

Correspondence

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Forget community care – reinstitutionalisation is here

Although we agree that care in the community is perceived as a failure within the public domain and definitively as portrayed by the media, there are a number of issues around deinstitutionalisation that have not been addressed by Professor Leff (2001). Certainly, the apparent invisibility of community teams, the muddling of schizophrenia with personality disorder, ‘split mind’ and homicides, and the modern prevalence of homelessness are all factors. More important, perhaps, is that we do not really know why community care developed during the second half of the 20th century, and why it is now returning to what a 19th-century editor called ‘bricks and mortar humanity’ (Wynter, 1859).

It may be that the studies following the planned resettlement of asylum populations quoted by Leff show no subsequent homelessness in the discharge populations, but this ignores the new long-stay problem. That is to say younger patients, who have never been through the asylum system, and who go in and out of in-patient units on the revolving-door circuit. Leff’s experience of 20% of patients being homeless is out of date, current levels being nearer 40% or even 50% in our east London wards, for example. Another third are people readmitted from hostels, and now no longer accepted by these because of ‘risk management’, drug use or other ‘difficult’ behaviours.

This leads on to concerns about violent crime, in that there has been a decrease in the proportion of violent crimes committed by people with mental illness, but not a decrease in the numbers. This may reflect generally rising crime rates, but we remain ambivalent, in psychiatric circles, about the relationship between schizophrenia and criminality,

and there seems to be a tendency to try to gloss over it. This also has an impact on what Leff calls the ‘mixed economy of care’, and a ‘complex network of inter-linked facilities and professionals’. In fact this is a Gormenghast-like labyrinth, with voluntary agencies, privately run hostels, and forensic units carefully trying to ward off all difficult comers and, in the case of the latter, usually being full. The proportion of time spent on interface issues (e.g. meetings, letters, telephone conversations) compared with patient care is rising remorselessly.

Whether you call something a continuing care unit, a 24-hour nursing staffed hostel or a medium secure rehabilitation unit does not matter, since essentially you are reproducing the asylum. The fact of the matter is that we are now entering a period of reinstitutionalisation, in both the UK and other parts of the world, for reasons that we do not really understand. Deinstitutionalisation occurred in all Western industrialised countries, at a different pace and linked to very distinct national events such as the Psychiatry-Enquete in Germany, the Law 180 in Italy or Powell’s ‘water tower’ speech in this country.

Now, there seems to be a similar underlying pattern across various countries. This time, it is reinstitutionalisation with a rising number of forensic beds, new-style institutions in the form of supported housing, and an increasing frequency of compulsory treatment. It is not just a matter of perceptions, but rather a notion of public safety. Thus, we see a rising tide of individualist preference over communal support (e.g. the car *v.* the train), a widening gap between stronger and weaker groups in society (e.g. the rich and the poor), and a medico-legal climate of blame and risk attribution. There is probably a realistic balance between what community care can do and what might benefit from old or new kinds of institutions, but such

balanced acceptability needs more careful research.

Leff, J. (2001) Why is care in the community perceived as a failure? *British Journal of Psychiatry*, **179**, 381–383.

Wynter, A. (1859) Editorial: Non-restraint in the treatment of the insane. *BMJ*, 418.

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Compensation claims after whiplash neck injury

Although the effort in the study by Mayou & Bryant (2002) is substantial, we find that there is a tendency in such studies to fail to account for at least two important confounding variables. Our own experience, in both clinical and medico-legal practice, is that asking patients about pre-accident emotional stress is too often unreliable. Interviews with family members and review of employment records and reports often uncovers a wealth of data on these patients that was otherwise not forthcoming. Yet this is a difficult task in research studies in most cases. What is less difficult, however, is seeking the opportunity to review all pre-accident medical records, which often refer to lengthy or recent histories of significant life stressors. This is important; if some of the subjects who reported a lack of pre-accident emotional difficulties in a study actually have them, they confound the comparison of emotionally vulnerable *v.* non-vulnerable accident victims. No difference will appear to exist between the two groups because in reality they are much more alike than the researchers can know. Although researchers do use methods that suggest self-reported data is still valid, if the purpose of the research is to study psychosocial variables, then short-cuts or surrogate measures are not sufficient.

Also, post-accident stressors unrelated to an accident (e.g. death of a friend or family member, or moving house) have been shown, albeit in a small group of subjects, to be important predictors of whiplash outcome (Karlsborg *et al.*, 1997). In research, to obtain this information, one need merely ask the subjects to check off what may seem like a list of not uncommon life events. We have found in clinical and medico-legal practice that patients tend to be more forthcoming about reporting these events, although we are impressed at how frequently people

manage to cope and keep working after many stressful life events, and yet have work disability and develop post-traumatic stress disorder after minor motor vehicle collisions. Perhaps it is as Sir John Collie remarked long ago:

'In short, the essential quality of a thing is its worth to the individual, and its value to him is its power to serve his private ends. On one occasion, when examining a working-man for an injury to his thumb, he observed me examining the terminal phalanx of one of his fingers, which had been partially removed, obviously as the result of a former accident. "That," said he, "is of no importance; it was done at home!" (Collie, 1917).

