

Also of concern is the lack of evaluation of harm to patients caused by what is essentially a screening programme of high-risk individuals. Such programmes are known to be associated with harm in a variety of forms. These include overdiagnosis, overtreatment and anxiety concerning the illness being investigated.⁴

Last, for a patient to give informed consent to participate in this kind of programme, they should be informed of the uncertainties inherent in it and the likelihood or otherwise of benefit to them of such a screening.

It is time to take stock and critically review which, if any, of these investigations are necessary for our patients.

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- 3 Fourth Joint Task Force of the European Society of Cardiology and Other Societies on Cardiovascular Disease Prevention in Clinical Practice. European guidelines on cardiovascular disease prevention in clinical practice: executive summary. *Eur J Cardiovasc Prevent Rehabil* 2007; **14** (suppl 2): E1–40.
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Scarcity of evidence base on management of acutely disturbed patients

Brown *et al* give a useful insight into the practice at seven intensive care units all over the country.¹

Their results show that 22% of patients were given rapid tranquillisation using the intramuscular route and 68% were not given any rapid tranquillisation medication at all.

The results table is confusing and the numbers do not add up; 3% appear not to have been given any medication at all, which causes concerns about the referral process to psychiatric intensive care units (PICUs) and whether patients were appropriately placed.

The study does not clarify the legal status of the patients and does not throw any light on the level of aggression of the patients in PICUs.

The most common diagnosis was schizophrenia/schizo-affective disorder (54%), followed by mania (19%) and substance misuse (8%). The diagnosis for 19% of patients has not been provided in the study.

- 1 Brown S, Chhina N, Dye S. Use of psychotropic medication in seven English psychiatric intensive care units. *Psychiatrist* 2010; **34**: 130–5.

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Authors' reply

We are keen to encourage a wider discussion of the issues around the treatment of patients admitted to psychiatric intensive care units (PICUs) and welcome the opportunity to address points raised by Acharya & Sadiq. In writing the paper¹ we made a series of judgements about how best to present a

large volume of data in an easily assimilated form and we are sorry if some of these decisions led to a lack of clarity.

One of the main findings of the study was that most PICU patients are safely managed without recourse to forced intramuscular (IM) medication, indeed that some patients are managed without any psychotropic medication at all. The study only collected data about treatment while the patients were in a PICU (this was a pragmatic decision as many patients came from and returned to distant units where data collection was not feasible). We suspect that some of the patients who did not receive any psychotropic medication in the PICU had received medication before transfer, possibly in the form of medium- or long-acting antipsychotic injection. Others will have received medication after transfer to the acute ward. The diagnoses of those patients who did not receive any medication were: schizophrenia (1), depression (2), drug-induced psychosis (1), substance dependence (2), personality disorder (2), anxiety (1) and adjustment disorder (1).

The numbers in Table 1 do not always add up to 100% because some patients appear in several categories, for example: they were given IM rapid tranquillisation and IM zuclopenthixol acetate. All figures were rounded to the nearest 0.5%; with this caveat we are confident that the appropriate figures (from text and table) do add up to 100%.

The primary diagnoses of patients aggregated into the category 'other' were: learning (intellectual) disability, dementia, Asperger syndrome, obsessive-compulsive disorder, anxiety, adjustment disorder, and intoxication with drugs or alcohol.

We address the legal status of the patients and the level of behavioural disturbance more fully in a companion paper.² With respect to the legal status of the patients, the findings were: 10 informal (3%), 7 on Section 5(2) (2%), 123 Section 2 (37%), 158 Section 3 (48%), 1 Section 4 (<1%), 9 Section 37 (3%), 19 a range of forensic sections covering different transfers from prison (6%).

With respect to measurement of behavioural disturbance and mental state, we used the Brief Psychiatric Rating Scale (BPRS) and those subscales (hostility score, three-item Factor V cluster and five-item hostility cluster) which focus on behavioural disturbance. The mean BPRS score fell from 58.2 on admission to 39.8 on transfer from PICU; the respective figures for the hostility score, Factor V and hostility clusters were: 4.2 to 1.8, 9.2 to 5.5 and 17.3 to 11.1.

We hope that these details clarify the points raised by Acharya & Sadiq.

