in practice psychiatry is still a shortage speciality. Trainees can therefore be encouraged to apply for registrar posts as soon as they pass their Part I; thus it is anticipated that the length of time at SHO level will be relatively short especially for "high flyers".

The increased supervision of training both for SHOs and registrars required by *Achieving a Balance* is surely beneficial to all trainees. Career counselling for "stuck doctors" is obviously very important but is currently seldom carried out in a systematic way. *Achieving a Balance* requirements clearly remedy this. Regular and formal review of registrars' progress by a regional based committee is also surely to be welcomed.

Thus although the requirements of *Achieving a Balance* involves the local scheme organisers, regional advisers, clinical tutors as well as College convenors and their teams with extra work, rotational schemes can be devised which benefit trainees. In such cases "controversy, ill-feeling and loss of morale" should not occur.

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Discharge summaries

DEAR SIRS

With reference to the article in the series 'Audit in practice' entitled 'Audit of psychiatric discharge summaries' (*Psychiatric Bulletin*, October 1990, **14**, 618–620). I was somewhat concerned to note that there did not appear to be any attention paid to the fact that many general practitioners either read the discharge summaries to the patient, hand the summary to the patient so that he or she can read it, or leave the patient in the surgery with the summary conveniently placed in front of him/her while the GP attends to other matters.

While I agree that a good summary is important for the psychiatric notes, I would feel that the best method of producing a summary for the GP should consist of the name and address of the patient, a diagnosis not exceeding six words, and the current medication and whether or not there is follow-up from the psychiatric service and in what form this would be.

Possibly, given the fact that at Highcroft Hospital there are 23 psychiatrists, the average contact with GPs is so low that they have not experienced these matters.

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DEAR SIRS

As we cited in our *Bulletin* report 'Audit of psychiatric discharge summaries', we have conducted a questionnaire study of the 234 general practitioners who refer patients to Highcroft Hospital in order to determine their preferences for format of a discharge communication from psychiatric hospital (Craddock & Craddock, 1989). We asked general practitioners to choose their preferred summary from three specimen summaries and 208 (89%) general practitioners responded. The briefest summary (very similar to Dr Launer's suggestion) was chosen by only 8% of respondents; 26% opted for a full and detailed summary filling $2\frac{1}{4}$ sides of A4 typescript while the majority (66%) preferred a summary of intermediate detail (with a length of one side of A4 typescript). We used the same methodology to determine which specimen summary the 23 psychiatrists at Highcroft Hospital preferred to have filled in the case notes as a record of the admission: 74% opted for the detailed summary and 26% for the summary of intermediate detail. There was a significant difference ($P < 0.001$) between the preferences of general practitioners and psychiatrists and we concluded that a single summary cannot adequately meet the needs of both psychiatrists and general practitioners.

We suggest that general practitioners are sent a summary on one side of A4 typescript which contains details specifically pertinent to the general practitioner's future management of the case (which will include many, but not all, of the 23 items we list in our *Bulletin* report). We believe that the general practitioner should also be sent a copy of the detailed hospital summary (which may be discarded if not wanted). Such a scheme would satisfy the preferences of 92% of the general practitioners we surveyed.

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Reference

CRADDOCK, N. & CRADDOCK, B. (1989) Psychiatric discharge summaries: differing requirements of psychiatrists and general practitioners. *British Medical Journal*, **299**, 1382.

A form of drug audit in mental handicap

DEAR SIRS

The drug treatment of mentally handicapped patients in hospital and community is complicated by issues which do not arise as frequently in general psychiatric practice. In mentally handicapped people there is, first, the question of how their level of understanding affects their capacity to consent to treatment. Second, psychiatric diagnoses are often less clear cut. Third, abnormal brain structure and function may affect the response to drugs. Fourth, carers

https://doi.org/10.1192/pb.15.2.111-b Published online by Cambridge University Press

play a crucial part in the effective management of treatments.

