the columns

correspondence

Crisis teams

Sir: In 1997 we worked in two crisis assessment and treatment teams (CATTs) in the western suburbs of Melbourne, Australia. We found the work stimulating and are grateful for the opportunity to have worked in a highly developed community psychiatry service. It is therefore easy for us to agree with many of the points made by Carroll *et al* in their description of the Northern Crisis Assessment and Treatment Team (*Psychiatric Bulletin*, November 2001, **25**, 439–441). While the article stimulated a degree of nostalgia for our time in Australia it has also encouraged us to make a few comments based on our collective experience.

It is true that the most skilled clinicians staff CATTs. Undoubtedly, this is because the work is seen as more challenging, is more prestigious and provides better pay. However, not only can this denude the other teams within the area (case management team and in-patient team) of the most motivated clinicians, it also begets an elite team with a strong culture. The strong team culture does help ensure effective teamwork within the CATT, but we found that it can be exclusive and cause strained relations with members of other teams, damaging the effective working of the area mental health service as a whole (the wider team).

As gatekeepers the CATT clinicians see all patients prior to admission to assess suitability for home treatment. In practice this can be cumbersome. The situation can occur where an acutely unwell patient is assessed in turn by his/her case manager, a doctor in the case management team, a CATT clinician and possibly a CATT doctor. Then, if admission is required, he/she is assessed by the admitting doctor and nurse. Where the aim is to create a seamless service, we found that the inter team strife and procedural arrangements sometimes created seams.

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Meeting mental health need in prisons

Sir: Birmingham's article (*Psychiatric Bulletin*, December 2001, **25**, 462–464) succinctly captures the current difficulties in providing adequate mental health care for prisoners. The description of poor facilities, inadequate resources and the difficulty of providing care and therapy in a non-therapeutic environment will be instantly recognisable to practitioners working within prisons.

Having had the opportunity to work as a locum medical officer and a visiting psychiatrist at a women's prison, and viewing the same problems from different sides of the fence, it is evident that forensic psychiatrists have a prominent role in developing 'coordinated, integrated services' for mentally disordered offenders. Rigid, ineffective and inefficient procedures can be improved, resulting in an improvement in care and, more importantly, removal of the barriers preventing these individuals from accessing the services that they are entitled to.

In my experience this involves the training of non-medical staff in the recognition of mental disorders and reducing the stigma and discrimination attached to being 'a psychiatric patient'. Additionally, evidence of ineffectiveness can be collected, using audits and surveys, and the results presented to those involved in the commissioning and purchasing of medical services. In our own case this involved completing an audit of the referral process, which revealed excessive waiting times, long waiting-lists and indiscriminate presentation and follow-up, as a result of which the system was altered after consultation with prison staff. As Birmingham correctly states, identifying and managing these individuals earlier has resulted in a noticeable improvement within the prison environment.

Finally, from our experience it is not the identification of these individuals that is the major difficulty, rather it is the management of complex, multiple health care needs in a setting that currently cannot meet those needs, with resources both inside and outside prisons already stretched. More optimistically, with the NHS now being involved in providing health care within prisons, there is now an opportunity to deliver effective, integrated services.

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The natural history of amphetamine misuse

Sir: Though Moselhy *et al* (*Psychiatric Bulletin*, February 2002, **26**, 61–62) describe a reluctance by some services to make use of amphetamine substitution therapy, across the UK as a whole there is a large number of individuals who are receiving it. The fact that it is yet to be subjected to a randomised controlled trial is therefore of some concern.

With more substantial evidence lacking, there is a danger that amphetamine substitution will be regarded as entirely analogous to methadone substitution. This would be erroneous. Long-term prescribing of methadone can be justified, and has been shown to be effective, because heroin dependence has the quality of a long-term relapsing illness. Unfortunately, little is known about the natural history of amphetamine use, and users may be much better able to make changes without the help of a prescription.

An analysis of 156 amphetamine and heroin users who presented for treatment in Cornwall on more than one occasion over 7 years, showed that amphetamine users were more likely to switch both their main drug and their main route of use between presentations (details available from the author upon request). Taken together with the fact that cohorts of amphetamine users in the UK have been found to be younger than comparable heroin users, this would imply that amphetamine users are less likely to experience long-term patterns of problematic use over many years. If this is the case, long-term prescribing may do more harm than good.

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