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Drug-related movement disorders: training experiences of psychiatrists

AIMS AND METHOD

A questionnaire was sent by post to 185 psychiatrists in Devon and Cornwall to investigate training in the assessment and management of drug-related movement disorders and current training needs.

RESULTS

Responses were obtained from 143 psychiatrists (77%). Formal training was reported by 67 out of 140 (48%). Only 26 out of 142 (18%) had received

formal training in the use of rating scales, which were rarely used. The mean level of satisfaction with training received was below the mid-point on a 5-point scale at 2.76 (s.d.=1.23). Mean levels of confidence in the assessment and management of drug-related movement disorders were just above mid-point at 3.25 (s.d.=1.04) and 3.16 (s.d.=0.99) respectively. Specific training was thought to be necessary by 135 out of 141 psychiatrists (96%)

and there were high levels of interest in further training, particularly from those below consultant grade.

CLINICAL IMPLICATIONS

Drug-related movement disorders affect patients' adherence to medication and their quality of life. Psychiatrists need more structured clinical training in assessing and managing these disorders in order to provide the best clinical care.

The introduction of antipsychotic medication has vastly improved the lives of patients with schizophrenia and related disorders. Unfortunately, a frequent side-effect is the development of drug-related movement disorders, which occur most frequently with the older, conventional antipsychotics, but remain a problem in a significant proportion of patients even with the newer, atypical antipsychotic drugs (Gervin & Barnes, 2000; Cortese et al, 2004). Drug-related movement disorders can confound the clinical assessment of psychiatric symptoms and are associated with physical disability, subjective distress, poor adherence to medication, poor psychosocial and occupational adjustment (Barnes & McPhillips, 1996) and poor quality of life (Browne et al, 1996). Routine monitoring and recording of drug-related movement disorders is recommended (American Psychiatric Association, 1997; Marder, 2000; Owens, 2000; National Institute for Clinical Excellence, 2002) and assessment procedures are available to assist in their diagnosis (Gervin & Barnes, 2000).

Studies from the USA and Canada suggest that doctors should increase their awareness of these disorders and require more training in their assessment and management (Hansen et al, 1992; Cortese et al, 2004). As anecdotal evidence suggested a similar situation in the UK, we conducted a survey of psychiatrists to assess previous training experiences, satisfaction with training, confidence in the assessment and management of drug-related movement disorders, and current training needs.

Method

Following ethical and data protection approval and piloting, a self-completion questionnaire was sent to 185 psychiatrists with a permanent post in one of four National Health Service trusts in Devon and Cornwall. Those not responding within 3 weeks were sent

reminders by post and a final attempt was made to obtain responses by telephone. Although the survey was not anonymous (to enable contact with respondents), data were treated as confidential. The questionnaire covered professional status, training experiences and levels of confidence in the assessment and management of drug-related movement disorders, the use of rating scales and interest in further training.

Results

Completed questionnaires were received from 143 psychiatrists (77%). Data were analysed using the Statistical Package for the Social Sciences version 11 for Windows. To reflect the stage of training and clinical experiences, responses were grouped as: (a) senior house officers and specialist registrars (SHO/SpRs), $n=48$; (b) associate specialists/staff grades/chief medical officers (associate specialist/staff grade/CMO), $n=34$; (c) consultants, $n=61$. The mean number of years in psychiatry was 3.6 years (s.d.=3.3) for SHO/SpRs; 9 years (s.d.=5.9) for associate specialist/staff grade/CMO and 17.3 years (s.d.=6.1) for consultants. Sixty-four respondents (45%) held a current post in adult services.

Training received in assessment

Of 140 respondents who answered the question, 67 (48%) had received formal training in the assessment of drug-related movement disorders, for example, seminar and/or tutorial. Of consultants, 45 out of 60 (75%) were trained compared with 14 out of 48 (29%) SHO/SpRs and 8 out of 32 associate specialist/staff grade/CMOs (25%) ($\chi^2=31.13$, d.f.=2, $P<0.001$). Of the 65 who gave details about the amount of formal training received, 20 (31%) reported 1 h or less, 30 (46%) reported half a day or less and 15 (23%) indicated 1 day or more.



Of the 73 psychiatrists who had received no formal training, 49 (67%) had received informal training, with 33 reporting 1 h or less. Multiple responses were allowed to indicate the main sources of informal training, which were consultants (94%) and self-teaching (33%). There were 24 psychiatrists who had received neither formal nor informal training in the assessment of drug-related movement disorders, representing 17% of the 140 who responded to this question.

Training and use of rating scales in assessment

Respondents were also asked about formal training, amount of use and perceived utility of rating scales for assessment. Only 26 psychiatrists (18%) had received any formal training in the use of the rating scales and the vast majority (91%) used them rarely or not at all. On a scale of 1 (not very useful) to 5 (very useful), the mean rating was 2.14 (s.d.=1.12).

