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.

***Deirdre Hussey** Honorary Lecturer in Psychiatry for Later Life, University College Hospital Galway, Co. Galway, Ireland, email: dhussey2@gmail.com, **Kevin Foy** Senior Registrar in Psychiatry for Later Life, **Karena Meehan** Consultant Psychiatrist in Psychiatry for Later Life, University College Hospital Galway, Co. Galway, Ireland

doi: 10.1192/pb.33.4.154b

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=TTr4F-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 Sasz, 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.

Neeraj Joshi CT1, Greater Manchester West Mental Health Trust, email: neerajjoshi81@yahoo.co.uk

doi: 10.1192/pb.33.4.155

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. & LEWITH, 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.

Richard Sankar ST2 trainee in psychiatry, Moorgreen Hospital, Southampton, ***Peter Childs** Consultant Psychiatrist, Hawthorn Lodge, Moorgreen Hospital, Botley Road, West End, Southampton SO30 3JB, email: peter.childs@hantspt-sw.nhs.uk

doi: 10.1192/pb.33.4.155a

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

columns

Colleges whose members are also at risk (n=1).

The Royal College of Psychiatrists has since established the Psychiatrists' Support Service. (This happened after the data from our survey were collected, and therefore did not affect responses.) It can provide members who are victims of stalking with telephone psychological support, practical advice and legal guidance, provided by other psychiatrists with appropriate training and experience. It can also refer members for specific legal advice or psychological treatment. At the time of writing, the service has helped a total of 148 members, of whom only 3 were primarily concerned about stalking. No employers have, to date, requested advice on how to deal with stalking. We hope that awareness of the service increases and that it can go some way towards meeting the need shown by our survey.

LION, J. R. & HERSCHLER, J. A. (1998) The stalking of clinicians by their patients. In *The Psychology of Stalking: Clinical and Forensic Perspectives* (ed. J. R. Meloy): pp. 163–173. Academic Press.

PATHÉ, M., MULLEN, P. E. & PURCELL, R. (2002) Patients who stalk doctors: their motives and management. *Medical Journal of Australia*, **176**, 335–338.

PURCELL, R., POWELL, M. B. & MULLEN, P. E. (2005) Clients who stalk psychologists: prevalence, methods and motives. *Professional Psychology, Research and Practice*, **36**, 537–543.

TJADEN, P. & THOENNES, N. (1998) Stalking in America: findings from the National Violence Against Women Survey. *Morbidity and Mortality Weekly Report*, **49**, 653–655.

WALBY, S. & ALLEN, J. (2004) *Domestic Violence, Sexual Assault and Stalking: Findings from the British Crime Survey. Home Office Research Study 276*. TSO (The Stationery Office).

***Catherine Penny** ST3 in Psychiatry, Central and North West London Mental Health NHS Foundation Trust, North House, Uxbridge Road, London UB1 3EU, email: cpenny@nhs.net, **Seán Whyte** Consultant Forensic Psychiatrist, South West London Community Forensic Team, Springfield Hospital

doi: 10.1192/pb.33.4.155b

Inviting service users and carers into the consultant appraisal interview – three's a crowd?

Since April 2001, consultant appraisal has given doctors a formal and structured opportunity to reflect on their work and to consider how their effectiveness might be improved. Although wide-ranging evidence may be submitted, it is implicit that the consultant appraisal interview only takes place between two doctors. The guidance does allow for a third party but this is not encouraged: 'Where, for whatever reason, a third party needs to contribute to an appraisal – or, indeed, where a special appraiser has to be called in – this should also be discussed and agreed well in advance' (Department of Health, 2001). Indeed, absence of lay involvement may seem unusual at a time when professional regulation is changing: 'Professional regulation is about fairness to both sides of the partnerships between patients and professionals. To command the confidence of both, it must also be seen to be fair, both to patients and to health professionals' (Department of Health, 2007). Therefore, it is a good time to consider new ways of engaging service users and carers in the development and assessment of doctors.

For the past 2.5 years, consultants in Mersey Care National Health Service Trust have been inviting a service user or carer to sit in during their annual appraisal interview, selecting them from a pool of service users and carers who are actively engaged in the work of the Trust. Objectives had been set by the Trust's executive directors and the chief executive, with a service user or carer present. I decided to be the first to undergo a consultant appraisal with a service user present in July 2006, and since that time over 20 such appraisals have been undertaken.

There appear to be a number of advantages. One is promoting the work of consultants, because often the service user or carer is unaware of the breadth of responsibilities of a consultant. Another is fostering a culture of openness and a sense of pride. Perhaps extra effort is put into those appraisals when it is known that a service user or carer will be present. Also, having another person present widens the debate, offering perspectives that might not have been considered otherwise. Commitment to meeting objectives may be enhanced when a third party is witness to the discussion.

However, there may be some disadvantages. For example, some have suggested that it will not be possible to give critical feedback in the presence of a service user or carer. Although this is not necessarily true, the appropriateness of such feedback in the interview needs to be weighed against other evidence that might have accumulated during the year. Also, extra time spent organising the adapted appraisal needs to be considered. Issues about confidentiality are managed by making it very clear that the discussion remains confidential.

The invitation to a third party does provide a new perspective to the appraisal interview, and opening it to select others demonstrates a confidence and culture that should enhance the process and provide better outcomes.

DEPARTMENT OF HEALTH (2001) *Appraisal for Consultants Working in the NHS*. Department of Health.

DEPARTMENT OF HEALTH (2007) *Trust, Assurance and Safety: The Regulation of Health Professionals*. TSO (The Stationery Office).

David E. Fearnley Consultant Forensic Psychiatrist and Medical Director, Mersey Care NHS Trust, Trust Offices / Central Administration Building, Parkbourn, Maghull, Liverpool L31 1HW, email: dave.fearnley@merseycare.nhs.uk

doi: 10.1192/pb.33.4.156