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simply fixing problems in their minds or their brains. Biological research and treatments in psychiatry are necessary in this endeavour, although it would be foolish to deny that there is a problem when they dominate. Indeed, it was the then president of the American Psychiatric Association (not himself a post-psychiatrist, we believe) who complained that too much psychiatry followed a 'bio-bio-bio model'.[4]

Post-psychiatry is a tendency within the Critical Psychiatry Network, a small group of psychiatrists united mainly by their dissatisfaction with the *status quo*. We accept that there is a great deal wrong with the *status quo*, but we choose to put our faith in ordinary mental health professionals and service users who have worked steadily to change attitudes and to try to develop better, more user-friendly psychiatric services. This seems more fruitful to us than self-righteous separatism.

Psychiatry is having something of an identity crisis at present. Under rather different circumstances, Gramsci[5] wrote: 'The crisis consists precisely in the fact that the old is dying and the new cannot be born; in this interregnum a great variety of morbid symptoms appears'. Despite its good intentions, there is little chance that post-psychiatry will achieve much by suggesting that a set of inconsistent and logically flawed ideas can renew the profession. Like Sokal,[6] we believe that 'truth' and 'facts' are important because they are one of the few weapons that the weak have against the strong. Post-psychiatry is a distracting irrelevance. The real task is to shift the intellectual centre of gravity of the actually existing profession.

1 Bracken P, Thomas P. Beyond consultation: the challenge of working with user/survivor and carer groups. *Psychiatr Bull* 2009; **33**: 241–3.

2 Bracken P, Thomas P. Authors' response. Invited commentary on . . . Beyond consultation. *Psychiatr Bull* 2009; **33**: 245–6.

3 Holloway F. Common sense, nonsense and the new culture wars within psychiatry. Invited commentary on . . . Beyond consultation. *Psychiatr Bull* 2009; **33**: 243–4.

4 Sharfstein SS. Big Pharma and American psychiatry: the good, the bad and the ugly. *Psychiatr News* 2005; **40**: 3.

5 Gramsci A. *Selections from the Prison Notebooks*. Lawrence and Wishart, 1971.

6 Sokal A. A physicist experiments with cultural studies. *Lingua Franca* 1996; May/June: 62–4.

***Rob Poole** Professor of Mental Health, Glyndwr University, Academic Department of Mental Health, Technology Park, Croesnewydd Road, Wrexham LL13 7YP, email: rob.poole@wales.nhs.uk, **Robert Higgo** Consultant Psychiatrist, Liverpool Assertive Outreach Team

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Authors' reply: We would like to thank Philip Cowen,[1] and Rob Poole & Robert Higgo (see letter above) for taking the time to comment on our editorial.

Cowen rightly raises the question of coercion and perhaps this should have featured more centrally in the editorial. It is certainly a major issue for service users and their organisations – although many will accept that some sort of control and/or coercion is needed to deal with risky behaviour, many complain that the dominance of a psychopathological framework means that few alternatives are presented to people in times of crisis. Sometimes it is the lack of alternatives that leads to conflict, which in turn leads to coercion. People who do not think of themselves as having an illness (even when they are 'well') understandably resent the idea that what they are offered in times of crisis is simply hospital and medication. When alternatives to hospital are available they are often used positively by service users. In their book, *Alternatives Beyond Psychiatry*,[2] Stastny & Lehmann bring together descriptions of such alternatives from many parts of the world. If coercion does become necessary, we do not believe that psychiatry possesses the sort of predictive science that would justify its being the lead agency. We agree fully with Cowen that this is primarily a political issue and only secondarily a medical one.

We also agree with Cowen that modern science provides not only explanatory models, but also 'some degree of mastery over the natural world'. But the practical utility of a scientific model does not provide proof for the 'truth' of that model. The Romans could build magnificent aqueducts but we would now regard many of their ideas about the nature of the natural world as mistaken. In addition, 'mastery' is not always a positive. In many ways, it is the idea that science could, or should, be about providing us with 'mastery' over the world that has given rise to contemporary (postmodern) interrogations of the Enlightenment project.

