columns

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Community psychiatry in developing countries – Sri Lanka

Sir: We have read the article "Community psychiatry in developing countries – a misnomer?" (Farooq & Minks, *Psychiatric Bulletin*, June 2001, **25**, 226–227) with interest.

The content of the article is also very relevant to our country. The majority of patients live with their families and it is in this setting that almost all psychiatrists (grossly inadequate in number for the entire population) practise. A few reasonably organised community rehabilitation centres are available only in the major cities.

We agree fully that psychiatry in developing countries should be rooted in primary health care. With this in mind, the state health authorities in Sri Lanka have taken measures to place medical officers with a basic training in psychiatry in the hospitals, where there are no qualified psychiatrists, and the medical schools too have laid a greater emphasis on giving better training in psychiatry for undergraduates.

However, adopting the term 'primary care psychiatry' would not be prudent because primary care implies a basic level of care available to all (Declaration of Alma Ata) and would not include the greater degree of services that will have to be provided for those with psychiatric illness who live in the community. In this sense, the service provided should be more in line with the principles of community psychiatry, albeit somewhat different from that implemented in developed countries.

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Lithium non-adherence

Sir: MacCleod and Sharp's attention to lithium non-adherence is welcome (*Psychiatric Bulletin*, May 2001, **25**, 183–186). I have concerns, however, that the authors' conclusion may instil complacency, given that they state that "all patients were defined as currently compliant".

The study uses a definition of non-compliance that requires both subjective and objective criteria to be fulfilled. A patient is then deemed 'compliant' by default if they do not meet both sets of criteria. Thus, for instance a patient in the study could have no measurable lithium in his or her serum at all but be deemed 'compliant' because he or she and his/her psychiatrist judge him or her to be so. Clinicians' judgements of patients' compliance have been found wanting in almost every study in which they have been tested. In fact the sensitivity of clinical judgement for detecting non-compliance has been quoted as an embarrassing 10% (Stephenson *et al*, 1993).

The authors have not cited any of the work in this field in the past 10 years. In a recent study of compliance in lithium clinics (Schumann *et al*, 1999) it was noted that 53.9% of patients discontinued lithium prophylaxis at some time. Even more striking is the finding that 76 days is the median duration of continuous lithium adherence before patients elect to discontinue treatment (Johnson & McFarland, 1996).

Given the potentially catastrophic outcomes of medicine non-adherence in major mental illness there remains a priority to identify strategies that will enhance adherence with the medicines we prescribe.

JOHNSON, R. E. & McFARLAND, B. H. (1996) Lithium use and discontinuation in a health maintenance organization. *American Journal of Psychiatry*, **153**, 993–1000.

SCHUMANN, C., LENZ, G., BERGHÖFER, A., *et al* (1999) Non-adherence with long-term prophylaxis: a 6-year naturalistic follow-up study of affectively ill patients. *Psychiatry Research*, **89**, 247–257.

STEPHENSON, B. J., ROWE, B. H., HAYNES, R. B., *et al* (1993) Is this patient taking the treatment as prescribed? *Journal of the American Medical Association*, **269**, 2779–2781.

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That 'Praecox feeling'

Sir: 'Anonymous' (*Psychiatric Bulletin*, July 2001, **25**, 275) should not be too worried that his or her children will develop schizophrenia. The Finnish adoptive family study (Tienari *et al*, 1994) suggests that the genetic risk is buffered by a happy family.

TIENARI, P., WYNNE, I. C., MORING, J. *et al* (1994) The Finnish adoptive family study of schizophrenia. Implications for family research. *British Journal of Psychiatry*, **164** (suppl. 23), 20–26.

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the college

Distinction awards

College nomination procedures in England and Wales

The Department of Health is currently undertaking a review of the procedures, operation and practice of the distinction and meritorious service award scheme. The following paper describes the College's current nomination procedure in England and Wales. It may be necessary to change this procedure when details of the new arrangements are received from the Department of Health. Further details will, therefore, appear on the College's website (http://www.rcpsych.ac.uk).

The President has identified two distinction awards advisers in each NHS region in England (apart from London, which has four advisers) and two in Wales. At least one, and often both, of the advisers will also serve on his or her regional awards committee. Statistics showing the speciality/gender/ethnic backgrounds of those consultants eligible for awards are produced each year by the College secretariat. Although awards continue to be made on merit, regions, faculties and sections are asked to consider these statistics when submitting their list of recommendations.

Towards the end of the year the distinction awards advisers in England and Wales, in consultation with the chairmen of divisions and other senior award holders, produce a list of nominations in rank order for their region. The chairmen of faculties and sections (if eligible), in consultation with senior award-holders in their faculty or section, also produce lists in rank order. Senior College officers meet to consider members who have made a significant contribution to the College. They will also consider individual nominations from College members concerned that they have been overlooked. Any College member wishing to be considered in this way should write to the College Secretary by the end of October, requesting an Advisory Committee on Distinction Awards curriculum vitae (ACDA CV) questionnaire form.

These various lists of nominations are sent to the College and are merged to

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form one composite list. This is then sent to all committee members, together with the CV questionnaires (but not the citations) shortly before the College's annual distinction awards meeting, usually held at the end of January.

