'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.

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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.

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

https://doi.org/10.1192/S0007125000168175 Published online by Cambridge University Press

for their exercise. Formal recognitions – laws, regulations, policies – may assist but do not suffice on their own. The thrust of our exploratory report into the making of psychiatric advance directives was twofold. First, when presented with the opportunity and a modicum of support, many service users prove eager and able to participate in planning for future treatment eventualities: taking inventory, lining up support and laying out preferences. But second, the invitation to draft needs to be a credible one. At least in the context we studied, the system of care appears to be woefully out of step with that readiness and ability.

In line with the first, we would join Dr Zinkler in welcoming all manner of collaborative arrangements and shared decision-making that represent practical steps towards a progressively more transparent and reciprocally accountable service system. In line with the second, however, we would underscore the formal importance of one critical ingredient in the programme that Henderson *et al* (2004) studied: the appointment of a designated third party to ensure that crisis plans are faithfully integrated into treatment.

Such positions serve two purposes. They are strategic mechanisms for expediting the formal agreement to negotiate mutually acceptable treatment plans, bridging the power differential and ensuring that each side is heard. They are also the administrative equivalent of 'earnest money' – the collateral or upfront investment that ratifies an institutional commitment. Once standardised, that small modification has the potential to build the necessary momentum to alter 'the way we do business here', which makes for sustainable change.

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Doctors and lawyers

Sarkar & Adshead (2005) present important issues regarding the nature of the relationship between psychiatrists and patients in the process of judicial hearings, focusing particularly on the conflict that may arise from differing roles. There are two points I wish to add.

First, the outcome of hearings is very much a result of the behaviour of all players present, and there are ways as clinicians we may work to reduce harm that may arise from them. During reform of the Mental Health Act in New Zealand in the early 1990s, very similar dynamics emerged between judges, counsel for patients (always provided in New Zealand), review tribunal members and psychiatrists acting as responsible clinicians under the Act. To address these difficulties, the New Zealand Law Society recommended that counsel take on a 'best outcomes' approach, assisting the patient to achieve the best they could, rather than strictly following the letter of the patient's instructions (McCarthy & Simpson, 1996). Such recommendations decreased damaging adversarial exchanges in committal and tribunal hearings, because of an awareness that 'juridogenic' harm could be long-lasting, and that such hearings were not criminal ones.

We also noted that the behaviour of clinicians could have a significant impact on how coercive or procedurally fair committal processes were for the patient. It came to be recommended that the psychiatrist shares their report to the tribunal with the patient and their counsel, and works through the issue of agreement or disagreement with the patient in advance of the hearing (Ministry of Health, 1997). This appears to have reduced possible negative impacts on the therapeutic relationship and may increase the patient's satisfaction because of their sense of having received an opportunity to voice their opinion and scrutinise the basis of their detention. Such an outcome can be achieved if the process is managed openly by psychiatrists, and in an inquisitorial but non-confrontational manner by legal officers.

Second, civil committal is not simply a loss of liberty, but a focused loss of liberty whose purpose is the restoration or maximising of autonomy, for a person whose competence is lowered by mental illness. Liberty is therefore restored through detention and treatment, unlike other forms of state-mandated detention (e.g. detention that is motivated as punishment and public protection). Sadly, civil committal is increasingly being misused overtly or covertly for primary public protective purposes alone, in the absence of a competence-lowering disorder. One senses that some of Sarkar & Adshead's concern relates to the committal hearings for the latter group of 'patients'. In 'dangerous and severe personality disorder' one is acting for security needs, with limited therapeutic health impact. In 'dangerous and severe schizophrenia' one is acting for the health needs of the patient, if the risk is symptom driven, and protecting the public is secondary. The due process protections necessary for these two different uses of civil committal may indeed need differing hearings.

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One hundred years ago

Dr. KRAFFT-EBING'S *Textbook of Insanity* [*Textbook of Insanity*. By Dr. von R. Krafft-Ebing, late Professor of Psychiatry and Nervous Diseases in the University of Vienna. Translated from the last German edition by Professor C. G. Chaddock, M.D., of St. Louis University, with introduction by Frederick Peterson, M.D., President of the New York State Commission in Lunacy. Philadelphia; F. A. Davis and Co. 1905. (Demy 8vo, pp. 654. 4 dollars.)] has enjoyed such wide popularity,

https://doi.org/10.1192/S0007125000168175 Published online by Cambridge University Press