the columns

correspondence

Is liaison psychiatry something we 'must do'?

The National Director for Mental Health, Louis Appleby, is optimistic about the improvement in mental health services (*Psychiatric Bulletin*, December 2003, **27**, 441–442). However, he acknowledges that we are some way off providing care that our patients deserve and we would like to deliver. In the same issue of the *Psychiatric Bulletin*, Ruddy and House (*Psychiatric Bulletin*, December 2003, **27**, 457–460) show that this is particularly true for liaison psychiatry. In addition to their survey of the Northeast of England, they cite work that indicates that liaison psychiatry services are inadequate or non-existent in many areas. This is despite the joint recommendations of the Royal Colleges of Physicians and Psychiatrists (2003).

Appleby (2003) asserts that in England and Wales the Department of Health has no certain way of dictating where resources go, and that such decisions have been devolved to local commissioning systems. This runs counter to the recent experiences of myself and colleagues when bidding for resources to provide effective liaison psychiatry services. Although there are well rehearsed clinical and financial arguments for specialist psychological care in general hospitals, a common response from the commissioners of local health services is that liaison psychiatry is not something they 'must do'. The allocation of resources is heavily influenced by government strategies and targets, which become the 'must dos' for the commissioners.

Liaison psychiatry has a particular difficulty in attracting new resources, because it implicitly contributes to other services meeting their targets, but is not itself an explicit target for funding. For example, general hospitals are currently trying to achieve attendance times of less than 4 hours for all patients attending an accident and emergency (A&E) department in the UK (Department of Health, 1999). A liaison psychiatry service can assist in ensuring patients with mental health problems do not have a prolonged stay in A&E, but it is usually not seen as a priority for new funding. Similar issues apply to targets set by the Department of Health in the various National Service Frameworks.

Professor Appleby underestimates the importance of national priorities in the local commissioning of health services. In a target-driven National Health Service (NHS), liaison psychiatry cannot expect to develop robust psychological services for medical and surgical patients unless it becomes an explicit government priority, and something that the NHS 'must do'.

DEPARTMENT OF HEALTH (1999) *Reforming Emergency Care: First Steps of a New Approach*. London: Department of Health.

ROYAL COLLEGE OF PHYSICIANS & ROYAL COLLEGE OF PSYCHIATRISTS (2003) The psychological care of medical patients: a practical guide (Council Report CR108). London: Royal College of Physicians & Royal College of Psychiatrists.

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Human rights and mental health services

Dr Fareed Bashir (*Psychiatric Bulletin* correspondence, December 2003, **27**, 463) is absolutely right in mentioning the influence that the European Convention on Human Rights (ECHR) had on the Mental Health Act 1983, long before its implementation into English law in 1998 (Human Rights Act 1998). In my article on Consent in medicine (*Psychiatric Bulletin*, August 2003, **27**, 285–289) I specifically mention the fact that the content of the ECHR was de facto accepted in Britain since the 1950s. Contrary to Dr Bashir's suggestion, I never expected that the implementation of the Human Rights Act 1998 was a sea-change or would dramatically improve the treatment of psychiatric patients. On the contrary, I pointed out how few practical changes are going to result from the Act in the short term. There is, however, the potential that human rights may be more actively considered in advance in future legislation. The changes the government made to the Green Paper on the new Mental Health Act confirm this, because they were clearly designed to make the Act compatible with the Human Rights Act 1998 (although many would doubt that they have). Furthermore, the case of Hercegfalvy *v.* Austria states that any beneficial treatment cannot amount to torture and therefore does not breach article 3 of the Human Rights Act 1998. This was specifically targeted with electroconvulsive therapy in mind. The fact that Mr Hercegfalvy was strapped to a bed for his own security may appear undesirable to us in Britain, but restraint is the tradition in most European countries. They find our use of control and restraint with enforced medication equally undesirable.

The case of HM *v.* Switzerland is no doubt interesting, but it should not be forgotten that all European countries work with coded law, which renders precedence much less important than it is here. It would be premature to anticipate how the English High Court would decide a similar case in the UK.

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Patient advocacy

Given the stated intention of the Royal College of Psychiatrists to review its position on patient advocacy in 2004 (Royal College of Psychiatrists, 1999; due for review 2007), it seems appropriate to highlight some findings of a recent qualitative study of 10 paid independent advocates on acute and continuing care wards in England. Although this collaborative venture aimed to explore the day-to-day experiences of advocates, participants felt that politically, advocacy was still bereft of real power within the National Health Service and advocacy projects were generally hampered by insecure funding.

