the columns

correspondence

Trainee's safety: West Midland survey

We did a postal survey of psychiatric trainees (n=70) based at six different psychiatric hospitals in the West Midland deanery, using a 32-item questionnaire covering issues related to trainees' safety as outlined in the College guidelines (Royal College of Psychiatrists, 1999). Forty-two trainees (60%) responded, of which 9 (21%) reported physical violence and 22 (53%) reported verbal threats. The major concern was that 13 (31%) trainees did not have access to safety alarms and 15 (35%) never wore a safety alarm. Even though the College guideline states that trainees must undergo breakaway training every 6 months, as many as 24 (57%) trainees did not have such training. Furthermore, 27 (64%) trainees did not find the seating arrangements at the out-patient clinics very safe, as compared with 35 (84%) for the accident and emergency psychiatry assessment rooms and 17 (41%) for the ward review rooms. Alarmingly, 20 (48%) trainees were not aware of the presence of safety alarm buttons on the ward, as compared with 32 (76%) on accident and emergency department and 27 (36%) for out-patient clinic rooms.

Our experience suggests that all deaneries and psychiatry hospitals have a lot of work to do to improve psychiatry trainee's safety.

ROYAL COLLEGE OF PSYCHIATRISTS (1999) *Safety for Trainees in Psychiatry [CR78]*. Royal College of Psychiatrists.

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Role of CAMHS in assessing children with suspected autism-spectrum disorder in Ireland

Ireland's national policy on mental health-care services *A Vision for Change* (Department of Health and Children, 2006) describes the role of child and adolescent mental health services (CAMHS) in the assessment of autism as limited to consultation on difficult diagnoses and specialist episodic treatment of acute psychiatric disorders. However, in 2007, Part 2 of the Disability Act 2005 became law and gave children with disabilities under 5 years of age entitlement to an independent assessment of their health and education needs, and a service statement identifying the services to be provided. Assessment officers oversee and coordinate the assessment and ensure that a report on its result is provided (Government of Ireland, 2007).

Our survey revealed that a quarter of the 214 children aged less than 5 years old who were referred to five Linn Dara CAMHS in Dublin (covering south inner city, south- and north-west Dublin and Co. Kildare) in the 10 months since the Act became law, were for autism-spectrum disorder assessment. In line with the recommendations of *A Visions for Change*, the majority of these referrals were considered inappropriate and effectively 80% of children referred for autism-spectrum disorder assessment were not seen.

Clearly this is not meeting the needs of children, and Linn Dara CAMHS, together with other CAMHS in Ireland, eagerly await the recommendations of the group set up by the Health Service Executive to clarify their role in the assessment of children with suspected autism and to make interim arrangements pending the development of the appropriate assessment services.

DEPARTMENT OF HEALTH AND CHILDREN (2006) *A Vision for Change. Report of the Expert Group on Mental Health Policy.* The Stationery Office Dublin.

GOVERNMENT OF IRELAND (2007) *Disability Act 2005.* The Stationery Office Dublin.

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High-dose antipsychotic prescribing: comparison survey

In May 2006, the Royal College of Psychiatrists published the consensus statement on high-dose antipsychotic medication, highlighting that up to a quarter of psychiatric in-patients are prescribed a high dose of antipsychotic medication (Royal College of Psychiatrists, 2006).

I carried out a cross-sectional survey collecting data on type, doses and combinations of antipsychotic medication used at the regional medium secure unit, general adult psychiatric wards and psychiatric intensive care unit. Data were analysed to calculate the proportion of patients on high-dose antipsychotic medication. Information sources were the prescription kardex and ward-based casenotes. The College's definition of high-dose antipsychotic was used (Royal College of Psychiatrists, 2006).

At the regional medium secure unit, 30% of patients on antipsychotic medication (n=12 out of the total 41) were on high-dose antipsychotics. On general adult wards and psychiatric intensive care unit this number was 6 (17%, n=35 on antipsychotic medication). Of the total study sample on high-dose antipsychotic medication (n=18), polypharmacy was present in 94% of the patients.

This survey shows that patients on forensic wards are almost twice as likely to be prescribed high-dose antipsychotics as those on psychiatric intensive care units and general adult wards. Patients on high-dose antipsychotic medication are not only at risk of increased side-effects but also arrhythmias and sudden death. More needs to be done to change prescribing habits and to encourage evidence-based prescribing.

ROYAL COLLEGE OF PSYCHIATRISTS (2006) *Consensus Statement on High-dose Antipsychotic Medication.* Council Report CR138. Royal College of Psychiatrists.

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