
columns

titles of their books? On the other hand, we know many service users who feel stigmatised by terms such as 'schizophrenia', 'borderline personality' and 'treatment resistant'.

Poole & Higgo seem particularly incensed by our positive engagement with certain strains of postmodernist thought. Our position is that one can argue for certain ideas, values and ways of life without resorting to the assumption that one has found the 'truth' or that one somehow has gained access to 'objectivity that transcends a particular paradigm'. We deny that this amounts to some sort of 'anything goes' philosophy. 'Truth' and 'facts' are indeed important, but they have very often been used by the powerful to silence the voices of the weak. The history of the 20th century is littered with disasters wrought by those who argued that they had science, facts and truth on their side.

Poole & Higgo go on to dismiss the role of the Critical Psychiatry Network. For some reason, they accuse the group of 'self-righteous separatism'. This is in spite of the fact that many individuals in the Network are active members of the Royal College of Psychiatrists and have participated positively in College meetings, including hosting a day-long seminar on critical psychiatry at the annual general meeting in 2005, as well as recent joint events with the philosophy, spirituality and transcultural special interest groups. Our editorial was written in response to a request from the *Psychiatrist Bulletin* editor and one of the authors (P.B.) gave one of the 'prestigious lectures' organised by the president, Dinesh Bhugra, last year.

The critical psychiatry network is made up of 'ordinary mental health professionals' who care deeply about their profession and who are committed to establishing connections with the service user movement in all its diversity. Individuals in the Network are also working to free our academic discourse from its toxic entanglement with Big Pharma. We assert that critical thinking: the ability to think outside the assumptions of one's profession, to reflect critically upon its history and its practices, is not a threat to psychiatry, rather it is a tool through which the profession can begin to establish positive relationships with the developing user movement.

1 Cowen PJ. A big tent? *Psychiatr Bull* 2009; **33**: 395.

2 StastnyT, Lehmann P. *Alternatives Beyond Psychiatry*. Peter Lehmann Publishing, 2007.

3 Rose S. *The Future of the Brain. The Promise and Perils of Tomorrow's Neuroscience*. Oxford University Press, 2005.

4 Moncrieff J. *The Myth of the Chemical Cure*. Palgrave Macmillan, 2008.

5 Laurance J. *Pure Madness How Fear Drives the Mental Health System*. Routledge, 2003: xix.

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Use of on-site testing for illicit drugs in forensic settings

The paper by Ghali[1] highlights the importance of training staff on the use of on-site urine testing kits. Although they are widely used in forensic settings where testing for illicit drugs forms an integral part of the overall management of patients,[2] staff receive very little training on the interpretation of test results. There are four possible interpretations: true positive, false positive, true negative and false negative.[3] A true positive test indicates that the person has used the drug, while a true negative test indicates absence of drugs in the sample. On the other hand, a false positive result can occur from the incorrect identification of the presence of substances, failure to acknowledge the chemical similarity of a prescribed medication with the drug of interest, and passive drug exposure. A false negative result may occur when the test's cut-off level is set above the limit of detection of the drug or due to sample adulteration.

A rigid interpretation of test results may have several undesirable consequences.[4] For instance, a false positive result may lead to false accusations being made against an innocent person resulting in suspension of leave, loss of privileges and possibly discharge from hospital. The last is more likely to be the case in patients with a personality disorder. In contrast, a false negative result may lead to a false perception that things are under control.

Training should incorporate understanding of the context of drug screening and ensuring the quality of samples to minimise errors in test result interpretation.

1 Ghali S. On-site testing for drugs of misuse in the acute psychiatric ward. *Psychiatr Bull* 2009; **33**: 343–6.

2 Durant M, Lelliott P, Coyle N. Availability of treatment for substance misuse in medium secure psychiatric care in England: a national survey. *J Forens Psychiatry Psychol* 2006; **17**: 611–25.

3 Wolff K, Farrell M, Marsden J, Monteiro G, Ali R, Welch S, et al. A review of biological indicators of illicit drug use, practical considerations and clinical usefulness. *Addiction* 1999; **94**: 1279–98.

4 Gordon H, Haider D. The use of 'drug dogs' in psychiatry. *Psychiatr Bull* 2004; **28**: 196–8.

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Review needs re-view

It is rather disappointing to see that the reviewer has not got the book's author's name correct.[1] I agree that some books may be too long to be completely read for the purpose of a review, but I suppose every book's author would want their name to be read in full and spelt correctly when a review is published.

Being a good friend of the book's author for a long time now, I can confidently say that Sree Prathap Mohana Murthy is a single name.

1 Oakley C. Get Through Workplace Based Assessments in Psychiatry (2nd edn) [review]. *Psychiatr Bull* 2009; **33**: 358.

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