Psychiatric Bulletin (1991), **15**, 574–582

Correspondence

Limitations of guardianship

DEAR SIRS

Weatherhead (*Psychiatric Bulletin*, June 1991, **15**, 341–343) makes pertinent points about the limitations of guardianship which are not confined to practice in Scotland. We describe a case in point where there is unanimous agreement between doctors, social services and family to invoke guardianship to secure a residential placement but inability to convey makes the order impotent.

A 76-year-old woman admitted to hospital under Section 2 in October 1990 had a 15 year history of recurrent depression requiring several admissions and treatment with ECT and antidepressants with diminishing response. Her husband died in 1989, leaving her alone, and she gradually deteriorated until she was living in an appallingly neglected state, having lost stones of weight and refusing access to her home. The house was in extreme disrepair and unsafe. Over years she had purchased a vast array of consumer items which had been hoarded but never used and filled the home. A bedroom was inaccessible because it was floor to ceiling with new goods, two bedrooms contained only brand new unwrapped fur coats, every drawer, cupboard and space was crammed with unopened food, sweets, china sets, boxed glassware, kitchen utensils, clothes and dozens of unworn shoes with multiples of the same object. The refrigerator contained mouldy food with sell-by dates in 1979 and psychotropic drugs prescribed over 30 years filled a dustbin bag. Her brother suffered from depression and hung himself two years ago.

High doses of antidepressants (clomipramine 300 mg nocte with lithium carbonate and l-tryptophan) produced limited improvement but she remains apathetic, solitary and unmotivated while sustaining her physiological needs but offering no subjective complaints. ECT has been refused.

She insists on returning home, refusing even to view a residential home but never attempting to leave hospital yet knowing she has been able to do so for six months.

Her current condition and poor prognosis, previous non-compliance and refusal to accept services make it inappropriate for her to return home. The house remains unsafe as repairs have been impossible because workmen cannot gain access to rooms and she refuses to sanction this work or give relatives power to act on her behalf.

Surely it is a nonsense that were this lady in residential care guardianship could detain her there, but as she is not we have no power to convey and detain her there. When the Act states that it gives "the power to require the patient to reside at a place specified" this is clearly a hollow statement and we are unable to act "in the interests of the welfare of the patient". It is anomalous that we could convey her to hospital "in the interests of her own health or safety" but not then to another establishment for the same reasons.

It is common practice for elderly people to be moved into residential care without any assessment by deceit and deception yet this is ignored and indirectly encouraged by the Act as a means of circumventing its inadequacies. The powers of guardianship must be reconsidered as it is failing to protect patients' rights and we would suggest that it should at least become possible to convey from hospital to other residences thereby ensuring patients are fully assessed and treated before such a decision is made.

If any reader has a solution to our particular dilemma we would be interested to hear from them.

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Psychological treatments

DEAR SIRS

The letter by Dr Stern (*Psychiatric Bulletin*, May 1991, **15**, 296) draws attention to the failure of psychiatrists to carry out psychological treatments. He is right to do so, but let us consider some of the reasons for this. Medical training with its emphasis on the soma leads to an orientation toward physical treatments and it is in fact from this direction that the major advances in treatment of psychiatric disorders has come. Psychological treatments are generally rather time-consuming and firm evidence for their effectiveness, certainly in the long term, is lacking. Then the trainee in psychiatry is not obliged to provide any evidence to the examiners for Membership of the Royal College of Psychiatrists, that he or she has acquired any competence in, or even attempted, psychological treatments; mere nodding acquaintance with textbook knowledge suffices.

Dr Stern also draws attention to the need for 'retooling' of behavioural and cognitive techniques. Again, he is correct if skill in application is to be acquired by trainees in psychiatry; trainees have a heavy work load and few will find several hours a week together with skilled supervision in the

therapies. Moreover rotational training schemes require that trainees are pitched into a new job every six months which certainly discourages application to any therapy which is likely to require more than an hour or so a week for a few weeks. A further problem with psychological treatments is the fact that many anxiety states, mild depressive states, and obsessional disorders respond rather well to antidepressant drugs and a trainee may be discouraged from persistence with a psychological approach if all along he suspects that the patient may show much greater benefit from such prescription.

Cognitive behavioural treatments, although relatively brief in comparison with psychodynamic approaches, do require further abbreviation if they are to be widely applied to the prevalent problem of anxiety. I realised this fact when, as a trainee myself, I worked in a neurosis treatment unit. It became apparent that the huge problem could only be effectively tackled if self-help methods were developed.

It has been my major effort, both as clinician and trainee of junior psychiatrists, to develop such an approach and the method of Anxiety Control Training has been described in detail in my text, *Clinical Neurosis* (1991). It is a technique which requires only two hours of therapist time per patient (six to eight weekly 15-minute sessions) and it is readily taught to others. My experience over many years of practice has been that trainees rapidly acquire competence after brief instruction and from the very first year of entry into training have the satisfaction of applying a brief psychological treatment which, if selection is correct, may be rapidly effective. Long-term follow-up study of the outcome of ACT has been delayed by the problem of securing research assistance for the requisite period but this has now been completed and the study submitted for publication. We have shown that patients continue to improve with regular practice of the technique following the brief intervention by the therapist. This information provides the basis for an optimistic statement by the trainee who, on departure for the next post on rotation, may not see the patient again.

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Reference

SNAITH, PHILIP (1991) *Clinical Neurosis* (2nd edition). Oxford: Oxford University Press.

Psychiatrists as managers

DEAR SIRS

Dr Stern's suggestion that psychiatrists who become involved with management do so because of "poor therapeutic skills" (Psychological treatments by psychiatrists? *Psychiatric Bulletin*, May 1991, **15**, 296) is a surprising generalisation, especially given Dr Stern's commitment to cognitive therapy!

Effective management depends not only on a sound grasp of the new NHS business ethic, but also on the ability to understand individual and group dynamics and the capacity to work effectively with teams. These skills are the bread and butter of good psychiatric practice, hence good psychiatrists are often good managers.

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DEAR SIRS

The letter from Dr Power-Smith in response to my previous letter in the *Bulletin* somewhat misses the point. I do not mean to imply that psychiatrists do not often make good managers, but rather to emphasise that our training in therapeutic skills ought to keep up with current developments. Unless this happens, psychiatrists would not be well equipped to carry out psychological treatments.

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Cost-benefit analyses of psychotherapeutic treatments

DEAR SIRS

Uncontrolled studies of group-analytic therapy, inpatient psychodynamic psychotherapy and behaviour therapy have demonstrated a post-treatment reduction in health service usage and improvements in measures of economic productivity. Studies of clinical psychology attachments to general practice have demonstrated similar findings.

Unfortunately there have been only two controlled studies of note in this country. A study of behaviour therapy for phobias and sexual problems (Ginsberg *et al*, 1984) confirmed the earlier uncontrolled findings from the same unit, although attrition rates were high despite a follow-up period of only one year. A more naturalistic controlled study of a clinical psychology attachment to general practice (Earll & Kincey, 1982) found no economic benefit, contradicting the uncontrolled work.

Work from the United States suggests that psychotherapy is broadly cost-effective, leading to lower utilisation of other health services, particularly for hospitalised patients in older age groups. But much of these data come from insurance company records and therefore have limitations. Firstly, the health insurance system works to limit the number of