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assessment. We would recommend this initiative as a successful model for others to use in decreasing waiting times and providing a more efficient and accurate screening process of referrals.

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*Elizabeth Jones Clinical Research Fellow in Psychiatry, Clare Lucey Consultant Child Psychiatrist, Liz Wadland Principal Family Therapist, Children and Families Consultation Service, Windmill Lodge, Uxbridge Road, Southall, Middlesex UB1 3EU

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POLASH M. SHAJAHAN, ANDREW M. MCINTOSH AND JONATHAN T. O. CAVANAGH

Admission patterns by psychiatric trainees

Are women patients as likely as men to be admitted for major mental illness?

AIMS AND METHODS

We hypothesised that the increased admission rate for men with major mental illness may be the result of men being preferentially admitted by psychiatrists. A questionnaire survey was devised and sent to all psychiatric trainees on the South-East Scotland

rotation. The questionnaire contained a series of psychiatric vignettes representing conditions varying in severity of risk.

RESULTS

Seventy-eight per cent responded to the questionnaire. Trainees were

more likely to admit patients representing a greater degree of risk irrespective of the gender of the patient.

CLINICAL IMPLICATIONS

The increasing admission rates for men with major mental illness is unlikely to be due to admission bias by trainees.

In-patient resources in psychiatry are increasingly limited, with only the most seriously ill or at risk patients being admitted in many regions throughout the country. Evidence is emerging for increased admission rates for young men with major mental illnesses in Scotland (Cavanagh & Shajahan, 1999). There may be many potential reasons for this, including increased morbidity in men, changing diagnostic patterns or even preferential admission of men. We hypothesised that the increased admission rate for men may be the result of men being preferentially admitted by psychiatrists, even though their 'severity' of illness may be the same as that of women.

The study

A questionnaire survey was devised and sent to all junior and higher psychiatric trainees (senior house officers (SHOs) and specialist registrars (SpRs) in the Lothian Region/South-East Scotland rotation. The questionnaire contained four psychiatric scenarios or case vignettes (see Appendix). These vignettes represented a range of severity of risk in terms of self-harm. At one end of the range (Scenario 1) the risk of self-harm could be perceived as relatively low. At the other end (Scenario 4) the risk could be considered substantial. The psychiatrists were asked to

rate along a five-point scale (definitely to definitely not) how likely they were to admit the person that the scenario related to. Half the psychiatrists received a questionnaire where Scenarios 1 and 3 related to female patients and Scenarios 2 and 4 related to male patients. The other half received a questionnaire where Scenarios 1 and 3 related to male patients and Scenarios 2 and 4 related to female patients.

Findings

One hundred and fourteen questionnaires were sent out randomly to 79 SHOs and 35 Registrars. Eighty-nine were returned representing a response rate of 78%. Figures 1a to d show the response patterns for the various case scenarios. The distributions did not follow a normal distribution and non-parametric statistics (Kruskal–Wallis) were used to analyse the data. The Kruskal–Wallis test showed a significant effect of admission by scenario ($\chi^2=244$, $P<0.0001$), but no overall effect on admission due to the gender of the patient ($\chi^2=0.86$, $P=0.35$). Figure 1a, Scenario 1, shows that the majority of psychiatric trainees were unlikely to admit the patient concerned irrespective of whether they were male or female. At the other extreme (Fig. 1d, Scenario 4) all trainees were either



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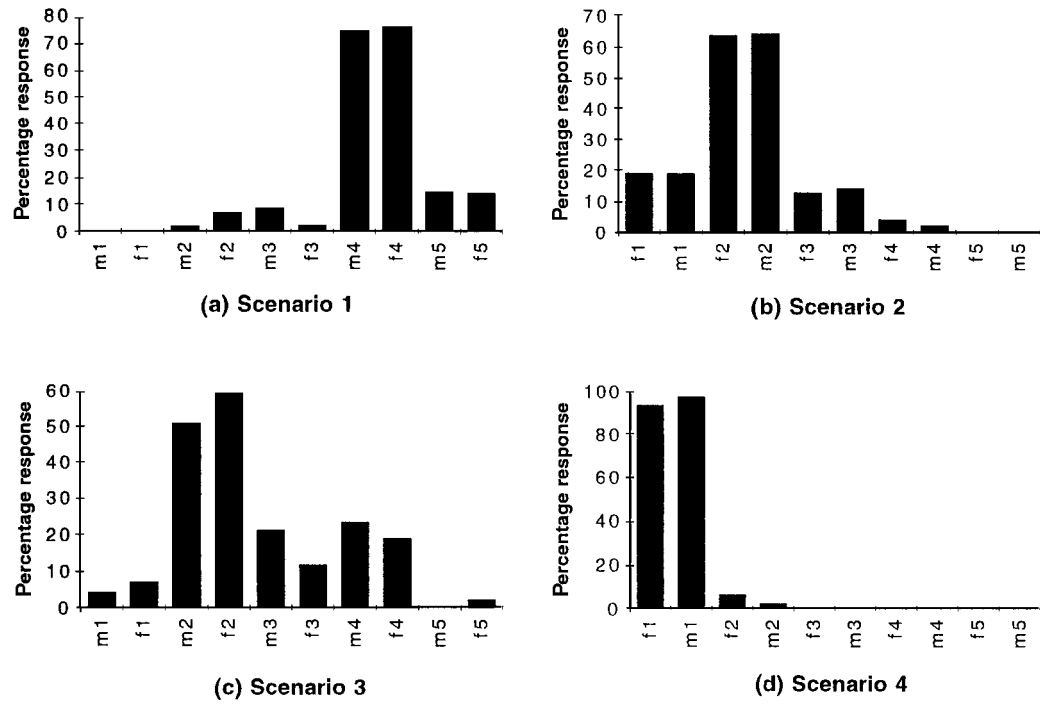


Fig. 1. 1, definite; 2, likely; 3, unsure; 4, unlikely; 5, definitely not; m, male; f, female.