Satisfaction with training received

Using a scale of 1 (dissatisfied) to 5 (very satisfied), the psychiatrists gave ratings of their satisfaction with the amount and quality of their training in the assessment of drug-related movement disorders (Table 1). One-way analysis of variance indicated a significant difference in the mean ratings of the three groups in terms of their satisfaction with both the amount of training received ($F(2,132)=6.99$, $P=0.001$) and its quality ($F(2,127)=7.27$, $P=0.001$). Scheffé's post hoc test showed that on each rating the associate specialist/staff grade/CMO group were less satisfied than the consultants.

Management

Of the 139 respondents providing details, 89 (64%) had had some formal training in the management of drug-related movement disorders, with consultants being more likely to have received training ($\chi^2=12.50$, d.f.=2, $P<0.01$). A majority of 68 (76%) reported less than 1 day training, 12 (13%) 1–3 days and 9 (10%) more than 3 days. The main sources of training were consultants (83%) and 'other staff' (26%); almost half of training was via courses and standard MRCPsych teaching.

Levels of confidence in assessment and management

Using a scale of 1 (not very confident) to 5 (very confident), the psychiatrists rated their confidence in assessing and managing drug-related movement disorders (Table 2). One-way analysis of variance indicated a significant difference in the mean ratings of the three groups in terms of their confidence in both assessment ($F(2,139)=8.52$, $P=0.001$) and management ($F(2,138)=7.59$, $P=0.001$). Scheffé's post hoc test showed that for each item the SHO/SpRs group were less confident than the consultants.

Training needs

Of 141 psychiatrists who answered the question, 135 (96%) thought that specific training was required for drug-related movement disorders. Multiple responses were allowed to indicate a possible range of professionals who should provide the training. The responses of 128 psychiatrists were that training should be given by: consultants, 95 (74%); SpRs, 60 (47%); other staff, 43 (34%); associate specialist/staff grade/CMO, 27 (21%). 'Other staff' included comments that the training should be given by anyone with the necessary expertise and interest. Of 53 consultants, 38 (72%) thought that consultants should provide the training. There was agreement among all grades that the training should be given early, that is, in the first 6 months or the first year of the MRCPsych course.

Interest in receiving specific training

Using a scale of 1 (not very interested) to 5 (very interested), psychiatrists were asked how interested they would be in receiving further training in assessment of drug-related movement disorders by physical examination or observation, assessment by use of rating scales and in management (Table 3). One-way analysis of variance showed a significant difference in the mean ratings of the three groups for interest in further training: in assessment by examination/observation ($F(2,138)=11.54$, $P=0.001$), assessment by rating scales ($F(2,135)=8.84$, $P=0.001$) and management ($F(2,136)=12.64$, $P=0.001$). Post hoc tests showed that, with the exception of training in the use of rating scales, both the SHO/SpRs and the associate specialist/staff grade/CMO groups

Table 1. Satisfaction with the amount and quality of training in assessing drug-related movement disorders

	SHO/SpRs	Associate specialist/ staff grade/CMO	Consultant	Total
Satisfaction with amount of training, mean (s.d.) level from 135 responses	2.49 (1.22)	2.33** (1.12)	3.18** (1.19)	2.76 (1.23)
Satisfaction with quality of training, mean (s.d.) level from 130 responses	2.88 (1.05)	2.69** (1.10)	3.50** (1.05)	3.12 (1.11)

CMO, chief medical officer; SHO, senior house officer; SpRs, specialist registrars.

** $P<0.01$ Scheffé's post hoc test.

**Table 2. Confidence in the assessment and management of drug-related movement disorders**

	SHO/SpRs	Associate specialist/ staff grade/CMO	Consultant	Total (n=141)
Confidence in assessment, mean level (s.d.)	2.92** (1.03)	3.00 (1.06)	3.64** (0.91)	3.25 (1.04)
Confidence in management, mean level (s.d.)	2.85** (0.94)	2.94 (1.14)	3.52** (0.83)	3.16 (0.99)

CMO, chief medical officer; SHO, senior house officer; SpRs, specialist registrars.
** $P < 0.01$ Scheffé's post hoc test.

were more interested in receiving further training than the consultants.

Discussion

Our survey identified little formal or informal training of psychiatrists in the assessment or management of drug-related movement disorders. Overall levels of satisfaction with both the amount and quality of training were also low. A similar pattern emerged for levels of confidence in assessment and management. Even the consultants, who were the most confident, had a mean level of 4 on a 5-point scale (the small standard deviations indicate the similarity of response among this group). Most psychiatrists were not trained to use rating scales, rarely used them and felt they were of limited clinical use.

