on-call junior psychiatrist is suitable to act as nominated deputy.

SALLY-ANN COOPER
RUTH HARPER

University of Leicester
Clinical Sciences Building
Leicester LE2 7LX

Reference

COOPER, S.-A. & HARPER, R. (1992) Section 5(2): who acts as the consultant's nominated deputy? *Psychiatric Bulletin*, **16**, 759–761.

Section 5(4)

DEAR SIRS

I was disappointed to see this title to an article in the March 1993 issue of the *Psychiatric Bulletin* as it represents a sad view of editorial policy.

All Acts of Parliament are divided into sections and sub-sections, so this title is meaningless. This is particularly true with the Mental Health Acts of the different countries of the UK, where section numbers do not necessarily coincide with respect to content.

Furthermore, the authors do not at any point in their article include a formal statement of the content of the particular section though they do outline its use. They assume that all readers are familiar with the jargon, because of course that is what it is, of the psychiatric professionals. This is also true of their reference to other sections of the Act, 5(2), 2 and 4.

Professor John Gunn wrote a letter to the *Bulletin* shortly after the implementation of the Act proposing the use of abbreviated titles for relevant sections so that their general function was apparent to all readers. This proposal has been taken up by the Examinations Sub-Committee for use in the examinations.

I suggest that a similar policy is followed by the *Bulletin* in particular, and indeed in all situations within the College where sections of the Act are discussed.

PHILIP SEAGER

11 Haugh Lane
Ecclesall, Sheffield S11 9SA

That a description of the function of the particular function of the Act would be a much more useful and appropriate title is accepted and we will endeavour to ensure that this occurs in future. *Eds.*

Audit of in-patient antidepressant use

DEAR SIRS

Much has recently been written about the use of selective serotonin re-uptake inhibitors (SSRIs) in the treatment of depression where it seems their place has not been established (Ferrier *et al*, 1992).

To investigate local prescribing habits, a point prevalence survey of antidepressant use in in-patients was undertaken at Bootham Park Hospital in York. On the day of the census there were 96 in-patients, 41 of whom were on antidepressants. More than half of these were on SSRIs (22). Reviewing the case-notes revealed that 14 patients were on antidepressants for the first time (five on SSRIs, nine on tricyclic and related antidepressants (TCAs)). Both the patients on SSRIs and those on TCAs were treated with antidepressants alone, and in combination with lithium, neuroleptics and ECT (except sertraline). SSRIs were prescribed more often than TCAs in those patients with depression plus dementia and those with high suicide risk, as would be expected.

The commonest rationale for specific current antidepressant treatment was suicide risk (four on SRRIs, one on TCA[lofepramine]), intolerance of SSRI/TCA (2,3) and failure of SSRI/TCA (3,4). No written rationale was found in 18 of the 41 patients on antidepressants. Prescription of SSRIs varied between the seven consultants (range 0/5 patients on antidepressants to 6/6).

The results appear to reflect both the current trend towards widespread use of SSRIs and the lack of consensus about their indications. Although the rationale for particular antidepressant use is complex and includes patient, medication and physician factors, to produce a written statement explaining why a particular type of medication is used would be a useful objective for the audit cycle. Regular documentation of reasons behind the prescription of SSRIs and TCAs would be beneficial not only for individual patient management but to aid more focused future research to clarify and perhaps reach consensus regarding the physical management of depression.

SIMON L. BALMER

Bootham Park Hospital
York YO3 7BY

Reference

FERRIER, I. N., SILVERSTONE, T. & ECCLESTON, D. (1992) Selective serotonin re-uptake inhibitors: use in depression. *Psychiatric Bulletin*, **16**, 737–739.

Cutting costs without cutting corners: a case for sound pharmacotherapy

DEAR SIRS

Working for Patients proposed a health care system based on managed competition between care providers with treatments priced in advance. The working Group of the Royal College of Psychiatrists expressed concern about such a system. Glover

(1990) underscored the importance of self regulation of the medical profession through medical audit. He pointed out the dangers of a narrow, efficiency oriented view of audit which could cut corners too far and produce sub-standard care.

