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Trainee's workload and support in out-patient clinics: Keele survey

A postal survey of psychiatric trainees (*n*=52) based on the Keele rotational scheme in the West Midlands deanery was conducted using a 19-item questionnaire to establish the extent to which the workload and support for trainees comply with the College guidelines (Royal College of Psychiatrists, 2003). Thirty-two trainees (61%) responded, of which 14 (43%) always discussed patients seen in out-patient clinics with their consultant during weekly supervision which should be used for educational rather than clinical purposes. However, 28 (87%) trainees indicated that they had no formal training in writing letters to general practitioners and 21 (65%) had not received any supervision. Although the College guidelines specify that trainees should not be expected to perform duties beyond their competence without adequate supervision, about 50% accepted that they sometimes deal with too complex cases for their level of experience without sufficient help. Alarmingly, 9 (28%) trainees indicated that supervision for new patient clinics was rarely available, out of which 5 (15%) trainees had less than 1 year's experience in psychiatry which raises concern. This survey illustrates the importance of adequate supervision in out-patient clinic settings and emphasises the need for trainees to use weekly supervision to enhance their clinical skills and theoretical knowledge to enable them to discharge their duties effectively.

More needs to be done to change the allocation of complex patients with no supervision to trainees with limited level of experience.

ROYAL COLLEGE OF PSYCHIATRISTS (2003) *Basic Specialist Training Handbook*. Royal College of Psychiatrists.

***Alfia Ubaidullah** Core Trainee Year 1, North Western Deanery, Royal Bolton Hospital, Bolton BL4 0JR, email: ualfia@gmail.com, **Jayaraj Padmanabhan** Associate Specialist in Psychiatry, St George's Hospital, Stafford

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Adult ADHD: the new kid on the block has grown up

Knowledge, practices and attitudes towards adult attention-deficit hyperactivity disorder (ADHD) were studied using a semi-structured questionnaire. There were 38 respondents (58% response rate, including 16 consultants) to the anonymous survey of 74 clinicians attending a training day in Stoke-on-Trent.

Four clinicians (10%) had actual experience dealing with adult ADHD and two of these had occasional transfer meetings with children and adolescent mental health services (CAMHS). Overall, 50% of respondents felt confident enough to diagnose adult ADHD in spite of having no actual experience and 63% felt confident enough to prescribe medication for adult ADHD.

Two clinicians were sceptical about the validity of the diagnosis and another consultant referred to the need for further evidence of treatment efficacy. Although 24% of clinicians felt life-coaching alone would suffice, 50% favoured a treatment combination of psychostimulants and life-coaching. The majority identified a need for further training. Almost everyone indicated a service gap at the time of transition from CAMHS to adult psychiatry.

Our survey highlights a mismatch between clinicians' perceived confidence and their actual experience in diagnosis and treatment of adult ADHD (Nutt *et al*, 2007). Expert opinion suggests adult ADHD is underdiagnosed and mistaken for other conditions (Asherson, 2004). Prevalence rates of adult ADHD is estimated at around 4%, which is four times higher than that of schizophrenia and, despite that, in our survey most clinicians (90%) did not have any actual adult ADHD patient contact. This raises the question of whether respondents' high confidence in diagnosing and prescribing is misguided and whether they indeed have the knowledge and skills to manage adult ADHD.

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***Anis A. Ahmed** Speciality Registrar (ST3), North Staffordshire Combined Health Care NHS Trust, Stoke-on-Trent ST4 6TH, email: amisahmed@doctors.org.uk, **Stephanie Cress** Specialist Registrar, **Lisetta Lovett** Consultant Psychiatrist and Senior Lecturer, North Staffordshire Combined Health Care NHS Trust

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Audit of a perinatal psychiatric clinic

Maternal mental health is an important topic because of the high risk of relapse of women with mental illnesses after delivery, poorer obstetric outcomes (Lewis & Drife, 2004) and the complex clinical issues that arise in prescribing for pregnant or breastfeeding women. The National Institute for Health and Clinical Excellence (NICE) has recently published guidelines on antenatal and postnatal mental health (National Institute for Health and Clinical Excellence, 2007).

As part of our liaison psychiatry service, we instituted an out-patient clinic exclusively for pregnant women and new mothers with common mental health problems. Close links were developed with the maternity unit and referrals accepted from two specialist mental health midwives and a consultant obstetrician with a special interest in the field. Referral criteria included women with anxiety or depression who required advice around psychotropic use during pregnancy or the puerperium.

An audit of the clinic was conducted using audit criteria suggested in the 2007 NICE guidelines. Overall, 51 patients were referred over the first 7 months. A total of 27 (53%) patients were on a psychotropic prior to referral to our clinic. Of these, 19 (70%) were taking medications

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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

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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

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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

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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

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