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Bed numbers as a limitation to acute in-patient care

Dr Middleton suggests that the Mental Health Act Commission's criticism of acute psychiatric in-patient services in its last biennial report is a reflection of rising expectations and increased awareness of human rights, rather than an indication of any recent deterioration in such services (*Psychiatric Bulletin*, November 2006, **30**, 404). As the principal author of the report (Mental Health Act Commission, 2006*a*), I am less sanguine.

Although Dr Middleton lists a number of 'recurrent issues' in acute care, he does not mention the key issue of bed pressures. This has an impact across many acute services, leading to 'over-occupancy' of beds; delayed admissions; and the use of leave for bed-management purposes; as well as disruption and distress for patients and distraction for staff. Concern over these matters has been raised with increasing urgency by many Mental Health Act commissioners over recent years, and now by the psychiatry sub-committee of the British Medical Association Central Consultants and Specialists Committee (*BMA News*, 2006). A recent paper on bed occupancy suggests that, over the past 2 years, certain areas in England have experienced unprecedented problems in finding beds for the admission of patients under the Mental Health Act 1983 (Mental Health Act Commission, 2006*b*).

Dr Middleton is surely correct to suggest that recognition of acute in-patient care as a psychiatric specialty would be unlikely to address the most pressing difficulties facing the acute in-patient sector, not least because the improvement of patient services is a matter for clinical teams (as well as hospital managers and service commissioners) and not just the nominally responsible clinician. Indeed, in some services it would appear that improvement may be reliant upon a much more fundamental question of resources: beds for the patients.

BMA NEWS (2006) Doctors warn of psychiatric bed shortages. *BMA News*, 20 October 2006.

MENTAL HEALTH ACT COMMISSION (2006*a*) *In Place of Fear? Eleventh Biennial Report 2003–2005*. TSO (The Stationery Office).

MENTAL HEALTH ACT COMMISSION (2006*b*) *Who's Been Sleeping in My Bed? The Incidence and Impact of Bed Over-Occupancy in the Mental Health Acute Sector*. http://www.mhac.org.uk/Pages/documents/publications/who's%20been%20sleeping%20in%20my%20bed%20-%20MHAC%20bed%20occupancy%20survey.pdf

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doi: 10.1192/pb.bp.31.2.76

Recruitment and retention in psychiatry – the role of PMETB

A trend has been noted for trainee psychiatrists who obtain their College Membership to opt for staff grade and associate specialist grade (SAS) posts (Vassilas & Brown, 2005). This contributes to consultant shortages (Mears *et al*, 2002) and presents the Postgraduate Medical Education and Training Board (PMETB) with an opportunity to provide solutions.

Our survey of SAS psychiatrists in Birmingham (n=55) found personal reasons (62%) and wanting further clinical experience (45%) to be the most common reasons for taking an SAS post. Of those who have passed the MRCPsych part I examination, 69% and 50% respectively cited personal reasons and gaining clinical experience, but for those with College Membership, pay protection (75%) and additional clinical experience (75%) were the reasons.

It may be that SAS posts are considered more flexible in terms of personal and family life. With PMETB's proposal for two pathways to specialist registration, a run-through training programme and career posts, doctors might still be attracted to career posts with the incentive of pay protection, and endeavouring to keep trainees on the training path might prove difficult. None the less, the majority of those with MRCPsych part I (88%) and all with part II wanted to resume their training, therefore mechanisms need to be clarified for re-entering training systems.

The desire for additional clinical experience brings into question trainees' perception of their basic training. This adds to concerns about reduced working hours and the development of specialised teams impinging on opportunities for experiential learning (Brown & Bhugra, 2005). Could PMETB's more structured, focused and standardised approach to training be the answer?

BROWN, N. & BHUGRA, D. (2005) The European Working Time Directive. *Psychiatric Bulletin*, **29**, 161–163.

MEARS, A., KENDALL, T., KATONA, C., *et al* (2002) *Career Intentions in Psychiatric Trainees and Consultants*. Department of Health.

VASSILAS, C. A. & BROWN, N. (2005) Specialist registrar training: at the crossroads (again). *Psychiatric Bulletin*, **29**, 47–48.

