

Leff, J. (2001) Why is care in the community perceived as a failure? *British Journal of Psychiatry*, **179**, 381–383.

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Author's reply: Regrettably, Dr Hoencamp has misinterpreted a number of phrases in my editorial. Rather than calling for increasingly restrictive legislation, I was warning the reader against this alarming consequence of public and governmental misperceptions of care in the community. On another point, I certainly did not mean to imply that closing psychiatric hospitals is itself an indication of a successful policy. The evidence of success to which I was referring consists of the growing body of research showing that the quality of life of discharged long-stay patients is improved by relocation in community homes (e.g. Leff & Trieman, 2000). Dr Hoencamp is of course right that in-patient facilities will continue to be needed, but there is no reason for them to be located in the outdated structures of the psychiatric hospitals. There are undoubtedly problems with admission wards in district general hospitals, but these can be remedied by improved architectural design and the provision of alternatives such as acute day hospitals (Creed *et al*, 1990).

Although many asylums were deliberately built outside of towns, urban expansion brought them within the ambit of residential areas. Even those that remained remote, engendered in the public mind the image of life-long incarceration. I agree with Dr Hoencamp that more should be done to publicise community mental health services. We should be proud of what has been achieved and promote a high visibility. He raises the issue of the diversity of psychiatric disorders and the difficulty the public and the media have in distinguishing them. This dilemma faces any organisation attempting to change public attitudes towards people with mental illness and the services they need. The Royal College of Psychiatrists' campaign 'Changing Minds: Every Family in the Land' addresses a wide range of psychiatric disorders, while the World Psychiatric Association's 'Global Campaign against the Stigma of Schizophrenia' focuses on that one condition. Hopefully the results of these programmes will indicate which is the more effective strategy. However, early results from the

World Psychiatric Association campaign indicate that education aimed at teenagers in schools produces the most positive change in attitudes. A good strategy would seem to be the inclusion in the school curriculum of information about the diversity of disorders and treatment modalities in psychiatry.

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Use of outcomes measures by psychiatrists

Gilbody *et al* (2002) highlight the poor adherence of psychiatrists to using instruments to measure clinical outcomes. Assessment tools and outcome measures have been in use among practitioners working with people with learning disability for many years. There are many validated tools and reliable measures available for use in clinical practice that are routinely used. The take-up of assessment tools and outcome measurements has perhaps been influenced by the proportion of this patient group who have poor verbal skills, making access to their mental state and internal world a challenge to the clinician.

Observation of behaviour is an important element of assessment of mental health problems in people with learning disabilities. The Mini Psychiatric Assessment Schedule for Adults with Developmental Disability (PAS-ADD) is commonly used to detect psychopathology in people presenting with challenging behaviour that may be due to mental illness. It has been shown to have good reliability and validity (Prosser *et al*, 1998). The Health of the Nation Outcome Scales for People with Learning Disabilities (HoNOS-LD) is a useful tool to measure change over time to a therapeutic intervention (Roy *et al*, 2002). Clinical observations can be carried out by any clinician in the multi-disciplinary team trained in the application of these clinical tools.

It could be argued that the use of these instruments is reductionist and does not communicate the breadth of human experience and suffering of patients. Where language fails to express the impact of mental illness and social distress, I would hold that the use of rating scales can objectively indicate the nature of the suffering and the effectiveness of interventions made in patient care.

I believe the key to the use of tools in the future will depend on educating trainees to use these instruments and allowing them to be freely available in clinical practice. Of course they would gain greater prominence in practice were they to form part of assessment in the MRCPsych examinations!

Gilbody, S. M., House, A. O. & Sheldon, T. A. (2002) Psychiatrists in the UK do not use outcomes measures. National Survey. *British Journal of Psychiatry*, **180**, 101–103.

Prosser, H., Moss, S., Costello, H., et al (1998) Reliability and validity of the Mini PAS-ADD for assessing psychiatric disorders in adults with intellectual disability. *Journal of Intellectual Disability Research*, **42**, 264–272.

Roy, A., Matthews, H., Clifford, P., et al (2002) Health of the Nation Outcome Scales for People with Learning Disabilities (HoNOS-LD). *British Journal of Psychiatry*, **180**, 61–66.

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Dissent as a symptom: why China has questions to answer

In his letter taking issue with our claim that psychiatry is abused by the Chinese authorities for political control purposes, Dr Sing Lee (2001) cites his own experience in examining patients there suffering from 'qigong-related mental disorder'. He concludes that this culture-bound syndrome both exists and can be a serious condition, and that the psychiatric detention of *Falun Gong* practitioners in China today is therefore not a sign of the political abuse of psychiatry. Without challenging the validity of Chinese psychiatrists' diagnoses of qigong-related mental disorder in particular cases, it should be stressed that the Chinese authorities themselves hardly ever mention this diagnosis when justifying the psychiatric detention of *Falun Gong* practitioners. Indeed, recent articles in the Chinese psychiatric literature have stated

that this diagnosis is not generally applicable to *Falun Gong* practitioners, who are instead alleged to be suffering from a separate and more serious condition (albeit one not recognised in the official Chinese *Classification of Mental Disorders*) for which the term 'evil cult-related mental disorder' has conveniently been coined (Shen & Gong, 2000).