Advocates saw their independence from staff as vital, both to them and service users, but constructive working relationships with psychiatrists and nurses were equally important for advocates in achieving desirable outcomes. Most participants did feel relationships with clinicians were generally good, although all had encountered some defensiveness or hostility from some, even allowing for the tension that *should* exist between

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advocate and clinician (Graley *et al*, 1996). In some cases participants suggested that previous advocates had created mistrust by behaving unacceptably. On the other hand, some older nurses and psychiatrists seemed unconvinced by any moves to support greater patient autonomy.

Confusion over the role of the advocate remained common, even among those supportive of advocacy, and participants felt that clinicians might be more reassured of the legitimacy of advocacy if advocates had access to recognised and standardised training themselves.

An account of this project may be found in the February and June 2003 editions of *The Advocate*, the newsletter of the UK Advocacy Network.

GRALEY, R., MOONEY, L. & CONLAN, E. (1996) Relationships with staff. In *Advocacy Code of Practice* (eds E. Conlan & T. Day) (developed by UKAN for the Mental Health Task Force User Group) Department of Health, London.

ROYAL COLLEGE OF PSYCHIATRISTS (1999) Patient advocacy (Council Report CR74). London: Royal College of Psychiatrists.

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Referral letters to child and adolescent mental health services

In the face of substantial demand, many out-patient child and adolescent mental health services (CAMHS) triage referrals on the basis of referral letter information. The validity of this procedure is uncertain; it is often asserted that referral letters provide a poor guide to clinical status. Using routinely collected data from one CAMHS team, we investigated the congruence between the main problem highlighted in the referral letter, and the subsequent specialist assessment diagnosis.

Among 98 children whose main problem in the referral letter was a behaviour problem, there were various diagnoses at assessment: hyperkinetic disorders formed the single largest group (23%), with almost as many emotional (17%) or conduct disorders (17%). Hyperactivity/inattention was the main problem in 39 referral letters: 51% of these children subsequently received a diagnosis of hyperkinetic disorder. Four of the eight children whose main problem in the referral letter was an eating problem received a diagnosis of anorexia or bulimia. The greatest specificity was from the 83 letters highlighting emotional symptoms as the main problem: 67% received a diagnosis of an emotional disorder (two combined with conduct disorder). Thus, letters identifying emotional problems or hyperactivity/inattention often provided a guide to clinical diagnosis.

However, children referred with 'behaviour problems' could be found to have any of a number of clinical diagnoses at assessment. This suggests that such referrals cannot be reliably triaged before assessment without considering additional information. This presents a serious problem for services with substantial assessment waiting lists. Other factors that might also influence triage, such as the child's functional impairment, problem severity, or risk behaviour, need similar investigation.

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the college

Annual election of Honorary Officers

Notice to Fellows and Members

Fellows and Members of the College are reminded of their rights in connection with the elections for the offices of Dean, Registrar, Treasurer, Editor and Librarian. All Honorary Officers are eligible for re-election.

The nominating meeting of the Council will be held on 26 April and the last date for receiving nominations will therefore be 24 May. The relevant Bye-laws and Regulations are printed below:

Extracts from the Bye-laws

Section XII – the other Honorary Officers

1. The Council shall, in accordance with the Regulations, make its nominations for the offices of Dean, Registrar, Treasurer, Editor and Librarian at the first meeting after the name of the President for the next ensuing College year has become known. Written nominations for the above Honorary Offices, accompanied in each case by the nominee's written consent to stand for election, may also be lodged with the Registrar at such time as may be prescribed by the Regulations, provided that each such nomination is supported in writing by not less than twelve Members of the College who are not members of the Council.
2. The Dean, Registrar, Treasurer, Editor and Librarian shall be elected from amongst the Fellows, by the Members of the College, in each case in accordance with the procedure prescribed by the Regulations.

Section XIV – the Registrar and Deputy Registrars

3. The Registrar shall hold office as such for a term of not more than five consecutive College years.

Extract from the Regulations

Section XII – election of the other Honorary Officers

1. The method of electing the Honorary Officers other than the President, the Vice-Presidents, Sub-Deans and Deputy Registrars shall be the same as that for electing the President*, save that nominations from Members of the College who are not members of the Council shall be lodged with the Registrar between the first day of June in any calendar year and the date which is four clear weeks after that meeting of the Council which is the first held after the name of the President for the next ensuing College year has become known.

** i.e. Written nominations, accompanied in each case by the nominee's written consent to stand for election, may be lodged with the Registrar, provided that each such nomination is supported in writing by not less than twelve Members of the College who are not members of the Council. An election by ballot shall be held in accordance with the provisions of the Regulations.*

Winter Business Meeting 2004

The Winter Business Meeting of Council was held at the Royal College of Psychiatrists on 27 January 2004. Thirty-three Members of the College were present.

Minutes

The Minutes of the Winter Business Meeting held at the Royal College of

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