the columns

correspondence

Remember patients' views

Sir: The Government is said to be strongly committed to the principle of partnership between the NHS and patients (Stuart, 1999). A recent Government document, *Patient and Public Involvement in the New NHS* (NHS Executive, 1999) emphasises the importance of 'patient partnership' as central to the work of the NHS Executive. Hence an increasing amount of emphasis is being placed upon managers and clinicians to involve patients in the planning of the delivery of services. Little work has been done in this area. We would like to share the findings of a study of the preferred choice of psychiatric patients regarding the site for out-patient clinics, and the factors that influenced their choice.

Previously, in-patient psychiatric services for the Borough of Solihull were provided at Hollymoor Hospital, a traditional psychiatric hospital, approximately 15 miles from the centre of Solihull. Out-patient services were provided at Lyndon Clinic, a resource centre within the locality. When Hollymoor Hospital closed, in-patient services were transferred to the purpose-built Solihull Hospital, a District General Hospital. At this stage there was an opportunity to transfer out-patient clinics to the new hospital.

A questionnaire was designed to determine patients' preferences regarding the site for out-patient clinics – Lyndon Clinic or Solihull Hospital – and also the factors that influenced their choice. The questionnaires were distributed by the receptionist to 100 consecutive attendees at Lyndon Clinic and the patients were asked to complete and return them anonymously. The response rate was 100%. Data were analysed using the Chi-squared test.

Of 100 responses, 69 subjects had visited the new hospital, and only these data were analysed further. Of the 69, 51 (74%) preferred that the out-patient clinics be held at Lyndon Clinic, 11 (16%) preferred that the clinics be transferred to Solihull Hospital and 7 (10%) had no preference.

Parking and the availability of a convenient bus route were the only significant factors in determining patients' preference for the site of the clinic. Surprisingly, the quality of the reception, waiting area, the décor and the presence of catering facilities did not influence the choice of the site.

Many hospitals are large, centrally located establishments and often have poor provision for car-parking, which may lead to unnecessary increased levels of anxiety in patients. We invite comments from others on experience in this area and recommend that managers examine and consider these factors when planning services.

NHS EXECUTIVE (1999) *Patient and Public Involvement in the New NHS*. Leeds: NHS Executive.

STUART, G. (1999) Government wants patient partnership to be integral part of NHS. *British Medical Journal*, **319**, 788.

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Learning disability teams and mental health trusts

Sir: As O'Hara discusses (*Psychiatric Bulletin*, October 2000, **24**, 368–369), there are interesting times ahead for community teams for adults with learning disabilities (CTLD). Such teams provide a range of services of which mental health is only one component. CTLDs reside within community, rather than mental health, trusts, with important consequences. O'Hara highlights two of these: perpetuation of a model of separate health services for people with learning disabilities and difficulties implementing key areas of health care policy such as the Care Programme Approach. Partitioning CTLDs between mental health and primary care trusts would help to delineate their specialist mental health component. It would also help to achieve the ideological goal of 'mainstreaming' while respecting the need for specialist psychiatry.

However, I am concerned about how CTLDs will be received by mental health trusts. Perhaps the single biggest priority of a general mental health trust is to maintain general psychiatric services and when limited resources are available specialist teams cannot always take their worth for granted. Without mention in the National Service Framework, newly relocated CTLDs may find themselves particularly vulnerable and will need to work especially hard to earn status and support. This may be an uphill task where learning disability specialists have little or no significant general psychiatry experience at higher training level and risk being perceived by some colleagues (themselves with no useful training in learning disability) as professional outsiders.

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New *BNF* maximum recommended dose for haloperidol

The maximum recommended dose for haloperidol has been reduced from 100 mg (rarely 120 mg) to 30 mg a day for oral therapy and from 60 mg to 18 mg a day for intramuscular administration in the latest edition of the *British National Formulary* (*BNF 40*; British Medical Association & Royal Pharmaceutical Society, 2000). This dosage change has not been widely publicised; we only became aware of it through a message posted on the UK Psychiatric Pharmacists' website by a pharmacist, Margaret Rotchell. It appears that the changes to the maximum recommended dosage of Serenace (manufactured by Norton Healthcare) were made to the drug's licence back in September 1998 but have not been brought to the attention of doctors and pharmacists.

The dosage change has implications for patients who are receiving haloperidol on a Form 38 or 39, as the dosage they are receiving may no longer be 'within *BNF* limits' and therefore may not be covered by these forms. Inevitably, more patients will now be considered as being on 'high dose' antipsychotic therapy and should be the subject of physical monitoring (Thompson, 1994). Strictly speaking, these patients should be made aware that they

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