the columns

correspondence

Real-life prescribing

We agree with the recent audit of Meagher & Moran (*Psychiatric Bulletin*, July 2003, **27**, 266–270), in which they reported that real-life prescribing differs from evidence-based guidelines. Our audit of Cambridge's rehabilitation service (a tertiary referral centre) was carried out over 1 week in June 2003. Two-hundred and seventeen patients were receiving antipsychotic medication through our pharmacy: 171 received oral medication alone, 29 long-acting intramuscular medication and 17 combined oral and intramuscular medication. Similar to Meagher & Moran, we found antipsychotic polypharmacy in 56 patients (26%), but 26 of these were receiving clozapine plus adjunctive, e.g. sulpiride. Polypharmacy was evident in the in-patients, with 52% of our 58 in-patients receiving more than one antipsychotic in comparison to 16% of the 159 out-patients, implying that polypharmacy might be a transient phenomenon. No one was prescribed thioridazine or droperidol.

We found, using a percentage of the British National Formulary (BNF, 2003) maximum recommended limit, a practical method of calculating the total daily dose as two-thirds of our patients were prescribed atypical monotherapy. Sixteen of our patients (7.4%) received antipsychotics above BNF maximum limits, while Meagher & Moran found 4.9% received more than 1000 mg chlorpromazine equivalents (CPZEs). Yorston & Pinney (2002) state that there are a number of problems with the use of CPZEs and also report that there is no simple linear relationship between CPZEs and percentage of BNF maximum limits for high doses. This may account for some of the differences found. Another explanation may be the number of patients with treatment-resistant schizophrenia.

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Prescribing errors in psychiatry

We read with interest the paper by Paton & Gill-Banham (*Psychiatric Bulletin*, June 2003, **27**, 208–210). They say there are no systematic studies of prescribing errors in psychiatry. We have recently published an analysis of prescribing errors detected by pharmacists working in a 400-bed specialist psychiatric hospital (Haw & Stubbs, 2003). A panel of three assessors (two consultant psychiatrists and the head pharmacist) screened and classified errors according to the definition and classification of Dean *et al* (2000). Error severity was rated on a four-point scale.

During the one-month study period, 311 errors were detected that met the study definition. Fifty-six per cent were rated as clinically insignificant, with only 9% rated as having the potential to cause the patient harm, and none as potentially life-threatening. A greater proportion of the more serious errors had been made by non-consultant psychiatrists. Prescription writing errors (e.g. transcription errors) (88%) were more common than decision-making ones (e.g. prescribing a drug to which the patient has a known allergy) (12%). The error rate for non-psychotropics was twice that for psychotropics, perhaps reflecting psychiatrists' greater familiarity with the latter.

Our findings are broadly similar to those of Paton & Gill-Banham (2003), but we found most errors to be of the prescription writing (clerical) type. We agree that clinical pharmacists have a role to play in detecting errors. However, we found that in 42% of cases, the drug involved had already been administered. Most errors would probably have been detected at the source by electronic prescribing with computerised physician decision support.

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HAW, C. & STUBBS, J. (2003) Prescribing errors detected by pharmacists at a psychiatric hospital. *Pharmacy in Practice*, **13**, 64–66.

PATON, C. & GILL-BANHAM, S. (2003) Prescribing errors in psychiatry. *Psychiatric Bulletin*, **27**, 208–210.

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Pre-registration house officer training in psychiatry

I was interested to read your article regarding pre-registration house officer training in psychiatry (Herzberg *et al*, May 2003, **27**, 192–194). I am also interested and glad to hear of your findings regarding trainees' improved confidence and target skills as well as high rates of satisfaction.

In 1981, in Sheffield, I was involved in one of the first pre-registration house officer posts in psychiatry in this country. This pre-registration house officer training was reviewed by O'Dwyer (1999).

From my experience of doing the psychiatry 4-month post as the first in a rotation of psychiatry, medicine and surgery, I personally felt this was of great benefit – particularly in relation to communication skills and gaining a wider view of illness within the context of a person's life and family relationships. It also helped raise my awareness of the importance of appropriate settings and privacy when interviewing patients and discussing issues that are distressing. This was a help as well as a hindrance when I was subsequently to be a surgical and medical house officer, where one has to clerk in large numbers of patients within busy wards or Accident and Emergency departments with only curtains drawn and little privacy, e.g. prior to major surgery such as mastectomy.

The pre-registration house officer post helped me to gain further insight into and develop communication skills, to consider wider issues and to have a wider perspective when interviewing physically ill patients on medical and surgical wards. Therefore, this should be considered alongside the 'target skills in psychiatry' when planning pre-registration training.

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O'DWYER, J. M. (1999) Psychiatric training of pre-registration house officers, *Psychiatric Bulletin*, **23**, 283–285.

