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Exposure to acute child psychiatry presentations for core psychiatrists

We are writing to draw attention to the lack of clarity provided by the Royal College of Psychiatrists regarding the role of the core trainee psychiatrist in assessing child and adolescent psychiatry patients out of hours. We believe it is important this issue is addressed as it confers broad implications for training, recruitment and service delivery. Crises of paediatric mental health tend to present out of hours. Ireland's 4th annual child and adolescent mental health service report details 'striking patterns in the number of [self-harm] presentations seen': 51% of presentations were in the 8-hour period of 7pm to 3am.[1] This finding appears typical for paediatric psychiatry liaison services around the UK.

It is well known that in some trusts core trainees are excluded from child and adolescent mental health services (CAMHS)-led out-of-hours care pathways. This situation seems particularly unsatisfactory given that placements in developmental psychiatry are no longer obligatory. By failing to adequately furnish our future adult psychiatrists with skills in child and adolescent mental health, we are reinforcing a culture whereby young people are potentially falling through the care gap between CAMHS and adult mental health services.[2,3] Indeed, this very issue is highlighted in a joint paper from the inter-faculty group of the child and adolescent psychiatry and the general and community psychiatry faculties which presents recommendations for the provision of psychiatric services to adolescents and young adults.[4] Furthermore, by restricting the level of exposure to child psychiatry, we are doing little to encourage core trainees to perceive the specialty as a future career option.

As well as having an impact on the quality of training, the issue has far-reaching implications for patient care. The current lack of clarity fosters an atmosphere of uncertainty as situations arise where no one knows who holds responsibility to clerk a young person on arrival, thereby leading to potential delays in the patient being seen. Emergency department delays are a source of great concern to acute care trusts and create negative attitudes to psychiatric services in general. If we cannot manage to work in a safe and effective way, we are further contributing to the hostility not only towards our specialty but also to our patients, who are at their most vulnerable.

It is therefore our view that there should be an explicit expectation for core trainees to have exposure to the full range of acute psychiatric presentations, including child and adolescent patients, out of hours. It is of course essential that this experience would be supported by robust and accessible supervision structures in the form of a second on-call specialty trainee or consultant child psychiatrist. Although we recognise that the College is unable to tell trusts how to deliver their out-of-hours services, it would be helpful if the core psychiatry curriculum contained more robust guidance as to the role of the core trainee in assessing child and adolescent psychiatry cases out of hours. Such a move would help to create clarity as well as holding local education providers to account.

Declaration of interest
R.C. sits on the College's Emergency Care Taskforce, which is currently considering the value of out-of-hours training.

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Psychiatry for medical students: need for a more holistic approach to teaching?

We are two medical students who wish to offer a perspective on undergraduate education and psychiatry.

During our student placement, we attended the old age psychiatry module at the Northern Deanery MRCPsych programme focusing on dementia and ethics. This was aimed at trainees and not specifically medical students but we were surprised to find that this was not above our level of knowledge. This prompted discussion of undergraduate psychiatry training more broadly, which we felt focused too heavily on the diagnosis of mental illness and less so on the holistic approach to the patient and their presentation as covered by the MRCPsych course. From our experience of undergraduate psychiatry we feel that the assessment by means of a logbook of conditions encourages students to find patients with a certain diagnosis, and in doing so overlooks the true essence of psychiatry. To our mind this incorporates the ability to consider all aspects of a patient's life and formulating these, while demonstrating compassion for another person at a time of most need.

Through choosing a 6-week placement in old age psychiatry we have been able to explore the specialty more thoroughly and broadly than facilitated within the standard undergraduate programme, and we have realised how little of psychiatry we have been exposed to as undergraduates. We have become more aware of the importance of considering the patient's personal and social circumstances alongside their diagnosis, and how these can influence each other. Specifically, the importance of a sound ethical approach to practice has been highlighted through the higher-level teaching we

experienced, where the Mental Capacity Act was discussed in detail.