We do not believe that mental healthcare can, or should, be centred on a primary discourse which is scientific–technical in nature. However, this does not mean that biomedical science has no role to play in helping people who endure episodes of madness or distress. The sort of neuroscience we value is the sort articulated by Steven Rose, Professor of Biology and Director of the Brain and Behaviour Research Group at the Open University and one of Britain's leading scientists. Rose argues for a neuroscience which is non-reductive, humble and able to engage positively with philosophy and the humanities.[3] We are also not anti-psychopharmacology but we want a pharmacology that has freed itself from the corruption of Big Pharma, and one that moves away from the notion that we can only understand the action of anti-psychotic drugs in relation to outdated concepts like schizophrenia.[4]

Poole & Higgo are less generous in their response to our paper. Indeed, we find it hard to understand how they have reached some of their conclusions. At no point do we characterise recent moves on the part of the Royal College of Psychiatrists or other organisations to engage with service users as 'inauthentic'. The kernel of our argument is that this engagement can and should develop from consultation into collaboration. We believe that most psychiatrists actually welcome this. Nor do we at any point dismiss the ideas of those users and carers who understand their problems in biomedical terms. However, one does not have to be a critical psychiatrist to know that a very large percentage of service users and their organisations are deeply unhappy with what is offered to them by psychiatry and, in particular, the way in which psychiatry frames their difficulties. The health editor of *The Independent*, Jeremy Laurance, took time away from his usual work to survey mental health a few years ago. He travelled to different places in England and spoke to many service users on his way. He writes: 'The biggest challenge in the last decade has been the growing protest from people with mental health problems who use the services. There is enormous dissatisfaction with the treatment offered, with the emphasis on risk reduction and containment and the narrow focus on medication. They dislike the heavy doses of anti-psychotic and sedative drugs with their unpleasant side effects, and a growing number reject the biomedical approach which defines their problems as illnesses to be medicated, rather than social or psychological difficulties to be resolved with other kinds of help'.[5]

It is nonsense to suggest that simply acknowledging this dissatisfaction (while at the same time accepting that a certain number of service users are happy with the *status quo*) amounts to a 'lack of respect for the diversity of opinion within the service user movement'.

Poole & Higgo also object to our use of the word 'madness' and indeed accuse us of embracing 'the language of bigotry'. We would point out that there is no set of words that will be acceptable to everyone in the mental health field and we certainly do not use the term 'madness' in order to offend. The word has been used in many different cultural and academic writings as well as by organisations such as Mad Pride and the Icarus Project. Do the makers of the film *The Madness of King George* also stand accused of bigotry? Are Richard Bentall, Roy Porter, Jeremy Laurance, and a host of others, guilty of 'inappropriate modishness' for using 'madness' in the

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titles of their books? On the other hand, we know many service users who feel stigmatised by terms such as 'schizophrenia', 'borderline personality' and 'treatment resistant'.

Poole & Higgo seem particularly incensed by our positive engagement with certain strains of postmodernist thought. Our position is that one can argue for certain ideas, values and ways of life without resorting to the assumption that one has found the 'truth' or that one somehow has gained access to 'objectivity that transcends a particular paradigm'. We deny that this amounts to some sort of 'anything goes' philosophy. 'Truth' and 'facts' are indeed important, but they have very often been used by the powerful to silence the voices of the weak. The history of the 20th century is littered with disasters wrought by those who argued that they had science, facts and truth on their side.

Poole & Higgo go on to dismiss the role of the Critical Psychiatry Network. For some reason, they accuse the group of 'self-righteous separatism'. This is in spite of the fact that many individuals in the Network are active members of the Royal College of Psychiatrists and have participated positively in College meetings, including hosting a day-long seminar on critical psychiatry at the annual general meeting in 2005, as well as recent joint events with the philosophy, spirituality and transcultural special interest groups. Our editorial was written in response to a request from the *Psychiatrist Bulletin* editor and one of the authors (P.B.) gave one of the 'prestigious lectures' organised by the president, Dinesh Bhugra, last year.

