



the columns

correspondence

Is liaison psychiatry something we 'must do'?

The National Director for Mental Health, Louis Appleby, is optimistic about the improvement in mental health services (*Psychiatric Bulletin*, December 2003, **27**, 441–442). However, he acknowledges that we are some way off providing care that our patients deserve and we would like to deliver. In the same issue of the *Psychiatric Bulletin*, Ruddy and House (*Psychiatric Bulletin*, December 2003, **27**, 457–460) show that this is particularly true for liaison psychiatry. In addition to their survey of the Northeast of England, they cite work that indicates that liaison psychiatry services are inadequate or non-existent in many areas. This is despite the joint recommendations of the Royal Colleges of Physicians and Psychiatrists (2003).

Appleby (2003) asserts that in England and Wales the Department of Health has no certain way of dictating where resources go, and that such decisions have been devolved to local commissioning systems. This runs counter to the recent experiences of myself and colleagues when bidding for resources to provide effective liaison psychiatry services. Although there are well rehearsed clinical and financial arguments for specialist psychological care in general hospitals, a common response from the commissioners of local health services is that liaison psychiatry is not something they 'must do'. The allocation of resources is heavily influenced by government strategies and targets, which become the 'must dos' for the commissioners.

Liaison psychiatry has a particular difficulty in attracting new resources, because it implicitly contributes to other services meeting their targets, but is not itself an explicit target for funding. For example, general hospitals are currently trying to achieve attendance times of less than 4 hours for all patients attending an accident and emergency (A&E) department in the UK (Department of Health, 1999). A liaison psychiatry service can assist in ensuring patients with mental health problems do not have a prolonged stay in A&E, but it is usually not seen as a priority for new funding. Similar issues apply to

targets set by the Department of Health in the various National Service Frameworks.

Professor Appleby underestimates the importance of national priorities in the local commissioning of health services. In a target-driven National Health Service (NHS), liaison psychiatry cannot expect to develop robust psychological services for medical and surgical patients unless it becomes an explicit government priority, and something that the NHS 'must do'.

DEPARTMENT OF HEALTH (1999) *Reforming Emergency Care: First Steps of a New Approach*. London: Department of Health.

ROYAL COLLEGE OF PHYSICIANS & ROYAL COLLEGE OF PSYCHIATRISTS (2003) *The psychological care of medical patients: a practical guide* (Council Report CR108). London: Royal College of Physicians & Royal College of Psychiatrists.

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Human rights and mental health services

Dr Fareed Bashir (*Psychiatric Bulletin* correspondence, December 2003, **27**, 463) is absolutely right in mentioning the influence that the European Convention on Human Rights (ECHR) had on the Mental Health Act 1983, long before its implementation into English law in 1998 (Human Rights Act 1998). In my article on Consent in medicine (*Psychiatric Bulletin*, August 2003, **27**, 285–289) I specifically mention the fact that the content of the ECHR was de facto accepted in Britain since the 1950s. Contrary to Dr Bashir's suggestion, I never expected that the implementation of the Human Rights Act 1998 was a sea-change or would dramatically improve the treatment of psychiatric patients. On the contrary, I pointed out how few practical changes are going to result from the Act in the short term. There is, however, the potential that human rights may be more actively considered in advance in future legislation. The changes the government made to the Green Paper on the new Mental Health Act confirm this, because they were clearly designed to make the Act compatible with the Human Rights Act

1998 (although many would doubt that they have). Furthermore, the case of *Hercegfalvy v. Austria* states that any beneficial treatment cannot amount to torture and therefore does not breach article 3 of the Human Rights Act 1998. This was specifically targeted with electroconvulsive therapy in mind. The fact that Mr Hercegfalvy was strapped to a bed for his own security may appear undesirable to us in Britain, but restraint is the tradition in most European countries. They find our use of control and restraint with enforced medication equally undesirable.

The case of *HM v. Switzerland* is no doubt interesting, but it should not be forgotten that all European countries work with coded law, which renders precedence much less important than it is here. It would be premature to anticipate how the English High Court would decide a similar case in the UK.

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Patient advocacy

Given the stated intention of the Royal College of Psychiatrists to review its position on patient advocacy in 2004 (Royal College of Psychiatrists, 1999; due for review 2007), it seems appropriate to highlight some findings of a recent qualitative study of 10 paid independent advocates on acute and continuing care wards in England. Although this collaborative venture aimed to explore the day-to-day experiences of advocates, participants felt that politically, advocacy was still bereft of real power within the National Health Service and advocacy projects were generally hampered by insecure funding.

Advocates saw their independence from staff as vital, both to them and service users, but constructive working relationships with psychiatrists and nurses were equally important for advocates in achieving desirable outcomes. Most participants did feel relationships with clinicians were generally good, although all had encountered some defensiveness or hostility from some, even allowing for the tension that *should* exist between