the columns

correspondence

New procedure for submitting letters

In order to speed up the publication of correspondence and to encourage debate among our readers and authors, all letters to the Editor must from 1 January 2009 be submitted online as eLetters. Hard-copy submissions or submissions sent by email will no longer be considered. To submit an eLetter, please go to the *Psychiatric Bulletin* website http://pb.rcpsych.org. Click 'submit an eLetter' in the box at the top right of the screen when viewing online the article on which you wish to comment. If your letter is a general one, and not in response to a specific article, please click the link 'eLetters' on the *Psychiatric Bulletin* homepage and follow the instructions. We aim to publish eLetters online, if accepted, within 10 days of submission. A selection of these letters will be included in subsequent printed issues.

Patricia Casey
Jonathan Pimm

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Ethical conflicts in mental health law

Psychiatry is not exclusively the only medical specialty conflicting with legislation on capacity, although within public health medicine this occurs rarely (Lepping, 2008). Individuals with capacity can be legally detained, if they have an infectious disease placing the public at risk (Public Health Act 1984, s38/39).

The ability to legally detain individuals under this Act and the Mental Health Act 1983/2007 is derived from the European Convention of Human Rights, article 5(1)(e). This states that, 'everyone has the right to liberty except in the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind . . .'. This legislation and its interpretations made by courts make no consideration of capacity [*Winterwerp v. Netherlands*, 1979] and take a utilitarian approach to the treatment of the mentally ill.

The Human Rights Act 1998 demands that British legislation is read in a compliant manner with the European Convention of Human Rights, but as the Convention takes a utilitarian approach to mental illness we would argue the Human Rights Act in this context is not a rights-based legislation as suggested. We agree with Lepping that the Mental Capacity Act 2005, a primarily rights-based legislation, is in ethical conflict with the utilitarian approach of the Mental Health Act 1983/2007, but it equally conflicts with the European Convention of Human Rights.

LEPPING, P. (2008) Is psychiatry torn in different ethical directions? *Psychiatric Bulletin*, **32**, 325–326.

Winterwerp v. Netherlands [1979] 2 ECHR.

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PRN sedative prescribing in the elderly

Doctors admitting elderly patients to hospital frequently prescribe sedation as required or *pro re nata* (prn). They may do this for a variety of reasons, including inexperience, habit and to avoid disturbing a medical colleague at night.

Here we report the results of an audit to determine the frequency of *prn* sedative prescribing in the elderly.

A prospective and retrospective case note and drug chart analysis of all patients admitted to the old age psychiatry wards during 3 months (1 November 2007–31 January 2008) was completed at the Highgate Mental Health Centre in North London. A total of 35 patients were admitted during this period; of these, 31 notes and drug charts (89%) were available and analysed. As many as 45% of patients were prescribed *prn* sedation on admission, of which only 16% (n=5) had a clear indication for sedation documented. One patient who should have been prescribed sedation, was not.

The majority of sedative prescriptions appeared to be made routinely and, therefore, inappropriately.

Further training and support for doctors, nurses and other clinical staff on wards should be encouraged to raise awareness of inappropriate prescribing of sedatives in the elderly.

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Attendance at psychiatric clinics

We conducted a 1-year retrospective study of attendance at a general National Health Service psychiatric clinic in London between 2005 and 2006. We aimed to compare attendance rates between grades of doctors and identify demographic and organisational factors affecting attendance. Previous publications on the subject had identified relatively poor attendance in psychiatric clinics compared with other medical specialties (Killaspy, 2006) and variation between different grades (McIvor *et al*, 2004). Little improvement had been noticed between 1969 (Nehama) and 2004 (McIvor *et al*), taking into account the variation in settings and significant changes to the structure of mental healthcare in the UK. In our study, we looked at the clinics covered by 13 doctors with various degrees of seniority and experience. Appointments were set for 30 min on average at a community hospital in a suburban area with good transport links. The overall attendance rate was 72.4%, ranging between 79.1% for consultant psychiatrists and 63.8% for associate specialists, with intermediate figures for specialist registrars (72.3%) and senior house officers (66.3%). We also found significantly better attendance for morning clinics and on Wednesdays. There was no significant difference between male and female service users or between new and follow-up appointments. Most missed appointments were an isolated event but a small number of service users (n=61) were responsible for 38% of overall non-attendance, having missed between 3 and 12 appointments in that year.

columns

KILLASPY, H. (2006) Psychiatric out-patient services: origins and future. *Advances in Psychiatric Treatment*, **12**, 309–319.

McIVOR, R., EK, E. & CARSON, J. (2004) Non-attendance rates among patients attending different grades of psychiatrist and a clinical psychologist within a community mental health clinic. *Psychiatric Bulletin*, **28**, 5–7.

NEHAMA, V. S. (1969) Non-attendance at a psychiatric follow-up clinic. *British Journal of Psychiatry*, **115**, 475–476.

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Non-engagement and the assertive outreach team

The concept of non-engagement lies at the heart of the Assertive Outreach Team (AOT) model (Stein & Test, 1980). However, in our experience there is widespread misunderstanding within mental health services about what this term means. Apart from non-engagement, the other primary criterion for acceptance into an AOT is a diagnosis of a severe and enduring mental illness, which is likely to lead to several secondary factors, including dual diagnosis, a history of self-neglect, repeated hospital admissions, chaotic lifestyle and housing problems.

