



the columns

correspondence

Chance of success is irrelevant

At the conclusion of their article, (Singh & Moncrieff, 2009) the authors state that patients should be told of the chances of an appeal being successful (about 12%). This assertion is fraught with difficulty. If this information is handled badly, the patient may feel that the doctor is trying to intimidate them out of appealing. It is like saying, 'You can appeal, if you want old boy, but your chances are only one in eight.' Many patients already labour under the misapprehension that if they appeal, they will only make things worse for themselves and this fear will only increase if a doctor glibly tells them of the low odds of success. I always try to emphasise to patients that they should appeal, as it is their right and it will not affect their care. I would recommend that this type of information would best be provided by the patient's solicitor as part of their discussions with the client, as to their instructions. The solicitor will appear a more neutral person to impart this information than the doctor who has them compulsorily detained. Appealing for release from detention is the patient's right, not a treatment decision such as which medication or therapy to advise. As such, discussions about its success rate, if at all, should be with the patient's solicitor.

SINGH D. K. & MONCRIEFF J. (2009) Trends in mental health review tribunal and hospital managers' hearings in north-east London 1997–2007. *Psychiatric Bulletin*, **33**, 15–17.

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Diabetes and liaison psychiatry: what about transition?

There are very few diabetes centres in the UK with a psychiatrist as part of the team (Dalvi *et al*, 2008). Our service in Leeds is

one of those few and has been in existence since 1998. Prompted by the Dalvi 12-month case-note review describing a service in London (Chelsea and Westminster) (Dalvi *et al*, 2008), we compared it with our service (for 2008).

There were several similarities, including the number of patients referred, their gender split, rates of non-attendance and range of interventions offered. The differences included referral source (usually consultant diabetologists in Leeds but diabetes nurse specialists in London), presenting complaints (broadly coping difficulties in Leeds, low mood in London) and who provides the various interventions (liaison psychiatrists in Leeds but, apart from initial assessment, the majority in London are seen by a clinical psychologist). The most striking difference, however, is with regard to the type of diabetes diagnosed in those referred and their age. In Leeds, 84% of referred individuals have type I diabetes, across a total patient age range of 18–74 years, whereas in London, 44% of those referred have type I diabetes and the age range is much more limited (31–71 years). There is great disparity between the two services as regards the percentage of younger people (age 30 years and younger) referred from the diabetes service to liaison psychiatry – 64% in Leeds, none in London. The fact that none of the patients seen in London are in their teens or twenties is surprising to us, particularly given the increasing focus nationally upon the relatively high prevalence of psychological and psychosocial difficulties experienced by people with diabetes in the stage of 'transition' (i.e. moving from childhood to adulthood with diabetes). National and regional working groups are calling for the provision of specific physical and mental health services for people aged 16–25 years, to come in line with existing requirements within the National Institute for Health and Clinical Excellence diabetes guidance (National Institute for Health and Clinical Excellence, 2004) and National Service Framework (Department of Health, 2001; 2007). Dalvi *et al* (2008) do not mention any separate service for the psychological needs of younger people with diabetes in their centre – either they are not being

identified as requiring specialist psychological help or they are not referred on for that help. If this is the case, and given the increasing recognition of the particular needs of this group, we would wish to raise the issue of this apparent gap in service provision.

DALVI, M., FEHER, M., CAGLAR, E., *et al* (2008) Liaison psychiatrist in a specialist diabetes centre. *Psychiatric Bulletin*, **32**, 461–463.

DEPARTMENT OF HEALTH (2001) *National Service Framework for Diabetes: Standards*. Health Service Circular (HSC 2001/026). Department of Health.

DEPARTMENT OF HEALTH (2007) *Making Every Young Person with Diabetes Matter: Report of the Children and Young People with Diabetes Working Group*. Department of Health.

NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE (2004) *Type 1 Diabetes in Children, Young People and Adults (NICE Guideline CG15)*. NICE.

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Quality of dementia referrals to later life psychiatry service

Optimal care of patients is dependent on accurate and appropriate communication between primary and secondary care. This is particularly important in disorders of cognition where patients may forget their medical history and other important information. With this in mind, we examined 91 consecutive referrals from general practitioners of patients with possible dementia. The reasons for referral included diagnosis (62.6%), management (36.3%) and long-term care (1%). The referral letter was typed in 70% of letters; up to 30% of handwritten letters were illegible. There was no mention of next of kin in 83.5% of letters, despite the fact that patients could not be relied on to attend clinical appointments due to their memory problems. The telephone number was unmentioned in 56% of letters, which made setting up initial appointment more



difficult. Current medications and medical history was stated in 75.8% and 76.9% of the letters respectively. The past psychiatric history and family history was only stated in 28.6% and 6.6% of the letters, despite being of obvious importance. Social circumstances were mentioned in 53.8% of the letters. The Mini-Mental State Examination results and blood tests were recorded in only 13.2% of referral letters. The letters showed that in 90% of patients no X-rays were done, with only 6.6% of patients having computed tomography brain scan and 3.3% of patients having magnetic resonance imaging completed.

