the columns

correspondence

Antipsychotics preferred by mental health professionals

Bleakley *et al* (*Psychiatric Bulletin*, March 2007, **31**, 94–96) reported a survey of professional opinion (including 65 doctors) from the Maudsley NHS Foundation Trust on antipsychotic medication. They found that aripiprazole, olanzapine and risperidone were popular.

We undertook a similar survey (Taylor & Brown, 2007) of all College members and fellows in Scotland some 18 months earlier. Coincidentally our paper was with the editorial staff of the *Bulletin* shortly before Bleakley *et al* commenced their survey. In our survey 544 psychiatrists from all specialties replied, representing 59% of the total in Scotland. Risperidone was clearly the preferred antipsychotic (29% of the total 'vote'), and it may be worth noting that risperidone is due to come off patent soon. Our study also was undertaken only 6 months after the UK launch of aripiprazole, possibly confounding views on that medication. We also collected opinions on electroconvulsive therapy and treatment preferences for depression, with some surprising results.

Collective expert opinion can be an interesting form of evidence, complementing experimental data. However, it is time sensitive and dependent on the population surveyed.

TAYLOR, M. & BROWN, T. (2007) "Do unto others as . . ." Which treatments do psychiatrists prefer? Results from a national survey. *Scottish Medical Journal*, **52**, 17–19.

Mark Taylor Consultant Adult Psychiatrist, Springpark Centre, Glasgow G22 5EU, email: mark.taylor@glacomen.scot.nhs.uk

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I was surprised by the results of the recent study about which antipsychotics mental health professionals would take themselves (*Psychiatric Bulletin*, **31**, 94–96). I was particularly surprised about the popularity of aripiprazole (18.6%) and quetiapine (11.2%), because this is in sharp contrast to recent results suggesting that these are likely to be less effective than olanzapine, risperidone and amisulpride when outcome measures other than Positive and Negative Syndrome Scales (PANSS) scores are applied. This is true for in-patient (McCue *et al*, 2006) and outpatient settings (Lieberman *et al*, 2005; El-Sayeh *et al*, 2006; Haddad & Dursun, 2006; Jones *et al*, 2006).

Despite this emerging evidence, amisulpride was only preferred by 1.1% and clozapine by 6.9%. It was particularly disconcerting that aripiprazole was preferred by 18.6%, although most people admitted that they had hardly any experience with this drug. It is possible that aripiprazole is seen as being relatively free of side-effects because professionals have not accumulated any experience with the drug and that they are responding to undue influence from pharmaceutical representatives. The study certainly throws up the question why major research results either do not filter through or are not being considered, despite very little evidence with certain drugs. Results from independently funded studies should be disseminated to all colleagues. This may have to be facilitated locally by academic psychiatrists or postgraduate education programmes.

EL-SAYEH, H. G., MORGANTI, C. & ADAMS, C. E. (2006) Aripiprazole for schizophrenia: systematic review. *British Journal of Psychiatry*, **189**, 102–108.

HADDAD, P. & DURSUN, S. M. (2006) Selecting antipsychotics in schizophrenia: lessons from CATIE. *Journal of Psychopharmacology*, **20**, 332–334.

JONES, P. B., BARNES, T. R., DAVIES, L., *et al* (2006) Randomised control trial of the effect of quality of life of second versus first generation antipsychotic drugs in schizophrenia: cost utility of the latest antipsychotic drugs in schizophrenia study. *Archives of General Psychiatry*, **63**, 1079–1087.

LIEBERMAN, J., STROUP, T. S., McEVOY, J. P., *et al* (2005) Effectiveness of antipsychotic drugs in patients with chronic schizophrenia. *New England Journal of Medicine*, **353**, 1209–1223.

McCUE, R. E., WAHEED, R., URCUYO, L., *et al* (2006) Comparative effectiveness of second-generation antipsychotics and haloperidol in acute schizophrenia. *British Journal of Psychiatry*, **189**, 433–440.

Peter Lepping Consultant Psychiatrist and Honorary Senior Lecturer, University of Wales, Llwyn-y-groes Psychiatric Unit, Wrexham Maelor Hospital, Wrexham LL13 7TD, Wales, email: peter.lepping@new-tr.wales.nhs.uk

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Transitional services for neurodevelopmental disorders

As Verity & Coates (*Psychiatric Bulletin*, March 2007, **31**, 99–100), our service also recognised that there was little specialised provision for young people with attention-deficit hyperactivity disorder (ADHD) beyond the upper age limit of child and adolescent mental health services (CAMHS), but also recognised a need for young people with autistic-spectrum disorders.

