correspondence

Time for candid debate about the difficulties of managing patients

Sir: May I comment on the misunderstanding which seems to be occurring between two of my colleagues. Dr Mohan (*Psychiatric Bulletin*, April 2000; **24**, 155) worries that Professor Maden's (*Psychiatric Bulletin*, December 1999; **23**, 707–712) view on relaxing the treatability criterion for patients held under the legal classification of 'psychopathic disorder' will mean that psychiatrists are more concerned with public protection than treatment of patients. I am aware that this view is commonly held, and indeed it has some origins in the original parliamentary debate on the Mental Health Act 1983, when the age limit for the treatment of patients deemed to be 'psychopathic' (which was originally set at 21 years) was lifted. Some lawyers and politicians have fondly imagined in the past that psychiatrists were willing and able to identify individuals they took a dislike to and lock them up in one of their mental hospitals on an indefinite basis simply for tidiness and/or security rather than for treatment.

Professor Maden is of course right; the reverse has occurred. Doctors have never been keen to admit homeless and/or long-term patients into hospital even when there were plenty of beds. In recent years the position has been exacerbated by the very sharp fall in the number of psychiatric beds available. We are now faced with the situation that patients who any member of the public or a profession other than psychiatry can see are in serious need of psychiatric care are rejected by psychiatrists on the grounds that they are 'psychopathic' and 'untreatable'. This has already led to some damage of the profession's image and indeed to a remarkable consultation document published by the Home Office recently which is proposing that psychiatrists be forced, in some way yet to be specified, to take on patients they believe fall into this category.

We are in a frightful muddle about this and as such are vulnerable to political initiatives which will damage both the interests of patients and of the psychiatric profession. Professor Maden is right. The appropriate stance for a caring profession is to say 'yes, we will try to help whenever we can' rather than 'no, take that patient away'. We need to couple this type of approach with very strong representations for proper resources to undertake that task and we need to accept that not every psychiatrist will want to treat every kind of patient as seems to be the general expectation at the moment.

I believe the time has come for a much more open and candid debate about the difficulties of managing some patients in all diagnostic categories, the level of resources which are actually required, the need for greater sub-specialisation, and the need, therefore, for more psychiatrists. If this is put within the context of 'we the psychiatric profession will do whatever we can to alleviate suffering attributable to mental disorder' we will not be accused either of neglecting our responsibilities, or of turning ourselves into a security service. I do not know any psychiatrists who wish to become quasi-jailers and attempts by the current government to give us such a role will not succeed because, while jailers constitute an important caring profession, they are different from psychiatrists.

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Cognitive–analytical therapy – a most suitable training for psychiatrists?

Sir: Not surprisingly, I welcome the paper by Harvey Rees (*Psychiatric Bulletin*, April 2000, **24**, 124–126). Cognitive–analytic therapy (CAT) was always intended to offer a NHS-relevant model of psychological therapy and management. Rees comments on the need for a "robust evidence base for its effectiveness", in this respect. It should be noted that the development of the model over the past 25 years has involved both conceptual developments and numerous small scale studies of both process and outcome. These are recorded in three books and over 50 papers published in peer-reviewed journals and a number of further papers are due to appear in a special section of the June issue of the *British Journal of Medical Psychology*. Much of this work has been focused on borderline personality disorder. Bowing to current definitions of 'robust', and despite considerable ethical and design problems, we have now embarked on a large scale randomised controlled trial of 24-session CAT in this category of patients. Despite favourable referees' reports and a completed feasibility study, this inexpensive study of a group of currently neglected patients who have a very low spontaneous recovery rate, a high suicide rate and are high consumers of resources has failed to attract research and development funding.

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Place and purpose of research training

Sir: The ability to appraise research and apply the results to everyday clinical practice currently has a high profile. At present, one-fifth of all higher training time for psychiatrists is allocated to research activities in the form of the research day. The need for two sessions per week devoted to research has been questioned, and a working party of the Collegiate Trainees' Committee (CTC) was formed to consider the place of research training within the specialist registrar years. Their findings can be found in a report published on the College website (Ramchandani *et al*, 2000).

This report continues to recognise research as an integral part of higher training in psychiatry, but argues for increased flexibility in the use of the research day. At present the *Higher Specialist Training Handbook* states that "the HSTC now requires two sessions each week to be devoted to planning, conducting and communicating the

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