columns

## The European Computer Driving Licence

We read with great interest the article 'Psychiatrists and the information age' by Dr Holloway (*Psychiatric Bulletin*, July 2005, **29**, 241–243). The article highlights informatics and the need for a good information technology (IT) infrastructure within the National Health Service (NHS).

Healthcare organisations may well have a poor track record in IT training, but the European Computer Driving Licence (ECDL; http://www.ecdl.nhs.uk) was not mentioned. This is now the standard for basic IT skills within the NHS. The course incorporates seven modules covering basic concepts, communication and the workings of Microsoft Office. Total study time is estimated to be from 30 to 70 h. Learning can be either self-directed or under supervision. Exams are taken under supervision in a local accredited test centre. Despite training and funding being made available to nearly all NHS staff, it is often only the administration arms of the service that take up the course.

Having undertaken ECDL training in Leeds we both feel much better equipped to embrace the modern age of informatics. It is a misconception that the ECDL is beyond psychiatrists from an older generation, since it is a perfectly accessible course designed for those with minimal IT skills. For those who quickly master the course, advanced training modules are also available. For the purposes of informatics and clinical governance we encourage all psychiatrists to incorporate the ECDL into their personal development plan.

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## The role of a community forensic mental health team

Drs Turner and Salter show a positive enthusiasm for the follow-up of certain community patients with a previous forensic background by generic mental health teams (*Psychiatric Bulletin*, September 2005, **29**, 352). They call into question the role played by forensic community teams. Referring to Dr Dowsett's report entitled 'Measurement of risk by a community forensic mental health team' (*Psychiatric Bulletin*, January 2005, **29**, 9–12) they state that there are a number of patients who '. . . are often easier to manage than many non-forensic patients. . . '.

Having worked in both community general adult teams and forensic settings, my experience is that general teams are relatively wary and reluctant to engage with patients who have been labelled as 'forensic'. I have observed this in areas where there are highly developed medium secure services and those with none. I have certainly observed that the handover of 'forensic' patients in general adult teams is often a prolonged and protracted affair, not accounted for by natural delays resulting from the sharing of information and risk assessment. There is a delay over and above the normal handover process.

The reasons for this may be a perception that 'forensic' patients should remain so for the rest of their lives, a fear of violence or of the responsibility for caring for an offender with mental health problems, or a perceived lack of skills.

I would argue that community forensic teams are the ideal solution to caring for those in the transition from medium security to the community. These services are patchy, with some areas being better served than others.

Drs Turner and Salter state that '. . . use of the HCR–20 [Historical/Clinical Risk – 20] is not especially difficult. . . '. This may be true, but I doubt busy general teams would have time to administer it. I also do not agree with Dr Pyott (*Psychiatric Bulletin*, September 2005, **29**, 352) that tools such as the HCR should be used to decide which teams or services should follow-up patients, i.e. generic *v.* forensic. This is oversimplistic and I think there is some validity in allowing a certain fluidity to remain between general and forensic services. The HCR–20 is no replacement for good clinical skills and interview techniques and should never be used in isolation.

Finally, community forensic teams have a role in supporting services and colleagues in prison psychiatry. I am currently working for a psychiatric inreach team in a prison, and have on four recent occasions enlisted the support and help of local community forensic services. They have helped coordinate responses from appropriate teams, and generally provided support, liaison and advice to our service. We have struggled to obtain similar support from general adult services.

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