Correspondence

In-patient *v.* out-patient status

Sir: In his article, 'New community mental health law: the conditional discharge model' (*Psychiatric Bulletin*, April 1999, **23**, 195–198) Dr Phillip Sugarman states that the Hallstrom case (1986) established that the renewal of detention of patients on (Section 17) leave was illegal. Readers should be aware of Mr Justice Richards ruling in the case R *v.* The Managers of Warley Hospital (Brentwood, Havering and Barking Community Healthcare Trust) and Dr Jason Taylor (May 1998).

In this case, the patient, who was admitted with a drug-induced psychosis and following setting fire to her home, was granted extended periods of Section 17 leave while being reviewed weekly on the ward round and being detained under Section 3 of the Mental Health Act on the grounds of mental illness and psychopathic disorder. The patient was in receipt of oral antipsychotic medication and agreed to take this. Restraint from alcohol and recreational drug usage were stipulated by the Section 17 leave form. At the time of renewal of the Section 3 order the patient was having four nights a week leave and staying with reliable friends in the community, having no independent accommodation. The Section 17 leave was gradually extended to seven days over a six-week period. Efforts were made to find an appropriate staffed hostel. Almost four months after the renewal of her Section 3 order the patient again took amphetamines and was readmitted, floridly psychotic.

There was an unsuccessful legal challenge to the renewal of the Section 3 order. In his judgement, Mr Justice Richards took the view that the Hallstrom and Gardner cases (1986) represented an extreme end of a spectrum and that in these circumstances the patients were clearly best regarded as out-patients rather than in-patients. He stated: "whether a patient who has temporary leave of absence is an in-patient or out-patient will often be one of fact and degree." The patient concerned was being prepared as part of a programmed approach to gradually reintroduce her into the community while attempting to reduce the risk factors. Mr Justice Richards also expressed the view that the matter must be looked at broadly and that the presence of the patient overnight on the ward prior to the ward round, the urinalysis and the availability of in-patient therapies could not be whittled away piecemeal in such a manner as to produce a result in which there is, in truth, no in-patient treatment at all.

The ruling is interesting in that it attempts to help delineate the nature of what constitutes in-patient (whereby a patient continues to be detained and is not merely liable to be detained) versus out-patient status and takes a global view of a treatment approach targeted at gradual community reintegration while accepting that in such circumstances renewal of Section 3 orders while a patient was on moderately substantial Section 17 leave with weekly ward round review was lawful.

References

R *v.* Hallstrom and another ex parte W (1986) QB, 1090.

R *v.* Gardner and another ex parte L (1986), ALL ER, 306.

R. *v.* The Managers of Warley Hospital ex parte Barker (1998) COD, 309.

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Institutional racism in psychiatry

Sir: Hickling & Hutchinson (*Psychiatric Bulletin*, March 1999, **23**, 132–134) have provoked a debate in the commentaries on their paper about the influence of racism on mental health. Irrespective of causal links between the two, there remains the issue of how racism in psychiatry and the wider health service can be combated. The definition used in the report of the Stephen Lawrence Inquiry (MacPherson, 1999) may help in clarifying the nature of institutional racism: "the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin." Using this definition, institutional racism has been shown to exist both in the delivery of mental health services and within the medical profession (Parkman *et al*, 1997; Esmail *et al*, 1998). Surely the Royal College of Psychiatrists must have a role to play: can the College demonstrate that it is taking the issue of institutional racism seriously and if not, why not? A simple first step would be for the College to determine if there is any racial bias in the awarding of fellowships.

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References

ESMAIL, A., EVERINGTON, S. & DOYLE, H. (1998) Racial discrimination in the allocation of distinction awards? Analysis of list award holders by type of award, specialty and region. *British Medical Journal*, **316**, 193–195.

MACPHERSON, W. (1999) *The Stephen Lawrence Inquiry*. London: The Stationery Office.

PARKMAN, S., DAVIES, S., LEESE, M., *et al* (1997) Ethnic differences in satisfaction with mental health services among representative people with psychosis in South London: Prism Study 4. *British Journal of Psychiatry*, **171**, 260–264.

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Sir: Hickling & Hutchinson (*Psychiatric Bulletin*, March 1999, **23**) are to be congratulated on their attempt to link the experience of racism to mental illness for a general psychiatric publication. Yet, apart from Fanon, there is nothing so very new in this (Parker & Kleiner, 1975; Royer, 1977; Littlewood, 1981; Adebimpe, 1984). Where they have failed is in not suggesting any intermediate pathways between a social and political situation and the neuropsychological consequences of what psychiatry takes as schizophrenia. Not an easy undertaking admittedly: though the apparent high rates in Irish and Maori people, and other groups, might suggest something which links politics to self-depreciating identity via language use.

The authors use of 'pejorative' is puzzling given that they themselves consider an identity as a 'psychosis'. My account of *tabanka* in Trinidad was to show how this type of sexual desertion was locally construed as a form of illness (Littlewood, 1993). Indeed in the early 1980s it was common for country people to maintain there was a ward in the state psychiatry institution specifically for victims of *tabanka*.

References

ADEPIMPE, V. R. (1984) American blacks and psychiatry. *Transcultural Psychiatric Research Review*, **21**, 83–111.

LITTLEWOOD, R. (1981) Anthropology and psychiatry: an alternative approach. *British Journal of Medical Psychology*, **53**, 213–225.

— (1983) *Pathology and Identity: The Work of Mother Earth in Trinidad*. Cambridge: Cambridge University Press.

PARKER, S. & KLEINER, R. (1975) *Mental Illness in the Urban Negro Community*. New York: Free Press.

ROYER, J. (1977) *Black Britain's Dilemma*. Roseau: Tropical Printers.

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Sir: Hickling & Hutchinson's (*Psychiatric Bulletin*, March 1999, **23**, 132–134) criticism of international classification systems is erroneous. Such diagnostic systems have been internationally piloted (Sartorius *et al*, 1988) and the resulting consensus accounts for the priority given to form rather than content. Thus, the symptomatic concerns of patients from all cultures may map poorly onto rigid diagnostic guidelines. In this and other respects, the proposed 'roast breadfruit psychosis' resembles the descriptions of de Clérambault's, Capras and Othello syndromes (Enoch & Trethowan, 1979). They represent human beliefs and behaviours, which only become classifiable when exaggerated to a psychotic degree. The memorable and symbolic themes of such syndromes make them a favourite of examiners, the topic of coffee room discussions and the inspiration for works of fiction (McEwan, 1998). This attention is, perhaps, out of proportion to their prevalence.

Diagnosis should be a synthesis of classification and understanding. By proposing a content-based diagnostic category, the authors are asking mental health professionals to risk ignoring the meaning of patient's complaints; to act as an arbitrator of cultural authenticity and to adopt a term of intra-racial abuse as an eponym. Do the authors expect that use of the term roast breadfruit syndrome will improve the relationship of psychiatrists and African–Caribbean patients?

References

ENOCH, M. D. & TRETHOWAN, W. H. (1979) *Uncommon Psychiatric Syndromes*. Bristol: John Wright and Sons.

MCEWAN, I. (1998) *Enduring Love*. London: Vintage.

SARTORIUS, N., JABLENSKY, A., COOPER, J. E., *et al* (eds) Psychiatric classification in an international perspective. *British Journal of Psychiatry*, **152** (suppl. 1), 1–52.

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Replicating mistakes in Aboriginal mental health

Sir: Dr Laugharne, in his article about working with an Aboriginal community in Australia (*Psychiatric Bulletin*, February 1999, **23**, 111–113), shows great sensitivity and insight into the historical, political and social context that

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