Correspondence

EDITED BY STANLEY ZAMMIT

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High-security hospitals†

I have been invited to respond to Dr Exworthy and Professor Gunn's critique of the review of security at the high-security hospitals (Exworthy & Gunn, 2003, this issue). Our report (Tilt *et al*, 2000) made 86 recommendations, all of which were accepted by the Government.

As I read the critique the main argument is that the team ignored the importance of relational security and was too preoccupied with physical and procedural security. I think this is a serious misinterpretation. The authors do not appear to have taken sufficient account of section 2 of the report, specifically paragraph 2.5, in which we said:

> 'In the view of the review team it is important that patients feel engaged and committed to the hospital. The provision of a full and purposeful activity and therapy programme is essential both for treatment purposes and as a significant part of the creation of a secure and safe environment. In the same way, the review team believes that beyond specific individual and group therapy it is important for a patient's daily life to be as active and demanding as possible having regard to the constraints of individual illness/disorders. It is for this reason the review team's recommendations have two main thrusts
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> - an increase in therapy and activity for patients
> - an upgrading of physical and procedural security to safeguard the public, staff and patients' (Tilt *et al*, 2000: p. 5).

The Faulk (1985) formula for a successful secure unit cites: (a) sufficient physical security appropriate to the patients; (b) high staff ratios; and (c) a therapeutic policy which encompasses individual programmes.

In my view this does not go far enough. Providing high staff ratios offers very little unless the staff are properly trained, motivated and managed. One of the shortcomings we found in the three hospitals was that although good therapy, expertise and

resources were available, they were significantly underused because there was little or no management information or action to ensure that the best possible outcomes were achieved from the resources made available.

In terms of the specific criticism that we neglected relational security, it is worth recording that recommendations 7, 15 and 57 related specifically to this aspect. The authors also assert that there was no clinical member on the enquiry team. This is not correct – one member of our team had extensive clinical experience, including working in high-security hospitals. Beyond that, in each of the three hospitals we spent time consulting many clinicians, including psychiatrists, and were struck by how many suggested to us that the existing security arrangements at that time were inadequate.

I believe firmly, as did all the members of my team, that the key to running successful treatment-oriented high-security hospitals lies in ensuring that the public, patients and staff feel safe about their operation. I believe our recommendations are making a positive contribution to that.

Exworthy, T. & Gunn, J. (2003) Taking another tilt at high secure hospitals. The Tilt Report and its consequences for secure psychiatric services. *British Journal of Psychiatry*, **182**, 469–471.

Faulk, M. (1985) Secure facilities in local psychiatric hospitals. In *Secure Provision* (ed. L. Gostin). London: Tavistock.

Tilt, R., Perry, B., Martin, C., et al (2000) *Report of the Review of Security at the High Security Hospitals*. London: Department of Health.

Sir Richard Tilt   Independent Review Service for the Social Fund, Fourth Floor, Centre City Podium, 5 Hill Street, Birmingham B5 4UB, UK

How should advance statements be implemented?

Papageorgiou *et al* (2002) are quite right to point out that advance directives (or advance statements) have potentially

beneficial effects on the processes of care, but the best way of implementing and evaluating them is far from clear. They chose a randomised controlled trial (RCT) to evaluate the effectiveness of advance statements, and used the number of compulsory admissions a year later as the main outcome measure. They found that advance statements had little impact on the outcome of care.

Different research methodologies exist to answer different types of research question, and while RCTs may be appropriate for establishing the effectiveness of an intervention, they provide little information as to the best way of implementing and delivering an intervention, especially complex interventions such as advance statements, which serve the ethical purpose of trying to preserve individual autonomy. In view of this we have to consider the power relationships between service users and mental health services. The authors appear to be aware of these relationships. The booklets in which their patients wrote their directives clearly stated that patients' wishes could be overridden by compulsion. This raises many questions.

Who 'recruited' patients into the study? How did recruitment take place? What steps were taken to inform service users about the pros and cons of advance statements? How were service users, professionals and structures of care such as the Care Programme Approach process prepared for advance statements? These questions concern power, values and interest. Do professionals really consider advance statements to be helpful, and take their implementation seriously? If not, how might this affect the way patients respond when asked whether they want to write an advance statement? The discussion in the paper indicates that staff may have had a 'lack of sustained awareness' of advance statements over the follow-up period. Our experience in Bradford indicates that a considerable amount of developmental work with mental health professionals and service users is necessary if advance statements are to be implemented.

The Medical Research Council (2000) has prepared a framework for use of RCTs for complex interventions, which sets out four stages of development. It starts with pre-clinical justification for the intervention, followed by modelling (defining the intervention and understanding the relationships between the component parts), and concluding with long-term