the columns

correspondence

Qualifications in clinical education for psychiatrists

We were interested to read the article by Dinniss *et al* (*Psychiatric Bulletin*, March 2007, **31**, 107–109) on qualifications in clinical education for psychiatrists. We wish to draw attention to postgraduate programmes in medical education (including MSc, PGDip and PGCert) run by Durham University, which did not feature in the list. These are particularly relevant in that Dinniss *et al* identify a number of deficiencies in the course they undertook: some modules only had marginal relevance to their needs, and they would have valued greater opportunities to develop practical skills in delivering teaching and supporting learning. Our programmes have a strong bias towards practical approaches as opposed to being focused on research, although of course good teaching practice is also research informed. Details of our courses are available from the Durham University website at http://www.dur.ac.uk/school.health/postgraduate/taught/medicaleducation

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New Ways of Working threatens the future of the psychiatric profession

I sometimes wonder if I am the only psychiatrist who has misgivings about the direction our professional body is heading under New Ways of Working for Consultant Psychiatrists. Its impetus came from recruitment and retention problems in the profession some time ago, but the climate has now changed and many candidates are clambering for posts that trusts would have previously struggled to fill. In some areas there is a real threat of redundancies among doctors.

Out-patient clinics have largely been condemned by the new system as being purposeless and inefficient. I am not sure that service users would agree and the perspective of primary care has yet to be obtained. Most people who have an illness want a humane assessment by somebody who understands their problem, has seen it before and knows how to treat it. The professional status to deliver this only comes with experience and training. Assessment, diagnosis and treatment of people newly referred to psychiatric services can therefore not be so easily delegated to other professional groups who are not trained in diagnostic theory or nationally assessed for their ability to perform this important task.

If we, as a consultant body, see a small number of cases, while supervising others who are seeing vastly more people than ourselves, it is only a matter of time before we lose respect, credibility and competence. We are the most highly paid professional group within the mental health services and questions will be asked about whether we offer value for money.

A major service that consultant psychiatrists have offered in the past has been continuity of care. Patients have been seen at a point where their illness begins, through a period of turbulent in-patient care, back out into the community, through remission, relapse and, hopefully, recovery. The fact that there is somebody who knows their history, and has seen them through thick and thin, is I suspect of vital importance to most service users. With the functionalisation of services and division of in-patient and out-patient services, we are destroying this continuity, leading to a situation where bits of care are being individually managed in a limited way with nobody overviewing the case as a whole. It is my view that quality of care is suffering as a direct result of this.

There is no other professional group currently that has the academic background status in society, or the infrastructure for continuing professional development to take forward evidence-based psychiatry and to improve the quality of care for people with mental health problems. Nobody wishes to see burnt-out or ill psychiatrists, but psychiatrists of the future have to maintain substantive, direct contact with the patients for professional survival and, indeed, to have anything significant to offer the health service.

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Specialist psychiatric rehabilitation teams – a historical anomaly?

For many years, psychiatric rehabilitation teams worked to resettle patients from the long-stay 'asylums' into the community. This process is now virtually complete and with rising financial pressures in the National Health Service specialist rehabilitation services are under threat in many parts of the UK (Holloway, 2005).

In 2004 a review was undertaken of all people in high-support placements, largely residential homes, funded by the London Borough of Newham, and 30 people, most with chronic schizophrenia, were felt to no longer need the level of support they were receiving. Community mental health teams were encouraged to refer these people to the Newham Rehabilitation and Recovery Team, with aim of aiding their resettlement in more independent accommodation.

Two years on we reviewed the case notes of the 30 people that were originally identified. Nine had successfully moved on, mainly to housing schemes offering a few hours of support each week. Two placements had failed within a short period; both people had alcohol problems. Cost savings were estimated to be in excess of £200 000. Team members felt that a person's enthusiasm to move was related to the likely success. Close links with the council housing department were also thought to be important.

Our small study suggests that specialist rehabilitation teams can be effective in moving people with mental health problems into more independent placements. This can produce substantial financial savings and fits the College's vision for rehabilitation services to reduce