of the British Association of Sports and Exercise Sciences, happening in the late 80s.

The involvement of psychiatrists in sports has been more anonymous, as psychiatry not only carries a stigma but is also the antithesis of *Mens sana in corpore sano* (Carranza, 1999). Society perpetuates the problem by seeing sportsmen as highly-skilled entities, rather than primarily as human beings with strengths and weaknesses. Because of this, sports professionals in need of psychiatric help usually approach services as a last resort, during the final stages of their problem.

The FA strategy should be made extensive to other sports and, ideally, implemented at all levels. It would also be desirable to consider the inclusion in the strategy of professionals such as psychiatrists, who could play not only a therapeutic (Begel, 1992) but, equally important, a preventative role. Psychiatry can also complement psychology providing clinical input, or working together in a wider strategy towards changing behaviour in the public, and attitudes related to sport in society in general.

BEGEL, D. (1992) An overview of sport psychiatry. *American Journal of Psychiatry*, **149**, 606–614.

CARRANZA, F. (1999) Attitudes of Sportsmen to Psychiatry. Hamburg: Congress of Psychiatry.

MARTIN, S. B., WRISBERG, C. A., BEITEL, P. A. *et al* (1997) NCAA Division I athletes' attitudes toward seeking sport psychology consultation: the development of an objective instrument. *The Sport Psychologist*, **11**, 201–218.

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## Combination therapy

Bains and Nielssen (2003) discourage the combined prescription of a (conventional) depot antipsychotic preparation with oral atypical medications, on the grounds that there is 'no published research to support such a combination on theoretical or practical grounds'. The authors considered that 'use of atypical antipsychotics may be seen as a way of minimising distressing side-effects and also reducing the risk of developing tardive dyskinesia (by allowing the use of lower net doses of depot antipsychotic)'. Ultimately, however, they appear not to accept this approach, stating that 'none of the treating psychiatrists [in their study] offered this rationale for treatment'.

Combination therapy with an atypical antipsychotic agent can, in some poorly-compliant patients, represent the most viable way of ensuring the delivery of an effective dose of antipsychotic medication, while at the same time limiting (especially extrapyramidal) side-effects.

Moreover, some patients, while rejecting varying doses of depot antipsychotic medication, are more accepting of a fixed dose of the injected preparation, with temporary addiction of an oral agent, the dose of which can be easily adjusted according to mental state and requirements.

The scientific literature and professional guidelines recommend antipsychotic monotherapy. However, while it is accepted that this should be a standard principle in antipsychotic prescribing, there seems to be a – perhaps substantial – minority of patients for whom the combination of oral atypical and depot conventional antipsychotic appears to be more appropriate. The authors' apparent espousal of a blanket rejection of combination therapy is therefore unfortunate.

BAINS, J. S. & NIELSSEN, O. B. (2003) Combining depot antipsychotics in forensic patients: a practice in search of a principle. *Psychiatric Bulletin*, **27**, 14–16.

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# the college

## Prevention in Psychiatry CR104, February 2002, 94 pp, £7.50 Summary

It is a truism that prevention is better than cure, yet preventive activities generally have low priority among interventions undertaken by psychiatrists. This report aims to provide psychiatrists and others involved in the promotion of mental health and the care of people with mental illnesses with an evidence-based approach to preventive interventions.

It begins with a background section, introducing concepts related to mental health promotion and the prevention of psychiatric disorders. Prevention is then considered in relation to the different stages of the life cycle, beginning in the womb and ending with the approach of death. Life cycle chapters are provided for the prenatal period and infancy; childhood, puberty and early adolescence; late adolescence and young adulthood; adulthood; older people; and the stage of approaching death. Account is taken of the fact that the influences acting at one stage of the life cycle will impact on the rates of disorder in later stages. Further, traumatic events such as physical or sexual abuse will impact not only on the individual concerned throughout the life cycle, but on subsequent generations.

Preventive activities are then considered in relation to the different settings in which they can take place. Settings considered include the neighbourhood and the community; early years provision, school and higher education; the workplace; residential care settings; the criminal justice system and prisons; primary care settings; the general hospital; and specialist psychiatric settings. In all of these, preventive activities relevant to psychiatric disorders need to be placed and maintained on the agenda, and the report provides practical, evidence-based information on how this may be achieved.

The Working Party has tried to keep the report brief and clear. To make the material more accessible, some information has been summarised and presented in the form of bullet points. A small number of key references to each section are provided for those readers wishing to pursue the subject further.

## Domestic Violence

### Council Report CR102 April 2002, £7.50. 44 pp.

This policy statement on domestic violence was produced by a working group under the chairmanship of Dr Gill Mezey. The following are the key points:

- Psychiatrists need to have a working knowledge of the aetiology, effects and range of interventions available for victims of domestic violence.
- Domestic violence, that is the physical, sexual or emotional abuse of an adult victim by an adult perpetrator in the context of an intimate relationship, occurs in around 23% of women and 15% of men over their lifetime.
- Women are more likely to sustain physical injuries than male victims, they are more likely to experience repeated assaults and they are more likely to report emotional distress or fear as a result of the violence.
- Domestic violence is associated with psychiatric illness, including depressive



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