A neurodevelopmental disorders clinic has been funded to extend the upper age limit of the local CAMHS by a year, giving the young person an additional year to consider a trial without medication. The young person and their family are helped to access voluntary and statutory agencies for support, educational, vocational and leisure opportunities, and housing and financial aid.

Our service also has limitations, with no additional nursing, social work or psychology input. The greatest limitation is the lack of adult services. Of the seven young people seen in 2006, only one met the criteria for referral to adult services. One young person was able to reduce and stop medication successfully. For one young person, the general practitioner agreed to take over prescribing and monitoring. For the others, there are no appropriate adult services except in the private sector. There is currently no tertiary service for adults with ADHD locally and those with autistic-spectrum disorders are considered too able for learning disability services.

Although it has been recognised that adolescents with mental health problems have been poorly served (Singh *et al*, 2005), and there has been development in services for early psychosis and transitional arrangements between CAMHS and adult services, the group of young people with neurodevelopmental disorders has been forgotten.

SINGH, S. P., EVANS, N., SIRELING, L., *et al* (2005) Mind the gap: the interface between child and adult mental health services. *Psychiatric Bulletin*, **29**, 292–294.

Nicole Karen Fung Specialist Registrar in Child and Adolescent Psychiatry, Northbrook Child and Family Unit, Solihull B90 3LX, email: nkf@doctors.org.uk

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columns

Involuntary admission in Ireland

Putkonen & Völlm (*Psychiatric Bulletin*, March 2007, **31**, 101–103) are not entirely correct in their assertion that Ireland and Finland are alike in their non-requirement for non-medical authorities to be part of the decision-making process for involuntary admissions. Although in Ireland the initial process requires a medical practitioner to recommend an involuntary admission and a consultant psychiatrist to authorise it, the application is usually made by a non-medical person. Also since the Mental Health Act 2001 was fully implemented in November 2001 there is now a barrister-at-law, a layperson and a solicitor, as well as an additional two psychiatric consultants, involved in the review process which automatically follows each involuntary admission.

The new Act brought Ireland into line with its obligations under the European Convention on Human Rights and Fundamental Freedoms and with the European Convention on Human Rights Act 2003.

Guy Molyneux Specialist Registrar in Psychiatry, Psychiatric Unit, Adelaide and Meath Hospital, Tallaght, Dublin 24, Ireland, email: guymolyneux@eircom.net

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Reasons for entering staff grade posts

I was surprised that Fung *et al* (*Psychiatric Bulletin*, February 2007, **31**, 76) did not find non-availability of a National Training Number (NTN) to be a primary reason for entering staff grade and associate specialist grade (SAS) posts. I passed the MRCPsych part II in June 2006 following which there were no NTNs available locally. I was aware that a few candidates were applying before results came out and in retrospect I wish this is something I had pursued more actively. However, at that time I could not have known the intensity of competition for NTNs that would be precipitated by the approach of run-through training.

It was apparent that I would not secure a higher training post before the senior house officer rotation ended and therefore I applied for a staff grade post locally. Fung *et al* cite pay protection and additional clinical experience as the primary reasons for entering SAS posts. Although these are without doubt benefits of holding the post I did not see them as reason enough for postponement of higher training. I entered staff grade because I had no alternative.

My feeling from discussion with senior colleagues is that times have changed. Previously doctors would work as staff grades to accumulate additional clinical experience or for other reasons, and enter higher training when they felt ready to do so. With the introduction of Modernising Medical Careers (MMC) competition has become more intense and there is a general feeling that in future it will be much more difficult if not impossible to re-enter training from career grade posts.

Although I have been lucky enough to secure one of the last NTNs it required numerous applications, more than would have been allowed under MMC. I have certainly benefited from pay protection and additional clinical experience, however I could not cite these as reasons for entering the grade in the first place.

Mark Fielding Staff Grade Doctor, Department of Old Age Psychiatry, St Martin's Hospital, Clara Cross Lane, Bath BA2 5RP, email: mark.fielding@yahoo.co.uk

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Teaching qualifications for psychiatrists

Dinniss *et al* (*Psychiatric Bulletin*, March 2007, **31**, 107–109) described their experience of the MSc in Clinical Education which they completed through the Peninsula Postgraduate Health Institute which is affiliated to the Universities of Exeter and Plymouth. My experience of pursuing a Postgraduate Certificate in Academic Practice (PGCAP) at King's Institute of Learning and Teaching (KILT) in London bears some similarities.