Referrers often misconstrue these criteria. They see the secondary list as having equal weight as the primary, believing that AOTs specialise in working with difficult-to-manage service users, whereas in fact there is no evidence for this (Burns, 2004). Special skills of AOT staff lie in developing a good therapeutic relationship with individuals with a primary diagnosis of severe and enduring mental illness who have not engaged with the community mental health team (CMHT) at all, and this is a powerful determinant of how well a person will respond to professional input (Priebe & Gruyters, 1993).

Referring to AOT individuals with a severe mental illness who are only partially engaging with the CMHT on the grounds that these particular people are deemed chaotic (Burns, 2004), high-risk and hard to manage is not risk-free. Transitions between teams are known to be times of high risk for service users (e.g. increased suicide rates in individuals moved from in-patient to out-patient care; Crawford, 2004). If AOTs accept service users who are engaging with their CMHT, they may contribute to the removal of a support network to which the person has become accustomed. It may be very difficult for service users to make the change from dealing with two or maybe three familiar individuals to as many as eight or nine unfamiliar AOT staff. Accepting inappropriate users is demoralising for members of an outreach team, who have been trained and have chosen to work with a particular, non-engaging patient group (Libberton, 2000). Not only will AOTs feel pressured to accept more such referrals, but in the process CMHTs are in real danger of becoming de-skilled.

Lastly and most importantly, individuals are likely to experience a sense of loss or rejection when transferred to an AOT with all the attendant risks of morbidity and mortality. We believe that it is vital that AOT and CMHT staff have a good, shared understanding of what is meant by the term non-engagement and that inappropriate referrals are not accepted. The Department of Health has rightly made clear that any change in emphasis to simply increase a team's number of service users by taking on people who are not suitable for AOTs should be avoided (Department of Health *et al*, 2005).

BURNS, T. (2004) *Community Mental Health Teams. A Guide to Current Practice*. Oxford University Press.

CRAWFORD, M. J. (2004) Suicide following discharge from in-patient psychiatric care. *Advances in Psychiatric Treatment*, **10**, 434–438.

DEPARTMENT OF HEALTH, NATIONAL INSTITUTE OF MENTAL HEALTH IN ENGLAND & CARE SERVICES IMPROVEMENT PARTNERSHIP (2005) *Assertive Outreach in Mental Health in England. Report from a Day Seminar on Research, Policy and Practice*. CSIP (http://www.csip.org.uk/silo/files/ao-seminar-report.pdf).

LIBBERTON, P. (2000) Getting your ACT together. *Mental Health Nursing*, **20**, 14–17.

PRIEBE, S. & GRUYTERS, T. (1993) The role of the helping alliance in psychiatric community care. A prospective study. *Journal of Nervous and Mental Disease*, **181**, 552–557.

STEIN, L. I. & TEST, M. A. (1980) Alternative to mental hospital treatment. I. Conceptual model, treatment program, and clinical evaluation. *Archives of General Psychiatry*, **37**, 392–327.

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Repeat prescribing in secondary care: are there any standards?

Repeat prescribing in secondary care mental health service has implications regarding cost, workload, service user safety and convenience. The standards available for repeat prescribing (National Prescribing Centre, 2004) apply to primary care, but there is no guidance for secondary care.

We undertook a survey of repeat prescribing practices at a community mental health team (CMHT). All psychotropic medications prescribed at the same dose on three or more consecutive appointments were considered repeat prescriptions unless otherwise specified.

Prescribing over the previous year was examined in a sample of 42 case notes. A total of 35 (83%) had a clear record of which psychotropic agents were being prescribed by the CMHT and which ones by primary care: in 23 (66%) of these, this was recorded in the text of the letter from a general practitioner (GP) and in 21 (60%) it was in the list of medications at the beginning of the letter. In 20 (57%) out of 35 case notes, this record was highlighted (bold/coloured ink). Forty individuals had received the same dose of psychotropic over at least three consecutive appointments; of these, 30 (75%) received their repeat prescriptions from primary care, 4 (10%) from the CMHT and in 6 (15%) it was not clear who was supplying medication. Of the four individuals receiving repeats from the CMHT, three had clear documentation of the reason for this. The total number of individual prescriptions generated as repeats by the CMHT for this sample was only four. There was a handwritten record in the notes in all of them and in two also a photocopy of the prescription(s).

We therefore recommend the following.

1. There should be a clear record, in medical notes as well as in the GP letter, stating which psychotropic agents are being prescribed by secondary care and which ones by primary care.
2. All the repeat prescriptions generated at the secondary care service should be recorded.
3. Where service funding is such that repeat prescribing budgets are directed through primary care trusts, individuals who are on a stable dose of a psychotropic agent should normally obtain repeat prescriptions from their GP.
4. Should it be appropriate to deviate from this general framework for an individual service user, the reason for this and the estimated duration of repeat prescribing of the agent by secondary care should be clearly documented and communicated to the GP.

NATIONAL PRESCRIBING CENTRE (2004) *Saving Time, Helping Patients. A Good Practice Guide to Quality Repeat Prescribing*. NPA.

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