Almost all of the respondents thought that specific training in the assessment and management of drug-related movement disorders should be given within the first year of the MRCPsych course. Consultants, SpRs or others with the necessary expertise and interest were the most frequently endorsed as potential sources of training. The highest levels of interest were shown by those below consultant grade, particularly for management of the disorders. It is possible that the relative lack of training and confidence among younger clinicians might be the result of a recent underemphasis on assessment and management of these side-effects, which has arisen from a misconception that the problem has been solved by the use of atypical antipsychotics.

The curriculum for the training of psychiatrists in the UK states that trainees should have an in depth knowledge of adverse drug reactions, including their prevalence and those that require appropriate corrective action. Clinical competency includes the ability to explain the effects and side-effects of medication to patients (Royal

College of Psychiatrists, 2001). The clinical guidelines for schizophrenia produced by the National Institute for Clinical Excellence state that the clinician should monitor both therapeutic progress and tolerability of drugs on an ongoing basis, including screening for extrapyramidal side-effects such as tardive dyskinesia (National Institute for Clinical Excellence, 2002). These recommendations indicate that knowledge of the assessment and management of drug-related movement disorders is crucial.

Methodological limitations of our study include its retrospective design, with reliance on participants' memories of training and, because it was a postal survey, some data were missing. However, we had a good response rate and the results should reflect the training experiences and perceived training needs in Devon and Cornwall. We do not know to what extent these findings generalise to other parts of the UK. However, given that the training of psychiatrists is based on a standard curriculum (currently under review, Royal College of Psychiatrists, 2001), there are no obvious reasons why they should not.

Conclusion

This survey indicates that current training provision is ad hoc and insufficient. There is a definite need for more training with greater structure in both the assessment and management of drug-related movement disorders. This is important if we want to provide the best clinical care for our patients.

Declaration of interest

None. Funding detailed in Acknowledgements.

Table 3. Interest in receiving further training for assessing and managing drug-related movement disorders

	SHO/SpRs	Associate specialist/ staff grade/CMO	Consultant	Total
Interest in training in assessment by physical examination, mean level of 141 responses (s.d.)	4.02** (1.25)	4.06** (1.07)	2.98** (1.42)	3.60 (1.38)
Interest in training in assessment by rating scales, mean level of 138 responses (s.d.)	3.87** (1.23)	3.71 (1.29)	2.86** (1.38)	3.41 (1.38)
Interest in training in management, mean level of 139 responses (s.d.)	4.35** (1.02)	4.15** (1.07)	3.25** (1.38)	3.85 (1.29)

CMO, chief medical officer; SHO, senior house officer; SpRs, specialist registrars.
** $P < 0.01$ Scheffé's post hoc test.



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Service user involvement in training: the trainees' view

AIMS AND METHOD

A questionnaire survey was conducted of trainees across the South-West London and St George's Basic Specialist Training Scheme in Psychiatry to explore their attitudes towards service user involvement in training.

RESULTS

Fifty-two completed questionnaires were received; 20 trainees (38%) had

not attended teaching sessions where a user was present; 35 trainees (67%) were agreeable to service user involvement in examinations. Reservations concerned the objectivity of service users in examination rating and their role as an expert on assessing the trainee's skill. Awareness of user involvement strategies and policies in their trusts were not matched with actual participation.

CLINICAL IMPLICATIONS

Service users should be involved in teaching in an expert capacity and also in examinations, with safeguards regarding transparency and objectivity of the marking schemes in place.

From June 2005 all trainees in psychiatry were required to receive training directly from people with mental health problems. The medical profession has often been reluctant to change its traditional beliefs (Crawford, 2001). Many doctors accept the idea of user and carer involvement in education in principle but still view it as a threat. It involves a fundamental shift from an 'expert doctor'-centred model to one focused on the patient's need (Pietroni et al, 2003).

The South-West London and St George's Mental Health NHS Trust has developed a policy on service user involvement in service planning and development entitled 'Putting Users at the Head of Services: A Framework for Involving People with Mental Health Problems and Their Relatives/Friends'. The trust has collaborated with service users to develop guidelines and a teaching tool for interacting with users with personality disorders (Barlow et al, 2006).

In many medical schools there is increasing emphasis on empathy with the patient. For example, during the objective structured clinical examinations in psychiatry at

St George's Hospital Medical School the trained actors or service users are asked to rate the student's rapport.

Despite Mukherjee & Nimmagadda's (2005) assertion that trainees accept user involvement in education, we found no evidence that trainees' views had been collected and analysed in a systematic way. Fadden et al (2005) stressed the need for preparation of trainees and exploration of their anxieties prior to receiving training from service users and carers.

In light of a dearth of studies, we decided to survey the trainees attending the MRCPsych part 1 and 2 courses at the South-West London and St George's Basic Specialist Training Scheme in Psychiatry for their views on user involvement in teaching, during examinations and in service planning.

Method

We developed a questionnaire with a focus group of senior house officers (SHOs) to assess attitudes and experience with user involvement; users were not