Correspondence

A model for managing violence in acute adult admission wards

A retrospective survey of contemporaneous electronic case records in a male psychiatric intensive care unit (PICU) in central London was carried out for 2012. The notes were scrutinised for records of serious violence where there was threat to life or limb that resulted in patients being given rapid tranquillisation and seclusion. The survey revealed that of 72 admitted individuals, 58% were responsible for this degree of behaviour. Most incidents (67%) were perpetrated in multiples by slightly fewer than 25% of all those who were admitted. This suggests an average of 3 serious incidents per patient.

In a meta-analysis on in-patient aggression,[1] a literature review shows that the estimated percentage of aggression on acute admission wards is extremely variable, with figures quoted from 8 to 44%. A third of in-patients have experienced violent or threatening behaviour, with higher figures for staff – 41% of clinical staff and almost 80% of nursing staff working in in-patient units have experienced aggressive behaviour. It is important therefore to understand the strength of association between risk factors for in-patient aggression and the extent to which these disruptive and distressing events can be predicted and prevented.

In the present retrospective survey, it was clear from the data that the incidence of violence decreased consistently week on week; 45% of all behaviours (n=80) requiring emergency nursing intervention occurred in the first week of all admissions. This reduced to 15% by the second week and 7.5% by the third week, however, by week 8 there was a rise to 13%. This is an interesting observation which may indicate the point at which PICU becomes counter-productive. Department of Health guidelines for PICU admission recommend that admission should not ordinarily exceed 8 weeks.[2]

The observation that the first week represents the highest risk period of an admission fits in well with previous data. This high-risk period could be an opportunity to monitor imminent behaviours through routine enhanced nursing observations, allowing a proactive rather than reactive response style bearing the brunt of staff/patient interactions.[3,4] The observations of week-on-week reduction in serious violence could be explored further with a case–control study. Although resource intensive, ultimately any procedure that is likely to reduce violence to staff and patients is worth pursuing.

1 Dack C, Ross J, Papadopulous C, Stewart D, Bowers L. A review and meta-analysis of the patient factors associated with psychiatric in-patient aggression. *Acta Psychiatr Scand* 2013; **127**: 255–68.

2 Department of Health. *Mental Health Policy Implementation Guide: National Minimal Standards for General Adult Services in Psychiatric Intensive Care Units (PICU) and Low Secure Environments*. Department of Health, 2002.

3 Papadopolous C, Ross J, Stewart D, Dack C, James K, Bowers L. The antecedents of violence and aggression within psychiatric in-patient settings. *Acta Psychiatr Scand* 2012; **125**: 425–39.

4 Bowers L, Gournay K, Duffy D. Suicide and self-harm in inpatient psychiatric units: a national survey of observation policies. *J Adv Nurs* 2000; **32**: 437–44.

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Neuroimaging in dementia: how best to use the guidelines?

Kuruvilla *et al*[1] completed an audit cycle on neuroimaging practice after national and European guidance was adapted to local resource availability. The audit showed an improvement in the number of patients who have had at least one form of neuroimaging performed from 68 to 76%, and although this was not statistically significant, it seems to suggest a general improvement in the service provided, as reflected also in the improved documentation of the reason for not requesting neuroimaging and in having no significant impact on waiting times. Improvement in the service may also be reflected in a patient and relative satisfaction survey that could be carried out.

In a similar study (details available from the author on request), I audited the practice of a memory clinic in Southport, Merseyside, against 2006 National Institute for Health and Care Excellence (NICE) guidance on dementia,[2] which stated that 'structural imaging should be used in the assessment of people with suspected dementia' and that magnetic resonance imaging (MRI) 'is the preferred modality [. . .] although computed tomography (CT) scanning could be used'. The audit included 75 patients and showed that 56 (75%) had at least one neuroimaging procedure performed: 53 (95%) of these had CT scans and only 1 patient had an MRI scan. My audit revealed a similar problem with documentation of reasons for not scanning patients, with 31% of patients who were not scanned lacking such documentation compared with 50% in Kuruvilla *et al*'s initial audit. In my study a re-audit was not carried out.

An additional aim of my study was to look at whether the diagnosis of dementia subtype, provisionally made based on clinical interview and using scales such as MMSE and ACE-R, was changed following neuroimaging. This revealed that the diagnosis was changed following a scan in 45% of cases, mostly from Alzheimer's or vascular dementia into a mixed-type dementia. It also showed that no provisional diagnosis was documented in 38% of case notes reviewed, suggesting that clinicians were perhaps uncomfortable about making a diagnosis before a scan was performed.

Bearing in mind that NICE guidelines are driven partly by cost-effectiveness, studies such as Kuruvilla *et al*'s provide good support for the usefulness of adapting these guidelines to the local availability of resources, which results in better care for patients with dementia.

1 Kuruvilla T, Zheng R, Soden B, Greef S, Lyburn I. Neuroimaging in a memory assessment service: a completed audit cycle. *Psychiatr Bull* 2014; **38**: 24–8.

