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Lost in translation

Working with their patients through interpreters has become a frequent requirement for psychiatrists, particularly in inner-city areas. The increase in immigration, which includes people in need of mental healthcare, has meant that many psychiatric assessments cannot be conducted without such assistance (Tribe & Ravel, 2002). Treatment is invariably based on the trust that patients have, or not, in mental health professionals. An interpreter, who may be someone that patients have never seen before or may never see again, could represent an unknown person that may not be trusted. One additional emerging problem that we have been encountering at our practice is that some 'interpreters' may have agendas of a political nature that lie outside their contractual remit within the mental health services.

We have been referred many patients who have fled persecution in their native countries and suffer from sequelae of trauma, including torture. Both the assessment and treatment of these patients depend on the disclosure of their experiences. If they are unable to communicate in English, the assistance of a trustworthy interpreter is necessary. However, their countries of origin may regard such information as politically sensitive and potentially damaging, and would prefer for it to remain undisclosed. Our own experience, and that of other colleagues, indicates that there may be some interpreters with apparent links to such regimes. There is a growing concern not only that these particular interpreters may not always accurately translate, but also that they may breach confidentiality. Moreover, health services other than mental health services may rely on interpreters for communication with patients under their care. Dissemination of confidential information to third parties can potentially have serious consequences for patients should they decide to return to their native countries, as well as for their relatives and friends back home.

Many interpreters are recruited through agencies that may not be in a position to fully ascertain their credentials or qualifications. In the circumstances, it is preferable to rely on well-known and appropriately referenced interpreters whenever possible in order to ensure confidentiality and safety for this patient group. A practical alternative may be to use the services of translators who are either established in the UK or who originate from a different country but are proficient in the patient's language.

TRIBE, R. & RAVEL, H. (2002) *Working with Interpreters in Mental Health*. Brunner-Routledge.

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Legislative discrimination against people with mental health problems

A young, male patient with complete remission of his symptoms of schizophrenia realised to his consternation that section 136 under the Mental Health Act 1983 came up on Criminal Records Bureau check (enhanced disclosure). The patient had since his breakdown 3 years ago successfully returned to his university studies and was simply applying for a holiday job as a gardener at a local rest home when he discovered the problem.

As part of his university course he will have to do a placement year in a company and fears that the disclosure will lead to discrimination against him in the competitive selection process. We were advised by the trust solicitor that the local chief constable would have discretion to remove the information from the disclosure form. This was denied as 'the details were factual at the time'.

In our view this is stigmatising and unnecessary. Adding this information to a person's criminal record sends out a signal that people with mental health problems are inherently dangerous and need to be excluded from certain areas of work. If people with mental health problems are dangerous that should be reflected in their actual convictions, not by having had a breakdown requiring a section. Surely, the police would never keep a record of patients with diabetes or gall bladder problems.

We wish to draw attention to the overlooked area of mental health legislation as a barrier to employment for those with mental illness. According to a new study, only 14.5% of people with schizophrenia were in competitive employment (Rosenheck *et al*, 2006). Unquestionably, allowing discrimination as described above to continue is not going to facilitate improvement in this number. In the absence of national guidelines it seems absurd that the police have unrestricted powers to make decisions of this nature regarding matters in which they have not been trained. This area needs to be urgently addressed to reduce the burden of stigma and discrimination on an already vulnerable group of people.

ROSENHECK, R., LESLIE, D., KEEFE, R., *et al* (2006) Barriers to employment for people with schizophrenia. *American Journal of Psychiatry*, **163**, 411–417.

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Insidious undermining of the liaison nursing role

Kewley & Bolton's survey (*Psychiatric Bulletin*, July 2006, **30**, 260–263) of London liaison psychiatric services raises concerns that government pressures to observe 4-hour targets in accident and emergency (A&E) departments may have compromised liaison input for other general hospital patients. Almost all teams surveyed fell short of College recommendations regarding service provision (Royal College of Physicians & Royal College of Psychiatrists, 2003) and the recent threats to liaison services in Oxford and London suggest that resources will not become available to meet these standards. Compounding this issue is the trend towards merger of crisis resolution teams and liaison psychiatric nursing teams to cut service costs. Community patients in crisis may tend to be prioritised over patients within the hospital, irrespective of the level of need. This undermines the

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skills specific to liaison nursing and their unique role in general hospitals.

Our recent survey at Chelsea and Westminster Hospital of the provision of psychosocial assessments to A&E patients presenting with suicidal thoughts or behaviours showed that 90% received full assessment by the liaison team or duty psychiatrist, with plans for further action communicated to their general practitioner (or community mental health team). This level of service was achieved with a liaison nursing team managing 85% of out-of-hours clients without medical input, with implications not only for 4-hour targets but also for the European Working Time Directive on junior doctors' working hours. Any further threats to liaison services run counter to the government's efforts to tackle suicide targets, to address the psychological needs of patients with cancer, HIV, neurological disorders, cardiovascular disease and diabetes, and its obligation to uphold employment law.

