# 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.

**Ahmed S. Huda** Consultant Psychiatrist, Pennine Care NHS Foundation Trust, Early Intervention Team, 133 Astley Street, Dukinfield SK16 4PU, email: ahmed.huda@penninecare.nhs.uk

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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.

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**Ashish Rana** ST3 in Liaison Psychiatry, ***Peter Trigwell** Consultant in Liaison Psychiatry, Department of Liaison Psychiatry, Leeds General Infirmary, Great George Street, Leeds LS1 3EX, email: peter.trigwell@leedsth.nhs.uk

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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