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Oluwatayo & Friedman that there is need for a national approach and guidance on minimum standards.

The Mental Health (Care and Treatment) (Scotland) Act 2003 enshrines in law a requirement for National Health Service (NHS) boards in Scotland to make appropriate provision for admitting mothers with their babies for treatment of mental illness in the postnatal period. The Act also encourages NHS boards to collaborate in delivering services. Recent guidance (Scottish Executive Health Department, 2004) emphasises the need to develop community, maternity liaison and specific primary care services in tandem with in-patient provision, and sets minimum standards for care for both mother and baby. A formal Scottish Executive Health Department review of progress towards implementation of the Act in October 2005 is ongoing. Inevitably this has led to an approach that is national in aspiration.

Scottish provision remains patchy, with one six-bed unit serving the west, but plans are rapidly developing in other areas through regional planning structures, with close communication between those involved in running existing services and those commissioning new provision. What has become clear from our experience is that specialist provision must involve collaboration across wide geographical/population areas to ensure viability of services and development of appropriate knowledge and expertise.

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SCOTTISH EXECUTIVE HEALTH DEPARTMENT (2004) *A Framework for Mental Health Services in Scotland: Perinatal Mental Illness/Postnatal Depression Admission and Support Services*. Edinburgh: Scottish Executive Health Department.

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## Transfer from child to adult mental health services

Singh *et al* (*Psychiatric Bulletin*, August 2005, **29**, 292–294) discuss the risk of disrupted care for young people who outgrow child and adolescent mental health services (CAMHS).

Lincolnshire Partnership NHS Trust has a protocol for good practice surrounding transfer of a young person's care from child to adult mental health services. However, in an audit of these procedures involving 82 young people aged 17 or 18 years who were discharged from three of our community CAMHS teams over a 2-year period, only seven were transferred to adult services. CAMHS clinicians identified 32 other young people who left the service with unresolved mental health problems: a suitable adult service could not be found for one young person, 21 young people dropped out of CAMHS and ten young people did not want to be referred to adult services.

The paucity of psychological therapies in adult mental health services created difficulties for CAMHS clinicians in finding suitable follow-on services. Perhaps the prospect of an inevitable ending with no further support contributed to the high drop-out rate of young people approaching the end of the service available to them in CAMHS? Some young people clearly said they did not want to have to 'start from the beginning' in establishing a therapeutic relationship with a new worker. Others were perhaps influenced in declining ongoing care by the perceived stigma of adult services.

Our audit findings add to the evidence that the current differing perspectives of CAMHS and adult mental health services create gaps in services through which vulnerable young people fall.

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## Are psychiatrists real doctors?

The survey of psychiatric trainees in Scotland by Dr Robinson (*Psychiatric Bulletin* February 2005, **29**, 62–64) showed that a significant amount of physical healthcare is being provided by psychiatric trainees.

In my experience, south of the border the situation is no different, particularly in psychiatric long-stay facilities such as rehabilitation units and forensic units where a large degree of physical morbidity exists. Cormac *et al* (2004) reported high rates of avoidable health risks such as smoking, obesity, central weight distribution and excessive weight gain.

The role of the trainee is to identify and manage problems for which they often may have received no formal training. After completion of pre-registration house jobs, direct entry to psychiatric training schemes is not uncommon. The notion of managing, for example, an individual's diabetes, hypertension or obesity may be quite alien never mind being able to recognise strange skin complaints and other problems commonly encountered in primary care.

I have experience and training in primary care which I have found invaluable in dealing with my patients' physical health problems. The National Service Framework for Mental Health requires health promotion and appropriate access to and delivery of primary care for patients with mental disorders (Department of Health, 1999). It may be of value to consider the training needs of psychiatric trainees with regards to management of physical health problems.

CORMAC, I., FERRITER, M., BENNING, R., *et al* (2005) Physical health and health risk factors in a population of long-stay psychiatric patients. *Psychiatric Bulletin*, **29**, 18–20.

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## Physical health of patients in rehabilitation and recovery

I read with interest the article by Dr Greening (*Psychiatric Bulletin*, June 2005, **29**, 210–212). I have recently undertaken an audit of the physical healthcare of patients in our rehabilitation and recovery unit in Warwick. Unfortunately, my preliminary results show a similar picture to that reported by Dr Greening.

However, we do have a local general practitioner (GP) who has two sessions allocated per week for the review of any physical health problems: the type of 'shared care approach' suggested by Lester (2005) and Bickle (2005). It must be stressed though that it is not the responsibility of our GP colleagues to trawl through reams of notes (which most rehabilitation patients have) but rather up to the psychiatric team to ensure that patients are having appropriate investigations that can then be discussed with primary care.