ROYAL COLLEGE OF PHYSICIANS & ROYAL COLLEGE OF PSYCHIATRISTS (2003) *The Psychological Care of Medical Patients. A Practice Guide* (Council Report CR108). Royal College of Physicians & Royal College of Psychiatrists. http://www.rcpsych.ac.uk/files/pdfversion/cr108.pdf

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'Research day' – is it a misnomer?

Okolo & Ogundipe (*Psychiatric Bulletin*, July 2006, **30**, 275–277) could not substantiate why the research day was considered useful by consultant psychiatrists in the West Midlands, but the majority of trainees had used the day for non-research purposes. Perhaps this is why it was considered useful. Certainly, with the changing face of training in psychiatry and the emphasis on new ways of working for consultant psychiatrists (Department of Health, 2005), the day could be used to enhance skills that would be useful to consultants.

It was noted that the day was not particularly productive in terms of publications and no mention was made to this effect. Other issues for discussion are the local availability of suitable training and supervision for research, access to statistical advice, and the lack of clear consensus on what to do in the day. If the day is going to be used to pursue other interests, we need to rethink whether our current approach is beneficial. For example, Hewson *et al* (2006) proposed that management experience should be an integral part of training for future consultants at an earlier stage. Most would wish to have protected time to acquire specialised skills. We suggest a more pragmatic approach to the research day. Perhaps the first step would be to rechristen it (for example, 'career enrichment day'). This day could be utilised by the specialist registrar to pursue their particular field of interest, be it research, a higher degree, audit or management.

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HEWSON, L., HOOPER, S. & WORRALL-DAVIES, A. (2006) Taking on the management: training specialist registrars in child and adolescent psychiatry. *Psychiatric Bulletin*, **30**, 71–74.

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Regional specialist registrar training day – our experience

As training day coordinators for the North-West Higher Training Scheme in Adult Psychiatry, we read with interest the article by Dr Ogden (*Psychiatric Bulletin*, August 2006, **30**, 310–312) on developing a regional specialist registrar day. We would like to report on similar training days that have been an integral part of the North-West Higher Training Scheme for the past 5 years. Our training days are similar in most aspects to the Merseyside ones, but with some important differences.

We have 10 training days per year with full support of the local specialist training subcommittee. Unlike the Merseyside specialist registrar training days, the venues in our case are rotated regularly, as our scheme covers a wide geographical area. Pharmaceutical companies sponsor the venue and catering, and the speakers give their time and expertise for free. Although the majority of the speakers come from the north-west, we have been able to secure others from further afield. Attendance at the training days is mandatory and the average attendance is around 75%.

The topics covered during the training days include a broad range of core clinical, managerial and personal development skills; for example, our next training day is on court room skills, with trainees giving expert evidence and undergoing cross examination by a barrister in a mock courtroom.

Similar to Dr Ogden's experience in Merseyside, the training days have helped in improving communication and in fostering a sense of community among the specialist registrars.

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Blood glucose testing

The results reported by Dr Tarrant (*Psychiatric Bulletin*, August 2006, **30**, 286–288) on blood glucose testing for adults prescribed atypical antipsychotics are far more impressive than we obtained when we audited prescribing on acute psychiatric wards in four health districts in the West Midlands in 2004. Adherence to blood glucose testing ranged from 8 to 47% between these units for patients on atypical antipsychotics. These rates are poor even when allowing for an unwillingness of some patients with acute illness to agree to blood tests (Hodgson & Adeyemo, 2004).

In 2004 we carried out a survey of 181 consultant psychiatrists working across the West Midlands and found that only 52% undertook blood glucose monitoring and only 29.6% believed that psychiatrists should monitor the physical health of their patients. This survey underlined the tension between primary and secondary care over physical health monitoring for those with serious mental illness. The recent guidelines (National Institute for Health and Clinical Excellence, 2006) for the management of bipolar disorder recommend an annual physical health review in primary care. However, while a patient is in hospital it is difficult to justify any lack of monitoring of physical health given that psychiatry is a medical specialty. Abrogation of responsibility for physical evaluation of patients has implications for the profession as a whole. Acknowledgement of this responsibility is reflected in the College's requirement that candidates perform a physical examination in the both parts of the Membership examination. However, consultant psychiatrists are unlikely to maintain these skills, which is a compelling argument for basing the physical healthcare of those with serious mental illness in primary care.

HODGSON, R. E. & ADEYEMO, O. (2004) Too little, too late? Physical examinations performed by trainee psychiatrists on newly admitted psychiatric patients. *International Journal of Psychiatry in Clinical Practice*, **8**, 57–60.

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