the columns

correspondence

'Confused messages'

The issue of whether drug treatment services are providing methadone maintenance in line with the available evidence is an important one. However, the survey by Joseph & Moselhy (*Psychiatric Bulletin*, December 2005, **29**, 459–461) requires further clarification in order to contribute to the debate. In Table 1 they classify services as either 'Community drug teams' or 'Addiction treatment units'. In the discussion they imply that the latter are in fact non-statutory agencies. The discussion also implies that the only community-based services are the community drug teams. It would seem likely that the majority of the services are community based, both statutory and non-statutory, since the 'move towards' community-based treatment in fact goes back 20 years (Advisory Council on the Misuse of Drugs, 1982). The discussion mistakenly states that the Home Office (2000) document *Reducing Drug Related Deaths* advises against the prescribing of controlled drugs to drug users. The next sentence does refer to tablets and ampoules in this context but the reader could be left confused.

The notion of 'opiophobia' is interesting. Reasons which would explain practice by doctors that is out of step with the evidence include lack of awareness of the evidence, philosophical disagreement despite the evidence, and a lack of access to supervision of methadone consumption. In some cases there can be cause for reasonable clinical caution, for example in cases of polysubstance misuse. For patients, possible reasons for opiophobia include lack of awareness and fear of the criticism of family members or childcare agencies of doses perceived as 'high'. Impending incarceration in prison, where effective detoxification from doses of methadone towards the upper end of the dose range may not be available, may also make patients resistant to effective treatment. This is certainly a topic that would benefit from further audit, intervention and re-audit.

ADVISORY COUNCIL ON THE MISUSE OF DRUGS. (1982) *Aids and Drug Misuse Part 1*. London: TSO (Stationery Office).

HOME OFFICE (2000) *Reducing Drug Related Deaths*, p. 72. London: TSO (Stationery Office).

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Is flexible training still an attractive alternative?

As mothers of young children, our decision to train flexibly was made to enable us to achieve an optimal work/home balance. Overall, it has been a favourable experience, although we have encountered some difficulties. The West Midlands training scheme is efficient and encouraging, our consultants are supportive and our peers are understanding. This is in contrast to the situation in other medical specialties, and it is encouraging to report that psychiatry is one of the most accommodating.

However, as flexible trainees we often experience problems with staff in the personnel and finance departments caused by their perceived increase in paper work as a result of flexible training. A recurring complaint from the majority of flexible trainees is the failure of the finance department to pay them the correct wages. This problem has escalated owing to the new pay deal for flexible trainees which does not seem to have been communicated clearly to the personnel and finance departments. There seems to be no alternative than to enter into prolonged and time-consuming discussion with staff in these departments and it can take many months to resolve the situation. Unfortunately we have also discovered that our pensions have been incorrectly calculated. This has caused one of us so much stress that she has chosen to return to full-time training.

At a time of uncertainty for trainees, our hope is that serious thought continues to be given to making flexible training an attractive alternative for those who would otherwise not return to training. Competency-based assessment should suit flexible trainees who often work efficiently in fewer hours. However, improved communication between the deanery and staff in the personnel and finance departments would help to alleviate some of the financial problems encountered.

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Dearth of consultant psychiatrists applying to become Mental Health Act Commissioners

According to the Mental Health Act Commission's *Eighth Biennial Report* (which covers the period 1997–99) there were 150 Commissioners, 25 of whom were psychiatrists. In 2004 the Commission was restructured so that the number of Commissioners was reduced from 180 to 100. The duties of the Commissioners were altered and this was reflected in the new job descriptions for the Local Commissioners and the Area Commissioners.

We are two of only three psychiatrists who were reappointed at the time of this reconfiguration. Chris Heginbotham, the Chief Executive of the Mental Health Act Commission, has told us of his disappointment that so few psychiatrists applied. This dearth of psychiatrists is a great pity as the Commission's role is to safeguard the interests of all people detained under the Mental Health Act 1983 and to keep under review the exercise of the powers and duties contained in this Act.

We do not know why so few psychiatrists applied for the posts of Mental Health Act Commissioners. It may be that doctors employed full time on the new consultant contract find this external commitment difficult to negotiate with their trusts. However, we would strongly recommend that Members of the College apply to become members of the Commission.

MENTAL HEALTH ACT COMMISSION (1999) *The Mental Health Act Commission, Eighth Biennial Report 1997–1999*. London: TSO (Stationery Office).

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