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conducted in the West Midlands a year after it became mandatory to involve users and carers in psychiatric training. Completed questionnaires were received from 180 trainees and included specialist registrars from all specialties and senior house officers from all four rotations. A greater percentage of trainees (64% v. 47% in Babu *et al's* survey) were aware of the College requirement for user and carer involvement in training. As with Babu *et al's* survey, the most common setting was during case presentations (77%). As many as 61% of senior house officers had experienced user and carer involvement in their Member of the Royal College of Psychiatrists' academic programme compared with only 23% of specialist registrars.

The majority wanted users and carers to share their experiences and perspectives (82%) and to give feedback about their ability, attitudes and skills (70%). This was less so for involvement in planning teaching programmes (22%) and in selection of trainees onto training schemes (17%). This may be a reflection of the same reservations highlighted in Babu *et al's* survey. Livingston & Cooper's (2004) recommendation for training and support to users and carers would be essential in addressing these concerns. The introduction and implementation of this major component in training requires balancing the sensitivities and needs of both service users and trainees. Drawing from the experiences of other training schemes and the results of further research and audit will be an integral part in furthering this area of training.

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## Whose line is it anyway?

There is an assumption (by psychiatrists) that all physical care is the territory of the general practitioner (Tarrant, 2006), whereas psychiatrists tend to focus on arranging appropriate monitoring of medications that they are prescribing. However, there is a growing awareness of the *global* physical health needs of those with severe and enduring mental illnesses. This is confounded by the current lack of a clear consensus from multiple and differing guidelines on the necessary monitoring for both primary and secondary care.

Patients with severe mental illness, such as schizophrenia, bipolar disorder and depression, are said to lose 25 years or more of life expectancy (Newcomer & Hennekens, 2007); the majority due to cardiovascular disease (CVD). It is not surprising then that psychiatric patients tend to have a higher prevalence of independent predictors of CVD including smoking, hypertension, obesity, a sedentary lifestyle and hyperlipidaemia – an 'inherent' predisposition to CVD. However, there seems to be some disparity in prevention efforts for cardiovascular mortality when comparing individuals with severe mental illness and the general population. In a correspondence letter to the *Bulletin*, Dr Mohd (rightly) expresses his concern that action needs to be taken when any results or measurements are found to be abnormal. Results are often duly communicated to general practitioners by letter but may easily be overlooked. He goes on to suggest that we (psychiatrists) should initiate anti-lipid treatment ourselves (Mohd, 2006).

Yet, according to the most recent Joint British Societies' guidelines, the indications to commence antilipid therapy are quite clear: 'at high risk' – atherosclerotic disease, diabetes or a high total CVD risk > 20% (British Cardiac Society *et al*, 2005). However, in patients with severe mental illness, the total CVD risk is often below 20% for that specific period of time.

Most research has focused on the impact of some antipsychotic medication being linked to quite marked

hypercholesterolaemia (Correll *et al*, 2007). The reasonable deduction is that these patients can be offered an alternative, less lipid-inducing antipsychotic and/or lifestyle changes. Lifestyle advice is often difficult to implement on the background of ongoing and enduring psychiatric illness given that use of healthcare services often decreases after the onset of a psychiatric disorder.

Some may argue that cardiovascular risk in patients who are stable on regular antipsychotic medication should be treated the same as anybody else with the same risk factors. However, given that patients with severe and enduring mental illness (with/without antipsychotic medication) are 'inherently' predisposed to CVD, would it be sensible just to wait until the risk passes the 20% threshold? Or is there a 'missed opportunity' here.

Closer attention is needed, first, to the choice of psychotropic drug treatment and second, more aggressive in-hospital use of monitoring and interventions to identify and reduce risk. In this target-driven culture, we often assign arbitrary values to continuous and often fluctuating biological variables. Perhaps we ought to abandon the notion of 'one threshold fits all'; instead, use our clinical judgment to initiate treatment based on overall risk.

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