the columns

correspondence

Recruitment from India

I appreciate the efforts of Gupta & Gupta (*Psychiatric Bulletin*, March 2006, **30**, 81–84) in highlighting some of the difficulties faced by consultant psychiatrists recruited from India but think that the article could have been complemented by data from a survey of the 84 consultants recruited.

The differences in the working environment in the UK, especially multidisciplinary teamworking and corresponding power differentials, could prove difficult for consultants accustomed to ways of working in India. Apart from mentoring and induction training to tackle these issues at trust level, there is a role for the College Continuing Professional Development Committee to devise specific programmes to address these concerns.

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Brief psychotherapy by trainees under the new shift system

Mace *et al* (*Psychiatric Bulletin*, January 2006, **30**, 7–10) showed that significant improvements can be achieved by inexperienced psychiatric trainees providing brief psychotherapy under supervision.

Over the past 18 months we have each held full-time psychotherapy posts at St Michael's Hospital, Warwick and have provided brief (6-month) courses of psychotherapy to patients under supervision. This coincided with the introduction of the shift system at St Michael's Hospital and we each had 2.5 weeks of night duties on a 1 in 11 shift rota system during each 6-month placement. In addition to 12.5 days of annual leave this represented a significant interruption to the continuity of psychotherapy.

Continuity of treatment is at the core of psychotherapy (McGauley & Humphrey, 2003). Hence the new shift system may have a negative impact on brief psychotherapy treatment by trainees in the UK. It is important that future studies investigate this further.

McGAULEY, G. & HUMPHREY, M. (2003) Contribution of forensic psychotherapy to the care of forensic patients. *Advances in Psychiatric Treatment*, **9**, 117–124.

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Methadone maintenance programmes

Kumar & Rajwal (*Psychiatric Bulletin*, January 2006, **30**, 16–18) raise issues related to the adequate dose of methadone for treatment of opioid dependence. They reported that 54% of patients who participated in the survey used opiates in addition of their prescribed methadone. It would have been relevant to know the doses of methadone that this group were receiving compared with those that did not report additional opiate use. Low-dose methadone treatment has been strongly associated with poor outcomes in clinical studies (Amato *et al*, 2005). Observational studies and randomised controlled trials indicate that there is a linear dose–response relationship between methadone dose and heroin use. The likelihood of using heroin decreases as the dose of methadone increases (Ward *et al*, 1998). Evidence suggests that the appropriate methadone dose during maintenance treatment should be between 60 and 120 mg/day for most people (Department of Health, 1999), with some requiring significantly higher doses and some patients stabilising on lower doses. The prescription of methadone doses in this range results in greater retention of patients in treatment programmes and less heroin use while in treatment.

We would argue that the evidence clearly indicates that optimising methadone dose on an individual basis may reduce the number of patients who continue to use opioids in addition to their prescribed methadone. We suggest that supervised daily consumption should be normal practice until the patient is stabilised.

AMATO, L., DAVOLI, M., PERUCCI, C., *et al* (2005) An overview of systematic reviews of the effectiveness of opiate maintenance therapies: available evidence to inform clinical practice and research. *Journal of Substance Abuse Treatment*, **28**, 321–329.

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Exploitation or experiential learning?

Dr Sundeep comments that psychiatric trainees having to perform 'inappropriate duties' and considers this exploitation (*Psychiatric Bulletin*, February 2006, **30**, 75). I agree that good training is crucial for producing the consultants of tomorrow but think that we must not lose sight of how we learn. Workplace experiential learning gives a broader understanding of how the hospital and its systems work. Consultants have expanding roles beyond the more traditional clinical ones and early exposure to finding patients beds, for example, can enhance understanding of bed management and allocation of resources, giving the trainee a more-rounded education. I feel that these 'inappropriate duties' can actually be beneficial if they do not become routine and are balanced with appropriate clinical duties and study time.

On a more cautionary note, with the probable increase in the number of medical care practitioners, trainees need to be careful about what they will or will not do, or trusts might find a cheaper and more flexible alternative to senior house officers.

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https://doi.org/10.1192/pb.30.6.234-b Published online by Cambridge University Press