property is kept in good order, that buildings are insured, and tax affairs dealt with. They can apply to use capital to pay for nursing home or similar care or to maintain the patient at home. They can also apply for special authority to make loans and investments on the patient's behalf or to buy a piece of special equipment or furniture for the patient's benefit.

Living wills (advance directives)

Powers of attorney and the Court of Protection deal only with material assets. Living wills are concerned with decisions about treatment, especially at the end of life. A person in sound mind might stipulate that, should he or she become incapable of decisions and develop particular grievous illnesses, then certain treatments should, or should not, be given.

In the United Kingdom "living wills" have no legal force. But they have moral force in such issues as relief of pain, the vigour of treatment in terminal disease, or in resuscitation decisions. Views of relatives, close friends, or appointed attorneys carry moral force if they are based on evidence of what the likely wishes would have been when the patient was well.

Various drafts of advance directives are available, and an excellent book considers the subject in detail (see below).

Research

Questions of consent to research on severely demented people (as on children) remain problematic. Again, consent of close relatives is always desirable, but has no legal force. Ethics committees understandably find these issues difficult.

Practical points

- "Advance directives" have no formal place in English law, but are part of the current agenda of active debate. In the absence of precise legal provision, the doctor must, as in all things, be seen to act in good faith, taking into account any evidence of what the patient would have wished had he or she had the capacity validly to indicate this.
- The Alzheimer's Disease Society now has an agreement with Lawnet, a group of solicitors who offer a named person specialising in the type of advice carers need. There is a fee, but people referred by the Society may receive an initial half hour consultation free of charge.

Further information

The Public Trust Office (Protection Division, Stewart House, 24 Kingsway, London WC2B 6JX, tel 0171 269 7000) makes available a *Handbook for Receivers* and a booklet of *Guidance on Enduring Powers of Attorney*. Similarly, the Court of Session (Meldrum House, 15 Drumsheugh Gardens, Edinburgh EH3 JQG, tel 0131 220 1898) in Scotland provides a booklet of *Information for Families of Persons Subject to Curatory*.

A detailed consideration of "living wills" is given in *Let Me Decide: The Health Care Directive that Speaks For You When You Can't* by W Molloy and V Mepham, published by Penguin in 1993.

The rise of counselling and the return of alienism

Simon Wessely

Current services for those with mental disorders show two trends. Psychiatric services are becoming concentrated on the care of those with "severe mental illness," largely (but unjustifiably) synonymous with chronic psychosis. The retreat of psychiatry from the care of those with non-psychotic mental disorders has helped the growth of counselling services for these patients. However, there is no evidence that non-directive counselling is effective for such disorders, in contrast to the evidence for the effectiveness of other treatments that are usually delivered by psychologists or community psychiatric nurses. By retreating from the concerns of general practice and general medicine, psychiatry is returning to the days of alienism: in Victorian terms, the care of "the mad." Possible consequences include increasing expectations of psychiatric services that cannot be met, a loss of skills within psychiatry, and increased demoralisation in the mental health services.

Department of Psychological Medicine, King's College School of Medicine and Institute of Psychiatry, London SE5 8AF
Simon Wessely, *reader*

BMJ 1996;313:158–60

According to recent media stories, British psychiatrists are becoming concerned that scarce resources are being diverted away from the care of seriously mentally ill patients and instead are being given to unnecessary and inappropriate services such as counselling. One headline caught the flavour of the debate—"Worried well force aside the mentally ill."[1] Advocates of counselling respond to such charges with vigour, pointing to the popularity of counselling and claiming that such services can prevent mental disorder and reduce the use of other hard pressed services.

At issue is a fundamental question about mental health services. How can we balance the competing, and often contradictory, requirements of need, demand, and effectiveness? Who really is in need? Who best is able to meet that need? Should patients always get what they want anyway?