We believe that it would benefit undergraduates to experience a more realistic and rounded placement in psychiatry and truly consider the social implications of mental illness. As it currently stands, undergraduate education in psychiatry is oversimplified to focus on diagnosis and does not acknowledge the capabilities of medical students to adopt a holistic approach. An opportunity to consider all aspects of a psychiatrist's role may encourage more students to consider a career in this field.

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Factors associated with the use of community treatment orders

In his article Curtis[1] highlights one of the limitations of the OCTET study,[2] in that patients selected for randomisation may not have been suitable for community treatment order (CTO) placement in the first place. In his conclusions he suggests there may be a small subgroup of patients for whom CTOs are enormously beneficial. Perhaps clinicians need more clarity of the characteristics of the 'revolving door' patient better to assess suitability for supervised community treatment.

Most clinicians will have a personal construct of the epidemiological and clinical characteristics of revolving door patients, although this may not be explicitly defined. There is no consistency in the literature as to the definition of revolving door, and previous research in the UK has shown that predictors of readmission are varied and not consistently replicated across studies. Research carried out when the practice of 'long leash' Section 17 leave was widespread showed that those placed on extended leave had a history of more frequent compulsory admissions, increased recent dangerousness to others, and decreased adherence to their out-patient follow-up prior to admission.[3]

A case–control study was conducted at Leeds Partnership NHS Foundation Trust in 2010, and approved by the local research and development department as a service evaluation. The aim was to compare characteristics of patients placed on CTOs and those discharged from Section 3, to elicit which factors were associated with CTO placement. All patients placed on a CTO between November 2008 and February 2010 were included as cases, and controls were randomly selected from patients who had been detained under Section 3 of the Mental Health Act, but whose Section was rescinded within the same week that the CTO was commenced. A ratio of two controls for each case increased the power of the study. This amounted to 56 cases and 112 controls. Characteristics chosen for analysis were those which previous research had suggested may be of importance and where collection was feasible. The characteristics of the patients placed on CTOs were broadly similar to those recruited into OCTET.

Analysing variables individually, patients on CTOs were significantly more likely ($P<0.05$) to be single, have a principal diagnosis of schizophrenia, a history of violence, a higher number of previous admissions, a history of criminal conviction and a higher number of convictions within the past year. On logistic regression analysis, patients on CTOs were significantly more likely to have a principal diagnosis of schizophrenia and a higher number of previous admissions.

There remains the outstanding question of who belongs to the elusive group of patients for which CTOs are effective, if indeed this group exists. This study provides insight into the demographic and historical factors that are influencing clinicians' decisions to implement CTOs. There is no proof so far that CTOs are effective in their aims. Perhaps we need to look again at who the truly 'revolving door' patients are and take this objective evidence into consideration at the point of deciding whether to initiate supervised community treatment.

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Misunderstanding recall

Smith *et al*[1] should be congratulated for their investigation into the use of the additional conditions that are sometimes included in community treatment orders (CTOs). The Reference Guide to the Mental Health Act 1983 (15.16–15.19) and the Mental Health Act Code of Practice (25.29–25.35) describe the nature of these conditions and how they relate to the recall of patients. Although patients do not have to consent formally to CTOs, or the conditions, in practice they will need to attempt to cooperate with them. However, these additional conditions are not directly enforceable. The Reference Guide (15.30) sets out the criteria the responsible clinician must use when considering recall. These criteria do not refer to additional conditions, and there is no power of recall if a patient on a CTO fails to comply with them. I agree with Smith *et al* when they claim that many patients on CTOs wrongly believe that if they are unable to adhere to additional conditions they will inevitably be recalled to hospital, and that the prevalence of this misunderstanding is inconsistent with the principles set out in chapter 1 of the Mental Health Act Code of Practice. One of the roles of independent mental health advocates is helping patients obtain information about, and understand their rights under, the Mental Health Act 1983. In my opinion this is an issue that they should prioritise, as should all those who monitor the use of the Act. As Smith *et al* point out, these circumstances raise serious legal and ethical issues.

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