There is clearly an argument in favour of a formal training in postgraduate education or perhaps specifically clinical education. Specialist registrars/ST4 trainees might wish to enhance their skills and provide a better quality of teaching based on a strong theoretical background and practical experience.

The PGCAP has been a worthwhile experience, improving my teaching skills, knowledge of educational theory and facilitating reflective teaching practice. I have become more aware of issues relating to curriculum design and assessments. I believe this knowledge will be helpful for educational or clinical supervisory roles under Modernising Medical Careers.

Drawbacks of the PGCAP are that it is not discipline specific (although what has been learnt can easily be applied to all disciplines) and the course is expensive. To address the issue of discipline specificity, perhaps the College's Education and Training Centre might consider setting up a course aimed at psychiatric educators. Trusts could assist trainees with costs of courses through special budgets for medical education.

Chidinma Nwosu Specialist Registrar, Community Drug and Alcohol Team, 36/42 Hare Street, Woolwich SE18 6LZ, email: chidinma.nwosu@slam.nhs.uk

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I agree with Dinniss *et al* (*Psychiatric Bulletin*, March 2007, **31**, 107–109) that an MSc in Clinical Education is a worthwhile qualification, as there will be increasing pressure on senior clinicians to take an active part in teaching medical students and trainees. As society expects the healthcare system to be more and more transparent, clinicians will be held more accountable for their teaching and workplace-based assessments.

Learning to teach well means questioning the effectiveness of some of the old teaching methods, exploring new ideas and trying out new methods in different situations. Having started the MSc in Clinical Education in the past year, I find the experience extremely rewarding and enlightening. Being a product of the 'old system' of medical education where didactic teaching (lecture-based) dominated the curriculum, I found the principles of adult learning and the various techniques of small-group teaching quite fascinating. The feedback I received from medical students about the effectiveness of these techniques has been encouraging.

There is no doubt that there is an increasing demand for clinicians to deliver high-quality education, and a qualification in clinical education could become an essential rather than a desirable requirement for future consultant posts in the National Health Service.

AntonyThekkepalakkal Antony Specialist Registrar in Psychiatry, Devon Partnership NHS Trust, Wonford House Hospital, Exeter EX2 5AF, email: laluanto@yahoo.com

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Medical students are generally aware of the medical responsibilities that await than on qualification, but perhaps are not as aware of the inherent teaching responsibilities that will form an integral part of their professional duties. This is no different in psychiatry, and it is commonplace to expect psychiatric trainees to take responsibility for teaching medical students on attachments, despite having received minimal training in effective teaching methods.

Although I agree with the recommendation of Dinniss *et al* (*Psychiatric Bulletin*, March 2007, **31**, 107–109) that an MSc in Clinical Education is a worthwhile qualification for consultant psychiatrists, I would argue that junior trainees in psychiatry should also be strongly encouraged to enhance their clinical teaching skills, as some trainees deliver as much teaching to medical students as their consultant colleagues.

The time constraints of combining an MSc with professional examinations could be avoided by undertaking a more manageable course such as the 1-year Higher Diploma in Clinical Teaching which is currently being offered by our

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Department of General Practice. This focuses on clinical teaching skills of explanation, effective questioning, delivering feedback, bedside teaching techniques student assessment and evaluation of teaching. Given the effect that undergraduate psychiatry teaching may have on subsequent career choice (Brockington & Mumford, 2002), it could be argued that improving the teaching skills of our trainees will pay dividends for recruitment into psychiatry.

BROCKINGTON, I. & MUMFORD, D. B. (2002) Recruitment into psychiatry. *British Journal of Psychiatry*, **180**, 307–312.

Camilla Langan Clinical Lecturer in Psychiatry, Department of Psychiatry, Clinical Science Institute, National University of Ireland, Galway, Ireland, email: camilla.langan@nuigalway.ie

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Have you got a right please?

The emphasis on the proposed health bill is to protect workers and the general public from second-hand smoke. Passive smoking causes about 12 000 deaths per year (Royal College of Physicians, 2005); 500 of these are due to exposure at work.

As my workplace extends to patients' homes, should I not expect the same protection as I would in an NHS building and therefore demand that a patient ceases to smoke in their own home? Community doctors and nurses, who spend vast amounts of time in patients' homes would argue that the amount of second-hand smoke inhaled per day is sometimes very high. Many of us have been in the situation where we battle through a smog of smoke just to find the patient. The next hour is painful, every breath a chore, until we hear a polyphonic wheeze deep inside our own struggling lungs. We leave and take our first heavenly gasp of fresh air, but every breath for the remainder of the day is tainted by the smell of ashtray clinging to our clothes.

