columns

not recommended by NICE; citalopram was the most common (n=10, 53%).

Twenty-two patients (43%) were prescribed a psychotropic drug in our clinic and the most common choice in pregnancy was fluoxetine. This was used in 14 cases (14/22, 64%). Amitryptiline was used in 4 cases (4/22, 18%) and the remaining 4 cases were each given nortryptiline, dosulepin, sertraline and chlorpromazine respectively (the latter two for breastfeeding women). Dosulepin was used in pregnancy for one patient despite not being recommended by NICE. This was a joint decision with that individual after considering the risks and benefits.

Whenever the prescription of an antidepressant was recommended, the pros and cons should have been discussed at length with the patient and their family, yet only 16/22 cases (73%) had clear documentation in the notes that this had taken place. Moreover, we were dismayed to realise that no patients were presented with written material to assist them in understanding the risks of prescribing psychotropic drugs in pregnancy or breastfeeding, despite NICE guidelines that such visual aids should be considered standard.

The audit suggests the need to improve training in primary and secondary care to reduce the number of pregnant and puerperal patients prescribed inappropriate psychotropics. It also highlights the dilemmas in providing women with appropriate written information regarding antidepressants in pregnancy and breastfeeding. The greatest concern for women is around possible teratogenic effects but the evidence base in this area is both rapidly changing and limited, with small-scale, descriptive studies that need to be carefully interpreted. Information from the UK National Teratology Information Service (www.nyrdtc.nhs.uk/Services/teratology/teratology.html) is very helpful but is not presented in such a way that makes it easily accessible to patients.

LEWIS, G. & DRIFE, J. (2004) *Why Mothers Die 2000–2002. The Sixth Report of Confidential Enquiries into Maternal Deaths in the United Kingdom*. RCOG Press.

NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE (2007) *Antenatal and Postnatal Mental Health. Clinical Management and Service Guidance*. NICE (http://www.nice.org.uk/nicemedia/pdf/CG45fullguideline.pdf).

***Baljinder Powar** Specialist Registrar in General Adult Psychiatry, The Bradgate Mental Health Unit, Groby Road, Leicester LE3 9DZ, email: bspowar@hotmail.com, **Geraldine Swift** Consultant in Consultation Liaison Psychiatry, **Sarah Winston** Staff Grade in Consultation, Liaison Psychiatry, Arrowepark Hospital, Wirral, **Sanjay Khurmi** Specialist Registrar in General Adult Psychiatry, Birmingham and Solihull Mental Health NHS Foundation Trust, Community Drugs Team, Birmingham

doi: 10.1192/pb.33.1.37b

Responsible medical officers and mental health review tribunals

Doctors have been found wanting when it comes to understanding legislation relating to mental health review tribunals (Nimmagadda & Jones, 2008). However, it is clear that Nimmagadda & Jones (2008) also are lacking in legal knowledge with regard to the status of doctors as responsible medical officers (RMOs) at mental health review tribunals.

The question of the status of RMOs appearing before tribunals became so controversial that regional chairs of tribunals issued the following guidelines based on the old tribunal rules (J. Wright, personal communication, 2005).

1. The RMO does not have an automatic right to represent the authority.
2. The RMO is entitled to represent the authority under the provisions of rule 10 of the Mental Health Review Tribunal Rules 1983. This is the only means by with the RMO can acquire full rights of representation.
3. The RMO may be permitted by the tribunal to take such part in the proceedings as the tribunal thinks proper pursuant to rule 22(4). This amounts to a form of 'quasi-representation' the circumstances and parameters being set by the tribunal.
4. Rule 22(1) states: 'the tribunal may conduct the hearing in such manner as it considers most suitable bearing in mind the health and interest of the patient and it shall, so far as appears to it appropriate, seek to avoid formality in its proceedings'.

The authors make no mention of the potential harm to the therapeutic alliance between doctor and patient by the RMO adopting an adversarial, quasi-legal role at mental health review tribunals (Nimmagadda & Jones, 2008).

I am not aware of any provision in the new rules coming into force on 3 November 2008 which alters the position (Office of Public Sector Information, 2008). The critical issue was whether the RMO was witness, representative of the responsible authority or both?

