columns

College's reply: I am grateful to Dr Veasey (2000, this issue) for raising this matter. The College has to balance its obligations to members with its main purpose of raising standards in psychiatry. Sometimes this is a difficult balancing act.

Members will be aware that Council has recently agreed to establish an External Clinical Advisory Service. This will offer expert external advice to NHS trusts on any psychiatric service which is not functioning effectively. Further details of the service, which will be of assistance to College members as well as protecting patients, will appear on the College's website. Dr Peter Snowden has been appointed Director of this service.

You will be glad to know that the College has made a robust response to the recent Tilt Report and copies of this response will also be available on the College's website in the near future.

VEASEY, D. A. (2000) Further comments on inquiry panels (letter). *Psychiatric Bulletin*, **24**, 393.

John L. Cox President, Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG

Psychotherapy within old age psychiatry

Sir: Murphy (2000) looked at the provision of psychotherapy services for older adults by sending questionnaires to psychotherapy departments. She reported that respondents felt, largely on the basis of low referral numbers, that the needs of this group were not being met. The survey did not address the provision of psychotherapy within old age psychiatry departments. The NHS review of the psychotherapies (NHS Executive, 1996) highlighted the underrepresentation of older people and people with chronic illness and physical disabilities among those treated with psychotherapies. Garner (1999) has already argued that attitudes are slowly changing and she herself exemplifies the inclusion of psychoanalytic psychotherapy within old age psychiatry. Our own service includes a clinic offering systemic therapy to older adults and their families (Benbow & Marriott, 1997).

One possible criticism of psychotherapies within old age psychiatry is that older adults may be offered a second-rate service. This implies that therapists working in these areas are not properly trained, or supervised, or experienced. Might they, in fact, provide a better service? They combine psychotherapy training and expertise with understanding and practical expertise in the area of late-life mental health. This inclusive model may have other benefits, by facilitating referrals and incorporating psychotherapeutic understanding within the day-to-day work of an old age psychiatry service. We do indeed need to hold in mind the needs of older adults, as Murphy writes, but we should also recognise that needs can be met in different ways.

BENBOW, S. M. & MARRIOTT, A. (1997) Family therapy with elderly people. *Advances in Psychiatric Treatment*, **3**, 138–145.

GARNER, J. (1999) Psychotherapy and old age psychiatry. *Psychiatric Bulletin*, **23**, 149–153.

MURPHY, S. (2000) Provision of psycotherapy services for older people. *Psychiatric Bulletin*, **24**, 181–184.

NHS EXECUTIVE (1996) *A Review of Strategic Policy on NHS Psychotherapy Services in England*. London: DoH.

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Home treatment teams

Sir: The survey by Owen *et al* (2000) exemplifies the difficulties involved in researching home treatment teams, because of the multiplicity of definitions and wide nomenclature for services serving similar functions. Such diversity cannot be assessed adequately using a short survey and broad definition of the subject matter.

The definition of home treatment in the paper is much briefer than the broad definition in the questionnaire and the questionnaire refers to "access to community staff on a 24 hour basis", whereas the paper reports on "availability on a 24-hour basis". Such inconsistencies may give rise to inaccurate representations of what was surveyed. Furthermore, the questionnaire is internally inconsistent in referring to home treatment services both as an alternative to hospital admission and as a supplement to hospital-based services, which does not help identify the kinds of service being examined.

A similar but much more extensive recent (1998) survey (Orme, 2000) of nationwide crisis services found a wider penetration of services. Of 152 self-defined crisis services, 22 were identified as home treatment services offering an alternative to admission. Of these, eight offered a 24-hour service (seven of which were available only on an on-call basis out of office hours) and eight were staffed by nurses only.

Owen *et al* report high expectations for new developments in home treatment. However, during the period of data collection regarding crisis services, 10% ceased operating or were being considered for closure. Will home treatment services go the same way?

ORME, S. (2000) Intensive home treatment services. In *Acute Care in the Community* (ed. N. Brimblecombe). London: Whurr Publishers.

OWEN, A. J., SASHIDHARAN, S. P. & EDWARDS, L. J. (2000) Availability and acceptability of home treatment for acute psychiatric disorders. A national survey of mental health trusts and health authority purchasers. *Psychiatric Bulletin*, **24**, 169–171.

Andrew Sandor Lecturer in Social and Community Psychiatry, Royal Free and University College Medical School, Department of Psychiatry and Behavioural Sciences, Holborn Union Building, Archway Campus, Whittington Hospital, Highgate Hill, London N19 5NF, **Sarah Orme** Research Fellow, Psychology Division, University of Wolverhampton

Authors' reply: We welcome the letter from Sandor and Orme (2000, this issue) and await with interest the results of the study to which they refer. Without access to further information concerning this work it is difficult to comment upon their finding that some crisis services have ceased operating. Our study revealed an enthusiastic support for crisis services (Owen *et al*, 2000), and our own experience working in inner-city Birmingham has demonstrated that home treatment is an effective intervention, which is more acceptable to clients than hospital admission and is sustainable over many years.

The suggestion that it is inconsistent to refer to home treatment as both an alternative and an adjunct to hospital admission betrays a common misconception about crisis services. Many people who would otherwise have been admitted to hospital are able to be successfully supported during crisis by home treatment, yet hospital admission remains an essential part of acute psychiatric services. Clients of home treatment services not infrequently require admission to hospital, although the length of stay is often short, with early discharge and community support. It is also important to point out that home treatment makes use of other crisis residential alternatives to hospital, such as crisis houses or family sponsorship schemes, with good effect.