This audit showed that many general practice referral letters are missing basic information that can compromise the initial assessment of the patients. The letters should contain enough information to ensure that patients are managed safely and effectively.

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Internet electroconvulsive therapy

While undertaking my routine electroconvulsive therapy (ECT) clinic, I asked the anaesthetic nurse what she thought about the treatment. She said she would never have ECT because of all the 'things on the internet'. Out of curiosity, I did some basic searches on the internet about ECT. Worryingly, the idea that ECT is barbaric is all over the internet. There are harrowing accounts of ECT therapy so-called 'survivors' (<http://endofshock.com/>). There are also some complete online video tutorials explaining why ECT should not be used (www.youtube.com/watch?v=WBBtH14jEPI). One particularly concerning view is that put forward by actor Tom Cruise (www.youtube.com/watch?v=TTTr4F-5U29Q). These very public attacks by anti-psychiatry groups which centre on coercive practices and memory impairment cannot be ignored.

There have been many anti-psychiatric groups. As explained by Fink, 'In their early history they were led by scholars. For example Thomas Szasz, who felt that psychiatrists were used as a form of social control by government.'¹ In modern times, many anti-psychiatry groups are led by patients. Anyone can find numerous anti-ECT websites and videos on the internet, and as clinicians we need to be aware that many of our patients could be visiting these sites or could have their own blogs.

We need to actively provide alternative information and resources to give patients a fairer view of ECT to help them make the best decision. The website www.patient.co.uk might be a good place for such information.

FINK, M. (1999) *Electroshock: Restoring the Mind*. Oxford University Press.

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Complementary and alternative treatments in psychiatric out-patients

The use of complementary or alternative medicines or treatments in the general population is high – in the UK some 46% can be expected to use one or more in their lifetime (Bishop & Lewith, 2008). Despite the popularity of alternative treatments, we were unable to find any data examining usage among psychiatric patients. To investigate this, we conducted a survey of out-patient attenders at our general psychiatry clinics; 87 consecutively attending patients were asked about their use of alternative therapies.

We found that 8 (9%) patients were using complementary or alternative treatments: 3 aromatherapy oils, 1 oil of evening primrose, 1 chondroitin, 1 homeopathy, 1 Reiki therapy and 1 patient using a compound called *Adutwumwaa Bitters*. This preparation contains *rauwolfia vomitoria*, from which reserpine is obtained. Reserpine can cause depression through monamine depletion in synaptic vesicles.

We advocate that psychiatrists should routinely ask about the use of alternative treatments when assessing patients, as often patients do not volunteer this information to their doctors (Kamerow, 2007). It is possible that certain preparations or therapies may interact with medical treatments. This may contribute to the development, or exacerbation, of a psychiatric disorder.

BISHOP, F. L. & LEWIT, G. T. (2008) Who uses CAM? A narrative review of demographic characteristics and health factors associated with CAM. *Evidence-Based Complementary and Alternative Medicine*, **13 March**, doi:10.1093/ecam/nen023.

KAMEROW, D. (2007) Wham bam thank you CAM. *BMJ*, **335**, 647.

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Trust services for psychiatrists victimised by stalkers

Between 2 and 15% of Western populations report being stalked, depending on the stalking definition used (Tjaden & Thoennes, 1998; Walby & Allen, 2004). Doctors and other healthcare professionals are at higher than average risk (Lion & Herschler, 1998; Pathé *et al*, 2002; Purcell *et al*, 2005). The high prevalence, and distressing and dangerous nature of stalking are widely reported, but services for victims of stalking remain patchy. We examined what help mental health trusts provide for psychiatrist employees victimised in this way, and the potential demand for support from the Royal College of Psychiatrists.

In a study conceived and designed with the help of Drs Edward Petch and David Reiss, we sent questionnaires to the medical directors of all 115 statutory mental health service providers in the UK, and followed-up non-responders after 4 months: 65 (57%) responded. All but one respondent said their organisation would help psychiatrist employees who were victims of work-related stalking and 38 said they would also help with stalking that was not work-related. For work-related stalking, the most common types of help offered were: discussion with a manager ($n=36$ organisations); liaison with the police ($n=31$); discussion with the clinical team or educational supervisor ($n=30$); and support from the occupational health service ($n=30$). Less common were legal services ($n=17$); staff counselling or similar psychological support ($n=17$); changing the patient's care team ($n=6$); and psychological support sourced externally ($n=4$). Other types of help were reported by 14 organisations and included: financial support for security measures, advice from a trust specialist such as a security advisor or a human resources advisor, or from a forensic psychiatrist. The wide variation in responses, with many respondents not mentioning psychological support and very few mentioning practical interventions, indicates that locally available resources are inconsistent and that a central source of expertise, such as one provided by the College, might be beneficial.

Less than half ($n=27$) of the respondents thought a College service for stalking victims would be useful, 19 thought it would not be useful and 19 were unsure. Those who supported a College service thought it should provide: practical advice ($n=25$ respondents); psychological support ($n=17$); advice to the employer ($n=8$); legal support ($n=1$); and links with other Royal