

diseases.¹² In Zimbabwe, USAID and Development Alternatives have pilot projects employing micro-enterprise and microfinance programmes to respond to areas with high prevalence of HIV/AIDS.¹³ Although these programmes require evaluation, they recognise that gender inequalities exacerbate women's vulnerability to HIV infection. The response focuses on enhancing women's educational and economic opportunities.^{12 13} Individual freedom is at the core of each of these strategies, and public policies that create conditions in which individuals can exercise their ability to live the life they value are essential.

Finally, at the collective level, human freedom is essential to policy change and political action and must be enabled through guaranteed human rights and democratic institutions. Collective action—a group's ability to advance and effectuate change—in the political process and public sphere is important for shaping public policy about HIV/AIDS. In the United States, for example, AIDS activists collaborated through numerous organisations to influence values about HIV/AIDS (namely, reducing stigma and discrimination and increasing prioritisation) and to advocate for their own interests (namely, treatment of AIDS) in public decisions.¹³ Many argue that such advocacy has been so effective in the United States that AIDS assumes a priority that is beyond what its prevalence would warrant. The HIV/AIDS problem in developing countries is surmountable—and the scientific community has identified many of the necessary components to the solution.¹² Many of the remaining barriers to success—political will, social commitment, vision, and action—however, relate to problems of collective

action. National and global institutions must be reoriented to function more democratically and inclusively and be driven by the interests of individuals and groups they serve. This transition will require more than raising funds and targeting benefits. It calls for expanding the voice and power of all people, especially those with HIV/AIDS in developing countries, to advocate for their interests, shape their destiny, and help themselves and each other.²

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Compulsion and psychiatry—the role of advance statements

Liberation cannot be handed to the oppressed by the oppressor

Most psychiatrists accept reluctantly that from time to time they need to force patients to have treatment against their wishes. The British government's proposed changes to the Mental Health Act will increase compulsion in three ways. They will remove the requirement that a patient's condition must be severe enough to warrant admission to hospital, thus enabling compulsory treatment in the community; they will re-incorporate people with personality disorder; and they will introduce wider definitions of mental disorder and of treatment. Users of mental health services have long been concerned about compulsion and have tried to combat it. Twenty years ago groups such as Survivors Speak Out pioneered the use of crisis cards as a way of resisting compulsion in mental health emergencies. More recently, partly in response to the proposed legislation but also as part of a growing critical debate within the profession, psychiatrists have turned to advance statements (or advance agreements if made consensually with a mental health professional), in the hope that these will reduce compulsion and facilitate a more col-

laborative engagement with service users.^{1 2} An advance statement is a declaration made by a service user about preferences for treatment should future episodes of psychosis impair capacity. However, as no evidence exists for such interventions, the paper by Henderson et al in this issue is welcome (p 136).³

They found that patients who had joint care plans—a form of advance statement about care—were less likely to experience compulsion and spent fewer days detained in hospital than the control group. These results conflict with those from the only other study in this area. Papageorgiou et al found that advance statements had no impact on the outcome of care in terms of frequency of compulsory readmission or days spent in hospital.⁴ A striking feature of both studies is the high proportion of eligible patients who failed to make it to randomisation (Henderson et al, 66%; Papageorgiou et al, 73%).

Although joint care plans and advance statements differ, they share a collaborative approach to planning care in order to minimise compulsion. Despite this, many patients in both studies decided not to

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participate. This mirrors our experience in Bradford.⁵ Although a few people had negotiated advance statements individually with their consultants, two years of extensive development work with service users and mental health professionals generated a disappointingly low uptake of advance statements. Of 70 service users who attended presentations on advance statements only one took up the opportunity. This is puzzling. Attempts to reduce compulsion and increase the involvement of users in their care are noble objectives. Why are service users reluctant to get involved?

There are many possible reasons for this. Most people dislike making wills because to do so acknowledges the reality of death. Similarly service users may be reluctant to plan ahead because they prefer to deny the possibility of readmission. We want to focus on two ways of understanding this reluctance. The first concerns the appropriateness of using randomised controlled trials to evaluate complex interventions where it may be difficult to specify the active components, making replication difficult.⁶ The outcome of such interventions depends on contextual factors and how the participants interpret these. Joint care plans and advance statements are complex social interventions that occur in an intricate web of personal and professional relationships that are characterised by contested and competing values. Who had control of the processes of selection and initiation of joint care plans—service users or research staff? What training, preparation, and development work took place with users and staff? Meyer points out that action research is a more suitable method in such situations.⁷ The participatory nature of action research engages research subjects actively in the research processes of deciding the research questions, design, and implementation. It is more “democratic” than positivistic research and thus capable of taking different interests into account. The Bradford project used action research but still failed to enthuse service users. This implies a more fundamental problem relating to power and powerlessness.

Psychiatry, unlike any other branch of medicine, is the only specialty in which treatment is regularly given for extended periods against the person's wishes. Many service users do not consider themselves ill, yet find themselves forced to take medication. Another way of understanding the reluctance of service users to plan

ahead is that they feel demoralised, disempowered, and oppressed by years of compulsion in the mental health system. We must be circumspect in hoping that interventions such as advance statements will change the situation. Psychiatrists are not the only oppressors; we include here the panoply of state control of deviance, stigmatisation by society, and our collective social intolerance of difference. As psychiatrists we have a duty to engage with our patients' painful social realities while grasping positive opportunities, as Henderson et al have done, for more collaborative ways of working.³

Against the wider political context psychiatrists and mental health professionals are right to fear the effect that increased compulsion will have on their relationships with service users, but the idea that we can soothe the pain of greater compulsion with the balm of advance statements is simplistic. Liberation, as Paulo Freire put it, cannot be handed to the oppressed by the oppressor,⁸ but we must continue to work with service users to make greater freedom a possibility for them. This is why advance statements and joint care plans are so important.

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Spiritual needs in health care

May be distinct from religious ones and are integral to palliative care

Spiritual needs change with time and circumstances. The National Institute for Clinical Excellence guidance, *Supportive and Palliative Care for Adults with Cancer*, published in March 2004, acknowledges this and recommends that healthcare teams ensure accurate and timely evaluation of spiritual issues through regular assessment. This reflects the increasing emphasis on spirituality as a factor contributing to wellbeing and coping strategies.¹⁻⁴ A proliferation of textbooks and book chapters with titles containing the word “spirituality” seek to elucidate

what spiritual care is, how it might be assessed, and how needs might be met.⁵ However, a lack of consensus remains as to what spirituality actually is.⁶

Some key words occur quite regularly in the various descriptions of spirituality in journals and textbooks (box). In health research we should differentiate between the terms spiritual and religious since, if they are used interchangeably, reports of spirituality may be describing religious practice and affiliation.^{7,8} These can be interrelated. Spiritual belief may or may not be religious, but most religious people will be spiritual. A