More worryingly, Dr Lee makes no reference in his letter to the reality that the *Falun Gong* practitioners concerned were first arrested by the police, in most cases to prevent them from staging peaceful demonstrations against the Chinese Government's continuing suppression of their spiritual movement nationwide. To our knowledge, the articles from the Chinese psychiatric literature concerning *qigong*-related mental disorder that Dr Lee refers to in rebuttal of the claims of political psychiatric abuse in China do not address the cases of patients detained by the police – they were all apparently voluntary patients. On both the above key counts, therefore, the *Falun Gong* cases (all of whom were reportedly arrested and then forcibly committed) evidently fall into a different category from that with which Dr Lee is personally familiar.

The recently compiled evidence of the state abuse of psychiatry against political dissidents over the past decades (Munro, 2000, 2002), most of which comes from the official Chinese psychiatric literature, is overwhelming in quantity and specificity. Given this past track record, the burden of proof now clearly falls upon the Chinese authorities to convince their own citizens and the outside world that the several hundred reported cases of arrested *Falun Gong* practitioners sent to involuntary psychiatric treatment (see <http://hrreports.faluninfo.net/book4/CategoryIndex.htm>) are, as Dr Lee seems to believe, valid and suitable cases for treatment. The simplest way to do this would be for the Chinese authorities to allow suitably qualified outside observers free access to the *Falun Gong* psychiatric detainees so that their mental conditions can be independently evaluated. Thus far they have shown no such willingness, and several Chinese nationals who tried to document such cases have been jailed.

We acknowledge that Chinese psychiatry as a whole is not generally complicit in these politically motivated distortions of ethical psychiatry and that they are largely (though by no means entirely) confined to

the domain of forensic psychiatry. This was also true, however, in the case of the former Soviet Union and certain Eastern European countries, where political dissidents, religious nonconformists and others formed but a small minority of the overall psychiatric inmate population. Then as now, the key issue is that the numbers of those affected is none the less substantial, and that any psychiatric diagnosis based on politics – whatever the scale – poses a potentially wider ethical threat to the profession. This is why the World Psychiatric Association, through its Madrid Declaration on Ethical Standards (see <http://www.wpanet.org/home.html>), has specifically banned member societies from engaging in politically based diagnosis of any kind.

Finally, the most pressing point to note is that, whereas the incidence of such practices in China had apparently been steadily declining since the late 1980s, the Government's crackdown on *Falun Gong* since July 1999 has resulted in a sharp renewal of politically abusive psychiatry. Failure by the international psychiatric community to speak out clearly against this disturbing trend now could well give the green light to a further expansion of these measures by the Chinese authorities in their ongoing fight against domestic dissent of all kinds.

Declaration of interest

D.L. is a member of Amnesty International and an academic patron of the Friends of Falun Gong UK. R.M. was China researcher for Amnesty International (1986–1989) and principal China researcher for Human Rights Watch (1989–1998).

Lee, S. (2001) Who is politicising psychiatry in China (letter)? *British Journal of Psychiatry*, **179**, 178–179.

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— (2002) Political psychiatry in post-Mao China and its origins in the cultural revolution. *Journal of the American Academy of Psychiatry and the Law*, **30**, 97–106.

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Cognitive impairment v. dementia

The February 2002 issue of the *Journal* contained a number of useful reviews of the major disorders that lead to dementia. In his paper on vascular dementia, Stewart (2002) suggested that we need to be 'identifying cognitive decline at a much earlier stage than dementia'. It occurred to me some time ago that the term 'dementia' has outlived its usefulness. It derives from a time when mental health workers were few and only gross changes in mental state were noted and dealt with. It still carries with it the therapeutic nihilism of those times and even the anticholinesterase inhibitors do little to dispel this, as they work for only a minority and for a short period of time. The term suggests a black-and-white distinction ('demented' or 'not demented'). In fact there are infinite variety of shades of grey. I have had a number of experiences of patients being referred as 'demented' largely for 'disposal' and have found that when we have taken them off toxic medication, treated their chronic chest infections, improved their diabetes and hypertension care, reduced the severity of their heart failure, got rid of their anaemia and managed their depression, anxiety or psychosis etc. we have been able to discharge them home or to relatively inexpensive long-term care. I see the person as cognitively impaired, and work to reduce the severity of that impairment – not simply by prescribing anti-dementia drugs. The widespread use of standardised ratings, such as the Mini-Mental State Examination (Folstein *et al*, 1975) and more advanced variations such as Cambridge Examination for Mental Disorder of the Elderly (CAM-DEX; now revised, Roth *et al*, 1999) have greatly improved doctors' ability to screen cognitive function, and while National Institute for Clinical Excellence guidelines encourage us to think of a specific score that delineates those with dementia from those without dementia, we are all aware that this is driven by accountancy rather than by medicine. At a practical level it is possible to get through the working week without using the term dementia and more accurately convey the person's mental state by speaking of cognitive impairment and elaborating on which areas are intact and which are dysfunctional.

Having written the above I feel some reluctance to post it as I think it is likely to raise more hackles than nods of agreement. It is as if I have suggested putting down a