often able to consult problem cases with non-medical colleagues. This was a more useful learning experience than posting a referral letter, and I gained a greater understanding of how the training of allied professionals influences their overall approach.

Discussion

I am optimistic that community mental health care will be effective, but I cannot predict how communities will take to the idea of paying for their mental health care or whether appropriate care will be purchased responsibly. Without adequate resources for all levels of care it is certain that the most vulnerable will suffer unnecessary deprivation.

I am concerned that teaching programmes still stress the acquisition of clinical knowledge and skills at the expense of reinforcing the attitudes of hospital psychiatry, and that even higher trainees have difficulty receiving adequate management training within 'clinical' working hours.

It is worth emphasising that it is not the structure of a community service that matters for training purposes, but the fact that it functions, and provides the required experience.

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References

A CONSENSUS STATEMENT ON CARING FOR THE MENTALLY DISORDERED IN OUR COMMUNITIES (1987) A carer's perspective. *Bulletin of the Royal College of Psychiatrists*, **11**, 237–239.

FREEMAN, M. (1985) Training for community psychiatry. *Bulletin of the Royal College of Psychiatrists*, **9**, 29–32.

LANCET LEADING ARTICLE (1985) Psychiatry – a discipline that has lost its way. *Lancet*, **1**, 731–732.

NAISMITH, A. J. (1989) Community psychiatry – a training experience. *Psychiatric Bulletin*, **13**, 503–505.

SCOTT, J. (1988) Training implications of the shift to community-orientated psychiatric services. *Bulletin of the Royal College of Psychiatrists*, **12**, 151–153.

Psychiatric Bulletin (1991), **15**, 484–485

Audit in practice

Prescribing patterns in a psychiatric follow-up clinic

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There have been several surveys of prescribing for psychiatric patients (Muijen & Silverstone, 1987; Johnson & Wright, 1990) indicating inappropriate prescribing and a tendency towards polypharmacy. Most studies have looked at prescriptions for psychiatric patients in all settings (out-patients, day-patients and in-patients) in conglomeration rather than just out-patients. Out-patients experience a comparatively lesser degree of supervision (hence a greater risk of non-compliance) and have other opportunities to acquire prescriptions (e.g. through general practice). With this in view a pilot study to observe prescribing pattern in a follow-up clinic was performed.

The study

Methodology for this study has been described in detail elsewhere (Shah & Lynch, 1990) and is briefly summarised here. A pilot study was performed prospectively for two months (November and December 1988) in a registrars' follow-up clinic at a London teaching hospital.

All patients booked to attend the out-patient clinic were included. An itemised questionnaire of the various characteristics of the patients was completed with the aid of the case-notes, interview with the patients, and previous personal knowledge of the patients. The questionnaire included detailed items on current drug prescriptions.

Fisher's exact probability test and the χ^2 test were used to analyse the data.

Findings

The characteristics of all the out-patients and the differences between attenders and non-attenders in

this clinic have been described elsewhere (Shah & Lynch, 1990).

Of the 45 patients in the clinic, 38 (84%) were on prescribed psychotropic drugs; 19 (50%) of these 38 patients were on one drug only, 12 (32%) on two drugs; and 7 (16%) on three drugs. There was no significant relationship between the number of drugs prescribed and any of the characteristics of the patients including diagnosis.

The broad group of prescribed drugs included neuroleptics (n = 30), tricyclic antidepressants (n = 9), benzodiazepines (n = 7), lithium (n = 6), carbamazepine (n = 5), anticholinergics (n = 6) and chloral hydrate (n = 1). Neuroleptic prescriptions included depot (n = 13) and oral preparation (n = 17). Only one patient received more than one neuroleptic. Six patients were on lithium and five on carbamazepine; and of these, two received both for refractory affective disorder.

Seven (54%) of the patients with depression received antidepressants compared to two (6%) of the patients without depression ($\chi^2 = 13.09$, d.f. = 1, $P < 0.001$). Twenty-three (88%) of the patients with schizophrenia received neuroleptics compared to six (46%) of the patients without schizophrenia ($\chi^2 = 15.52$, d.f. = 1, $P < 0.001$). The prescription of benzodiazepines, lithium and carbamazepine was not associated with any diagnosis, but the numbers were small. All six patients on anticholinergics were on neuroleptics and had schizophrenia.

There were no differences between patients receiving depot neuroleptics and oral neuroleptics. All patients on depot had a diagnosis of schizophrenia and received the depot from the community psychiatric nurse (CPN) at a clinic held at the same time as the follow-up clinic. All patients receiving depots (n = 13, 100%) had access to a CPN compared to only six (23%) of the patients not receiving a depot ($\chi^2 = 24.88$, d.f. = 1, $P < 0.001$)

Comment

Over 84% of the patients were on prescribed psychotropic drugs. This is hardly surprising given that 87% of this clinic's patients had either schizophrenia or manic depressive illness (Shah & Lynch, 1990) and both these disorders can be chronic and recur requiring pharmacotherapy for treatment and prophylaxis. The majority of the patients (82%) received one drug (50%) or two drugs (32%) only and this is consistent with reports of a reduction in polypharmacy (Johnson & Wright, 1990), particularly in teaching centres (Muijen & Silverstone, 1987).

There was a strong statistical relationship between the prescription of antidepressants and depressive illness and the prescription of neuroleptics and schizophrenia. This indicates a puritanical approach of prescribing antidepressants for depressive illness and neuroleptics for schizophrenia and is consistent with trends towards more rational and logical prescribing based on diagnosis (Muijen & Silverstone, 1987; Johnson & Wright, 1990) rather than symptom profile.

Only one patient received more than one neuroleptic, supporting the modern trend away from polypharmacy. Depot neuroleptics are reported to enhance compliance once the depot has been administered, enhance contact between the patient and the CPN and allow CPN follow-up at home for defaulters. Despite these advantages and the chronic relapsing nature of schizophrenia, only 50% of the clinic's schizophrenics received depots. The CPN depot clinic was held at the same time as the follow-up clinic supporting the significance of long-term follow-up of schizophrenics on neuroleptics (Shah, 1990; Johnson & Wright, 1990).

Only six (13%) patients received anticholinergic drugs, confirming the modern trend towards using these drugs only if extrapyramical symptoms develop (Johnson & Wright, 1990) and with review of continuing prescriptions at regular intervals. Only seven (15%) patients were receiving benzodiazepines which is consistent with modern trends to prescribe these for clear indications on a short term basis with regular review.

The above study of a well supervised teaching hospital registrar follow-up clinic, held in collaboration with other members of that multidisciplinary team (e.g. CPNs), indicates a logical and rational prescribing pattern.

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References

JOHNSON, D. A. W. & WRIGHT, W. F. (1990) Drug prescribing for schizophrenic out-patients on depot injections. Repeat surveys over 18 years. *British Journal of Psychiatry*, **156**, 827–834.

MUIJEN, M. & SILVERSTONE, T. (1987) A comparative hospital survey of psychotropic drug prescribing. *British Journal of Psychiatry*, **150**, 501–504.

SHAH, A. K. & LYNCH, S. (1990) Characteristics of patients in a psychiatric follow-up clinic. *Psychiatric Bulletin*, **14**, 153–154.

—— (1990) Mental health review clinic. *Psychiatric Bulletin*, **14**, 427.