Finally, it is important to note that there are also financial risks in representing the responsible authority. Under rule 10 of the new rules, the tribunal may make a wasted costs order, which would be liable upon the individual representing the responsible authority (Office of Public Sector Information, 2008). This could occur owing to lapses leading to adjourned hearings for example.

If members are faced with complex high-risk tribunals where representation under the old rule 10 is necessary, my advice is to instruct a competent and skilled lawyer.

NIMMAGADDA, S. & JONES, C. N. (2008) Consultant psychiatrists' knowledge of their role as representatives of the responsible authority at mental health review tribunals. *Psychiatric Bulletin*, **32**, 366–369.

OFFICE OF PUBLIC SECTOR INFORMATION (2008) *The Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008*. TSO (The Stationery Office).

Fareed Bashir Consultant Forensic Psychiatrist, Greater Manchester West Mental Health NHS Foundation Trust, Adult Forensic Mental Health Service, Edenfield Centre, Bury New Road, Prestwich, Manchester M25 3BL, email: Fareed.Bashir@gmw.nhs.uk

doi: 10.1192/pb.33.1.38

Shortcomings of consultant psychiatrists representing their responsible authority at mental health review tribunals are clear (Nimmagadda & Jones, 2008).

The Mental Health Act does not stipulate that the responsible medical officer must attend the tribunal, and, not uncommonly, the task is delegated to a junior doctor; occasionally, this is a senior house officer, who knows little psychiatry and nothing of the Mental Health Act. Such individuals are easy prey for solicitors representing patients, and if they (the doctors) are persuaded to say that the patient does not have a mental disorder of a nature or degree which warrants further detention, the tribunal has little choice but to discharge the patient from hospital, whatever their reservations about the case.

It seems to me vitally important that the responsible medical officer is responsible and attends the tribunal, as he is the most skilled in protecting the responsible authorities' best interests.

NIMMAGADDA, S. & JONES, C. N. (2008) Consultant psychiatrists' knowledge of their role as representatives of the responsible authority at mental health review tribunals. *Psychiatric Bulletin*, **32**, 366–369.

Alan C. Gibson Retired Consultant Psychiatrist, Late Member Mental Health Review Tribunal, Woking, c/o Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG

doi: 10.1192/pb.33.1.38a

The responsible medical officer in the vast majority of cases is present at the hearing in the role of a witness. If they are to act as the representative of the responsible authority they are instructed to do this by their trust; this is usually in Section 37/41 cases. Therefore, Nimmagadda & Jones (2008) are incorrect in their assertion that consultant psychiatrists, when giving evidence at a tribunal, 'act in most cases as

columns

the representative of the responsible authority.'

NIMMAGADDA, S. & JONES, C. N. (2008) Consultant psychiatrists' knowledge of their role as representatives of the responsible authority at mental health review tribunals. *Psychiatric Bulletin*, **32**, 366–369.

Charles Montgomery Consultant Psychiatrist, Specialist Team in Early Psychosis (STEP), Wonford House Hospital, Dryden Road, Exeter EX2 5AF, email: cmontgomery@nhs.net

doi: 10.1192/pb.33.1.38b

Relationships in secure psychiatric units

Relationships between residents in secure psychiatric units cause clinicians a great deal of concern (Dein & Williams, 2008). The effective management of such liaisons pre- and post-discharge also needs to be considered.

Relationships in secure settings can and will happen. Robust plans need to be made while individuals are in-patients and in anticipation of their wish to move on together. Strict boundaries need to be maintained, although joint participation in various therapeutic activities can be facilitative and could be a positive rehabilitative endeavour. With the evolution of gender specificity in secure care, separation of units or wards may reduce the instances of relationships. Clinical decision-making needs to be at the fore, especially when relationships end, as all mental disorders are at risk of relapse, thereby increasing risks.

Those in relationships are unlikely to leave a unit (sometimes after being together for years) at the same time, for example where one individual is much further down the treatment and rehabilitation pathway, and they may not reside at the same post-discharge location. Decisions on harmonising care pathways can be difficult, requiring a comprehensive assessment of risk and management. The involvement of the Ministry of Justice in restricted cases can make decision-making more complex. Guidance from the Ministry of Justice at an early stage would be particularly advantageous, possibly inviting case-workers to care programme approach meetings.

Finally, we would like to note that relationships may not only be partnerships, but also include friendships.