Severely mentally handicapped patients are usually unable to understand treatment or consent meaningfully to it. Few are formally detained and compelled to accept treatment. Mentally handicapped people usually acquiesce to what is done to them and they take the medication they are given.

The efficacy of psychiatric drugs is generally less certain and less predictable in mentally handicapped people, many of whom have existing evident or presumed brain damage or cerebral dysfunction. Some patients are sensitive to very small doses. Others tolerate amounts of antipsychotic drugs well in excess of British National Formulary standard dosage schedules.

In the community care of mentally handicapped people the role of the carer is interposed between doctor and patient. The doctor needs to gain the co-operation and confidence of the carers. The patient's compliance with treatment often depends on the carer's conforming with the doctor's advice and instructions. Carers, including parents and relatives, sometimes have their own attitudes, idiosyncratic views and prejudices. They do not necessarily follow strictly guidance about the administration of medicines. They cannot always be relied on to take care of medicines. Accidentally, if not deliberately, they can make changes from the intended drug regime. They may say only what they want the doctor to know.

The form of audit below summarises a checklist of points which arise in the drug treatment of mentally handicapped patients and needs to be recognised, reviewed and recorded.

A Form of Drug Audit in Mental Handicap

Status of patient: informal/detained.

Consent: patient's capacity to understand and to consent to treatment
medical treatment and second opinions

Place of drugs in overall treatment strategy and individual programme plan (IPP)

Appraisal of drug treatment:

—appropriate to psychiatric diagnosis

—appropriate to age and sex

—ability of patient to manage own self-medication and to care safely for —medicines; possible individual differences in metabolism of drugs

Drugs prescribed: anti-psychotic, anti-depressant, lithium, anti-epileptic, anti-parkinsonism, others, e.g. Cyproterone: *dosage* – low/normal/high; increasing/static/reducing; oral/tablets/liquid; depot injection

Combination of drugs: rationale, risk

Duration of therapy: days/weeks/months

Periodic monitoring and review: ward round, drug review meeting, case conference

Side effects: patient's ability to understand and to report side effects: none/slight/serious; observed/complained of

Compatibility with other treatments: interaction with other drugs being taken

Blood plasma levels: lithium, anti-epileptics

Carers: involvement, attitudes, idiosyncratic views, understanding, willingness to care for medicines and handle their administration

Advice: information given to carer about medicines, e.g. handouts, patients' record cards.

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The role of physiotherapists in mental illness multidisciplinary teams

Dear Sirs

I am prompted to write after reading the article 'Educating the Psychiatrist of the 21st Century' by R. H. Cawley (*British Journal of Psychiatry*, August 1990, 174–181). His second educational theme covered mental health professionals and the psychiatric team, but did not mention physiotherapists. Our role is not fully appreciated, and there is a continual need to advertise our skills. We have been at pains to educate ourselves through a CSP validated course; we have a thriving special interest group, and regularly organise study days.

Physiotherapists are commonly thought of as being rehabilitators of the body rather than the mind. But there is a growing role for them as facilitators for the improvement of the mental health in conjunction with the physical health of their patients.

Patients suffering from mental illness are not exempt from physical problems. Our expectations and treatment plans are tempered by our knowledge and understanding of the patients' mental state and adjusted accordingly. We learn the value of interpersonal therapeutic relationships and counselling skills; attendance on ward rounds leads to an understanding of the roles of the other team members.

Physiotherapists are required to make an holistic assessment of the patient's problems and nowhere is this more apt than in the field of mental health, where body and mind are inseperable. We ask open questions and the nature of the answers indicates the patients' mental state.

Patients often blame their physical aches and pains for their mental state and will readily accept physical treatment because they believe it will make them better.

There is no stigma attached to seeing a physiotherapist. The practical way in which we assess problems and devise treatment programmes that encourage patients to utilise their own resources is

https://doi.org/10.1192/pb.15.2.111-b Published online by Cambridge University Press