These issues have been brought to attention by two changes. The first is the rise in the availability of couns-elling services; the second is the shift of psychiatry towards community care and the perceived hazards of that shift. These two developments are linked, and the increasing preoccupation of psychiatry solely with the care of patients with chronic psychosis has directly influenced the rise of counselling, without benefiting either the profession or most of those with mental disorder.

Counselling is popular, but is it effective?

The rise of counselling has attracted both attention and criticism. A recent editorial pointed to the general practice contract, the desire of general practitioners to reduce their workload, and the popularity of counselling as setting the stage for "an explosion of counselling."[2] Having joined the ranks of others who noted the lack of evidence for the efficacy of counselling ,[3-5] the authors concluded that "all counsellors in primary care should be properly trained, supervised, and supported,"[2] goals which have the energetic support of organisations such as the British Association for Counselling.[6] However, it seems logical to consider issues of efficacy and effectiveness before those of support and training. A properly trained and supervised person who delivers an ineffective treatment is hardly a sign of progress.

THE EVIDENCE FOR COUNSELLING

The evidence in support of counselling is scarce for several reasons. Defining the nature of the intervention is far from easy.[7] A recent book emphasised the importance of a single coherent theoretical model for counselling but made it clear that this model could be based on such radically different (and occasionally opposing) concepts as behaviour therapy, existential counselling, and psychodynamics and still remain within the meaning of the term counselling.[8] A term with so many meanings becomes, if not meaningless, then certainly impossible to assess. In one recent evaluation the counsellor provided not only brief psycho-dynamic therapy but also cognitive behavioural treatments for anxiety and depression, albeit without having had the relevant training.[9] Such diversity of theory is reflected in the diversity of the backgrounds of most counsellors.[3 7]

Attempts to unify these diverse approaches are unconvincing. General descriptions such as "providing an opportunity for the client to work towards living in a more satisfying and resourceful way"[6] are more mission statements than descriptions of treatment. Listening and empathic skills, frequently cited as a generic part of all counselling, are part of the job description of every health professional. For all these reasons the paucity of randomised controlled trials is not surprising, but of concern. Those that exist are rarely of adequate standard[5 10] and can be flawed by short and incomplete follow up.[11] Adverse effects are rarely considered.[5]

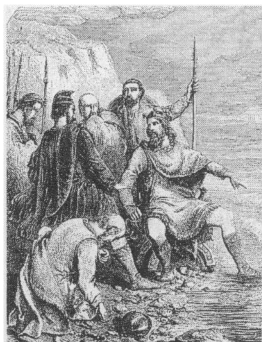
Are such cautions merely professional backbiting and "turf" disputes? People like talking about their problems, and if the listening ear is now provided by a counsellor rather than a priest or family doctor, should we be concerned? If better treatments exist, then the answer must be yes. Counsellors currently see a vast range of mental health problems—a recent paper listed anxiety, depression, marital problems, physical illness, abnormal grief, habit disorders, sexual problems, marital problems, obsessive compulsive disorder, personality disorder, and child sexual abuse.[9] Data from randomised controlled trials suggest that specific psychological treatments, such as cognitive therapy, behaviour therapy, brief psychodynamic therapy, and brief interpersonal therapy, can be effective for these disorders (with the possible exception of the last two conditions). It seems improbable that counselling will prove superior to more directive treatments for obsessive compulsive disorders, habit disorders, phobias, and sexual problems.

Some claim that counselling is effective because it reduces the use of antidepressants and referrals to other mental health professionals. In a recent study one of the claimed benefits was a 60% reduction in the use of antidepressants.[9] Such claims have not been confirmed,[12-14] but replacing an intervention of proved efficacy with one whose efficacy is much in doubt is not a satisfactory outcome measure, nor is a simple reduction in referrals to other professionals unless accompanied by improved efficacy and lower cost.

