the columns

correspondence

Reforming psychiatric care

Henderson and colleagues (*Psychiatric Bulletin*, March 2003, **27**, 81) make a number of flawed assumptions regarding the use of accident and emergency (A&E) departments by people with mental health problems, and the impact that assessment and waiting targets will have upon these patients. On the one hand, they agree that A&E departments can be an 'inappropriate environment' for psychiatric patients, yet at the same time appear to be advocating that targets to reduce such patients' length of stay in this setting be ignored, as they might compromise patient care.

The implication that A&E departments continue to be a 'major interface between mental health services and acute trusts' should be viewed as a significant failure by health policy planners, managers and clinicians. The fact that so many individuals who are experiencing mental distress end up accessing services via A&E is a reflection of the poor planning, lack of development and under-funding of mental health crisis and home treatment services. It is also, in our view, a reflection of the fact that psychiatrists and other mental health professionals continue to regard the A&E department as a 'default' location for the assessment and treatment of psychiatric emergencies. In the absence of viable alternatives, it is not unusual for mental health staff to advise patients and families to use A&E as the access point for services when faced with a psychiatric emergency or crisis. Such action should be discouraged and the needs of the patient and carer placed to the fore. The majority of patients are clear that A&E is not the place they want to be cared for when in crisis or acutely mentally unwell. There is also a significant amount of evidence that highlights the generally negative attitudes and lack of confidence that non-mental health staff display towards individuals with psychiatric problems (Pacitti, 1998; Hemmings, 1999). It is this information that needs to inform the way that services develop, rather than advocating resistance to 'externally-imposed' performance targets.

While there is often an issue regarding lack of 'ownership' of patients within the A&E department, this should be more accurately viewed as a failure on the part of mental health services to develop meaningful, relevant and accessible care and treatment plans for individuals experiencing mental health crisis. It is interesting to note that the authors of this article do not identify what percentage of patients attending their local A&E department in crisis are already known to mental health services. In our experience, these individuals can account for up to 50% of those attending (or advised to attend) A&E. Of these, a significant number do not have up-to-date care and treatment plans, and there is rarely any attempt to identify crisis management strategies during the period of remission. Add to this the lack of access to patient records and information systems within A&E, and it is easy to understand why this aspect of assessment and care is handled so badly in the emergency setting.

The fact that psychiatric assessments are often complex and time consuming is no reason to advocate that individuals with mental health problems should not have the right to expect the same standards in terms of assessment and waiting times as patients attending with a physical health problem. The time frames quoted by Henderson and colleagues are meaningless without an indication of *why* these assessments take so long. We would argue that this is again a reflection of under-resourced and poorly-planned arrangements for responding to crisis presentations and that, contrary to these authors' implication, there is no direct correlation between the length of time taken to perform an assessment and the quality of patient care.

It could be argued that, as mental health professionals, a 4-hour wait for psychiatric patients within A&E is something that we should be celebrating, as it has the potential to focus the attention of health commissioners on the importance of ensuring that dedicated and appropriately staffed mental health liaison services are provided within every district general hospital. This is an effective and established model of service delivery that remains underdeveloped. The establishment of separate teams 'akin to those used for trauma patients' would only serve to confuse commissioners, service users and general hospital colleagues.

HEMMINGS, A. (1999) Attitudes to deliberate self-harm among staff in an accident and emergency team. *Mental Health Care*, **2**, 300–302.

PACITTI, R. (1998) Damage limitation. *Nursing Times*, **94**, 38–39.

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Service changes without professional appraisal or consensus

With the modernisation of the National Health Service (NHS), much of the proposed changes in the mental health services are positive and benefit patients. Changes are not always debated fully within the health community and with service users, however. Changes introduced have repercussions elsewhere, which may not have been foreseen.

Within old age psychiatry, NHS continuing care has been less frequently considered necessary in recent years. Therefore, fewer dementia sufferers continue receiving their care within NHS facilities and are discharged to privately-run care homes. This shift leaves continuing care wards within the NHS unoccupied.

The majority of continuing care wards in recent years were purpose-built in the community, occupying isolated local hospital facilities. They were designed and built to accommodate medically-stable dementia sufferers and other long-term mentally disordered patients. These units do not have the same medical cover, nursing staffing levels and investigative facilities as centrally-located dementia assessment facilities. What future use should these sites be put to?

There may be expectation in many parts of the country to convert these units into dementia assessment facilities. The location, design and staffing (particularly outside working hours) of these units makes them far from ideal for this purpose. The Royal College of Psychiatrists' guidance is certainly at variance and raises clinical risk worries.

