the columns

correspondence

The limits of responsibility

Sir: In his haste to point out more pressing issues than the stigmatisation of people with severe mental illness (*Psychiatric Bulletin*, November 2001, **25**, 412–413), Bristow seems to have overlooked just how psychiatry came to be in this state in the first place.

Ever since its inception as a recognised speciality our profession has been hamstrung by a sense of inferiority whenever we compare ourselves to our more physically inclined colleagues. How many of us have never heard, or used, the quip that we are 'not real doctors', or experienced that small moment of deflation when we reveal our speciality to an interested enquirer? For decades we have dealt with this professional cringe in several ways. In our rush to embrace biological legitimacy, we seem to have forgotten the other two corners of the biopsychosocial triangle, or at least left them to others. We have also been happy to pick up whatever responsibility was going; in the 1960s and 1970s, when this responsibility concerned a group of people that few cared or even knew about, we were happy to hold onto it as a way of vouchsafing some sort of status. Now that the black pigeons of the asylum have come home to roost, it seems that Bristow is no longer a bird fancier.

Our profession would not have committed itself to the current status quo were it not for the poor regard in which it still holds itself. This regard derives from the unpleasant fact that psychiatrists are almost as stigmatised within the medical profession as our patients have been within society as a whole.

Just who should take responsibility for the behaviour of the mentally ill is a question for which no one yet has an answer, Howlett included (*Psychiatric Bulletin*, November 2001, **25**, 414–415). In the meantime, might psychiatrists not be in a better position than most to carry on making the best of a difficult job, one that they have in any case been doing for decades? Our professional liability will only decrease if we are seen to be confronting these issues rather than running away from them.

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Home treatment service

Sir: I would like to respond to the concerns raised by Sandor (*Psychiatric Bulletin*, December 2001, **25**, 486–487) regarding home treatment. He is correct to highlight the lack of a 'strong evidenced-based rationale'. However, his focus on 'model fidelity' is, in my view, misplaced.

It is tempting to fault models of service delivery on this basis, but surely this ignores more important issues? Instead we should focus on the important factors like patients' clinical and social outcomes. Other factors like service retention, adherence and satisfaction levels should also be borne in mind.

To suggest that an identikit model can be used in vastly different settings seems unrealistic. This creates a problem insofar as it acknowledges that model fidelity is an improbable goal. None the less, I would refer Sandor to the editorial by Slade & Priebe (2001), 'the challenge is to make the important measurable'. We could see this as following the lead of naturalistic pharmacological research (i.e. examining real-life scenarios).

Therefore, I would suggest that those assessing the impact of home treatment should acknowledge the deficiencies as outlined by Sandor. But it is imperative that we embrace the challenge to measure what is important.

SLADE, M. & PRIEBE, S. (2001) Are randomised controlled trials the only gold that glitters? *British Journal of Psychiatry*, **179**, 286–287.

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Mirror-image studies

Sir: I was pleased to find the data from my 1979 study of mirror-image studies of depot neuroleptics included in the meta-analysis by O'Ceallaigh and Fahy (*Psychiatric Bulletin*, December 2001, **25**, 481–484). These studies are rarely mentioned today, but they had two principal advantages when they were carried out, and these tend to be overlooked. First, the limited data they collected were as 'hard' as it was possible to get. Whether a particular patient is in or out of hospital on a particular day is a fact that even a vestigial record system can generally supply, while there is a legal requirement to record medication that is given.

Second, in a disorder where individual outcome and need for medication vary so widely, each subject is being compared with his/her own previous experience, and not with a theoretical average.

Of course, being in or out of hospital is not always directly equivalent to greater or less morbidity. However, in the circumstances of the NHS or similar services, this equivalent is broadly acceptable. Furthermore, in the real-life world of clinical research, there is simply no alternative to using this measure (Johnson & Freeman, 1972, 1973).

More fundamental, though, is the historical dimension. Mirror-image studies could only be done when there was a population of patients who had been on oral antipsychotics for a reasonable length of time and who could then be switched to depot treatment. This was possible in the late 1960s and 1970s, but hardly at all after that in Europe. It avoided any ethical problems.

Introducing depot drugs also had the effect of focusing attention on the need for continuity of care in schizophrenia and for setting up registers or information systems to prevent patients being overlooked by services (Freeman *et al*, 1979; Wooff *et al*, 1983). Historically, this coincided with the birth of community psychiatric nursing, which was able to reach a hard core of people who could not be persuaded to attend clinics regularly. This may be old hat now, but in the early 1970s it was revolutionary.

In Britain, depot treatment was developed by a small number of enthusiasts in provincial non-teaching hospitals. Early research efforts, including my own, were greatly encouraged by modest help from the E.R. Squibb company of the UK and its Medical Director, the late Dr Gerry Daniel. Without them, the effective development of essential maintenance medication – and of research into it – would have been much delayed.

FREEMAN, H., CHEADLE, A. J. & KORER, J. A. (1979) A method for monitoring the treatment of schizophrenics in the community. *British Journal of Psychiatry*, **134**, 412–416.

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