BNF recommended dosage

DEAR SIRS

We read with interest the report of Stanley & Doyle (*Psychiatric Bulletin*, May 1993, **17**, 299–300) about prescribing levels in the West Midlands regional secure unit. Both this experience and that of Fraser & Heppel (1992) represent special cases. Despite this Stanely & Doyle happily report few patients being prescribed doses above the British National Formulary (BNF) ranges.

We would like to report a similar exercise undertaken in an acute adult psychiatric unit based in a district general hospital serving a mixed urban and rural population. The drug charts for the in-patients of four consultants (excluding the drug and alcohol service) were reviewed on two occasions a month apart. The regular medication dosage for the last 24 hours was recorded and the PRN medication recorded as the single dose prescribed, the total dose given in the last 24 hours and whether any dose had been given. These observations were made (with the consent of the consultants) by CJB who was blind to the patients' diagnosis and without recourse to the medical notes.

The charts of 83 patients were reviewed. There were 129 regular prescriptions and 104 PRN prescriptions, a mean of 1.55 and 1.25 respectively per patient. Only two patients had no regular medication and only one virgin chart. Twenty regular (15.5%) prescriptions were for antidepressants, only one being a selective serotonin reuptake inhibitor. Sixty-two (48%) regular prescriptions were for neuroleptics including 14 depots (10.9% of regular prescriptions) and two (1.6%) for clozapine. Of the 104 PRN prescriptions, only 12 dosages (11.5%) had been given in the previous 24 hours. Procyclidine was the most commonly prescribed PRN medication (31 scripts, 29.8%) with temazepam close behind (27 scripts, 26%). Only one patient received regular medication in a dose above that recommended by the BNF, Modecate 200 mg two weekly (BNF maximum dose 100 mg two weekly).

The results suggest that the limits suggested by the BNF serve adequately for the majority of patients in an acute adult setting. Only the exceptional patient requires higher doses and this can be seen in the two studies cited above. There is little value in using very high doses of psychotropic drugs and there may be a worsening of outcome (e.g. Baldessarini *et al*, 1985). There is a need to ensure that clear indications are given for the use of medication above these guidelines and appropriate use of the Mental Health Act (1983) where informed consent cannot be obtained.

CHRISTOPHER J. BALL

Guy's Hospital
London SE1 9RT

RICHARD L. SYMONDS

Medway Hospital
Gillingham, Kent

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See also page 557.

Burnout

DEAR SIRS

In relation to Dr Watson's conference briefing on 'Burnout', (*Psychiatric Bulletin*, April 1993, **17**, 235) I would like to report the findings of a survey of psychiatric trainees I carried out in 1987.

The General Health Questionnaire (GHQ-30) and another questionnaire were sent to a 10% sample of trainees (180) in England and Wales. The survey was anonymous and the return rate 50%. Thirty-five respondents (39%) scored 5 or more on the GHQ-30, 17 suspected they had had a past psychiatric illness and, of these, 14 scored high on the GHQ-30, even though no longer apparently suffering from psychiatric illness. Distress sufficient to interfere with home life and work was reported by 37 (42%) and 33 trainees respectively and 24 (27%) had considered giving up psychiatry. Half reporting such distress said it lasted for weeks or months.

Reported as stressful were listening to others' problems/distress 28 (32%), dealing with violent/potentially violent patients 21, realising the limitations of treatment 20, staff relationships 13, on-call duties 11, over-work 9, suicidal/potentially suicidal patients 8.

These results indicate a significant level of chronic distress during psychiatric training. Non-responders appear to be more distressed than responders (Vernon *et al*, 1984; Firth Cozens, 1987) and, even if the 50% who did not respond are in full health, there is sufficient distress to warrant further attention.

In terms of the causes of "burnout', trainees' reports of stressful aspects of training fall mainly into the "problematic relationships" category, whether doctor-patient or staff. These issues need more attention and should be addressed during training as the relationship aspects of psychiatry, whether it be to staff or patients, remain crucial throughout the psychiatrist's working career.

