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NICE's restrictions on the use of acetylcholinesterase inhibitors

Ganeshalingam *et al* (2008) infer that prescribers are making clinical judgements rather than strictly adhering to the Mini-Mental State Examination (MMSE) score when deciding to prescribe acetylcholinesterase inhibitors under the revised National Institute for Health and Clinical Excellence guidance (National Institute for Health and Clinical Excellence, 2006).

We examined this issue in Southern Derbyshire by scrutinising application forms submitted by clinicians to our pharmacy department as a prerequisite to the issuing of these drugs.

In the year 1 June 2007 to 30 June 2008, 227 service users were initiated on acetylcholinesterase inhibitors by 7 clinicians working in old age psychiatry and 32 (14%) initiates scored above 20 on the MMSE, of whom 26 had a recorded diagnosis of Alzheimer's disease. Within this high-scoring group of individuals with Alzheimer's disease, MMSE score did not correlate with Bristol Activities of Daily Living (BADL) or Relative Stress Scale (RSS) scores (Spearman's r=0.06 and 0.16 respectively, P>10%), but BADL did correlate with RSS (Spearman's r=0.79, P<1%) – high functional impairment was associated with more carer stress. Almost half (n=12) of the 26 individuals showed such features of dementia as agitation, aggression or psychosis and 11 were anxious, depressed or apathetic. Only six had no recorded behavioural or psychological features of dementia.

These findings indicate that relying on the MMSE score to guide the prescribing of acetylcholinesterase inhibitors to people with apparently mild Alzheimer's disease is likely to represent poor practice. We propose that all individuals with an MMSE of 20 or above are given an acetylcholinesterase inhibitor unless sufficient evidence can be gathered to justify withholding it.

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Awareness and management of psychosexual and relationship problems in mental health services

Knowledge of psychosexual development and competency in the assessment and treatment of psychosexual disorder should be core components of psychiatry residency curriculum and psychiatric training (Scheiber *et al*, 2003; Nnaji & Friedman, 2008). Research indicates that many psychiatric training schemes fail to teach a broad range of human sexuality issues and that expert supervision and clinical training opportunities are lacking (Verhulst, 1992).

We undertook a study that monitored the assessment and training in psychosexual and relationship problems in general mental health services (Rele & Wylie, 2007). We devised a questionnaire that asked psychiatry trainees to report their perception of competency in dealing with service users' sexual dysfunction and relationship problems, the need to discuss potential sexual side-effects before and after starting psychotropic medication and the importance of a readily available psychosexual disorder clinic. In addition, we enquired about the emphasis, or otherwise, on psychosexual disorders and sexual health problems in general, both in medical school and during current psychiatric training. All psychiatry trainees (both basic and higher specialist trainees in adult and old age psychiatry) in the mid-Trent rotation were invited to complete the questionnaire.

Only 24% of trainees reported that they routinely ask service users about psychosexual history; of these, 65% felt comfortable about taking a detailed psychosexual history. The majority of participants (81%) felt they have received inadequate training and did not feel competent dealing with service users with a psychosexual disorder. Only 30% of trainees reported asking service users about sexual health side-effects when on psychotropic medication. All trainees preferred to refer the person to a local psychosexual disorder clinic (if available) rather than treat them themselves. To our knowledge, this was the first survey on competency of UK-based psychiatric trainees in taking a sexual and relationship history and management of sexual dysfunction of their patients.

Taking a sexual and relationship history should be an integral part of any psychiatric assessment. Nnaji & Friedman (2008) have failed to highlight the importance of a healthy relationship in their paper. Healthcare professionals need to be alert to the possibility of a sexual problem in service users and should be competent enough to be able to discuss it. Training in sexuality should be introduced in medical schools as a part of the undergraduate curriculum and a core part of psychiatric training curriculum, and trainees should be tested for their competency in dealing with sexual dysfunctions.

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