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doi: 10.1192/pb.bp.31.2.76a

Documentation of extrapyramidal symptoms

Kuruvilla *et al* (*Psychiatric Bulletin*, August 2006, **30**, 300–303) reported that a high percentage of respondents in their survey had not received formal training in the assessment (52%) or management (36%) of drug-induced movement disorders and mean levels of confidence in these skills were relatively low. We studied the documentation of extrapyramidal symptoms (EPS) in patients' notes at a Manchester teaching hospital.

A psychiatrist (S.M.) conducted a standardised neurological examination on a representative group of 25 psychiatric in-patients and out-patients aged 18–65 years with schizophrenia and under several consultants. Extrapyramidal symptoms were rated on standard rating scales

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and parkinsonism, akathisia and tardive dyskinesia were diagnosed using predefined scores. Twelve of the 18 patients (67%) prescribed an atypical antipsychotic and 6 of the 7 patients (86%) prescribed a conventional antipsychotic fulfilled criteria for an extrapyramidal syndrome. A subsequent review of the clinical notes for the preceding 12 months showed that only half of the patients with an extrapyramidal syndrome (9 of 18) had documented evidence of a management plan to treat the disorder and that only 1 of the 25 patients had a documented physical examination that recorded the presence or absence of extrapyramidal signs.

Our study indicates that EPS remain common in clinical practice despite the widespread use of atypical agents, that half of extrapyramidal syndromes are untreated and that screening for EPS is not routine. Possible explanations are that clinicians lack the knowledge, skills and confidence to assess and manage EPS or that they lack the time to address this aspect of care. We agree with Kuruvilla *et al* that clinicians need better education and training in this area.

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doi: 10.1192/pb.bp.31.2.77

Paperless working environment – a logistical nightmare?

I belong to a generation of psychiatrists who have learned to love the computer. We are also apparently proficient at using it and would naturally welcome the era of the electronic patient record.

Over the past few months, some trusts have introduced the RiO system, which creates an integrated electronic care record of patients across London (NPfIT; http://www.connectingforhealth.nhs.uk). The positive impact on our working lives is undeniable once the system is fully up and running: 24 h access to essential information across a wide geographical area would facilitate risk assessments and emergency care planning. We will also rid ourselves of the piles of indecipherable files cluttering our wards.

On closer inspection the trend carries practical implications that are yet to be addressed since investment in computers and related equipment has not followed. Few junior doctors have access to dedicated offices and often six to seven senior house officers share one terminal and an antiquated printer. These juniors, who already struggle to balance clinical duties and academic requirements, will have to find the time and the facilities to input information on a daily basis.

Ideally all doctors should be issued with laptops or hand-held devices. Alternatively administrative personnel could provide instant support to clinical staff. None of these scenarios is likely in the near future in a cash-strapped National Health Service. None the less imaginative solutions are required if we are to avoid the dream of a paperless work environment turning into a logistical nightmare.

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doi: 10.1192/pb.bp.31.2.77a

Sanctions on clients who use opiates on top of methadone

I agree with Dunn *et al* (*Psychiatric Bulletin*, September 2006, **30**, 337–339) that statutory drug services cannot meet all the needs of homeless people, who have chaotic lifestyles and multiple physical health, mental health and social needs. In view of this the outreach clinic model offers an innovative way of engaging this group of clients.

We know that methadone maintenance has a strong evidence base in harm reduction (Luty, 2003). The outcomes described by Dunn *et al* probably could be attributed to this, as evidenced by the decreased use of heroin, the amount of money spent and the number of injections per day.

However, I was not convinced that sanctions should not be imposed for continued opiate use, given the risk of overdosing. I appreciate that a harm reduction model is more concerned with reducing harm than achieving abstinence. The range of heroin use among the clients was quite wide (amount spent per day £10–£200). It is not clear whether the drop in heroin use and number of injections was a direct result of clients who stopped using opiates altogether. I would be interested to know whether any harm reduction actually took place in people who continued to use opiates on top of methadone.

Although I agree that there should be some leniency in the imposition of sanctions with this difficult group of clients, I feel that sanctions should be used at some point, if the methadone prescription is not achieving anything.

LUTY, J. (2003) What works in drug addiction? *Advances in Psychiatric Treatment*, **9**, 280–288.

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doi: 10.1192/pb.bp.31.2.77b