

'Toxicity' of any environment is determined by the stability of the social framework that governs the lives of individuals. It is debatable whether the variables of racism, alienation, political discrimination, unemployment, lack of opportunity, crime and fear of crime are more common in urban areas in developing countries. There is often no means of rural living for urban dwellers in these countries and many opt to escape through migration to foreign lands. Migration from the native country is therefore associated with a release from these stressful factors, as is the case of some ethnic groups in the Caribbean. In societies where environmental factors confer greater stress either in the native or the receiving country, the rates of psychosis will be higher and should not be attributed only to the base rates of the native country as proposed by Selten *et al.* If a social model were to be developed, consideration must be given to the time between assault and disease manifestation with a formula for lag time, rather than equating disease with geographical location at the time of manifestation.

The degree of urbanisation cannot simply be judged by the number of households per square kilometre. In developing countries, the division of areas into urban and rural is arbitrary; consideration must be given to the availability of basic amenities, geographical distance from cities and towns, the availability of newspapers and electronic media, the degree of literacy, transportation systems and the presence of household amenities. The fact that all people in Surinam have access to psychiatric care except for two remote districts that are looked after by medical missions suggests a movement away from rurality, since access to psychiatric care is a good index of development. Nevertheless, in many rural communities there is a distrust of Western psychiatric services and, as pointed out by Selten *et al.*, help is often sought from traditional healers. This can result in statistical inaccuracies in both directions, through leakage of cases and delay in first contact with the psychiatric services.

Our findings in Trinidad suggest that gender and ethnicity are important variables in 'urbanisation'. In more urbanised areas, more males aged between 15 and 29 years presented with schizophrenia than females. The affected young males were more likely to be of African descent. A neuroprotective effect of oestrogen in

females could be responsible for their low rates of schizophrenia, and neuronal plasticity in response to exposure to a new environment and its effects on the disease process is another area of possible future research.

Selten *et al.* and others have raised important questions that are relevant to Caribbean people and those who have migrated and settled abroad. Cross-cultural differences, environmental factors and gender affect the risk for the development of psychosis but the final common pathway of any disease is at the molecular level. Genetic factors must therefore also be taken into consideration.

Hutchinson, G. & Morgan, C. (2005) Social development, urban environment and psychosis. *British Journal of Psychiatry*, **186**, 76–77.

Selten, J.-P., Zeyl, C., Dwarkasing, R., et al (2005) First-contact incidence of schizophrenia in Surinam. *British Journal of Psychiatry*, **186**, 74–75.

Van Os, J. (2004) Does the urban environment cause psychosis? *British Journal of Psychiatry*, **184**, 287–288.

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Authors' reply: We thank Dr Maharajh for his reaction. We agree with his observation that it is uncertain whether the urban effect is also operative in Surinam. The sample size of our study was too small for definitive conclusions and the possibility remains that some patients in rural areas do not see doctors.

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Advance directives and advance agreements

The paper by Amering *et al.* (2005) adds to the growing literature on advance directives. The main difficulty with advance directives seems to be that with the available training programmes very few service users can be enthused to draft one. The authors recommend more training of service users and substantial administrative commitment from service providers.

The same could be said about advance agreements, another tool to empower patients to become partners in negotiating individualised treatment and care

in time of crisis. Advance agreements (*Behandlungsvereinbarungen*) are widely used in German-speaking countries and according to a quick web search are offered routinely in at least 50 psychiatric hospitals in Austria, Switzerland and Germany.

Unfortunately no systematic research on advance agreements has been conducted in these countries; the only trial that has been published is from the UK (Henderson *et al.*, 2004) and showed a significant reduction in the use of compulsory admission and treatment. Interestingly, advance agreements are seen as legally binding in Germany but not in the UK. Thomas & Cahill (2004) sceptically commented on the Henderson study that 'Liberation cannot be handed to the oppressed by the oppressor'. Basaglia (1979) would probably answer that this is precisely what the psychiatrist is supposed to do: 'to enter a dialogue with the patient, a dialogue not between subject and object, but between two human beings, who have become subjects. If we don't accept this logic of contradictions between two individuals, we should better trade bananas than work as doctors'.

Advance agreements, from the experience in German-speaking countries, are usually initiated by nurses and doctors working in in-patient settings, who have perhaps the strongest incentive to reduce compulsion in mental health (as those who restrain, detain and enforce treatment). Negotiating job plans with senior and junior doctors, with ward managers and nurses where time is allocated to discuss and draft advance agreements might be a way forward.

Amering, M., Stastny, P. & Hopper, K. (2005)

Psychiatric advance directives: qualitative study of informed deliberations by mental health service users. *British Journal of Psychiatry*, **186**, 247–252.

Basaglia, F. (1979) The power of the state and psychiatry. Quoted and translated from: *Die Entscheidung des Psychiaters, Bilanz eines Lebenswerks*. Bonn: Psychiatrie Verlag, 2000.

Henderson, C., Flood, C., Leese, M., et al (2004) Effect of joint crisis plans on use of compulsion in psychiatric treatment: single blind RCT. *BMJ*, **329**, 136–138.

Thomas, P. & Cahill, A. B. (2004) Compulsion and psychiatry – the role of advance statements. *BMJ*, **329**, 122–123.

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Authors' reply: In practice, rights are only as visible as the mechanisms put in place