in an average expert system makes the system untestable; at least if testability means that every potential pathway be tested. The expert system that flies your 'plane home from holiday is 'backed-up' by having a pilot on board. Hopefully, if the expert system decides to nosedive your 'plane into the ground, the pilot will take over the controls!

So what is the potential consequence for psychiatric research? Image analysis, done by computers, relies on expert systems. These are untestable. The very least we need to do is analyse our brain scans using two completely independent software programs. If, and only if, the two software systems produce the same results then we may be able to draw significant conclusions.

The problem, however, does not stop there. The scans themselves are produced by computer guided equipment. Serial scans by different machines have already been criticised in the literature. If results between research centres are to be comparable, then at least two scans per patient, done on different machines, and analysed by two different software packages may be needed. That makes four analyses per patient mandatory, whether or not the experimental design uses a 'case' v. 'control' methodology or not.

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Overuse of hypnotics for psychiatric in-patients

Sir: There still appears to be a widespread problem with hypnotic prescription for psychiatric in-patients despite advice from the *British National Formulary* (1994) and the Royal College of Psychiatrists (1988) which both state that hypnotics should not be routinely prescribed for in-patients unless there are specific indications.

Insomnia causes patients subjective distress but is not dangerous. Many psychiatric illnesses present with insomnia which does not usually need either immediate treatment or treatment in isolation from other symptoms. Treating insomnia too early can mask illness during assessment causing confusion in diagnosis. Hypnotics are addictive and expensive, and form a large proportion of the NHS drug budget on volume of prescription alone. Hypnotics should therefore not be indiscriminately prescribed.

Hypnotics are often prescribed by an on call doctor in the middle of the night or late evening for whom a significant motivation in prescribing was in not being disturbed by nursing staff further (Fry, 1985). Night sedation was also frequently started on the night of admission. However, as the duty doctor is not the key medical contact and often has inadequate knowledge of the patient's background and treatment plan, prescription of hypnotics by him or her is frequently inappropriate.

The solutions to this problem lie in proper education of staff and patients, in good communication and in consistency of treatment. Key points are:

(a) The patient needs to be educated that it is reasonable to expect initial insomnia in the early days of admission
(b) nurses may need reminding of simple management of mild insomnia with light physical exercise during the day, reducing caffeine intake in the evenings and reassuring some patients once their anxieties are understood
(c) duty medical staff should observe consistency of treatment and not feel pressurised by staff or patients to prescribe hypnotics inappropriately
(d) medical staff directly responsible for the patient's care must be explicit to other staff and patients about their policy on prescription of hypnotics for their in-patients.

Prescribing costs can be reduced and quality of care improved if hypnotics are prescribed appropriately. They should be prescribed mainly by the patient's own doctor, unless insomnia is "severe, disabling or subjecting the individual to extreme distress" (BNF, 1994). Nursing staff have an important role in containing patients' anxieties and in informing and educating them about appropriate management of their insomnia.

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Educating non-medical staff about the use of psychiatric drugs

Sir: The role of the psychiatric registrar in learning disability is constantly evolving, as patients are relocated from hospital sites into small group homes within the community. Many

of these homes are staffed by untrained nurses under the supervision of a trained nurse. The latter may have responsibility for several such homes. No longer are staff and patients visited routinely by the doctor. Instead, meetings are more likely to occur at times of crisis and thus, often result in the prescription of psychotropic drugs.

The prevalence of psychotropic drug use within adults with a learning disability living in the community, ranges between 14–36% (Aman, 1987). Drugs are often used to treat behavioural disturbance rather than overt psychiatric illness, and ideally should only be prescribed after a full assessment and after, or in conjunction with, behavioural or social interventions.

Non-medical staff often appear antagonistic towards the use of psychotropic drugs, expressing concern that their patients are being 'doped' and subjected to unnecessary and distressing side effects. They are often unclear why particular drugs are being prescribed and are keen to know more. While most staff have access to a *British National Formulary*, the information is full of medical jargon and may be difficult to understand.

In an attempt to fill this gap in the literature and to reduce the misunderstandings within the staff team when psychotropic drugs are prescribed, I have produced a small drug information booklet for non-medical staff. It summarises the main considerations before prescribing and the indications and common side effects of antidepressants, lithium, antiepileptics, antipsychotics, benzodiazepines and beta-blockers. The booklets have been distributed to staff during small group teaching sessions on the subject. Initial feedback, from untrained nursing staff and other health care professionals such as psychologists, occupational therapists and social workers, has been extremely positive.

Jorsh (1991) suggests that psychiatrists should be more closely involved in the teaching of nursing students and states that it is important that people within a multidisciplinary team are able to use and understand a common language. The psychiatric registrar is in an ideal position to take on this valuable teaching role within the learning disability field and may, in addition, benefit immensely from the experience.

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GILL SALMON, *Registrar in Psychiatry, Oxfordshire Learning Disability Trust*

Adolescent psychiatric services

Sir: Amidst the flurry of closures and growing concern about the future of dedicated adolescent psychiatric services, I am pleased to report that after many years of abortive attempts, Bristol will soon have its own adolescent in-patient and day patient service for the first time.

For more than 12 years, psychiatrists in the city have been working hard to develop such a unit. In spite of the well established local need and the hopeless situation of young people having to travel 60 miles or more for in-patient treatment, little progress has been made over the last decade. A major stumbling block has been the extreme difficulty in getting three independent health authorities to act in concert and agree on the funding, time-tabling and commissioning of any new service.

The advent of the NHS reforms and the purchaser/provider split allowed professionals in Bristol to channel their efforts towards the purchaser, and a helpful and co-operative series of planning meetings over the last 18 months has allowed the development to proceed for the first time. This joint planning between consultants from each of the three Bristol trusts and the purchaser, has enabled us to develop a sensible pragmatic operational policy with wholesale clinical support from potential referrers across the city. The purchaser was then able to invite local providers to put forward business cases for the unit and this process has now been completed.

The new unit will be developed by Frenchay Healthcare NHS Trust and, it is hoped, will open in April 1995. An ideal modern building has been found and within the next nine months a complete new adolescent psychiatric team will be recruited. I feel confident that this will lead to a significant improvement in services to this client group.

I strongly believe that the key to this success has been the close relationship with the purchaser. I would urge colleagues to be pro-active and energetic in developing this relationship. It is our experience that the development of a partnership with the purchaser, aimed at improving services for a neglected group, has led to this very positive outcome.

IAN SKELDON, *Frenchay Healthcare Trust, Bristol BS16 5EB*

Management of physical ill health in a psychiatric setting

Sir: Psychogeriatric in-patients with functional and organic disorders on acute wards suffer from more physical disease than other people. There is a relationship between physical disorder and