Pregnant workers will understandably go to great lengths to avoid cigarette smoke and subsequent harm to their baby. Is it not their right, and some might say the right of the unborn child, to refuse to enter the house of a patient who smokes?

Of course, it is unrealistic to expect patients to stop smoking in their own homes. We could, however, follow our friends in the health visitor sector who have been requesting for over a year that patients do not smoke for an hour prior to their visit. If this practice is recognised as a condition of the visit, by previous written request, it gives health workers the right to refuse to enter the home if this is not adhered to.

Some would say that asking patients not to smoke in their own homes goes too far, adding to the 'Big Brother' milieu in which we find ourselves. Others would say that the culprits' human rights appear to be more valuable than those of the innocents, and that these rights sometimes outweigh reason. Our needs are important and we should enforce a one-hour smoking ban.

ROYAL COLLEGE OF PHYSICIANS (2005) *Going Smoke-Free: The Medical Case for Clean Air in the Home, at Work and in Public Places*. Royal College of Physicians.

Matthew Cahill Specialist Registrar in Psychiatry, East London Rotation

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Payment for medication

Ethical deliberations aside, bribing patients with cash to accept depot medication clearly (and perhaps fatally) contradicts the message that the medication is a worthwhile and positive offering in itself. Moreover, it cheapens and demeans the receiver who becomes one whose beliefs can be bought out for a few quid; and the giver, who becomes one who needs sugaring to be acceptable. Contradictory messages regarding the value of psychiatry are the last thing people with schizophrenia need from us, never mind our staff and the public.

David Ogden Locum Consultant in Old Age Psychiatry, Forest of Dean, email: david.ogden@glos.nhs.uk

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Quality assurance of training standards

Professor Howard (*Psychiatric Bulletin*, February 2007, **31**, 41–43) highlights the training standards set out by the Postgraduate Medical Education and Training Board (PMETB; http://www.pmetb.org.uk). One of these states that all trainees must attend a departmental induction, which includes information on the curriculum, their duties and reporting arrangements.

We conducted a survey of the existing senior house officer (SHO) induction programmes in the Eastern Deanery to assess if any changes are needed to fulfil PMETB standards. Each area has a trust and local induction, which varied in format and content. Some programmes run on consecutive days and others are incorporated into lunchtime educational meetings. They all consist of sessions on medical staffing, on-call arrangements and talks by pharmacy staff. Some trusts include all mandatory training such as cardiopulmonary resuscitation, fire safety, etc. Lectures on specific skills (e.g. psychiatric emergencies), a tour of the hospital sites including the library, and meeting with clinical tutors or educational supervisors are commonly included in the induction programmes. A SHO handbook was provided by a majority of trusts. Only one trust gave an introduction to the psychiatric curriculum.

The SHO feedback showed that the most useful part of an induction programme was meeting with other colleagues and receiving practical information, including details of on-call arrangements and contact numbers. They favoured shorter sessions run over several weeks.

This survey reflects the variability of SHO induction programmes within one deanery. Clear guidance is needed to ensure the standardisation and quality of the programme throughout a region.

Claire Dibben Specialist Registrar in General Adult Psychiatry, **Kit Wa Chan** Specialist Registrar in General Adult Psychiatry, ***Carol Gregory** Consultant Psychiatrist and Clinical Tutor, Fulbourn Hospital, Cambridge CB1 5EF, email: carol.gregory@cambsmh.nhs.uk

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Rebound hypertension following withdrawal of clonidine

We report a 15-year-old girl with mild intellectual disability and Tourette's syndrome who also had features of hyperkinetic disorder. She had responded poorly to earlier trials of haloperidol and methylphenidate and was on 300 μg clonidine twice a day, 2 mg risperidone daily, 20 mg citalopram daily and 2 mg lorazepam a day. However, these medications were having minimal effects on her behaviour and her tics were also uncontrolled.

With no fixed protocol for clonidine withdrawal an enquiry was made to the hospital pharmacy and the manufacturer who suggested a withdrawal rate of 50 μg every third day. A week after the withdrawal regimen she was admitted as an emergency to the children's ward with symptoms of blurred vision and high blood pressure. All investigations were normal except for elevated cholesterol and triglyceride levels.

A literature search did not yield any results for a safe rate of clonidine withdrawal to avoid the potentially dangerous side-effects of rebound hypertension in children. The manufacturer, Boehringer Ingelheim, informed us that there were no recommendations for withdrawing clonidine apart from the fact that it has to be withdrawn gradually.

