non-linear kinetics. If patients smoking more than 7–12 cigarettes per day while taking clozapine decide to quit, the dose may need to be reduced by 50% (Haslemo *et al*, 2006).

Although patients may not quit during an admission their access to cigarettes may be limited, depending on leave status or other practicalities (e.g. availability of staff to escort them off the ward). The as-required prescription of nicotine replacement therapy, although strictly speaking off-license, may help cravings but it has *no* effect on clozapine plasma concentration.

All patients should be forewarned that in-patient settings are now smoke-free, and clinicians need to clarify and record smoking status on admission. They will also need to monitor clozapine plasma concentrations in smokers closely during admissions and shortly after discharge. All UK assays are performed at the Toxicology Unit, Kings' College Hospital, London, and electronic access to results is possible after registration (pathologyi.t@kch.nhs.uk). Savings made by clozapine dose reductions will mitigate the additional costs incurred!

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Mohammed Ashir Specialist Registrar in Psychiatry, Tomswood Rehabilitation Unit, Whipps Cross Hospital, London E11 1NR, UK (email: mohammed.ashir@nelmht.nhs.uk); **Louise Petterson** Consultant in Rehabilitation Psychiatry, Goodmays Hospital, London, UK

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Personality disorder in older adults: a pilot treatment model

We agree with the view of Mordekar & Spence (2008) that personality disorder does not 'burn out' with advancing age, that treatment options are limited and that more research into this area of psychiatry is needed, given that the UK has an ageing population.

The Department of Health (2001, 2003) has specifically targeted equity of access to integrated mental health services for people over 65 years of age and for people with personality disorder. In addition, NICE draft guidelines on the management of borderline personality disorder clearly support provision of integrated mental healthcare utilising a multi-model approach to psychotherapy interventions (National Institute for Health and Clinical Excellence, 2008).

We have embraced these recommendations in a pilot service for older adults diagnosable with personality disorder. The service comprises a half-day integrative group psychotherapy programme which adheres to a democratic 'mini therapeutic community' model (Pearce & Haig, 2008).

The group is facilitated by a multidisciplinary team embedded collaboratively within the local specialist services for adults of working age with complex needs (the Oxfordshire Complex Needs Service, OCNS), local psychological services and a community mental health team for older adults. Psychodramatic techniques are used to integrate psychodynamic, cognitive and behavioural models, alongside principles of biological psychiatry, into a coherent model that is responsive to individual needs.

The experience of the facilitators who work in similar groups with both working-age and older adults suggests that the various categories of personality disorder encountered in both age-groups are similar and that both groups respond to the therapeutic model and process in a similar manner.

The OCNS treatment ethos for adults of working age is based on a recovery model, and preliminary outcome audit results of an 18-month treatment programme demonstrate psychological and socio-economic benefits similar to the pilot for older adults (Scott & Attwood, 2008).

There are no apparent reasons why the outcome results from the OCNS mini therapeutic community programme should not be replicated in the older adult service. Early indications from the Social Functioning Questionnaire (SFQ), the Clinical Outcomes in Routine Evaluation (CORE) system, medication audits and client satisfaction data from this pilot group are similarly optimistic. The service is committed to further evaluation and research to demonstrate effectiveness of this model over time.

This pilot programme is unique in the UK and is currently being expanded across Oxfordshire to provide a more comprehensive model of inclusive service delivery to a group of service users traditionally excluded by virtue of diagnosis and age.

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Lisle M. A. Scott Psychiatrist, Oxfordshire Complex Needs Service (email: Lisle.Scott@obmh.nhs.uk); **Elizabeth Kemp** Counselling Psychologist, Older Adults' Service, Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust, UK

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Catatonia in present day society

Rajagopal (2007) suggests that catatonia is a unique syndrome that requires treatment in its own right, independent of any underlying disorder.

We conducted a postal survey of psychiatrists working in south-west England and in Wales, looking at their understanding of catatonia. We also enquired about the number of cases of catatonia encountered in a 2-year period, the presence of underlying/comorbid disorders, treatment type and response to treatment.

A large number of varied signs are associated with the syndrome (Bush *et al*, 1996) and they may be subtle and unrecognised. No specific diagnostic criteria for catatonia have been established, although most authors define the syndrome by the presence of motor signs. There is a growing evidence base for effective treatment, and recognition of catatonia is important to prevent significant morbidity (Rosebush & Mazurek, 1999).

In our survey, 96% of respondents understood catatonia as a syndrome in its own right and as a subtype of schizophrenia. For the majority of signs, 90% of respondents felt confident to give a definition but there was no consensus regarding which signs need to be present to diagnose catatonia. Only 28% of respondents reported seeing a case of catatonia and a range of different treatments were used.

Catatonia continues to be recognised, but the understanding of the condition differs, which could result in underdiagnosis and suboptimal treatment. The use of rating scales might ensure more that cases are identified. There is a need to raise awareness among clinicians of this often forgotten disorder.

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Sally A. Morgan Specialist Registrar in General Adult Psychiatry, CRHTT, 18 Denmark Road, Gloucester GL1 3HZ, UK (email: sallymorgan2000@yahoo.co.uk); **Dietmar Hank** Visiting Honorary Consultant in Neuropsychiatry, **Danny Rogers** Consultant Neuropsychiatrist, The Burden Centre, Frenchay Hospital, Bristol, UK

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