WELL DESIGNED TRIALS ARE NEEDED

Randomised controlled trials have provided evidence for the effectiveness of several of the psychotherapies but have yet to do the same for non-directive counselling. Such evidence may be forthcoming, but not from studies of "counselling" for "emotional problems." Instead what are needed are well designed trials for specific conditions using defined personnel.[15] Such studies are currently being funded by the Health Technology Assessment Programme and the Mental Health Foundation.

Even if a therapy works in a randomised controlled trial that does not mean it will always work elsewhere,[16] particularly if given by therapists with less experience and supervision.[17 18] Cognitive behaviour therapy given by a skilled clinical team is effective in the management of chronic fatigue syndrome,[19] but an unskilled therapist attempting the same might do more harm than good. The finding that much counselling is currently delivered by enthusiastic but unskilled and unsupervised staff,[20] or that less than 20% of counsellors working with cancer patients have any formal qualifications,[3] must be of concern.


MEPL

Trying to stop the spread of unstructured counselling services in general practice

We await the conclusions of the NHS Executive's strategic review of psychotherapy services, but the current growth of unstructured counselling services in general practice is unlikely to find much favour. Despite that, attempting to limit their spread is likely to appeal only to King Canute, since even if the case for counselling remains unproved, there can be no doubting its popularity.[5 21] Why?

What should psychiatric services do?

What psychiatric services should do may lie in the nature of modern psychiatry. Supporters of counselling sometimes make a point of distancing it from psychiatry, which is frequently seen, however unfairly, as authoritarian and stigmatising. The source of that stigma is not hard to find—it is the stigma of "insanity," since psychiatrists are concerned with the care of psychotic patients. This is their right and proper business. The effectiveness of modern drug treatment for the psychoses is beyond dispute, and there is increasing recognition of the effectiveness of non-drug treatments in preventing relapse.[22] However, despite the public image, psychosis has not been the only business of psychiatry. Unfortunately, some recent developments seem likely to bring the future practice of psychiatry more into line with public perception.

TARGETED RESOURCES

In the past few years government policy and influential sections of the profession have united to promote the concentration of resources on what has become known as "severe mental illness." Targeting resources at those most in need is the health services planners' version of motherhood and apple pie—who could dispute the wisdom of this approach? But there are two major drawbacks. Firstly, targeting resources onto a small number of people at the expense of the larger numbers of those with other mental disorders that may be more amenable to treatment is not necessarily a valid public health strategy.[23] Secondly, severe mental illness is increasingly equated with psychosis alone—of the four definitions provided in the key area handbook published by the Department of Health, three concern psychosis alone; one also includes major depression.[24] This tendency to equate severe mental illness with psychosis is not justifiable individually or epidemiologically. Patients with panic, phobic, and obsessive compulsive disorders typically have been ill for many years before presentation—years during which they may have been unable to undertake the simplest task such as shopping, socialising, or work.[25] Patients with chronic somatisation disorders have few equals in terms of personal morbidity and cost to the health service,[26] and depression and eating disorders are associated with both morbidity and mortality.

WHAT ABOUT NON-PSYCHOTIC MENTAL PATIENTS?

The obsession with severe mental illness means that psychiatry is in danger of withdrawing from the care of non-psychotic patients with mental disorder. While acknowledging the drawbacks of creating a "psychosis only" service, the director of the research unit of the Royal College of Psychiatrists recently stated that to solve the bed crisis in inner city psychiatry, necessary measures would include cutting such provisions as "outpatients clinics for new referrals from primary care, community psychiatric nurses working in primary care settings, and psychotherapy services."[27] That there is a

crisis can hardly be denied, but is that the best solution? It is only recently that psychiatrists and psychologists have recognised the burden of illness in primary care.[28 29] Withdrawing such services may reduce any influence the profession might have across the range of mental disorder—in developing new treatments for all types of mental disorder, teaching the skills necessary to carry them out, and ensuring that such treatments are appropriately evaluated.

