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# Correspondence

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## Training in adult general psychiatry

Sir: Deahl & Turner's *cri de coeur* (*Psychiatric Bulletin*, June 1998, **22**, 339–340) will have struck chords of recognition in many beleaguered and demoralised general psychiatrists. However, one word was missing from both their editorial and the accompanying article (Milton, 1998) – psychotherapy. This was odd since the authors discuss transference, the disappointment felt by newly appointed consultants about lack of direct patient contact and dual training for specialist registrars (SpRs) – including presumably dual training in general psychiatry and psychotherapy – which they merely describe as an “escape route”.

Consultant posts which combine a defined general psychiatry component with a specific but limited psychotherapy responsibility are currently rare but potentially attractive. The psychotherapy component might involve responsibility for psychological interventions in psychosis, an eating disorder service, a service for patients with borderline personality disorder or a psychotherapy day hospital. Leavening general psychiatry in this way can go some way towards addressing the discontent which Deahl & Turner so accurately depict. A required psychotherapy attachment as part of an SpR programme would be a first step towards this, and dual trained SpRs would be particularly well equipped to do such work. Can the College endorse such training, and can commissioners and trusts be persuaded to fund the consultant posts needed?

MILTON, J. (1998) So who wants to be a consultant general psychiatrist. *Psychiatric Bulletin*, **22**, 345–347.

JEREMY HOLMES, *Consultant Psychiatrist/Psychotherapist, Department of Psychiatry, North Devon District Hospital, Raleigh Park, Barnstaple, Devon EX31 4JB*

## Literature and clinical decision-making

Sir: James Warner & Robert Blizard (*Psychiatric Bulletin*, June 1998, **22**, 342–344) provide an illuminating account of the torment to be experienced by the tiro seeking to turn booklet learning into clinical practice. At the same time they add to the literature from academic non-clinicians who seem to be determined to deny

older people with dementia access to donepezil, and presumably other anticholinesterase inhibitors.

Perhaps I could put Drs Warner & Blizard out of their misery and at the same time reassure their patient's wife and perhaps even their patient, that common sense or clinical sense still has a part to play in medical practice.

There is an accumulation of evidence that the anticholinesterase inhibitors improve cognitive function, reduce non-cognitive symptoms and improve activities of every day living, in a proportion of patients suffering from Alzheimer's disease. Not everyone obtains improvement and there may be flaws which the purist will find in both the design and presentation of studies. Nevertheless most people will understand that these compounds hold out the prospect that some patients will gain benefit from a medication where, hitherto, there has been no hope that any medicine would achieve benefit. What the patient's wife is asking is that her husband be given the opportunity to see whether donepezil will help him. If the compound is tried and there is no change for the better she will be the first to agree with the clinician that there is no point in pressing on with the treatment. If, however, there is improvement or the arrest of a pattern of decline, both she and the clinician will be pleased, for this is not what their experience has led them to expect from the natural history of the disorder.

The clinical method is that, having reviewed the literature, weighing the possibility of benefit and the risk of adverse effects and explaining these to the patient and carer, the consultant who is familiar and confident in managing patients with this condition will prescribe the new treatment and monitor the outcomes.

Torment and headaches gone. Next patient please.

D. JOLLEY, *Professor in Old Age Psychiatry/Medical Director, Wolverhampton Health Care NHS Trust, Penn Hospital, Penn Road, Wolverhampton, West Midlands WV4 5HN*

## Licence to export methylphenidate

Colleagues who work with substance misusers are no doubt familiar with the regulations about carrying prescribed controlled drugs when travelling abroad.

A straw poll among child and adolescent psychiatrists suggested that child psychiatrists are not. As the prescribing of the controlled drug methylphenidate for hyperactivity becomes more common and the summer holiday period approaches, it seemed timely to seek clarification. A telephone call to the Drugs Branch of the Home Office (at 50 Queen Anne's Gate, London SW1H 9AT, telephone 0171 273 3806) yielded the following information.