Collie, J. (1917) *Malingering and Feigned Sickness* (2nd edn), p. 15. London: Edward Arnold.

Karlsborg, M., Smed, A., Jespersen, H., et al (1997) A prospective study of 39 patients with whiplash injury. *Acta Neurologica Scandinavica*, **95**, 65–72.

Mayou, R. & Bryant, B. (2002) Psychiatry of whiplash neck injury. *British Journal of Psychiatry*, **180**, 441–448.

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Regarding Mayou & Bryant's study (2002), it is interesting that the predictors of pain at 1 year are 'feeling not to blame for the accident', claiming compensation and 'anger cognitions'. With multivariate analysis, only claiming compensation at 3 months is a predictor of pain at 1 year. This means that feeling not to blame for the accident, initial anger or anger cognitions are predictors of pain only in claimants, otherwise not. Thus, of two patients, both not-at-fault, and both equally angry, it is the one who chooses litigation that will have the worse outcome. Why?

Does litigation/claims create a psychosomatic phenomenon that allows anger and victimisation to express itself as pain? Or are litigants more likely to be compelled to focus on all sources of aches and pains in their life (even pre-accident sources) by keeping pain diaries more often and by being instructed to see more physicians and therapists, to withdraw from more activities that hurt, to take more medications, to develop poor physical fitness, postural problems, medication adverse effects and anxiety?

It is further interesting that 14% of accident victims with no injury had bodily pain at 3 months! How does this happen? Is it a manifestation of psychological distress, or perhaps does pain occur as part

of life, even if not injured (or, for that matter, even if not involved in an accident)? The percentage of accident victims with pain at 1 year in the 'no injury' group is half that of whiplash injury victims with pain at 1 year (27%). As one does not expect whiplash injury to create an immunity from whatever is affecting the 'no injury group', half of the whiplash injury group was going to have pain at 1 year, even if they had had no injury, or had fully recovered from their injury, because the 'no injury' group gets pain anyway. Not all of the pain at 1 year in whiplash victims can thus be due to physical effects of the initial injury, since then there would be at least some additional burden of pain from whatever factors also cause pain in the 'no injury' group as well. Statistically, half of the chronic pain that exists in whiplash patients is independent of having had an initial physical injury.

The findings of this study also suggest that when a physician encounters a patient who is not to blame for an accident and who is feeling angry, the physician should very clearly advise that entering a claim will adversely affect the patient's health and is more likely to lead to chronic pain.

Mayou, R. & Bryant, B. (2002) Psychiatry of whiplash neck injury. *British Journal of Psychiatry*, **180**, 441–448.

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Authors' reply: Drs Kwan and Friel make familiar general points about the interpretation of prospective research. However, they underestimate the practical, methodological and ethical difficulties of obtaining and using medical records and of qualifying information about life events. It is also worth noting that in medico-legal practice it is very common for medical experts and lawyers to disagree about the significance of medical histories and of life events following the identified trauma.

Dr Ferrari's first paragraph over-interprets multivariate analysis dependent on statistical significance in concluding that initial anger or anger cognitions are early predictors of pain in claimants. Although there are some differences between claimants and non-claimants, our overall experience in this study, and in a previous paper which followed up claimants for 6 years, is that the two groups are very similar (Bryant *et*

al, 1997). The research findings, together with clinical experience, indicate that litigation is one of a number of reminders of the accident which do result in subjects focusing on their aches and pains. Further accidents, continuing medical complications and persistent financial difficulties are probably other important factors acting in a similar manner.

Fourteen per cent of accident victims with no recorded injury in the emergency department had pain at 3 months which was attributed to the accident. Perhaps the most likely explanation is that these people suffered minor musculo-skeletal injuries but that the symptoms did not become significant for hours or days after the accident. This is well described in relation to whiplash neck injury. It is therefore incorrect for Dr Ferrari to use our evidence to draw conclusions about the extent to which pain reported by whiplash patients may be independent of physical injury.

I also strongly disagree with Dr Ferrari's final conclusion that patients who are not to blame but angry should be advised not to enter a claim. The financial and other losses may be considerable and compensation desirable and even necessary. The more appropriate conclusion is that medical and legal procedures should take account of the patient's reactions and beliefs, avoid increasing distress and attempt to provide a sympathetic and rapid resolution of both the medical and the legal issues.

Bryant, B., Mayou, R. & Lloyd-Bostock, S. (1997) Compensation claims following road accidents: a six-year follow-up study. *Medicine, Science and the Law*, **37**, 326–336.

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Regional selectivity of novel antipsychotics

Xiberas *et al* (2001) measured D₂ receptor occupancy in striatum, thalamus and temporal cortex in patients treated with haloperidol, risperidone, amisulpride, clozapine and olanzapine. On the basis of their findings, they conclude that in the striatum and in the thalamus atypical antipsychotics induce a significantly lower D₂ binding index than haloperidol does. Their results are consistent with previous studies showing only small differences between striatal and temporal cortex blockade by traditional compounds and relatively selective D₂