Working with their patients through interpreters has become a frequent requirement for psychiatrists, particularly in inner-city areas. The increase in immigration, which includes people in need of mental healthcare, has meant that many psychiatric assessments cannot be conducted without such assistance (Tribe & Ravel, 2002). Treatment is invariably based on the trust that patients have, or not, in mental health professionals. An interpreter, who may be someone that patients have never seen before or may never see again, could represent an unknown person that may not be trusted. One additional emerging problem that we have been encountering at our practice is that some ‘interpreters’ may have agendas of a political nature that lie outside their contractual remit within the mental health services.

We have been referred many patients who have fled persecution in their native countries and suffer from sequelae of trauma, including torture. Both the assessment and treatment of these patients depend on the disclosure of their experiences. If they are unable to communicate in English, the assistance of a trustworthy interpreter is necessary. However, their countries of origin may regard such information as politically sensitive and potentially damaging, and would prefer for it to remain undisclosed. Our own experience, and that of other colleagues, indicates that there may be some interpreters with apparent links to such regimes. There is a growing concern not only that these particular interpreters may not always accurately translate, but also that they may breach confidentiality. Moreover, health services other than mental health services may rely on interpreters for communication with patients under their care. Dissemination of confidential information to third parties can potentially have serious consequences for patients should they decide to return to their native countries, as well as for their relatives and friends back home.

Many interpreters are recruited through agencies that may not be in a position to fully ascertain their credentials or qualifications. In the circumstances, it is preferable to rely on well-known and appropriately referenced interpreters whenever possible in order to ensure confidentiality and safety for this patient group. A practical alternative may be to use the services of translators who are either established in the UK or who originate from a different country but are proficient in the patient’s language.


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Legislative discrimination against people with mental health problems

A young, male patient with complete remission of his symptoms of schizophrenia realised to his consternation that section 136 under the Mental Health Act 1983 came up on Criminal Records Bureau check (enhanced disclosure). The patient had since his breakthrough 3 years ago successfully returned to his university studies and was simply applying for a holiday job as a gardener at a local rest home when he discovered the problem. As part of his university course he will have to do a placement year in a company and fears that the disclosure will lead to discrimination against him in the competitive selection process. We were advised by the trust solicitor that the local chief constable would have discretion to remove the information from the disclosure form. This was denied as ‘the details were factual at the time’.

In our view this is stigmatising and unnecessary. Adding this information to a patient’s criminal record sends out a signal that people with mental health problems are inherently dangerous and need to be excluded from certain areas of work. If people with mental health problems are dangerous that should be reflected in their actual convictions, not by having had a breakdown requiring a section. Surely, the police would never keep a record of patients with diabetes or gall bladder problems.

We wish to draw attention to the overlooked area of mental health legislation as a barrier to employment for those with mental illness. According to a new study, only 14.5% of people with schizophrenia were in competitive employment (Rosenheck et al, 2006). Unquestionably, allowing discrimination as described above to continue is not going to facilitate improvement in this number. In the absence of national guidelines it seems absurd that the police have unrestricted powers to make decisions of this nature regarding matters in which they have not been trained. This area needs to be urgently addressed to reduce the burden of stigma and discrimination on an already vulnerable group of people.


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Insidious undermining of the liaison nursing role

Keveley & Bolton’s survey (Psychiatric Bulletin, July 2006, 30, 260–263) of London liaison psychiatric services raises concerns that government pressures to observe 4-hour targets in accident and emergency (A&E) departments may have compromised liaison input for other general hospital patients. Almost all teams surveyed fell short of College recommendations regarding service provision (Royal College of Physicians & Royal College of Psychiatrists, 2003) and the recent threats to liaison services in Oxford and London suggest that resources will not become available to meet these standards. Compounding this issue is the trend towards merger of crisis resolution teams and liaison psychiatric nursing teams to cut service costs. Community patients in crisis may tend to be prioritised over patients within the hospital, irrespective of the level of need. This undermines the
skills specific to liaison nursing and their unique role in general hospitals. Our recent survey at Chelsea and Westminster Hospital of the provision of psychosocial assessments to A&E patients presenting with suicidal thoughts or behaviours showed that 90% received full assessment by the liaison team or duty psychiatrist, with plans for further action communicated to their general practi-
tioner (or community mental health team). This level of service was achieved with a liaison nursing team managing 85% of out-of-hours clients without medical input, with implications not only for 4-
hour targets but also for the European Working Time Directive on junior doctors’ working hours. Any further threats to liaison services run counter to the government’s efforts to tackle suicide targets, to address the psychological needs of patients with cancer, HIV, neurological disorders, cardiovascular disease and diabetes, and its obligation to uphold employment law.