For my audit I initially drew up a 'checklist' (standards) of the investigations that patients should have depending on what type of medication they are prescribed and how often, if at all, this ought to be repeated. I used the *Maudsley Prescribing Guidelines*, *British National Formulary* and consulted pharmaceutical companies in drawing up the standards for each psychotropic agent – one must not forget mood stabilisers and antidepressants that also require monitoring. Although rather time-consuming, it is a more rigorous method than collating the views of colleagues as done by Pitman (2005) prior to audit and is better than a battery of 'routine tests' which may be incomplete.

In addition, we have put together a health screen protocol for each patient that not only looks at issues such as diet,



https://doi.org/10.1192/pb.29.11.436-b Published online by Cambridge University Press

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smoking, body mass index and exercise but also, among other things, posture/mobility, eyes, ears, teeth/oral hygiene, hair/scalp, immunisation history (although this can be difficult!), menstrual cycle, urinary tract infections and constipation. Each female will also be given appointments for mammograms and cervical smear tests when necessary, as well as leaflets on breast examination. All male patients will be given leaflets on testicular examination, provided by the primary care service. We will review the protocols annually but some areas will need to be addressed more often.

The reasons for regular review of the physical healthcare of psychiatric patients are well documented. I hope that by implementing these protocols using the shared care approach we are promoting a better quality of life that our patients deserve.

BETHLEM & MAUDSLEY NHS TRUST (2003). *The Maudsley Prescribing Guidelines*, 7th edn. London: M. Dunitz.

BICKLE, A. R. (2005) Physical health of patients in rehabilitation and recovery: a case for surveying all records? (eLetter to *Psychiatric Bulletin*). http://pb.rcpsych.org/cgi/eletters/29/6/210#399

BRITISH MEDICAL ASSOCIATION & ROYAL PHARMACEUTICAL SOCIETY OF GREAT BRITAIN (2005) *British National Formulary* (March issue). London & Wallingford: BMJ Books & Pharmaceutical Press.

LESTER, H. (2005) Shared care for people with mental illness: a GP's perspective. *Advances in Psychiatric Treatment*, **11**, 133–139.

PITMAN, A. L. (2005) Lack of consensus over standards for physical investigations for psychiatric in-patients. (eLetter to *Psychiatric Bulletin*). http://pb.rcpsych.org/cgi/eletters/29/6/210#399

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## Roles and responsibilities of doctors in the provision of treatment for drug and alcohol misusers

Council Report CR 131, January 2005, Royal College of Psychiatrists and Royal College of General Practitioners, £10 40 pp

This document reflects the findings of a working group set up jointly by the Royal College of Psychiatrists and the Royal College of General Practitioners. The group had the support of the National Treatment Agency for Substance Misuse and the Department of Health. It is intended as a resource for commissioners, service providers and doctors, and seeks to clarify some of the issues surrounding the employment of doctors and deciding which doctors have the appropriate competencies to carry out various tasks in the treatment system.

There has been a large increase in the number of doctors from a range of professional backgrounds working with substance misusers. This increase has mainly been in primary care, as there are shortages of addiction psychiatrists and other experts in secondary care. The expansion in the numbers of general practitioners (GPs) involved has resulted in individual doctors working in different ways, with a variety of competencies. Titles now used include 'general practitioners with a special interest' and 'primary care specialists in substance use'. The new General Medical Services contract has defined locally and nationally enhanced services, which allow a degree of clarity in terms of the services a GP would be expected to provide to a drug misuser.

All organisations employing doctors need a robust clinical governance structure that addresses issues of education and supervision. The report recommends that appraisal must be carried out by a trained appraiser with experience of the clinical area. Supervision could be carried across different employing and specialty areas, so for example a consultant addiction psychiatrist could supervise a GP with special clinical interest working in their geographical area. Royal College of General Practitioners' regional leads are another potential source of support. In most circumstances, however, training-grade practitioners should be supervised by practitioners from the same discipline.

In some parts of the country, GPs are working as primary care addiction specialists. There is currently no recognised pathway for these individuals to obtain specialist qualifications, but draft criteria are suggested.

This document defines the following professional groups:

- psychiatrists: consultants in addiction psychiatry, consultants in general psychiatry with a special interest in addiction, consultants in general psychiatry
- GPs: GPs with a special clinical interest, GPs providing enhanced services, GPs providing core services
- other specialists: substance misuse specialists (in primary care), substance misuse specialists (from other professional backgrounds), other doctors on the specialist register, associate specialists, senior clinical medical officers, staff grades.

The competencies expected of each group are summarised. It is acknowledged that individuals will have a range of competencies and skills.

Doctors work within treatment systems and therefore may provide services over a range of National Treatment Agency Models of Care tiers. However, doctors with higher levels of competencies are generally more likely to be working in services that provide Tier 3 and Tier 4 interventions and to be more involved in management and strategic activities. In a treatment system there is a need for services at all levels, with input from GPs and specialists (either addiction psychiatrists or other specialists).



https://doi.org/10.1192/pb.29.11.436-b Published online by Cambridge University Press