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correspondence

Difficulties with buprenorphine

Taikato *et al* (*Psychiatric Bulletin*, June 2005, **29**, 225–227) provide a useful summary of the benefits of buprenorphine as a treatment for heroin misuse. However, the optimism with which it is described may have misled readers. Most importantly, they claim superior efficacy compared with methadone without citing supporting evidence. In terms of the most important outcome measures (retaining individuals in treatment and reducing heroin use) a recent Cochrane review clearly came down on the side of methadone (Mattick *et al*, 2004).

Buprenorphine undoubtedly remains an important treatment option because of its safety profile. However, in Cornwall, where we have more than 200 people receiving it and where supervised consumption at the local chemist has become the norm, this apparent advantage may not justify the extra cost and may be negated by problems with administration. Our experience has been that community pharmacists are unable to properly supervise consumption of the drug because administration under the tongue takes so long (sometimes up to 5 min). This difficulty, which is in contrast to methadone, has led to diversion of buprenorphine onto the black market, and subsequent intravenous use. Unfortunately, in France intravenous use has been linked with a large number of deaths (Kintz, 2001).

KINTZ, P. (2001) Deaths involving buprenorphine: a compendium of French cases. *Forensic Science International*, **121**, 65–69.

MATTICK, R. P., KIMBER, J., BREEN, C., *et al* (2004) Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. *The Cochrane Database of Systematic Reviews*, issue 2. Oxford: Update Software.

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Authors' reply: Drs White and Adams raise several points which we wish to address. First, in any discussion of the comparison of the clinical efficacy of buprenorphine and methadone it is important to delineate treatment for opioid

detoxification withdrawal and substitution/maintenance. The Cochrane review (Mattick *et al*, 2004) referred to by White and Adams compares these two drugs for opioid maintenance/substitution. The conclusion reached is that buprenorphine is an effective intervention for use in the maintenance treatment of heroin dependence but that it is no more effective than methadone at adequate doses. This result hardly 'clearly came down on the side of methadone' as declared by White and Adams.

The significance of the methadone dose in relation to efficacy was emphasised in our paper. There is evidence (Ward *et al*, 1999) to demonstrate that methadone stabilising doses of less than 50 mg are associated with higher patient drop-outs and doses greater than 60 mg are associated with longer stays in treatment and greater reductions in heroin use.

An updated Cochrane review (Gowling *et al*, 2005) investigated the effectiveness of buprenorphine in managing opioid withdrawal/detoxification and concluded that buprenorphine was more effective than clonidine but that there was no significant difference compared with methadone in terms of completion of treatment. However, it was suggested that the withdrawal symptoms might resolve more quickly with buprenorphine.

Second, our intention was to inform clinicians of the viability of buprenorphine as a treatment option for opioid dependence. The import of procedures and protocols for prescribing was emphasised. In this regard, we were interested in the Cornwall experience and particularly the difficulties encountered by community pharmacists with supervising buprenorphine administration. White and Adams poignantly bring to light the risks of diversion into the community when drug administration is not carefully monitored. Surely this highlights the need for local protocols and as such is in keeping with clinical governance principles. This approach should address the roles of pharmacies, diversion into the community, supervision, care plans and prescribing because it may be the best choice for the patient.

Finally, White and Adams comment on the 'optimism' which 'may have misled readers'. At no stage did we state that buprenorphine was superior in its efficacy to methadone, neither did we state that buprenorphine should be the mainstay

treatment for opioid dependence. Furthermore, reference to the French situation is of limited relevance to the UK. In France, methadone is not as readily available as a treatment option and buprenorphine is the mainstay treatment. It is also wise to remember that although systematic reviews underscore good clinical practice, they do not always translate accurately into clinical practice and the context within which one prescribes is an important factor.

If any element of optimism was present, it most likely reflected the authors' enthusiasm about the potential for extending the treatment options for those who struggle with opioid dependence.

GOWLING, L., ALI, R. & WHITE, J. (2005) Buprenorphine for the management of opioid withdrawal. *Cochrane Database of Systematic Reviews*, issue 2. Chichester: Wiley InterScience.

MATTICK, R. P., KIMBER, J., BREEN, C., *et al* (2004) Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. *Cochrane Database of Systematic Reviews*, issue 2. Oxford: Update Software.

WARD, J., HALL, W. & MATTICK, R. (1999) Role of maintenance treatment in opioid dependence. *Lancet*, **353**, 221–226.

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Specialist perinatal mental health services

We read with interest the paper by Drs Oluwatayo & Friedman on the provision of specialist perinatal mental health services in England (*Psychiatric Bulletin*, May 2005, **29**, 177–179). It is particularly worrying that, despite two confidential enquiry reports into maternal deaths identifying psychiatric disorder as the most common cause of death during pregnancy or within the first postnatal year (Confidential Enquiry into Maternal and Child Health, 2004), the number of specialist facilities has actually declined, and trusts in England do not regard such provision as a priority. We agree wholeheartedly with



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Oluwatayo & Friedman that there is need for a national approach and guidance on minimum standards.