Controlled drugs may be taken out of the country (exported) and any unused portion re-imported, without hindrance by HM Customs provided that certain documentation is carried. This documentation varies with the total quantity of drug involved. For methylphenidate the cut-off quantity is 900 mg, which I note is equivalent to 15 days' supply at maximum *British National Formulary* dosage.

Below this quantity patients should carry a letter from the prescribing doctor confirming they have been prescribed the medication and the quantity they will be carrying. Above this quantity patients are required to obtain a licence to export. This requires that the prescribing doctor writes, on the patient's behalf, to the Home Office stating the full name and address of the patient, the country they intend to visit, with departure and return dates, the name of the drug, its form and strength (e.g. methylphenidate, tablets, 5 mg) and the total quantity in words and figures that they will be exporting.

The Home Office generally requires at least a week's notice to issue the licence. Patients should also be made aware that this documentation allows only for the export and re-import of the controlled drug from and to the UK. The regulations regarding importing to destination countries vary and it is the responsibility of the traveller, not the Home Office or the prescribing doctor, to check with the embassy of the destination country. The Home Office Drugs Branch may, however, be aware of particular problems and be able to offer up-to-date information regarding these.

DAVID HAMER, *Senior Registrar in Child and Adolescent Psychiatry, Child and Family Therapy Services, Marsden Street, Chesterfield, Derbyshire S40 1JY*

### Psychiatric disorders in rural communities

Sir: We read with interest the editorial by Gregoire & Thornicroft (*Psychiatric Bulletin*, May 1998, 22, 273-277) and the paper by Smith & Ramana in the same issue (*Psychiatric Bulletin*, May 1998, 22, 280-284) concerning psychiatric disorders in rural communities. We

were, however, both perplexed and frustrated that two articles so obviously concerned with mental ill health were entitled "Rural mental health" and "Mental health in rural areas . . .", respectively. The use of euphemisms for mental illness appears to be a growth area in the psychiatric literature. "Mental health morbidity", the opening words of Smith & Ramana's abstract, is a good example of the kind of self-contradictory phraseology that can result. Gregoire & Thornicroft do not demonstrate any similar reticence in the use of the term "physical disease". This is perhaps not surprising given that the characterisation of such as "physical health morbidity" would not only be unwieldy, but self evidently perverse. Similarly, the fact that there is a high incidence of psychiatric illness and suicide in male farmers is not, we would argue, best conceptualised as a 'mental health problem' any more than a cardiac arrest is most appropriately described as a 'physical health problem'.

We suggest that we would be better served as a profession by having the courage of our convictions and being explicit with our patients in identifying significant 'mental health problems' for what they are - psychiatric illnesses (Roth & Kroll, 1986). To do otherwise is to invite conceptual muddle for the sake of a misguided psychiatric political correctness.

ROTH, M. & KROLL, J (1986) *The Reality of Mental Illness*. Cambridge: Cambridge University Press.

ANDREW BLAKEY, *Consultant Psychiatrist*, WALTER BRAUDE, *Consultant Psychiatrist, East Cheshire NHS Trust, Department of Psychiatry, Ingersley Building, Macclesfield District General Hospital, Victoria Road, Macclesfield, Cheshire SK10 3BL*

### 'Absconson'

Sir: I first came across the word 'absconson' about 12 years ago, when a colleague spoke of a patient as presenting a significant risk of 'absconson'. Since then I have come to find that many mental health workers, especially in the forensic side of our work, believe that the word actually exists in the language.

But of course it does not. Abscond, absconder, absconded, absconding - yes; absconson - no.

Fortunately, the English language is sufficiently flexible to take on new words. 'Absconson' is so useful that we might as well officially adopt it.

IKECHUKWU OBIALO AZUONYE, *Consultant Psychiatrist/Senior Lecturer, Adult Mental Health Unit, Lambeth Healthcare NHS Trust, 108 Landor Road, London SW9 9NT*