columns

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

doi: 10.1192/pb.31.7.273d

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

doi: 10.1192/pb.31.7.274

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

doi: 10.1192/pb.31.7.274a

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

doi: 10.1192/pb.31.7.274b

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

doi: 10.1192/pb.31.7.274c

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

doi: 10.1192/pb.bp.107.015362

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.

doi: 10.1192/pb.bp.107.015370