



the columns

correspondence

Should liaison psychiatry change its name?

In recent negotiations local healthcare commissioners told us that we would be unlikely to attract additional resources to our liaison psychiatry service until we changed our name because 'We don't know what you do!'. A suggested alternative is psychological medicine.

We asked 48 patients referred to our service and 108 general hospital staff for their preferred name for our service from a choice of four: psychological medicine, medical psychiatry, liaison psychiatry, hospital psychiatry. The preferences of the two groups were significantly different ($\chi^2=22.7$, $P<0.001$). The first choice of patients was psychological medicine (44%), with 27% preferring liaison psychiatry. The first choice of hospital staff was liaison psychiatry (42%), with only 16% preferring psychological medicine. A number of patients commented that the word 'liaison' was not well understood and 'psychiatry' was off-putting and intimidating. Hospital staff, however, commented that they were familiar with our service and that a change of name would be confusing.

We have decided to continue as 'liaison psychiatry' because we are well established and our service is understood by our referrers. However, we recommend that a newly established service consider psychological medicine as a name that is preferred by many patients, and one that may be perceived as less stigmatising.

One group that we have not surveyed is our commissioners. However, it is clear that without an alternative name we will have to educate them about the benefits of liaison psychiatry.

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Statutory role of the duty consultant

Dr Husain (*Psychiatric Bulletin*, August 2005, **29**, 316) makes a very pertinent point in response to my proposal that duty consultants be replaced by telephone advice. Some jurisdictions (most notably England and Wales) may require a face-to-face interview with a senior psychiatrist before a person can be detained.

However, the question remains whether or not such interviews contribute anything which could not have been achieved by other means. By making ourselves available 24 h a day, are we not, as a profession, effectively saying that we believe this to be clinically necessary? Legislators have responded to this perceived necessity but in doing so have paradoxically created the potential for the scenario described by Dr Husain, of urgent patient care being delayed. We have created a statutory demand for our services which is based on traditional working practices (prior to the revolutionary changes in telecommunications and mental health nursing), rather than on a rational appraisal of how best to utilise scarce resources and optimise patient care.

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Junior doctors' strange love of information technology

Dr Holloway (*Psychiatric Bulletin*, July 2005, **29**, 241–243) suggests that the education of the current generation of psychiatric trainees has emphasised information technology skills which psychiatrists of an older generation may be reluctant to embrace. A survey of 75 mental health doctors in Lincolnshire with a response rate of 64% ($n=48$, 38 males, 10 females, mean age=41 years, s.d.=10) confirmed that the overall knowledge of information technology was better among senior house officers (SHOs) and specialist registrars (SpRs) ($n=18$, 37.5%) than consultants and staff grade doctors ($n=30$, 62.5%). For example, 17 out of 18 SHOs and SpRs (94%) rated their knowledge of PowerPoint as good to excellent

compared with 13 out of 30 consultants and staff grade doctors (43%; $P<0.001$). Significant statistical differences were found between the two groups in the use of Excel (61 v. 29%, $P=0.05$) and searching medical databases (89 v. 60%, $P=0.049$). However, there were no statistically significant differences between the two groups in the use of Word (94 v. 76%) and Outlook Express (72 v. 67%). Use of the Statistical Package for the Social Sciences was limited in both groups (33 v. 20%). Consultants and staff grades did, however, use the trust's electronic patient information system more frequently than junior doctors (43 v. 17%). Perhaps the eventual introduction of electronic care records will lead any remaining reluctant psychiatrists into the information age.

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Changes in psychiatric education

I have read with interest recent publications regarding the proposed changes in psychiatric education (Brown *et al*, *Psychiatric Bulletin*, June 2005, **29**, 228–230; Royal College of Psychiatrists, 2005) and have wondered where psychotherapy training, as part of basic specialist training, will fit in. Currently, the recommended requirements (Royal College of Psychiatrists, 2003) are very difficult to achieve. Senior house officer (SHO) rotations have expanded in recent years and there are limited resources in many psychotherapy departments, especially for psychodynamic psychotherapy; therefore finding appropriate patients and supervisors is a problem.

In Nottingham, all SHOs attend an introductory course in psychotherapy, most have the opportunity to join a case discussion group and great steps are being taken to improve access to cases. It is hoped that consultant psychiatrists and other mental health professionals, with adequate training and supervision,



may be encouraged to supervise SHOs taking on appropriate cases within the community mental health teams. At present, the training requirements are not mandatory and are easily overlooked by SHOs, who either lack awareness of the recommendations, have limited access to training or who are dealing with the pressures of the current MRCPsych exams.

With the envisaged modular/workplace-based assessment equivalent to the MRCPsych, perhaps psychotherapy training will become more fully integrated into the system. Surely, experience in psychotherapy, psychodynamic and cognitive-behavioural therapy should be an essential part of training, to help develop listening skills, to better understand our patients and the roots of their problems and to encourage us to manage patients using the biopsychosocial model to the full.

