guidelines (Gill, 1993; Stanley & Doyle, 1993). Prescribing above BNF recommended maximum daily doses was of particular concern (6.5% and 50% of patients respectively). As results from these audits may not relate to the majority of psychiatric in-patients, we examined the prescribing of antipsychotic medication in a general psychiatric hospital over a 24 hour period in 1993. A similar audit had been performed two years previously.

Of 77 in-patients in general psychiatry wards, 55 received an antipsychotic medication. One patient received more than the BNF recommended maximum daily dose and two others could have done if all prescribed PRN doses were given. Six patients received more than one antipsychotic; two by more than one route. Of 42 in-patients in old age psychiatry wards (functional mental illness), 21 received antipsychotic medication. None were given or prescribed over BNF recommended maximum daily doses although there are often no specific guidelines for elderly people. Three patients received more than one type of oral antipsychotic medication.

Two years previously, 63 of 113 general and old age psychiatry in-patients received antipsychotics over a similar 24 hour period. One patient received an antipsychotic over recommended BNF limits. Eleven received more than one antipsychotic medication; seven by more than one route. Prescription of antipsychotic medication in excess of BNF guidelines is not common in this general psychiatric hospital setting (<1%), perhaps because of the addition of benzodiazepines for sedation or lower doses of more than one antipsychotic. Although both practices are probably safer alternatives, it is not clear how to assess the risk of using multiple neuroleptics.

'Chlorpromazine equivalents' are often used to estimate the additive risk of multiple neuroleptics (Stanley & Doyle, 1993). However, these are based on antipsychotic activity or dopamine receptor affinity, whereas BNF limits are principally related to the side effect profile. If one's concern with departing from BNF guidelines is from a medico-legal point of view (Gill, 1993), it may be of interest that there is no BNF recommended maximum daily dose for trifluoperazine.

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BOBBY TORKINGTON, SHELLEY HOGG, GUY POWELL, CHRISTINE MAIN and ANDREW BARKER, *St Ann's Hospital, Canford Cliffs, Poole BH13 7LN*

Age and sex differences in general practice benzodiazepine prescription in United Kingdom

Sir: Around 10% of people in Europe use tranquilisers, the majority being prescribed by general practitioners (Woods *et al*, 1987). However, there is little information on the circumstances of such prescriptions. We report on a survey of benzodiazepine prescriptions in a general practice in East London over a three month period. Of the total number of patients, 3.6% (302/8253) received benzodiazepines, 87% (7180/8253) being repeat prescriptions. There was an age-related increase in the prescription; 0.4% (18/3805) in the 18–44 year age range, 3% (75/2501) in 45–65 year group and 10.7% (209/1947) aged over 65 years.

The age-related difference was apparent in repeat prescriptions as well; one in eight (25/209) of those over 65 years had not had their medication reviewed in the preceding year and one in 23 (9/209) in the preceding three years. Only 4% (3/75) from the 45–65 year group and none aged 18–44 years fell into this category.

After correcting for sex distribution of the total population, women aged 45 to 65 years were twice as likely, and those over 65 years three times more likely, to receive benzodiazepines than men. The over-representation of elderly women was also observed by van der Waals *et al*, 1993. However, women were four times more likely to have their prescription reviewed in the preceding year.

Learoyd (1972) found that, among psychogeriatric patients, 16% presented with disorders attributable to side effects of psychotropic drugs and that in 20% this was the reason for hospital admission, the most frequently implicated agent being tranquilisers. They also cause drowsiness and unsteadiness resulting in increased likelihood of falls and fractures.

It seems that elderly patients who are most vulnerable to developing pharmacological interactions and central nervous system side effects are the ones more likely to receive benzodiazepines. Our findings suggest the need for more careful monitoring, given that 87% of the benzodiazepine prescriptions were repeats, and as many as one in eight of those over 65 years were receiving them without review of the need for continuation. In addition to clinical concern, this has implications for costing, the cost of medication and of clinical morbidity and hospital admission attributable to side effects of this medication.

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V. EAPEN, *University College London Medical School, London W1N 8AA*

Shortage of senior registrar posts

Sir: Recent papers in the *Psychiatric Bulletin* on requirements for appointment as a senior registrar (Bowen & Cox, 1993 and Izaguirre & Sireling, 1993) demonstrate clearly the problems facing trainees in psychiatry but only touch on the cause of the problem, i.e. the shortage of senior registrar posts. This was pointed out in our paper 'Outcome of Psychiatric Training' (Birchall & Higgins, 1991) and since then the situation has become worse. A review of the Classified Advertisements Supplements of the *British Medical Journal* for four recent consecutive weeks showed advertisements for 37 posts for consultant psychiatrists and only seven posts for senior registrars in psychiatry.

Of all trainees leaving the Mersey Region Training Scheme in Psychiatry during the past eight years, 62 were successful in the membership examination. Forty-three trainees left to take up senior registrar posts, nine trainees went abroad and the remaining ten went into posts which gave them a poor chance of obtaining a senior registrar post and therefore of reaching consultant status. Of the nine trainees who went abroad, three were returning to their own country, and six were emigrating, mainly because of difficulty obtaining senior registrar posts. Of the ten trainees remaining in the United Kingdom, five were thought unsuitable for higher training because of personal qualities but the remaining five probably were suitable. So, of 62 trainees successful in passing the membership examination, 11 (18%) might have become consultants in the United Kingdom were it not for the shortage of senior registrar posts.

In the Mersey region we are considering what help to give to trainees to ensure that those suitable for senior registrar training achieve this goal. It is likely that a similar situation exists in other regions. There are several vacancies for consultant posts in most health regions. Each consultant vacancy puts considerable strain on the other consultants and trainees in the unit affected, and results in impairment of training and of patient care.

The College is to be congratulated on obtaining agreement for an increase in manpower allocation of senior registrar posts for psychiatry. Unfortunately, due to financial constraints, health authorities may be reluctant to fund additional posts and it may be years before the planned increase is achieved. Urgent action is required to remove this artificial obstacle to the progress of trainees not only for their sake, but for the future of psychiatry. Unless this problem is addressed, the College's efforts may come to nought.

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ERIC BIRCHALL, *Fazakerley Hospital, Liverpool L9 7AL*

Training pack for senior registrars

Sir: Some 18 months ago I introduced a new appraisal and logbook/checklist as part of a training pack for senior registrars in the psychiatry of learning disability in Oxford. The components of the training pack are as follows.

Introduction

This brief section stresses the partnership which should exist between the trainee and supervisor. Also included is a summary of the services provided in the various placements.

Logbook/checklist

The logbook is seen as a checklist to help senior registrars build up a record of their experiences and knowledge. It is therefore intended to help direct senior registrars to those areas they may need to focus on to ensure a broad range of experiences in their training/development. It is stressed that this is not an assessment tool and should be perceived as belonging to the trainee. It also differs in many respects to the traditional logbook which is a record of cases seen or procedures carried out. It covers the following areas: assessment; formulation of problems: planning and implementation of intervention; assessment and intervention at various levels; visits to settings/agencies with people with learning disability; work with other professionals; breadth of experience; training/teaching; management development; and research.

Goal sheet

On each main clinical placement educational goals are set jointly between the educational supervisor and trainee. These are finalised with the scheme organiser at the goal planning meeting. Goals are reviewed one month into the placement, midway through the placement and at the end. The midway and final reviews involve the

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