Audit of the prescription patterns of psychotropic drugs is an under-researched area despite being the focus of vehement criticism. Crammer (1991) scathingly remarked: "Psychiatrists and GPs do not always prescribe the right drugs in the right dosage to get the best results possible." Wressell (1990) highlighted the common problems of drug prescription in mental handicap institutions, namely over prescription, polypharmacy, irrational prescription patterns and inadequate reviews leading to unnecessary, prolonged drug treatment. An audit (Childs, 1991) in a DGH unit revealed high levels of benzodiazepine prescriptions and excessive use of PRN medication. A subsequent survey suggested that audit can lead to substantial reduction in the amount of drugs prescribed. This study also noted the lack of supervision of junior doctors. Wright (1990) observed that stable, uncomplaining out-patients are too often left on the same high dose of neuroleptics which they were prescribed during an acute episode several years previously. This increased the risk of developing tardive dyskinesia, obesity and reduction of social functioning. Concurrent use of oral and depot neuroleptic medication, multiple divided dosage in well stabilised chronic schizophrenic patients and routine prescription of anticholinergics are not uncommon.

Most hospitals probably have stringent codes of practice of pharmacotherapy. Our aim is to highlight the unnecessary and avoidable economic burden which ensues as a result of undesirable prescription practices. There is a need to conduct medical audit of psychotropic prescription patterns in various psychiatric settings which should address actual cost of drugs and indirect costs (patient morbidity, quality of life, staff time etc); to improve the quality of supervision of junior doctors in pharmacotherapy; and perhaps to set up a sub-speciality of psychopharmacotherapy. If we take enough thought and care we can improve standards and reduce costs.

K. A. H. MIRZA

St James's Hospital
1 James's Street, Dublin

ALBERT MICHAEL

St Bartholomew's Hospital
London EC1A 7BE

References

CHILDS, P. (1991) Clinical audit effects a reduction in routine prescribing of benzodiazepine hypnotics. *Psychiatric Bulletin*, **15**, 625–627.

CRAMMER, J. L. (1991) Prescribing by psychologists? *Psychiatric Bulletin*, **15**, 34–35.

GLOVER, G. R. (1990) Medical audit and mental health care. *Psychiatric Bulletin*, **14**, 326–327.

WRESSEL, S. E. (1990) Reduction in antipsychotic drug dosage in mentally handicapped patients; A hospital study. *British Journal of Psychiatry*, **157**, 101–106.

WRIGHT, N. F. (1990) Observations on the management of depot neuroleptic therapy. *Psychiatric Bulletin*, **14**, 594–596.

Allocation of posts within a registrar training scheme

DEAR SIRS

Recently the size of some rotational training schemes has increased greatly with an expectation that this will more easily provide a mix of specialist and general posts. However, there is no generally agreed method of post allocation within such schemes and it may prove difficult to meet the needs of every trainee.

In SW Thames there are approximately 60 registrar posts allied to St George's Hospital, Tooting. The allocation of posts is decided by the trainees at a meeting held every six months. This is chaired by the trainee representative with the help of the rotation tutor. Each trainee states his or her first and second choice of post and a system of discussion and bargaining ensues before final agreement is reached.

A variety of factors affect the desirability of posts. Those in general psychiatry are popular in the six months before sitting the MRCPsych exam and those with a less arduous on-call rota are especially popular at this time. Specialist posts are most popular in the period between passing Part I and sitting Part II. However within the framework the popularity of a post may be affected by reports of previous incumbents regarding the level of consultant supervision, the perceived work-load, opportunities for research and even travelling distance to the hospital site.

The system is thought to be as fair as possible but there will inevitably be individuals who do not fare well in such meetings and, despite the overview of the clinical tutor, are left feeling hard done by. Changes to the system have been resisted by the trainees and yet one must ask if the present method of allocation is most appropriate?

One problem is trying to accommodate training commitments that may transcend a six month placement. The region has a particularly active training programme in psychotherapy and all trainees are encouraged to participate in individual, group and family therapies and to receive supervision. Once a commitment is made to, for example, a therapy group in a peripheral part of the rotation a trainee may be reluctant to accept a more central post because of the travelling time involved. Also, since only one post is allocated at a time, planning for