The Mental Health (Care and Treatment) (Scotland) Act 2003 enshrines in law a requirement for National Health Service (NHS) boards in Scotland to make appropriate provision for admitting mothers with their babies for treatment of mental illness in the postnatal period. The Act also encourages NHS boards to collaborate in delivering services. Recent guidance (Scottish Executive Health Department, 2004) emphasises the need to develop community, maternity liaison and specific primary care services in tandem with in-patient provision, and sets minimum standards for care for both mother and baby. A formal Scottish Executive Health Department review of progress towards implementation of the Act in October 2005 is ongoing. Inevitably this has led to an approach that is national in aspiration.

Scottish provision remains patchy, with one six-bed unit serving the west, but plans are rapidly developing in other areas through regional planning structures, with close communication between those involved in running existing services and those commissioning new provision. What has become clear from our experience is that specialist provision must involve collaboration across wide geographical/population areas to ensure viability of services and development of appropriate knowledge and expertise.

CONFIDENTIAL ENQUIRY INTO MATERNAL AND CHILD HEALTH (2004) *Why Mothers Die 2000–2002 – Report on Confidential Enquiries into Maternal Deaths in the United Kingdom*. London: Royal College of Obstetricians and Gynaecologists.

SCOTTISH EXECUTIVE HEALTH DEPARTMENT (2004) *A Framework for Mental Health Services in Scotland: Perinatal Mental Illness / Postnatal Depression Admission and Support Services*. Edinburgh: Scottish Executive Health Department.

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Transfer from child to adult mental health services

Singh *et al* (*Psychiatric Bulletin*, August 2005, **29**, 292–294) discuss the risk of disrupted care for young people who outgrow child and adolescent mental health services (CAMHS).

Lincolnshire Partnership NHS Trust has a protocol for good practice surrounding transfer of a young person's care from child to adult mental health services. However, in an audit of these procedures

involving 82 young people aged 17 or 18 years who were discharged from three of our community CAMHS teams over a 2-year period, only seven were transferred to adult services. CAMHS clinicians identified 32 other young people who left the service with unresolved mental health problems: a suitable adult service could not be found for one young person, 21 young people dropped out of CAMHS and ten young people did not want to be referred to adult services.

The paucity of psychological therapies in adult mental health services created difficulties for CAMHS clinicians in finding suitable follow-on services. Perhaps the prospect of an inevitable ending with no further support contributed to the high drop-out rate of young people approaching the end of the service available to them in CAMHS? Some young people clearly said they did not want to have to 'start from the beginning' in establishing a therapeutic relationship with a new worker. Others were perhaps influenced in declining ongoing care by the perceived stigma of adult services.

Our audit findings add to the evidence that the current differing perspectives of CAMHS and adult mental health services create gaps in services through which vulnerable young people fall.

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Are psychiatrists real doctors?

The survey of psychiatric trainees in Scotland by Dr Robinson (*Psychiatric Bulletin* February 2005, **29**, 62–64) showed that a significant amount of physical healthcare is being provided by psychiatric trainees.

In my experience, south of the border the situation is no different, particularly in psychiatric long-stay facilities such as rehabilitation units and forensic units where a large degree of physical morbidity exists. Cormac *et al* (2004) reported high rates of avoidable health risks such as smoking, obesity, central weight distribution and excessive weight gain.

The role of the trainee is to identify and manage problems for which they often may have received no formal training. After completion of pre-registration house jobs, direct entry to psychiatric training schemes is not uncommon. The notion of managing, for example, an individual's diabetes, hypertension or obesity may be quite alien never mind being able to recognise strange skin complaints and other problems commonly encountered in primary care.

I have experience and training in primary care which I have found invaluable

in dealing with my patients' physical health problems. The National Service Framework for Mental Health requires health promotion and appropriate access to and delivery of primary care for patients with mental disorders (Department of Health, 1999). It may be of value to consider the training needs of psychiatric trainees with regards to management of physical health problems.

CORMAC, I., FERRITER, M., BENNING, R., *et al* (2005) Physical health and health risk factors in a population of long-stay psychiatric patients. *Psychiatric Bulletin*, **29**, 18–20.

DEPARTMENT OF HEALTH (1999) *National Service Framework for Mental Health: Modern Standards and Service Models*. London: Department of Health

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Physical health of patients in rehabilitation and recovery

I read with interest the article by Dr Greening (*Psychiatric Bulletin*, June 2005, **29**, 210–212). I have recently undertaken an audit of the physical healthcare of patients in our rehabilitation and recovery unit in Warwick. Unfortunately, my preliminary results show a similar picture to that reported by Dr Greening.

However, we do have a local general practitioner (GP) who has two sessions allocated per week for the review of any physical health problems: the type of 'shared care approach' suggested by Lester (2005) and Bickle (2005). It must be stressed though that it is not the responsibility of our GP colleagues to trawl through reams of notes (which most rehabilitation patients have) but rather up to the psychiatric team to ensure that patients are having appropriate investigations that can then be discussed with primary care.

For my audit I initially drew up a 'checklist' (standards) of the investigations that patients should have depending on what type of medication they are prescribed and how often, if at all, this ought to be repeated. I used the *Maudsley Prescribing Guidelines*, *British National Formulary* and consulted pharmaceutical companies in drawing up the standards for each psychotropic agent – one must not forget mood stabilisers and antidepressants that also require monitoring. Although rather time-consuming, it is a more rigorous method than collating the views of colleagues as done by Pitman (2005) prior to audit and is better than a battery of 'routine tests' which may be incomplete.

In addition, we have put together a health screen protocol for each patient that not only looks at issues such as diet,