Since clonidine is used in children and young people to treat tic and conduct disorders, sleep disturbances, post-traumatic stress disorder, developmental

delay and attention-deficit hyperactivity disorder (Hart-Santora & Hart, 1992; Steingard *et al*, 1993; Singer *et al*, 1995), there is a need for a safe protocol that highlights the need for gradual withdrawal.

HART-SANTORA, D. & HART, L. L. (1992) Clonidine in attention deficit hyperactivity disorder. *Annals of Pharmacotherapy*, **26**, 37–39.

SINGER, H. S., BROWN, J., QUASKEY, S., *et al* (1995) The treatment of attention deficit hyperactivity disorder in Tourette's syndrome; a double-blind placebo controlled study with clonidine and desipramine. *Journal of Paediatrics and Child Health*, **95**, 74–81.

STEINGARD, R., BEIDERMAN, J., SPENCER, T., *et al* (1993) Comparison of clonidine response in the treatment of attention deficit hyperactivity disorder with and without comorbid tic disorders. *Journal of the American Academy of Child and Adolescent Psychiatry*, **32**, 350–353.

Alka S. Ahuja Consultant in Child and Adolescent Psychiatry, Department of Psychological Medicine, University of Wales College of Medicine, Heath Park, Cardiff CF14 4XN, **Rahul Srivastava** Locum Senior House Officer in Psychiatry, Cardiff, email: drrahuls@gmail.com

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columns

the college

Prison psychiatry: adult prisons in England and Wales

College Report CR141, February 2007, Royal College of Psychiatrists, £10.00, 52 pp

The prison environment is radically different from that with which most psychiatrists are familiar. Doctors may have limited control over health facilities in prisons and the delivery of services follows a radically different philosophy, being principally centred on security and control. Resources are also likely to be limited both in quantity and diversity. The epidemiology of mental disorder and the nature of the prison environment result in the role of the psychiatrist in prison being a particularly challenging one.

This report concerns itself with the development of psychiatric services in adult prisons in England and Wales. It is hoped that the guidance will be of relevance to other jurisdictions (it is not applicable to people under the age of 21 in prison establishments). It concentrates on generic services in prisons, and so does not generate recommendations on the needs of prisoners with special needs, nor on the particular needs of women or people from Black or minority ethnic groups with mental health problems in prison.

The report makes 26 recommendations to improve mental healthcare in prisons. These cover the areas of:

- role of the consultant psychiatrist in prison
- commissioning mental health services in prisons
- addiction services in prisons
- learning disability services in prison
- female prisoners
- old age psychiatry in prisons
- rehabilitation psychiatry in prison
- psychotherapy services in prison
- training

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Use of licensed medicines for unlicensed applications in psychiatric practice

College Report CR142, January 2007, Royal College of Psychiatrists £7.50, 32 pp

Drug treatment is an essential part of much of psychiatric practice in patients from a wide age range and across many diagnostic groups. Despite the availability of many classes of psychotropic drugs, a substantial proportion of patients will remain troubled by persistent, distressing and impairing symptoms, even after a succession of licensed pharmacological treatments. In this situation, many psychiatrists will consider the prescription of psychotropic drugs outside the narrow terms of their licence, as part of an overall plan of management.

As this aspect of clinical practice in psychiatry has recently come under some scrutiny, a working group of the Special Interest Group in Psychopharmacology (SIGP) of the Royal College of Psychiatrists was convened to examine the nature and extent of the use of licensed psychotropic drugs for unlicensed applications in psychiatric practice, to consider any potential benefits and risks associated with this aspect of clinical practice, to outline when this may be an appropriate part of the management of individual patients, and to make balanced recommendations for a suggested procedure when prescribing licensed medication for unlicensed applications.

This College Report summarises the discussions and conclusions of the working group, and incorporates feedback from the wider membership of the SIGP. It is recommended that unlicensed prescribing should only occur when licensed treatments have been used or excluded on clinical grounds; and when the prescriber is familiar with any possible benefits and risks of the medication being considered, and feels confident with the proposed treatment. Whenever possible the agreement of the patient should be obtained; but if not possible, this should be noted. Prescriptions should be started cautiously, and the subsequent progress of the patient should be monitored closely. If the treatment proves ineffective it should be withdrawn carefully and if effective, the patient should be reviewed regularly. This aspect of prescribing practice may be a suitable area for review within continuous professional development peer groups and for clinical audit within mental health services.

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