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columns

At the Faculty of Old Age Psychiatry meeting in London, this was a commonly shared anxiety expressed in the new consultants group. Perhaps other old age psychiatrists are unclear about the future fate of their previously continuing care units. If so, what are the future options? Can we have an options appraisal and informed debate within the profession with recommendations?

Tamal De, Consultant Psychiatrist, Barwise, Walton Hospital, Chesterfield S40 3HW

Institutional racism

Mike Shooter hardly needs my support on Ian Bronks' demand (*Psychiatric Bulletin*, April 2003, **27**, 155) for an apology and a retraction for his noting of institutional racism in psychiatry. 'Institutional racism' is a description of how an institutional system as a whole functions, not, as Dr Bronks argues, what is going on inside an individual practitioner's head.

Our President is to be congratulated on dealing with a depressingly still-continuing problem of disadvantage for ethnic minorities in the mental health system: increased sectioning (incidentally a most appropriate term), patient dissatisfaction, increased use of secure facilities and in some studies, higher dosages of psychoactive medication. If we are not involved with this at some level, then who? Blame the patient?

Roland Littlewood, Professor of Anthropology and Psychiatry, Department of Anthropology, University College London, Gower Street, London WC1E 6BT

MRCPsych exam visa considerations

I want to thank Dr Lucas (*Psychiatric Bulletin*, March 2003, **27**, 115) for taking the initiative to voice Senior House Officers' views. As an overseas trainee, I would like to draw the College's attention to one more point. There is enough anxiety about the MRCpsych exam and one could do without additional worry about visa applications to go to Ireland for the clinicals. It puts you under great pressure while you make travel arrangements within a 2-week period before the clinical exam and wait for the visa to arrive 'in time'. This may not be a common occurrence, and is a problem only for overseas trainees.

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obituaries

Mrs Renée Short

Formerly Labour MP for Wolverhampton NE, 1964–1987, Honorary Fellow of the Royal College of Psychiatrists and Honorary Member of the Royal College of Physicians

The most prestigious award a royal medical college can bestow on a lay person is to elect him or her to its Honorary Fellowship. This accolade was awarded to Renée Short at a ceremony during the annual meeting of the Royal College of Psychiatrists in 1988, where Professor Robert Bluglass gave an eloquent, detailed introductory eulogy. A further distinction followed in 1989, when the Royal College of Physicians elected her to its Honorary Membership, the two together indicating how widespread her services to medical matters had been.

But the briefest biography of Renée Short would suffice to highlight the polymathic interests of this remarkable lady, interests including, incongruously perhaps, the breeding of standard poodles that she showed at Crufts!

Renée Short (née Renée Gill) was born in Leamington Spa on 26 April 1916. She was educated at Nottingham Grammar School and Manchester University, where she studied French. At the University, she met André Schwartz, who as a Jewish student in Vienna, had to flee the Nazis. He changed his name to Andrew Short and went on to become a distinguished civil engineer. They married in 1940 and had two daughters.

After university, she embarked on her spectacular and varied career. She began as a freelance journalist, and wrote for social services journals and for *Tribune*. In parallel, she worked as a theatrical costumier and ran her own stage design business. Her interest in the theatre was lifelong, as witness her later membership of the Round House Theatre Council and as Chair of the Theatre's Advisory Council from 1947–1980.

Her highly-successful career in politics began as a councillor in Hertfordshire. Then, after two unsuccessful attempts, in 1955 and 1959, to enter Parliament, in 1964, she won the safe seat of Wolverhampton NE, a seat that she held with acclaim for the next 23 years.

In Parliament, she specialised in health and social services: she was the champion of a wide variety of causes, from the rights of junior hospital doctors through to the rights for abortion and action to combat obesity. But of major importance was her membership as a lay member of the influential Medical Research Council. Of particular relevance to psychiatry was her deep concern for care in the community, with special reference to adults with mental illnesses and those with learning disabilities, a concern that prompted her famous aphorism: 'any fool can close a hospital'.

But without doubt, Renée's major contribution to Parliament was achieved as (the first) Chair of the Commons Select Committee on Social Services, a position she held with distinction from 1979 until she retired in 1987.

Her hard left politics did not endear her to everyone, particularly because of her refusal to acknowledge the many iniquities of the Soviet Union, a blind spot that conceivably stemmed from her intense loathing of Fascism in all its vile forms. No matter what, she will be remembered by posterity not only by her politics, but as the champion of the oppressed and the underprivileged.

Renée Short died on 18 January 2003.

Henry R. Rollin

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