columns

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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columns

Psychiatrists on 28 April 2003 were approved as a correct record.

Election of Honorary Fellows

The following were elected to the Honorary Fellowship:

HRH The Princess Royal
Dr Abraham Halpern
Professor Philip Graham
Dr Genevra Richardson

Rehabilitation and recovery now

Council Report CR121, January 2004, Royal College of Psychiatrists, £5.00, 22 pp.

Rehabilitation and recovery services are a rewarding area of psychiatric practice; these services are in a continuing process of development, in response to the changing needs of the target population and to the changing political climate of mental health care delivery. The developmental journey for rehabilitation and recovery services is at a particularly interesting stage and offers many opportunities for psychiatrists to develop new skills over the course of their careers.

There are new developments in the way in which services are provided in partnership with service users, their families and other agencies. Rehabilitation and recovery services now provide unique opportunities for the development of longer-term therapeutic relationships with patients and their partners in care, and also offer the rewarding challenge of practical service development.

Most rehabilitation services have a developmental history that bridges deinstitutionalisation, reprovision in its many forms, community care and now social inclusion, working to reduce the impact of stigma and to promote recovery. Embracing the concept of recovery, and promoting the recovery ethos throughout rehabilitation service provision, probably represents a clear new direction.

This report describes the philosophy underpinning a modern approach to rehabilitation and recovery. It defines the service user population and gives a description of the range of service provision, together with the guiding principles that inform service development. These principles are based upon:

- enhancing the strengths and resilience of long-term service users and their families
- maintaining optimism for individual growth and recovery
- treating disability with respect and acceptance
- improving the holistic quality of life for those with the most severe disabilities
- reducing stigma and promoting social inclusion
- therapeutic risk-taking to promote personal responsibility.

New ways of working with service users and their carers lie at the heart of the specialty. The journey towards individual recovery while respecting individual disabilities must inform rehabilitation service development. The perspective of service users and their families, together with their many partners in care, can provide a powerful force for development and should be the starting-point for new work.

This report describes how services can be developed, monitored and evaluated, and gaps in services identified through collaborative partnership working. Assessment, treatments and interventions are described and the need to improve the evidence base for rehabilitation is outlined. Suggestions for an audit focus in local rehabilitation services are made, together with the latest recommendations for workforce planning.

Collaborative work with service users, peer group and inter-agency networking, research, service development and evaluation, and the training of other staff, all offer significant rewards to psychiatrists keen to respond to the challenge of providing a modern rehabilitation and recovery service. These services should lie at the heart of comprehensive community care, responding to the needs of those most at risk of living with severe disability, and aiming to promote their recovery.

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