Between them, both counselling and psychiatry are now failing many of those with mental disorders. Until better evidence of efficacy is provided, we must ensure that the growth in counselling does not divert resources away from access to such treatments as behaviour therapy, interpersonal therapy, or cognitive therapy that require rather more than a year of experiential training for effective delivery. Psychiatry is also failing patients. King and colleagues noted that inappropriate referrals to practice counsellors came about not because of a misguided belief in their effectiveness but because the lack of local psychiatric services left the general practitioner with little choice.[7] This reflects the increasing emphasis on the care of the long term psychotic patient, reinforced by government directive and the move to community care.

Victorian values and the demoralisation of psychiatry

The consequence of these changes will be an inevitable reduction of the scope of psychiatry, the skills necessary to practise psychiatry, and indeed the attraction of a psychiatric career. Current policy has increased the pressures on the profession, as shown by the seemingly endless stream of public inquiries (15 are currently in progress) into the "failures" of that policy,[30] despite a lack of evidence of any change in the risk to the public posed by mentally ill people.[31] At a time when the need for psychiatry to remain part of medicine is acute,[32] the profession is retreating from the general hospital and the general practitioner. Instead psychiatrists are being pressured to deliver the undeliverable—a service in which "failures" such as violent assaults and suicide never happen—and hence a service which will be blamed when they do.[30] Whether such policies will lead to discernable health gain remains to seen. What is now being seen is a fall in staff morale[33] and the current difficulties faced in staffing many psychiatric services.

The increasing equation of psychiatry with psychosis —and only psychosis—marks a return to the world of Victorian psychiatry. The great asylums may be gone, but alienism is coming back. In these circumstances it is not surprising that the public and general practitioners will turn to the increasing numbers of counsellors who appear to minister to every ill.

I am grateful to Chris Dare, Tony David, Mike King, Paul Lelliott, Anthony Mann, Matt Muijen, and Glenys Parry for help and advice.

Source of funding: None.
Conflict of interest: None.