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- 2 Brown S, Chhina N, Dye S. The psychiatric intensive care unit: a prospective survey of patient demographics and outcomes at seven English PICUs. *J Psychiatr Intensive Care* 2008; **4**: 17–27.

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Comment on the evaluation of the Time to Change anti-stigma campaign

The study by Abraham *et al*¹ suggests that a single exposure to selected Time to Change campaign material (those including the '1 in 4' message) delivered via post was not effective at improving attitudes towards people with mental illness.

Findings were based on a sample of 250 adults recruited through various adverts. The study showed that attitudes were not significantly better than in a group of the UK general public previously recruited for scale validation.

We are undertaking the overall evaluation of the campaign. Our evaluation design is based on a conceptual framework which describes stigma as problems of knowledge (ignorance/misinformation), attitudes (prejudice), and behaviour (discrimination). Therefore, in addition to measuring prompted campaign awareness, our evaluation included measures of mental health-related knowledge (measured by the Mental Health Knowledge Schedule), attitudes (measured by the Community Attitudes towards Mental Illness scale) and behaviour (measured by the Reported and Intended Behaviour Scale).² To address the multifaceted nature of the campaign, we use several levels of evaluation, including assessments of: the overall programme at a national level, specific target groups (e.g. medical students, trainee teachers) and regional and local interventions.³

Our initial evaluation of the campaign in Cambridge used a pre/post-evaluation design among the campaign target population. These findings suggested modest but significant changes in this group. An important finding was that although campaign awareness was not sustained following the first phase of activity, significant and sustained shifts occurred for knowledge items 2 weeks following the campaign. There was a 24% ($P < 0.001$) increase in the number of persons agreeing with the statement 'If a friend had a mental health problem, I know what advice to give them to get professional help', and a 10% ($P = 0.05$) rise in the number of people agreeing with the statement 'Medication can be an effective treatment for people with mental health problems'. Over this short-term activity, changes were not evident for attitudinal or behaviour-related questions.

Another difference between our evaluation and that of Abraham *et al* is that we found familiarity with mental illness to be associated with less stigmatising responses. Therefore, our findings suggest the possibility of significant further progress via more openness, disclosure and social contact. It is clear from these studies that further investigation is needed to address the most effective dissemination and communication of anti-stigma messages.⁴ Additionally, evaluation of the maintenance of changes over time and the additive effect of subsequent bursts of campaign activity will help us understand more about the effectiveness of this campaign in the long term. We are currently analysing data collected over the first year of the campaign.

Abraham *et al* also cite our paper comparing public attitudes in England and Scotland,⁵ and state: 'Unfortunately, there have been reports that national anti-stigma campaigns are not particularly effective'. In fact, this paper shows the opposite, namely that 'the results are consistent with early positive effects for the See Me anti-stigma campaign in Scotland'.

Declaration of interest

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Comic Relief and Shift. The funding sources had no role in the writing of this Comment.

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Role players' experience of psychiatric examinations

Professional role players are increasingly being employed in psychiatric training. There have been several studies of their experience. A Dutch study showed an 'unexpectedly high' rate of reported mild stress in those playing psychiatric roles.¹ An American study found that role playing mania and depression could be exhausting and that being more than 40 minutes in role with more than three or four repetitions was stressful.²

We were interested in the experience of UK professional role players. We conducted semi-structured interviews with ten professional role players, six women and four men, followed by two focus groups with the same individuals. They were taking part in local mock Objective Structured Clinical Examinations (OSCEs) and had between 5 and 10 years' experience of simulating patients with psychiatric disorders several times a year. They were recruited and trained by a professional trainer with a background in psychiatry.

Generally, the role players we interviewed felt appreciated and well looked-after at psychiatric OSCEs. They emphasised the value of seeing the full scenarios beforehand, including the instructions to candidates and examiners as well as examiners' score sheets. These inform their training sessions. Guided, collective training is crucial; they prefer not to rely on their imaginations to work out how a particular patient would behave. Role players' instructions should include directions on how to act the role; they felt that portraying the appropriate affect is important. Too long a history can make them anxious lest they forget bits; this detracts from their capacity to think and feel themselves into role.

Thinking and feeling oneself into role is a key aspect of method acting. The researchers in the Dutch study thought that method acting may have contributed to their role players' reported stress. They played 'emotionally and psychologically complex roles' only occasionally. Another study reported that role players find it difficult to 'turn off characterisation'.³