

# Invited commentary. Helping advocacy to work well<sup>†</sup>

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This paper draws attention to a difficult and neglected area. Patient advocacy, well defined by Thomas and Bracken, takes many forms. A common thread is the empowerment of patients so that they can express their needs and wishes more effectively. As the chairman of the College Working Group on Patient Advocacy mentioned in the paper, I became aware of the many existing schemes engaged in this field, of the good work they are doing, and how problems that may arise can best be avoided.

The College document *Patient Advocacy* is now available (Royal College of Psychiatrists, 1999). I am glad that the authors of this paper find it difficult to fault and, like them, I hope it will be widely read. My comments on this paper owe much to the College document, but are personal and should not be taken to represent the views of the Working Group on Patient Advocacy.

I would not be quite as defensive about the anti-psychiatry movement as Thomas and Bracken. Certainly, this movement caused a great deal of harm, especially to some young people with psychotic disorders and their parents. Yet it also resulted in bringing home to psychiatrists the need to listen with greater attention to people with 'crazy' ideas, and to make a greater effort to understand what they were trying to express. It made psychiatrists aware of the now widely admitted dangers of labelling. Indirectly, through the patient organisations it inspired, it also ultimately led to better collaboration between professionals and those caring for patients at home.

The Working Group canvassed for descriptions of advocacy schemes in action, and for the opinions of psychiatrists on their value. Numerous positive experiences were made available to us, with independent advocacy proving itself to be of greatest value where someone with limited ability to take control of events was facing a

succession of events or a major change in their life. Problems only tended to arise where advocates were untrained, not sufficiently independent of trusts, or where adversarial situations had been allowed to arise, usually because of inadequate services or poor communication between advocates and professionals.

Specific and sometimes difficult issues arise with particular patient groups, especially children, people with dementia and individuals with learning difficulties. When carers put forward views about management plans that seem right for them, but not for those for whom they are caring, whom should the advocate support? Patients from ethnic minority groups will get a better service if an advocate from the same ethnic group can provide information on relevant cultural beliefs, attitudes and values. Such advocacy can also counter a tendency to stereotype people from minority groups.

Finally, I would strongly endorse what Thomas and Bracken have to say about the need for psychiatrists to learn how to relate to patient advocates during their training. While mental health services are so inadequately funded, there will always be a tendency for an advocacy service to be seen as an additional, time-wasting irritant. Proper training in this area might help young psychiatrists to learn about how to recruit allies rather than make enemies out of patients, their families and those who try to empower them.

## Reference

ROYAL COLLEGE OF PSYCHIATRISTS (1999) *Patient Advocacy* (Council Report CR74). London: Royal College of Psychiatrists.

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<sup>†</sup>See pp. 327–329, this issue.