ROYAL COLLEGE OF PSYCHIATRISTS (2003) *Executive Summary. Requirements for Psychotherapy Training as Part of Basic Specialist Training*. London: Royal College of Psychiatrists. <http://www.rcpsych.ac.uk/traindev/postgrad/ptBasic.pdf>

ROYAL COLLEGE OF PSYCHIATRISTS (2005) *The Dean's Medical Education Newsletter, April 2005*. London: Royal College of Psychiatrists. http://www.rcpsych.ac.uk/traindev/postgrad/dean_05.pdf

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Gaps in adolescent services

Singh *et al* (*Psychiatric Bulletin*, August 2005, **29**, 292–294) highlighted problems at the interface between adolescent and adult mental health services. Some years ago in Brisbane (Australia) our adolescent services worked to a strict lower age limit of under 16 and referrals had to be of adolescents living at home and attending school. As an adult community service provider I encountered a young lady in crisis whom I considered required adolescent services – she was 15 and still at school. I phoned the relevant adolescent clinic. The response? So she was 15 and at school, but she had left home so she did not qualify for their service, despite the fact that the reason she left home that morning was because she had discovered that her mother was having sex with her boyfriend!

Perhaps this would not happen today? No, that can't be right as we have more 'non-service' delivery scandals than ever. Perhaps this wouldn't happen in the UK? Perhaps I'm just naive?

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The interface between child and adult mental health services

The divide between services for children and adults with mental health problems continues, so I was pleased to read the article by Singh *et al* (*Psychiatric Bulletin*, August 2005, **29**, 292–294) which draws our attention to this matter again.

However, I think that more emphasis should have been placed on the important role of training, particularly for junior psychiatrists and general practitioners (GPs) who will be in the vanguard of developing or commissioning services in the future.

With this in mind, I have started to run an induction session in child psychiatry for our child and adolescent mental health service (CAMHS) in Plymouth. This began as an hour but is now half a day and may shortly be a day-long event. It is intended for new senior house officers in psychiatry, who may be career psychiatrists or vocational GP trainees, and occurs every 6 months as part of their routine induction programme. The evaluation of these sessions has been very positive, with all trainees so far finding the sessions 'useful' or 'very useful'. This is the main reason that the length of the session will be extended: it seems to be filling a training need which is probably not met elsewhere. General practitioners not only have to deal with a considerable burden of psychiatric illness of both adults and children in primary care, but also receive very little training for this. Foreman (2001), for example, found that 47% of GPs sampled had no undergraduate training in CAMHS and 93% had negligible postgraduate experience.

The session includes an initial introduction to the CAMHS, followed by sections on self-harm and the local protocol for its assessment in young people, and the effects of parental mental illness on children. The second half of the session covers conditions commonly seen in a CAMHS which will continue into adult life, such as attention-deficit hyperactivity disorder and autistic-spectrum disorder. The teaching is interactive and videos provide a focus for discussion.

I would be interested to hear of other developments in CAMHS throughout the country on GP training in child and adolescent psychiatry. Perhaps the College should be developing an initiative to this end?

FOREMAN, D. M. (2001) General practitioners and child adolescent psychiatry: awareness and training of the new commissioners. *Psychiatric Bulletin*, **25**, 101–104.

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Ward rounds – patients' views

We have similar concerns regarding patients' views of ward rounds to White & Karim (*Psychiatric Bulletin*, June 2005, **29**, 207–209). Our service is a low secure forensic unit, which provides long-term rehabilitation in the West Midlands, and in contrast to general adult services in-patients have a 4-weekly ward round slot.

A recent review of records of 12 in-patients over a 6-month period highlighted that patient attendance at ward rounds has been poor – 2 patients attended frequently, 6 occasionally and 4 never. White & Karim fail to mention that standard nursing practice is to provide selective written and verbal feedback to patients after the ward round. Therefore the patients may feel that they do not need to attend as they receive comprehensive feedback without undergoing the ward round experience.

Hodgson *et al* (*Psychiatric Bulletin*, May 2005, **29**, 171–173) stressed the compromise position of the ward round as it struggles to serve both professional and patient needs. The duties of a doctor according to the General Medical Council include the need to respect the rights of patients to be fully informed in decisions about their care, to give patients information in a way they can understand and to listen to patients. By maintaining the practice of ward rounds in which patients choose not to participate, are we failing to involve patients in decisions about their care? Patients want individual consultant time and ward rounds do not allow this. Perhaps the way forward is to have both a team meeting followed by individual patient time with a consultant.

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Guidelines for prescribing injectable heroin and methadone

I was surprised to read that heroin prescribing was considered controversial (Luty, 2005). In the 1970s my colleague and I had no serious problems prescribing heroin and cocaine. In the 1980s and '90s Dr John Marks successfully prescribed heroin in Widnes but there was great hostility to his programmes. I have not seen his success mentioned in official or clinical discussion, including the 2003 guidelines from the National Treatment Agency for Substance Misuse. He has been 'air-brushed' out of history.