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Conference briefings

Medical out-patients with non-organic disorders

ANTHONY DAVID, Senior Lecturer in Psychological Medicine, King's College Hospital and the Institute of Psychiatry, London SE5

It is hard to believe that this coming together of the Royal Colleges of Physicians and Psychiatrists to discuss the patients that so often bounce back and forth between the specialists was the first of its kind.

"Reattribution" emerged as a buzz word. This describes the process of providing a rational explanation for the patient's symptoms which make the link between mental and physical states. No consensus emerged but it seemed that plausibility rather than accuracy was the order of the day.

Many physicians voiced their frustations at receiving psychiatrists' reports containing the familiar cliche "no formal psychiatric disorder". This was often applied to patients whose problems could be diagnosed from weighing their case notes rather than reading them. There is an important distinction between psychological *mechanisms*, which may be dysfunctional and psychiatric *disorders*. It is the ability to deal with the former confidently that physicians lack. Could "mistrust of doctors" be classed as an abnormal psychological mechanism?

Later the focus moved on to "dealing with the problem". "You can't teach old dogs new tricks" seemed to summarise the chances of changing senior physicians' skills in managing patients who did not fit into the sort of neat categories one reads about in the medical textbooks. Junior doctors are the people who should be trained in its application provided they can stay awake long enough.

Psychological approaches emphasise the importance of transference relationships and re-experiencing interpersonal conflict associated with symptoms, in therapeutic settings. Many speakers conceded that there remained a hard core of untreatable patients for whom "damage limitation" was the only hope. A take-home message was that there should be a distinction between bland reassurance – which relies heavily on the doctor's status and the patient's dependence – and the provision of "an accurate and convincing alternative to the patient's experience". The latter is claimed to mobilise the patient's own coping mechanisms and avoids conflict with the doctor.

Missing treatable psychiatric illness could be as serious as missing cases of cancer. But non-psychiatrists need guidelines on which patients to refer and on what grounds. While many constructive suggestions were made, it seemed obvious that only by a similar coming together of physicians and psychiatrists in their own clinics would a satisfactory partnership be forged. What was that they said about bland reassurance?

Joint conference held by the Royal College of Physicians of London and the Royal College of Psychiatrists on 24 January 1991 at the Royal College of Physicians, London.

The Proceedings of the conference will be published jointly by the Royal College of Psychiatrists and the Royal College of Physicians and will be available shortly.

Community care in crisis – homelessness and mental illness*

JULIAN H. RACE, Registrar, North Wales Hospital for Nervous and Mental Disorders, Denbigh, Clwyd LL16 5SS

One week before Christmas in the crypt at the Church of St Martin-in-the-Fields, Dr Malcolm Weller addressed a conference for CONCERN (Care of the Neglected: Combining Education, Rehabilitation and Nursing). The purpose of the conference was to highlight the plight of mentally ill, homeless people

**Conference held on 17 December 1990 at the Church of St Martin-in-the-Fields, London.*

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and to emphasise the strengths and shortcomings of the professional care available for them.

In London, the running down of mental hospitals has superceded adequate community provision and homeless, mentally ill people often face extreme difficulty in finding any sort of medical care. In recent years there have been severe cutbacks in the building of new houses. Housing corporations have reduced their funding and this has exacerbated the situation. Furthermore, public acceptance of mentally ill people in the community is difficult to achieve.

The professional network for aftercare is sadly often deficient. The Department of Health has asked for new discharge policies, with particular emphasis for people with special needs, such as the homeless mentally ill, but at present only one London borough has a policy for the discharge of homeless patients. In Haringey, no Section 117 discharge arrangements are available and statutory aftercare obligations fail because there are no approved social workers.

Dr Weller spoke of the three main groups of homeless people: the young, often with problems of employment and finance, who are sometimes mentally ill; middle-aged people who are often chronically destitute, some 40% of these mentally ill, with 22% actively deluded or hallucinating, and a third group homeless as the result of drug or alcohol abuse, maybe a consequence of mental illness.

The number of prosecutions of homeless people has doubled over the last two years and the Metropolitan Police are very concerned about the extent of vagrancy. The rate of conviction is directly proportional to the amount of homelessness and inversely proportional to availability of psychiatric beds.

CONCERN calls for emergency accommodation throughout the country, specifically for homeless mentally ill people; central funding for carers, a National Health Bed Bureau and provision from health authorities of some facility which can serve as a haven for mentally ill people with no fixed abode. It wants to see the closure programme for large city asylums postponed so that hospital and community facilities can run in parallel until such time that the community can manage independently.

The Seventh Annual Conference of the National Association for the Dually Diagnosed (Mental Illness/Mental Retardation)*

N. Bouras, Consultant Psychiatrist and Senior Lecturer, United Medical and Dental Schools, Guy's Hospital, London SE1 9RT

The National Association for the Dually Diagnosed (NADD) was started in the early 1980s by a small group of people who recognised the collective need for an awareness and understanding of the needs of people with a mental handicap who also had a mental illness. The intention was to bridge the gap between the primary service providers and therapists by highlighting important skill deficits whether oriented to mental health or mental handicap.

The Boston conference was attended by over 300 participants of different disciplines, mainly from the USA and Canada, including psychiatrists, psychologists, other professional therapists, administrators, residential and day-care staff. The theme was 'Back to the Future, Lessons of the Past – Challenges of the Future'. The first keynote speaker, Professor Frank Menolascino of Nebraska University, referred to the fallacies of the past, such as the psychometric mental age as a measurement, untrainability and untreatability. He highlighted the need for future services to be small, integrated, using an array of options, focused on the development of long-term stable relationships, supported by regional tertiary care centres for short-term in-patient and long-term out-patient treatment. The other keynote speaker, Dr Ludwig Szymanski of Children's Hospital, Harvard Medical School, drew attention to the training needs of mental health professionals and the necessity for interdisciplinary training schemes.

The 60 presentations were divided into nine symposia covering areas such as assessment and diagnosis, treatment methods with emphasis on pharmacotherapy, behaviour therapy, psychotherapy, therapeutic interventions for aggression and challenging behaviour, as well as organisation and delivery of services and techniques to train staff appropriate skills.

Dr Steven Reiss described the increasing use of standardised instruments for assessment of psychiatric disorders and presented a wealth of recent data on children and adults. The importance of accurate psychiatric diagnosis and the use of psychotropic medication based on current advances was emphasised by the main speakers in these subjects: Dr

**Conference held in Boston, Massachusetts in December 1990.*

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