‘definite’ or ‘very likely’ to admit, irrespective of whether male or a female. Scenarios 2 and 3 represented a more ‘grey’ area where there was a greater difference of opinion as to whether admission was appropriate or not. If anything, a trend was seen in a more likely admission for a woman than a man for Scenario 3.

Comment

Our hypothesis was not supported. Admission patterns for men and women are approximately the same. We managed a satisfactory response rate in terms of questionnaire surveys which represents the views of the majority of psychiatric trainees in this region. It is not surprising, and indeed reassuring, that psychiatric trainees are more likely to admit those patients with serious illness and who are obviously at risk of self-harm, and that there is no bias when it comes to assessing a man or a woman. It is of interest that there is less consensus when the case (Scenario 3) is less clear cut in terms of clinical risk of self-harm.

The increased first admission rate for men with major mental illness is unlikely to be due to preferential admission by psychiatrists and is more likely due to other reasons such as increased morbidity of major mental illness in men.

Appendix

Scenario 1

A 22-year-old male is referred with an eight-month history of low mood and feeling that life is not worth living. He has disturbance of sleep and appetite. On questioning he is not psychotic and does not have

immediate suicidal plans. He has not responded to first-line antidepressants.

How likely are you to admit this patient?

- Definitely
- Likely
- Unsure
- Unlikely
- Definitely not

Scenario 2

A 20-year-old female is referred with a two-month history of low mood and feeling that life is not worth living. She has disturbance of sleep and concentration. On questioning she feels people are talking about her and she is contemplating suicide. She has been on fluoxetine 40 mg/day for the last four weeks.

How likely are you to admit this patient?

- Definitely
- Likely
- Unsure
- Unlikely
- Definitely not

Scenario 3

A 21-year-old male is referred with a four-week history of worsening auditory hallucinations and anxiety. He states that his mood is low. On questioning he feels neighbours are discussing him. He does not have any suicidal ideas. He was started on chlorpromazine 100 mg/day by his GP two weeks ago.

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How likely are you to admit this patient?

- Definitely
 Likely
 Unsure
 Unlikely
 Definitely not

How likely are you to admit this patient?

- Definitely
 Likely
 Unsure
 Unlikely
 Definitely not

Scenario 4

A 20-year-old female is referred with a six-month history of bizarre behaviour and social withdrawal. She has boarded up the windows in her flat saying that people are spying on her. She has impaired sleep and appetite. On further questioning she has paranoid delusions and third person auditory hallucinations. She states that she is seriously contemplating suicide.

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*Polash M. Shajahan Specialist Registrar, MRC Brain Metabolism Unit, Royal Edinburgh Hospital, Morningside Park, Edinburgh EH10 5HF, Andrew M. McIntosh, Senior House Officer, Royal Edinburgh Hospital, Morningside Park, Edinburgh, Jonathan T. O. Cavanagh Research Fellow, University Department of Psychiatry, Royal Edinburgh Hospital

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JONATHAN STEELE, JANICE DUNCAN AND ANGELA SHORT

An audit of anti-muscarinic drug use at the State Hospital

AIMS AND METHOD

This paper is based on two audits carried out in 1996 and 1998 at The State Hospital, Carstairs. Each audit looked at anti-muscarinic drug use within the hospital, in relation to approved prescribing standards issued in 1996. All patients within the hospital on anti-muscarinic drugs were identified at the time of each audit. These prescriptions were compared with the approved prescribing standards. In the 1998 audit additional information was obtained

from the case notes and the consultants, when the approved standards were not met.

RESULTS

The percentage of patients on regular anti-muscarinic drugs, falling outwith the prescribing standards, reduced between the two audits. However, in 1998 a small number of patients were still outwith the approved prescribing standards set in 1996.

CONCLUSIONS

An improvement in the prescribing practice of anti-muscarinics occurred following the introduction of prescribing guidelines. However, the guidelines were not fully met in the 1998 audit. This demonstrates the need for further audit and continued monitoring of anti-muscarinic prescription at the State Hospital.

Anti-muscarinic drugs are intended for short-term use only (World Health Organization, 1990; Barnes, 1990; Bazire, 1998). They are widely used in psychiatric practice for the treatment of neuroleptic induced extrapyramidal side-effects (Barnes & McPhillips, 1996). However, these drugs have their own side-effects (British National Formulary, 1999) and in the long term may exacerbate serious movement disorders (Perris *et al*, 1979). In addition such drugs are sometimes misused by patients (Crawshaw & Mullen, 1984; Marken *et al*, 1996). Therefore, monitoring of anti-muscarinics in psychiatric practice would seem to be of considerable importance.

Two audits of anti-muscarinic use were carried out at the State Hospital, Carstairs – the sole provider of psychiatric care, in conditions of special security, in Scotland and Northern Ireland (Snowdon, 1995). The audit in 1996 indicated that some patients were prescribed these

drugs for extended periods without clear indication. Approved standards for the correct usage of these drugs was circulated in 1996. The audit was repeated in 1998 and compared with these standards.

Although patients are reviewed regularly at the State Hospital, there is a system for a more comprehensive multi-disciplinary review of the whole treatment/care package of each patient, at three monthly intervals. For this reason the standards that relate to anti-muscarinic prescribing focus on their continued prescription beyond three months.

Approved standards

1. After three months regular anti-muscarinic treatment, a reduction in dose or complete discontinuation of the anti-muscarinic should be considered at the patients case review. Following the