The President chairs the meeting and its members consist of the honorary officers, two distinction awards advisers in each NHS region in England and Wales, the chairpersons of division, faculties and sections (if they have awards). Its task is to produce the College's final list of nominations from the composite lists produced by the regions, faculties, sections and honorary officers. The College Secretary and her personal assistant provide administrative support.

Only the names on the composite list of nominations are considered at the meeting and then only if the CV questionnaires and citations have been received in advance of the meeting. The Committee member who has made the nomination will speak briefly on behalf of each candidate. Some names are removed from the list at this stage. The Committee are given ample time to consider the paperwork, together with the relevant statistics, and finally to cast their votes.

The final list of College nominations is then submitted to the ACDA. Further information of the distinction awards procedures can be viewed at http://www.doh.gov.uk/nhsexec/acda.htm.

Vanessa Cameron Secretary, Royal College of Psychiatrists

Eating Disorders in the UK: Policies for Service Development and Training

Council Report CR87
£7.50. 64 pp.

With the collaboration of the Consumers' Association, the Eating Disorders Special Interest Group surveyed specialist eating disorder services for adults in the UK, as a follow-up to a previous survey in 1991 – Council Report CR14, Eating Disorders. We found that specialist services had increased in number since 1991 but that many areas remain without access to nearby specialist services. Many patients are sent long distances for specialist care, and adequate follow-up after such care is frequently impractical. Eating disorders are of high prevalence, representing a major source of morbidity, predominantly in young women, and the standardised mortality ratio of eating disorders is among the highest of all psychiatric disorders. There is a substantial evidence base for treatment of anorexia nervosa and bulimia nervosa, although research is urgently required to establish the most effective treatment for many groups of patients. We recommend the following action:

(a) For each area of the country, specialist services should be established, with one consultant psychiatrist per million population.
(b) These services should provide a combination of out-patient, in-patient and day patient services, with an appropriate range of therapeutic interventions.
(c) Expenditure on staffing should be approximately £1 per head of population.
(d) Steps should be taken to increase the number of consultant psychiatrists with special expertise in the assessment and treatment of eating disorders.
(e) Similar problems apply to the treatment of children and adolescents with eating disorders. Services for this group should be fully surveyed and recommendations developed for improving provision.

The Eating Disorders Special Interest Group has undertaken to develop criteria for specialist training in eating disorders in view of the particular mix of psychiatric, psychological, medical and nutritional problems faced by this severely ill group of patients. Our aim is to correct the unacceptable variation in care between different parts of the UK caused by unequal distribution of services.

Paul Robinson Chairman, Eating Disorders Special Interest Group

Fitness to drive: The Driver and Vehicle Licensing Agency and the College

Following a few high profile cases involving driving by people with both physical and mental disorders, the Driver and Vehicle Licensing Agency (DVLA) was asked by the Government of the time to review the procedures and standards to define fitness to drive. The new set of standards, as a result, was published in 1995 as the first issue of *At a Glance* (DVLA, 1995) and was sent to all practising doctors in the UK. Not surprisingly, the first issue covered controversial issues such as blanket withdrawal of the driving licence if someone had an episode of psychosis requiring in-patient hospital treatment. Justified or not, such restriction was in direct conflict with changes of policy, such as the emphasis on community care and closure of mental hospitals, thus placing more and more people with mental disorders in the community with an increased emphasis on social normalisation. Alongside this came changes to the benefit system that often influenced an individual's ability to afford to travel by public transport for social or clinical reasons. Such changes to the circumstances were occurring at a time of deregulation of buses, leading to a reduction of the level of service for remote and small communities.

The Public Policy Committee (PPC), from time to time, received notification of difficulties in patient care from College members as a result. It was clear that psychiatrists were representing individual cases directly to the DVLA, sometimes with satisfaction and sometimes not. Besides the perceived difficulties in clinical care some clinicians were concerned about a lack of clarity on whose responsibility it is to notify the DVLA regarding change to the physical and mental health of their patients.

With this background, the PPC agreed to explore the possibility of establishing a dialogue with the medical advisory department of the DVLA. The Honorary Secretary of the PPC visited the DVLA to attend the Secretary of State's advisory panel meeting and presented the College's concerns. During that visit it became very clear that:

(a) there was limited room for manoeuvre because the regulations that govern driving are approved by Parliament
(b) the DVLA's role is promulgation of these standards
(c) since the original publication, the standards have been refined and continue to be refined in the light of the experience
(d) such refinement was taking place through final approval by the Secretary of State upon receiving recommendations from the Advisory Panel.

The advisory panel on mental health matters was initially set up as a subgroup of the panel that dealt with drugs and alcohol related issues and held separate meetings. The psychiatric panel now stands alone. Currently, there exist six such advisory panels, which deal with the following areas:

(a) cardiology
(b) neurology
(c) diabetes
(d) vision
(e) alcohol/substance misuse
(f) psychiatry.

The psychiatric panel meets twice a year, including once in the autumn when the date for the next meeting is set.

The following documents outline the College's policy on driving related matters:

(a) Psychiatric standards of fitness to drive large goods vehicles (LGVs) and passenger carrying vehicles (PCVs) were published in the *Psychiatric Bulletin* in October 1993 (Royal College of Psychiatrists).

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