DEIN, K. & WILLIAMS, P. S. (2008) Relationships between residents in secure psychiatric units: are safety and sensitivity really incompatible? *Psychiatric Bulletin*, **32**, 284–287.

***Muthusamy Natarajan** Specialty Registrar (ST5) in Forensic Psychiatry, The Hatherton Centre, Stafford ST16 3AG, email: muthusamy.natarajan@sssft.nhs.uk, **Jayanth Srinivas** Consultant Forensic Psychiatrist, The Hatherton Centre, Stafford

doi: 10.1192/pb.33.1.39

Mobile telephone text messaging of clinic appointments in psychiatry

Psychiatric out-patient clinics can have a high non-attendance rate. Department of Health figures for England showed 19.1% of appointments in mental health clinics were missed compared with an overall figure of 11.7% for all specialties (Department of Health, 2003). Many strategies have emerged to try to improve attendance and, more recently, trials of short-message-service appointment reminders have been reported in other specialties (Downer *et al*, 2006; Geraghty *et al*, 2008; Koshy *et al*, 2008). These have reduced non-attendance rates and have been inexpensive to run. There do not appear to be any studies involving text-message appointment reminders in mental health services and we decided to carry out a feasibility study in our general adult psychiatry out-patient clinics.

Unfortunately, we identified some unexpected difficulties. In our random sample of 50 patients, 38 (76%) owned a mobile telephone, which is in keeping with the national average. Of these 38 people, however, only 74% could remember their telephone number and only 53% were agreeable to being contacted by text message.

Short-message-service appointment reminders do, on the surface, appear to be a potentially useful and cost-effective method of improving psychiatric out-patient clinic attendance rates. Our study, however, highlights some difficulties in maximising the effectiveness of such a service and it seems unlikely that psychiatric clinics would provide as impressive results as those reported in other settings.

DEPARTMENT OF HEALTH (2003) *Hospital Activity Statistics*. Department of Health.

DOWNER, S. R., MEARA, J. G., DA COSTA, A. C., & SETHURAMAN, K. (2006) SMS text messaging improves outpatient attendance. *Australian Health Review*, **30**, 389–386.

GERAGHTY, M., GLYNN, F., AMIN, M., & KINSELLA, J. (2008) Patient mobile telephone 'text' reminder: a novel way to reduce non-attendance at the ENT out-patient clinic. *Journal of Laryngology and Otology*, **122**, 296–298.

KOSHY, E., CAR, J. & MAJEED, A. (2008) Effectiveness of mobile-phone short message service (SMS) reminders for ophthalmology outpatient appointments: observational study. *BMC Ophthalmology*, **8**, 9–14.

***Andrew Donaldson** Specialist Registrar, Perth City Community Mental Health Team, 8 St Leonard's Bank, Perth PH1 5HH, Australia, email: andrew.donaldson@nhs.net, **Ziad Tayar** Specialty Trainee, Perth City Community Mental Health Team, Perth, Australia

doi: 10.1192/pb.33.1.39a

corrections

Services for ethnic minorities: a question of trust. *Psychiatric Bulletin*, **32**, 401–402.

p. 401, col. 2, para. 1: The second sentence should read: High rates of illness and sectioning, it is simplistically assumed in the media and elsewhere, are the product of inappropriate practice on the part of mental health professionals although no one has ever shown that the Mental Health Act is used inappropriately in individual cases.

p. 402, col. 2, para. 2: The second sentence should read: This will bring a new responsibility on all of us to broadcast a more positive message to ethnic minority patients, their families and communities. That message is simple: you will be treated fairly.

The online version of this article has been corrected post-publication in deviation from print and in accordance with this correction.

Seamus MacSuibhne and Aoife Ni Chorcorain ('I wish to speak to a psychiatrist please': psychiatric vocabulary in phrase books. *Psychiatric Bulletin*, **32**, 359).

Only 4 of the 12 questions were answered correctly by more than half the participants and for 4 questions the proportion of those answering correctly did not differ significantly from the 0.25 that would be expected from chance (Consultant psychiatrists' knowledge of their role as representatives of the responsible authority at mental health review tribunals. *Psychiatric Bulletin*, **32**, 366–369).

doi: 10.1192/pb.33.1.39b