The critical psychiatry network is made up of 'ordinary mental health professionals' who care deeply about their profession and who are committed to establishing connections with the service user movement in all its diversity. Individuals in the Network are also working to free our academic discourse from its toxic entanglement with Big Pharma. We assert that critical thinking: the ability to think outside the assumptions of one's profession, to reflect critically upon its history and its practices, is not a threat to psychiatry, rather it is a tool through which the profession can begin to establish positive relationships with the developing user movement.

1 Cowen PJ. A big tent? *Psychiatr Bull* 2009; **33**: 395.

2 StastnyT, Lehmann P. *Alternatives Beyond Psychiatry*. Peter Lehmann Publishing, 2007.

3 Rose S. *The Future of the Brain. The Promise and Perils of Tomorrow's Neuroscience*. Oxford University Press, 2005.

4 Moncrieff J. *The Myth of the Chemical Cure*. Palgrave Macmillan, 2008.

5 Laurance J. *Pure Madness How Fear Drives the Mental Health System*. Routledge, 2003: xix.

***Pat Bracken** Consultant Psychiatrist and Clinical Director, West Cork Mental Health Service, Bantry, Co Cork, Ireland, email: Pat.Bracken@hse.ie, **Phil Thomas** Professor, Institute of Philosophy, Diversity and Mental Health, University of Central Lancashire

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Use of on-site testing for illicit drugs in forensic settings

The paper by Ghali[1] highlights the importance of training staff on the use of on-site urine testing kits. Although they are widely used in forensic settings where testing for illicit drugs forms an integral part of the overall management of patients,[2] staff receive very little training on the interpretation of test results. There are four possible interpretations: true positive, false positive, true negative and false negative.[3] A true positive test indicates that the person has used the drug, while a true negative test indicates absence of drugs in the sample. On the other hand, a false positive result can occur from the incorrect identification of the presence of substances, failure to acknowledge the chemical similarity of a prescribed medication with the drug of interest, and passive drug exposure. A false negative result may occur when the test's cut-off level is set above the limit of detection of the drug or due to sample adulteration.

A rigid interpretation of test results may have several undesirable consequences.[4] For instance, a false positive result may lead to false accusations being made against an innocent person resulting in suspension of leave, loss of privileges and possibly discharge from hospital. The last is more likely to be the case in patients with a personality disorder. In contrast, a false negative result may lead to a false perception that things are under control.

Training should incorporate understanding of the context of drug screening and ensuring the quality of samples to minimise errors in test result interpretation.

1 Ghali S. On-site testing for drugs of misuse in the acute psychiatric ward. *Psychiatr Bull* 2009; **33**: 343–6.

2 Durant M, Lelliott P, Coyle N. Availability of treatment for substance misuse in medium secure psychiatric care in England: a national survey. *J Forens Psychiatry Psychol* 2006; **17**: 611–25.

3 Wolff K, Farrell M, Marsden J, Monteiro G, Ali R, Welch S, et al. A review of biological indicators of illicit drug use, practical considerations and clinical usefulness. *Addiction* 1999; **94**: 1279–98.

4 Gordon H, Haider D. The use of 'drug dogs' in psychiatry. *Psychiatr Bull* 2004; **28**: 196–8.

Ian J. Yanson Specialty Doctor in Forensic Psychiatry, Nottinghamshire Healthcare NHS Trust, Rampton Hospital, Retford, Nottingham DN22 0PD, email: ian.yanson@nottshc.nhs.uk

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Review needs re-view

It is rather disappointing to see that the reviewer has not got the book's author's name correct.[1] I agree that some books may be too long to be completely read for the purpose of a review, but I suppose every book's author would want their name to be read in full and spelt correctly when a review is published.

Being a good friend of the book's author for a long time now, I can confidently say that Sree Prathap Mohana Murthy is a single name.

1 Oakley C. Get Through Workplace Based Assessments in Psychiatry (2nd edn) [review]. *Psychiatr Bull* 2009; **33**: 358.

Lena Palaniyappan Clinical Lecturer and Honorary Specialty Registrar, Division of Psychiatry, South Block 'A' floor, Queens Medical Centre, Nottingham NG7 2UH, email: Lena.Palaniyappan@nottingham.ac.uk

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