There remains a wider issue concerning the reluctance of psychiatrists to embrace developments in community mental health services despite the evidence of its efficacy and general acceptability (Smyth & Hoult, 2000). We strongly recommend that the debate in this area should focus on the opportunities that are becoming available in developing innovative crisis services in the context of the National Service Framework. Our failure to do so would once again result in psychiatry being left behind in the development and implementation of modern systems of psychiatric care.

OWEN, A. L., SASHIDHARAN, S. P. & EDWARDS, L. I. (2000) Availability and acceptability of home treatment for acute psychiatric disorders. A national

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columns

survey of mental health trusts and health authority purchasers. *Psychiatric Bulletin*, **24**, 169–171.

SANDOR, A. & ORME, S. (2000) Home treatment teams (letter). *Psychiatric Bulletin*, **24**, 394.

SMYTH, M. G. & HOULT, J. (2000) The home treatment enigma. *British Medical Journal*, **320**, 305–309.

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Prescribing and monitoring of valproate

Sir: The authors of a recent paper (Taylor *et al*, 2000) have drawn much-needed attention to the high prevalence of sub-therapeutic treatment of conditions such as mood disorders with carbamazepine or valproate. However, the authors have given much emphasis to the use of drug serum levels in monitoring the use of both these drugs in such conditions.

Personal experience suggests that there are potential pitfalls for the unwary in the interpretation of valproate levels. In particular, in a minority of patients it may be impossible to reach the stated trough threshold level of 50 mg/l, even at daily doses in excess of the licensed maximum and despite supervised compliance.

One possible reason for this is that valproate is highly (about 90%) bound to plasma protein at low body levels, but with increasing doses the binding sites become saturated and free levels rise. More active drug is thereby delivered to the central nervous system (CNS) (Dollery, 1991) without in some cases more than a marginal rise in measured (bound plus unbound) serum levels. This effect should be borne in mind if measured levels do not rise in proportion to a dose increase in a particular case.

Other factors confounding the interpretation of valproate levels include the fact that: the effects in the CNS considerably outlive the detectable presence of the drug in the body, possibly because of active metabolites; there is variable displacement from serum binding sites by free fatty acids; blood samples taken just before a dose may not consistently represent trough levels, because of possible entero-hepatic recirculation and diurnal variation in elimination (Chapman *et al*, 1982; Dollery, 1991). These factors explain, at least in part, why valproate measurements tend to be unreliable for some clinical purposes.

CHAPMAN, A., KEANE, P. E., MELDRUM, B. S., *et al* (1982) Mechanism of anticonvulsant action of valproate. *Progress in Neurobiology*, **19**, 315–359.

DOLLERY, C. (ed.) (1991) *Therapeutic Drugs. Vol. 2: Sodium Valproate*. Edinburgh: Churchill Livingstone.

TAYLOR, D. M., STARKEY, K. & GINARY, S. (2000) Prescribing and monitoring of carbamazepine and valproate – a case note review. *Psychiatric Bulletin*, **24**, 174–177.

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Changes to the MRCPsych examinations

Sir: Although the forthcoming changes to the Part I and II MRCPsych Examinations are on the whole welcome news (Katona *et al*, 2000), I hold several reservations regarding some of the alterations proposed.

After several years of post-graduate experience in psychiatry I sat an Observed Structured Clinical Examination as part of the Licentiate of the Medical Council of Canada. I had concerns about the inherent validity of the psychiatric section of the examination, which at times was clearly role-play. By including actors in psychiatric examinations, are we not making unnecessary and unwelcome changes?

Experience in the long case is equally if not more valuable to those who fail as to those who pass the membership examinations, and I feel disappointed this will now be subject to screening procedures in Part II, particularly as it has been removed from Part I. Denying experience of a long case until Part II, and lessening the emphasis on history-taking, may delay development of those skills gained in preparing for this aspect of the examination, many of which are fundamental to good clinical practice.

Should changes to our examinations not be moving us closer to rather than further from 'real world' psychiatry?

KATONA, C., TYRER, S. P. & SMALLS, J. (2000) Changes to the MRCPsych examinations. *Psychiatric Bulletin*, **24**, 276–278.

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Junior doctors' pay deal

Sir: From December 2000, additional duty hours will be replaced by a banding system based on the time spent 'actually working' on call. Psychiatry trainees will be paid significantly less than their colleagues in other specialities, who have shorter rest periods. While to an extent this is justified, the size of the pay differential is alarming and the higher level of stress experienced by psychiatrists (Dreary *et al*, 1996) is not recognised.

A house officer choosing a career may be faced with either a pay cut of £48 per year to take up psychiatry or a raise of £6413 per year to do general medicine. With the introduction of tuition fees, the British Medical Association estimates that the debts of final year medical students will rise from an average of £7738 in 1998 (Brooks, 1998) to up to £25 000 (British Medical Association, 1997). This will have grave implications for recruitment to psychiatry. The College needs to address this issue if it wants to attract doctors into our speciality.

BRITISH MEDICAL ASSOCIATION (1997) Briefing. *British Medical Journal*, **315**, 7107.

BROOKS, A. (1998) Medicine may become 'domain of the privileged'. *British Medical Journal*, **317**, 558.

DREARY, I. H., BLENKIN, H., AGIUS, R., *et al* (1996) Models of job-related stress and personal achievement among consultant doctors. *British Journal of Psychology*, **87**, 3–29.

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Introducing The Royal College of Psychiatrists' Cricket Club

Sir: I seek to reach readers who are interested in playing cricket. I intend to gather names of Inceptors, Members and Fellows of the College who support the idea of founding The Royal College of Psychiatrists' Cricket Club and also of those who are keen to play for the College.

If you are interested, please send me your name and address, with a brief playing history.

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