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Regional specialist registrar training day – our experience

As training day coordinators for the North-West Higher Training Scheme in Adult Psychiatry, we read with interest the article by Dr Ogden (Psychiatric Bulletin, August 2006, 30, 310–312) on developing a regional specialist registrar day. We would like to report on similar training days that have been an integral part of the North-West Higher Training Scheme for the past 5 years. Our training days are similar in most aspects to the Merseyside ones, but with some impor-
tant differences.

We have 10 training days per year with full support of the local specialist training subcommittee. Unlike the Merseyside specialist registrar training days, the venues in our case are rotated regularly, as our scheme covers a wide geographical area. Pharmaceutical companies sponsor the venue and catering, and the speakers give their time and expertise for free. Although the majority of the speakers come from the north-west, we have been able to secure others from further afield. Attendance at the training days is manda-
tory and the average attendance is around 75%.

The topics covered during the training days include a broad range of core clinical, managerial and personal development skills; for example, our next training day is on court room skills, with trainees giving expert evidence and undergoing cross examination by a barrister in a mock courtroom.

Similar to Dr Ogden’s experience in Merseyside, the training days have helped in improving communication and in fostering a sense of community among the specialist registrars.

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Blood glucose testing

The results reported by Dr Tarrant (Psychiatric Bulletin, August 2006, 30, 286–288) on blood glucose testing for adults prescribed atypical antipsychotics were far more impressive than we obtained when we audited prescribing on acute psychiatric wards in four health districts in the West Midlands in 2004. Adherence to blood glucose testing ranged from 8 to 47% between these units for patients on atypical antipsychotics. These rates are poor even when allowing for an unwill-
ingness of some patients with acute illness to agree to blood tests (Hodgson & Adeyemo, 2004).

In 2004 we carried out a survey of 181 consultant psychiatrists working across the West Midlands and found that only 52% undertook blood glucose monitoring and only 29.6% believed that psychiatrists should monitor the physical health of their patients. This survey underlined the tension between primary and secondary care over physical health monitoring for those with serious mental illness. The recent guidelines (National Institute for Health and Clinical Excellence, 2006) for the management of bipolar disorder recommend an annual physical health review in primary care. However, while a patient is in hospital it is difficult to justify any lack of monitoring of physical health given that psychiatry is a medical speci-
alty. Abrogation of responsibility for physical evaluation of patients has impli-
cations for the profession as a whole. Acknowledgement of this responsibility is reflected in the College’s requirement that candidates perform a physical examination in the both parts of the Membership examination. However, consultant psychiatrists are unlikely to maintain these skills, which is a compelling argument for baising the physical healthcare of those with serious mental illness in primary care.

Doctors should manage doctors

I completely agree with Dr Palin’s assertions (Psychiatric Bulletin, September 2006, 30, 353) that ‘psychiatrists should be selected for management roles on merit rather than simply because they are a doctor’ and that psychiatrists should aspire to ‘provide clinical leadership to all clinicians working within mental health services’ – not just the doctors.

The main point of the paper by Griffiths & Readhead (Psychiatric Bulletin, June 2006, 30, 201–203) to which Dr Palin refers was to identify the problems confounding those aspirations – lack of clarity in roles assigned to medical directors and managers, lack of sessional time and support to do a good job, and lack of clarity in the capabilities and training required. Even those with outstanding qualities for leadership may falter under such conditions.

The inference of Dr Palin from my summary of the Kerr/Haslam Report (Psychiatric Bulletin, June 2006, 30, 204–206) is the opposite of my own. The report concluded that one of the reasons psychiatrists got away with abusing patients for so long was because consultants were ‘all powerful’. Dr Palin fears that in promoting medical management the College may be sustaining the idea of ‘all powerful consultants’ having a right to key leadership positions irrespective of merit. Not at all, it was the absence of powerful well trained medical managers in the 1970s and ‘80s that allowed powerful consultant bodies to block scrutiny of consultant practice unless there was undeniable evidence of malpractice.

Psychiatrists will only gain credibility as leaders of other professions when they are managing their own profession well. As the Chief Medical Officer’s recent review of medical regulation confirms that is as yet far from sorted (Department of Health, 2006). He endorses the need for powerful managers, who are doctors themselves and therefore capable of sensitively managing performance of doctors. Uni-professional line management is usual in healthcare systems so that highly specialist workers can be understood and supported in the finer nuances of improving clinical practice by individuals with similar training and experience. Confidence in recognising and tackling unsatisfactory practice early in specialist areas is essential.

The College initiative in appointing a Vice-President to engage medical directors and managers in divisional and national networks, and with the College through a central Medical Director Executive, is proceeding along the lines Dr Palin seems to support (see Psychiatric Bulletin, September 2006, 30, 355–356). Collaboration with chief executives and the National Institute for Mental Health in England is seen to be the right approach for developing leadership roles and training for doctors along with other professions.

Redefining the role of medical director for the future is regarded as a fundamental first step to making things happen. Any medical director (or head of psychiatry in a trust without a medical director who is a psychiatrist) who has not yet received an invitation to a workshop on this subject please contact me.

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