R. HADDOCK

Middlewood Hospital
Sheffield S6 1TP

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Mental Health Review Tribunal – new decision form

DEAR SIRS

I was alarmed to see that the above forms were initially incorrectly worded as to the reasons for a patient's detention under the Mental Health Act 1983. That is, they asked the question whether the Tribunal was satisfied that, "it is not necessary for the patient to be detained for his 'health *and* safety' instead of for his 'health *or* safety' ". Since this error was pointed out, the decision forms have been correctly worded. However, I am concerned about the persistence of this fundamental mistake within the Mental Health Review Tribunal system and believe it reflects a widespread lack of clarity in the understanding and use of the Mental Health Act 1983.

I would suggest that consideration should be given to the relevant wording being changed throughout the Act to read:

> This ought to be so detained (i) in the interests of the patient's own health, or (ii) in the interests of the patient's own safety, or (iii) with a view to the protection of other persons.

I feel it is unfortunate to have such an obvious confirmation of the need for the Secretary of State for Health's investigation in relation to the MHA 1983 into whether "the present legal powers are being used sufficiently effectively".

ALISON ABRAHAM

The Princess Royal Hospital
Haywards Heath
West Sussex RH16 4EX

Charges for advocacy

DEAR SIRS

A patient admitted when manic appeals against a Section 3 detention and engages a legal representative. On the day of the tribunal, with a greatly improved mental state, he withdraws the appeal but naturally is still charged by the solicitor. The fee amounts to several hundred pounds.

In general I would counsel my patients against entering into a formal contract and incurring expenditure at this level while their judgement was impaired. Clearly in this case it would be improper to seek to dissuade a person from obtaining independent legal advice.

In April of this year eligibility for legal aid became more restrictive. Many more patients will be charged for legal advice at tribunals. Is it not time to consider an independent advocacy service, at no charge to detained patients?

J. C. BARNES

Phoenix House Acute Unit
Priory Park
Wells, Somerset BA5 1TH

The nominated deputy

DEAR SIRS

Section 5(2) of the Mental Health Act, 1983, provides for the responsible medical officer to nominate one deputy to act on his behalf, whereas no such provision existed in the 1959 Act. However, a national survey has revealed wide differences between health districts as to who acts as the consultant's nominated deputy during the daytime, although not at night (Cooper & Harper, 1992). We suggested that the on-call junior psychiatrist is the most suitable doctor to fulfill this role, and hence determined to study whether the outcome of section 5(2) is affected by who signs the form. We wish to report out findings.

Psychiatric services are provided on three main hospital sites in Leicestershire. Junior psychiatrists receive training in the purpose and provision of section 5(2) as part of an induction course, and are obliged to discuss cases with the responsible medical officer or on-call consultant prior to implementation of the section. The records of patients detained under section 5(2) at the three sites, during the year 1991, were scrutinised. The doctor implementing each section was noted, as was his status. Outcome of section 5(2) was recorded in terms of application for admission under sections 2 or 3, or reversal to informal status.

During 1991 there were 142 detentions under section 5(2) for which the signatory of the form and outcome of the section could be elucidated. Of the 28 patients detained by the responsible medical officer, 12 were subsequently admitted under section 2 of the act, five under section 3 and 11 reverted to informal status. Of the 114 patients detained by the on-call junior psychiatrist, 45 were subsequently admitted under section 2, 17 under section 3 and 52 reverted to informal status. Hence outcome was no different whether the section was implemented by the responsible medical officer, or by the on-call senior house officer/registrar, acting as the nominee.

Section 5(2) is an emergency provision. For the majority of hospitals the doctor most readily available to deal with emergencies is the resident on-call junior psychiatrist. If the on-call senior house officer/registrar was nominee to each consultant during the daytime as well as at night, this would provide for one doctor to be nominated as deputy for each 24 hour period. Analysis of outcome of section 5(2)s in Leicestershire supports the view that the