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Classification under Mental Health Act 1983 and consent to treatment

A ruling was recently passed in the Court of Appeal, and this judgment is likely to have a significant bearing on psychiatrists working with patients detained under the category of mental impairment and psychopathic disorder.

The Court was hearing an appeal against the decision of the high court about 'B', an in-patient at Ashworth hospital. B had been detained under a restriction order under the category of mental illness. The responsible medical officer had recommended to the Mental Health Review Tribunal (MHRT) that B suffers from a mental illness as well as a personality disorder. The MHRT chose not to reclassify B under the category of psychopathic disorder.

B was subsequently transferred to a ward in the personality disorder unit and B sought a judicial review claiming that he should not be treated for psychopathic disorder because he was not detained under that category. The high court dismissed the application and B's solicitors appealed against the decision.

The Court of Appeal heard the case in April 2003 and ruled that compulsory treatment could be given only for the mental disorder for which the patient has been detained.

Patients detained under the category of mental impairment and psychopathic disorder often have comorbid mental illnesses which may not be severe enough to warrant detention on their own accord. These patients often receive treatment for the mental illness even though they are not classified as having mental illness under the Act.

As a result of the ruling of the Court of Appeal, it will become necessary to reclassify all such patients under the additional category of mental illness, unless it can be established that psychotropic medication is being administered exclusively for the treatment of mental impairment or psychopathic disorder.

This is likely to present problems for patients who are under restriction orders because the RMO does not have the power to reclassify them and would need to wait for a tribunal to do the reclassification. If the tribunal chooses not to reclassify, it might become difficult to justify administration of psychotropic drugs to these patients.

It would be interesting to see if Ashworth Health Authority chooses to take the case to the House of Lords.

R(B) v. Ashworth Health Authority (2003) EWCA Civ 547 http://www.courtservice.gov.uk/Judgments.do

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Trainees' experiences of a Balint group

Many thanks to Das *et al* (*Psychiatric Bulletin*, July 2003, **27**, 274–275) for sharing their experiences of Balint group. We are fortunate to have a well structured local Balint group led by a psychotherapist, based on the Model of Transactional Analysis. Being honest, we started to attend the groups because it was mandatory and once we developed the necessary mindset, we found the sessions palatable, with an ability to reflect and ventilate our true feelings.

This has led to better understanding of interpersonal interactions across patients, families, staff and colleagues. No doubt our attitudes towards difficult patients and staff members has changed. Meeting regularly has promoted team bonding and has alleviated the distress of on call hours.

Balint groups must be identified as an essential component of psychiatric training. Despite Psychotherapy training being mandatory, very little has been done to implement these regulations locally.

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Advocacy in practice

I am writing on behalf of the Advocacy Working Party of the Royal College of Psychiatrists, which has been charged with the responsibility of updating the Council Report on Advocacy published in 1999.

Advocates working on behalf of patients are going to become a more regular feature of our working lives and we intend to produce a document that reflects real experiences, as well as ideal practice. To this end, we would like to invite any member of the College to write to us about their experience, both good, bad and indifferent, of advocacy in practice.

This would help up to formulate a realistic account of present practice, in the proposed chapter on the role and responsibilities of the psychiatrists and advocates.

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In defence of inquiry panels

As a colleague who has also protested about the iniquities of inquiries (Lowe, 1996), I am heartened by Mark Salter's latest contribution to the debate (Salter, *Psychiatric Bulletin*, July 2003, **27**, 245–247). A patient of mine was convicted of manslaughter and, although the internal inquiry exonerated the clinical team, an external inquiry serves other purposes very well rehearsed by Salter. It is desirable, however, to expect inquiry panel members (including non-psychiatrists) to accept clear boundaries, realistic terms of reference, to be inducted for the purpose, and to function as openly as possible. Panel members are learning progressively from their predecessors and do not have to accept a process that is irrational. Reports, unique in their individuality, include detailed psychiatric case histories from which clinical lessons can be drawn – though not necessarily fulfilling public expectations. More could be done to disseminate this knowledge officially (King, 2000).

The effects of inquiries are unpredictable but may lead to significant changes. The Clunis Inquiry heralded the introduction of supervised discharge orders (1996). Consultants invited to sit as inquiry panel members should be drawn from the likes of Dr Salter and not held in contempt by their colleagues (Veasey & Cox, 2000) for participating.

From April 2004, responsibility for independent reviews passes to the new Commission for Healthcare, Audit and Inspection (CHAI) and the Government would like to see a national specification for training in complaints investigation (Department of Health, 2003). The College should lobby to ensure that homicide inquiries are included in CHAI's remit. Contributions from past panel members and critics would help in formulating an appropriate training programme for psychiatrists and lay colleagues.

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VEASEY, D. & COX, J. L. (2000) Further comments on inquiry panels. *Psychiatric Bulletin*, **24**, 393–394.

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