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2 National Institute for Health and Clinical Excellence. *Dementia: Supporting People with Dementia and Their Carers in Health and Social Care* (Clinical Guidelines, CG42). NICE, 2006.

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Exposure to acute child psychiatry presentations for core psychiatrists

We are writing to draw attention to the lack of clarity provided by the Royal College of Psychiatrists regarding the role of the core trainee psychiatrist in assessing child and adolescent psychiatry patients out of hours. We believe it is important this issue is addressed as it confers broad implications for training, recruitment and service delivery. Crises of paediatric mental health tend to present out of hours. Ireland's 4th annual child and adolescent mental health service report details 'striking patterns in the number of [self-harm] presentations seen': 51% of presentations were in the 8-hour period of 7pm to 3am.[1] This finding appears typical for paediatric psychiatry liaison services around the UK.

It is well known that in some trusts core trainees are excluded from child and adolescent mental health services (CAMHS)-led out-of-hours care pathways. This situation seems particularly unsatisfactory given that placements in developmental psychiatry are no longer obligatory. By failing to adequately furnish our future adult psychiatrists with skills in child and adolescent mental health, we are reinforcing a culture whereby young people are potentially falling through the care gap between CAMHS and adult mental health services.[2,3] Indeed, this very issue is highlighted in a joint paper from the inter-faculty group of the child and adolescent psychiatry and the general and community psychiatry faculties which presents recommendations for the provision of psychiatric services to adolescents and young adults.[4] Furthermore, by restricting the level of exposure to child psychiatry, we are doing little to encourage core trainees to perceive the specialty as a future career option.

As well as having an impact on the quality of training, the issue has far-reaching implications for patient care. The current lack of clarity fosters an atmosphere of uncertainty as situations arise where no one knows who holds responsibility to clerk a young person on arrival, thereby leading to potential delays in the patient being seen. Emergency department delays are a source of great concern to acute care trusts and create negative attitudes to psychiatric services in general. If we cannot manage to work in a safe and effective way, we are further contributing to the hostility not only towards our specialty but also to our patients, who are at their most vulnerable.

It is therefore our view that there should be an explicit expectation for core trainees to have exposure to the full range of acute psychiatric presentations, including child and adolescent patients, out of hours. It is of course essential that this experience would be supported by robust and accessible supervision structures in the form of a second on-call specialty trainee or consultant child psychiatrist. Although we recognise that the College is unable to tell trusts how to deliver their out-of-hours services, it would be helpful if the core psychiatry curriculum contained more robust guidance as to the role of the core trainee in assessing child and adolescent psychiatry cases out of hours. Such a move would help to create clarity as well as holding local education providers to account.

Declaration of interest

R.C. sits on the College's Emergency Care Taskforce, which is currently considering the value of out-of-hours training.

1 Health Service Executive. *Fourth Annual Child & Adolescent Mental Health Service Report 2011–2012*. HSE, 2012 (http://www.hse.ie/eng/services/Publications/services/Mentalhealth/camhs20112012annualreport.pdf).

2 Singh SP. Transition of care from child to adult mental health services; the great divide. *Curr Opin Psychiatry* 2009; **22**: 386–90.

3 Singh SP, Paul M, Ford T, Kramer T, Weaver T. Transitions of care from child and adolescent mental health services to adult mental health services (TRACK study): a study of protocols in Greater London. *BMC Health Serv Res* 2008; **8**: 1–7.

4 Lamb C, Hill D, Kelvin R, Van Beinum M. *Working at the CAMHS/Adult Interface: Good Practice Guidance for the Provision of Psychiatric Services to Adolescents/Young Adults. A Joint Paper from the Interfaculty Working Group of the Child and Adolescent Faculty and the General and Community Faculty of the Royal College of Psychiatrists, May 2008*. Royal College of Psychiatrists, 2008.

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Psychiatry for medical students: need for a more holistic approach to teaching?

We are two medical students who wish to offer a perspective on undergraduate education and psychiatry.

During our student placement, we attended the old age psychiatry module at the Northern Deanery MRCPsych programme focusing on dementia and ethics. This was aimed at trainees and not specifically medical students but we were surprised to find that this was not above our level of knowledge. This prompted discussion of undergraduate psychiatry training more broadly, which we felt focused too heavily on the diagnosis of mental illness and less so on the holistic approach to the patient and their presentation as covered by the MRCPsych course. From our experience of undergraduate psychiatry we feel that the assessment by means of a logbook of conditions encourages students to find patients with a certain diagnosis, and in doing so overlooks the true essence of psychiatry. To our mind this incorporates the ability to consider all aspects of a patient's life and formulating these, while demonstrating compassion for another person at a time of most need.

Through choosing a 6-week placement in old age psychiatry we have been able to explore the specialty more thoroughly and broadly than facilitated within the standard undergraduate programme, and we have realised how little of psychiatry we have been exposed to as undergraduates. We have become more aware of the importance of considering the patient's personal and social circumstances alongside their diagnosis, and how these can influence each other. Specifically, the importance of a sound ethical approach to practice has been highlighted through the higher-level teaching we

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