1 Aitkenhead D. Worried well force aside mentally ill. *Independent on Sunday* 1995 Dec 10:5.
2 Pringle M, Laverty J. A counsellor in every practice? Reasons for caution. *BMJ* 1993;**306**:2-3.
3 Fallowfield L, Roberts R. Cancer counselling in the United Kingdom. *Psychol Health* 1992;**6**:107-17.
4 The treatment of depression in primary care. Leeds: University of Leeds, 1993. (Effective Health Care No 5.)
5 Corney R. The effectiveness of counselling in general practice. *Int Rev Psych* 1992;**4**:331-8.
6 British Association for Counselling. *Code of ethics and practice for counsellors.* Rugby: BAC, 1993.
7 King M, Broster G, Lloyd M, Horder J. Controlled trials in the evaluation of counselling in general practice. *Br J Gen Pract* 1994;**44**:229-32.
8 Dryden W, Horton I, Mearns D. *Issues in professional counsellor training.* London: Cassell, 1995.
9 Burton M, Sadgrove J, Selwyn E. Do counsellors in general practice surgeries and clinical psychologists in the National Health Service see the same patients? *J R Soc Med* 1995;**88**:97-102.
10 King M. Counselling services in general practice: the need for evaluation. *Psych Bull* 1994;**18**:65-7.
11 Boot D, Gillies P, Fenelon J, Reubin R, Wilkins M, Gray P. Evaluation of the short term impact of counselling in general practice. *Patient Education and Counselling* 1994;**24**:79-89.
12 Fletcher J, Fahey T, McWilliam J. Relationship between the provision of counselling and the prescribing of antidepressants, hypnotics and anxiolytics in general practice. *Br J Gen Pract* 1995;**45**:467-9.
13 Sibbald B, Addington-Hall J, Brenneman D, Freeling P. Investigation of whether on-site general practice counsellors have an impact on psychotropic drug prescribing rates and costs. *Br J Gen Pract* 1996;**46**:63-7.
14 Pharoah P. Do counsellors in general practice change the prescribing of hypnotics and anxiolytics? *J Prim Care Psychiatry* 1995;**1**:263-4.
15 Holden J, Sagovsky R, Cox J. Counselling in a general practice setting: controlled study of health visitor intervention in treatment of postnatal depression. *BMJ* 1989;**298**:222-6.
16 Pringle M, Churchill R. Randomised controlled trials in general practice. *BMJ* 1995;**311**:1382-3.
17 Weisz J, Donenberg G, Han S, Weiss B. Bridging the gap between laboratory and clinic in child and adolescent psychotherapy. *J Consult Clin Psychology* 1995;**63**:688-701.
18 Garfield S. Some problems with "validated" forms of psychotherapy. *Clinical Psychology: Science and Practice* (in press).
19 Sharpe M, Hawton K, Simkin S, Surawy C, Hackmann A, Klimes I, *et al.* Cognitive behaviour therapy for chronic fatigue syndrome; a randomised controlled trial. *BMJ* 1996;**312**:22-6.
20 Sibbald B, Addington-Hall J, Brenneman D, Freeling P. Counsellors in English and Welsh general practices: their nature and distribution. *BMJ* 1993;**306**:29-33.
21 Scott A, Freeman C. Edinburgh primary care depression study: treatment outcome, patient satisfaction, and cost after 16 weeks. *BMJ* 1992;**304**:883-7.
22 Mari J, Streiner D. The effects of family intervention for those with schizophrenia [revised 21 July 1995]. In: Adams C, Anderson J, Mari J, eds. *Schizophrenia module.* 2nd ed. Oxford: Update Software, 1995.
23 Shah A. The burden of psychiatric disorder in primary care. *Int Rev Psych* 1992;**4**:243-50.
24 Department of Health. *Key area handbook: mental illness.* 2nd ed. London: HMSO, 1995:99.
25 Marks I. *Fears, phobias and rituals.* New York: Oxford University Press, 1987.
26 Fink P. The use of hospitalizations by persistent somatizing patients. *Psychol Med* 1992;**22**:173-80.
27 Lelliott P, Audini B, Darroch N. Resolving London's bed crisis: there might be a way, is there a will? *Psych Bull* 1995;**19**:273-5.
28 Strathdee G, Williams P. A survey of psychiatrists in primary care: the silent growth of a new service. *J R Coll Gen Pract* 1984;**34**:615-8.
29 Corney R. Developing mental health services in the community: current evidence of the role of general practice teams. *J R Soc Med* 1994;**87**:408-10.
30 Eastman N. Towards an audit of inquiries: enquiry not inquiries. In: Peay J, ed. *Inquiries after homicide.* London: Duckworth, 1996:147-72.
31 Wessely S, Castle D, Douglas A, Taylor P. The criminal careers of incident cases of schizophrenia. *Psychol Med* 1994;**24**:483-502.
32 *The psychological care of medical patients: recognition of need and service provision.* London: Royal College of Physicians and the Royal College of Psychiatrists, 1995.
33 Onyett S, Pillinger T, Muijen M. *Making community care work.* London: Sainsbury Centre for Mental Health, 1995.

(Accepted 10 May 1996)

ONE HUNDRED YEARS AGO

LADY CANVASSERS

A NOVEL feature in the present contest for the election of Direct Representatives for England on the General Medical Council is the interest apparently taken in the contest by ladies. We have received from various sources, we will not say complaints, but communications which might have been complaints had the canvassers been less agreeable, of the ardour displayed by the fair friends of one or other candidate in seeking promises of support. We are not altogether sure that this intervention is calculated to serve the cause of the candidates whose interests the fair canvassers have at heart. We suspect that, male human nature being what it is, there is a tendency to resent these solicitations as an intrusion on the right of private judgment, and an imitation of political methods which are hardly in consonance with the dignity of a professional electorate.