(1990) underscored the importance of self regulation of the medical profession through medical audit. He pointed out the dangers of a narrow, efficiency oriented view of audit which could cut corners too far and produce sub-standard care.

Audit of the prescription patterns of psychotropic drugs is an under-researched area despite being the focus of vehement criticism. Crammer (1991) scathingly remarked: "Psychiatrists and GPs do not always prescribe the right drugs in the right dosage to get the best results possible." Wressell (1990) highlighted the common problems of drug prescription in mental handicap institutions, namely over prescription, polypharmacy, irrational prescription patterns and inadequate reviews leading to unnecessary, prolonged drug treatment. An audit (Childs, 1991) in a DGH unit revealed high levels of benzodiazepine prescriptions and excessive use of PRN medication. A subsequent survey suggested that audit can lead to substantial reduction in the amount of drugs prescribed. This study also noted the lack of supervision of junior doctors. Wright (1990) observed that stable, uncomplaining out-patients are too often left on the same high dose of neuroleptics which they were prescribed during an acute episode several years previously. This increased the risk of developing tardive dyskinesia, obesity and reduction of social functioning. Concurrent use of oral and depot neuroleptic medication, multiple divided dosage in well stabilised chronic schizophrenic patients and routine prescription of anticholinergics are not uncommon.

Most hospitals probably have stringent codes of practice of pharmacotherapy. Our aim is to highlight the unnecessary and avoidable economic burden which ensues as a result of undesirable prescription practices. There is a need to conduct medical audit of psychotropic prescription patterns in various psychiatric settings which should address actual cost of drugs and indirect costs (patient morbidity, quality of life, staff time etc); to improve the quality of supervision of junior doctors in pharmacotherapy; and perhaps to set up a sub-speciality of psychopharmacotherapy. If we take enough thought and care we can improve standards and reduce costs.

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Allocation of posts within a registrar training scheme

DEAR SIRS

Recently the size of some rotational training schemes has increased greatly with an expectation that this will more easily provide a mix of specialist and general posts. However, there is no generally agreed method of post allocation within such schemes and it may prove difficult to meet the needs of every trainee.

In SW Thames there are approximately 60 registrar posts allied to St George's Hospital, Tooting. The allocation of posts is decided by the trainees at a meeting held every six months. This is chaired by the trainee representative with the help of the rotation tutor. Each trainee states his or her first and second choice of post and a system of discussion and bargaining ensues before final agreement is reached.

A variety of factors affect the desirability of posts. Those in general psychiatry are popular in the six months before sitting the MRCPsych exam and those with a less arduous on-call rota are especially popular at this time. Specialist posts are most popular in the period between passing Part I and sitting Part II. However within the framework the popularity of a post may be affected by reports of previous incumbents regarding the level of consultant supervision, the perceived work-load, opportunities for research and even travelling distance to the hospital site.

The system is thought to be as fair as possible but there will inevitably be individuals who do not fare well in such meetings and, despite the overview of the clinical tutor, are left feeling hard done by. Changes to the system have been resisted by the trainees and yet one must ask if the present method of allocation is most appropriate?

One problem is trying to accommodate training commitments that may transcend a six month placement. The region has a particularly active training programme in psychotherapy and all trainees are encouraged to participate in individual, group and family therapies and to receive supervision. Once a commitment is made to, for example, a therapy group in a peripheral part of the rotation a trainee may be reluctant to accept a more central post because of the travelling time involved. Also, since only one post is allocated at a time, planning for

research projects may be difficult with an expectation that a project will be devised and written up in six months.

One suggestion has been that allocation should be decided by the rotation tutor after consultation with each trainee; however, this will inevitably lead to complaints of unfairness. Perhaps more than one post should be allocated at a time as this would make planning for research and psychotherapy easier. But unpredictability of failure in the MRCPsych exams makes this difficult. An amalgamation of these two alternatives together with the present system may prove most appealing to all.

Experiences in other training schemes might be profitably shared.

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Welfare workers reaching out across the poverty gap

DEAR SIRS

As unemployment in Britain reaches levels seen in the Great Depression of the 1930s, mental health care within the National Health Service and local authority social services is also under-going rapid change. We have been reconsidering access to welfare advice for patients of the Special Health Authority. "Social decline" (Jones *et al*, 1993) against a background of "social deprivation" (Thornicroft, 1991) is characteristic of our severely mentally ill clientele. Poverty often coexists with social disability related to mental illness, and it is evident (Leary *et al*, 1991) that the majority of such patients have difficulty seeking or gaining support by themselves. Feeding back through several channels (Caan, 1993), patients with limited resources or social support identified a lack of information about welfare rights and few sources of advice as major concerns. Welfare workers are a potential source of advice, and the Welfare Rights Unit identified a need to adapt provision of such advice to our clients. For example, the new Disability Living Allowance can have a big impact on patients (typically doubling their income), but its complexity means that considerable interprofessional liaison is necessary for each case and an experienced welfare worker requires over one hour to complete the forms. The process of gaining access to this allowance can be upsetting to patients, without skilled advocacy and facilitation, because of its negative focus on an individual's handicap.

To make access to advocacy and facilitation more comprehensive, rather than just reacting to the most vocal patients, the six welfare workers undertook a proactive "outreach" to all psychiatric in-patients across the Bethlem Royal and Maudsley Hospitals, for six months (July–December 1992). The impact of the new outreach style was evaluated by an independent auditor and compared with five six monthly periods between January 1990 and June 1992. A random sample of 100 admissions (from the Patient Administration System data) was investigated for each six month period. Prior to the outreach, only 200 out of 500 admissions had access to the welfare team (40%). The delay between admission and first contact with welfare officers was extremely variable (0–123 days) and rising with time (the regression slope was 1.57 days per six month period). A standard was then set that everyone should be assessed for need by their sixth week of admission, and every ward visited weekly by one welfare worker, who became a regular member of that ward's "multidisciplinary team".

Throughout the six months of outreach, delays to assessment of need and variability of this waiting time were reduced. For example, the mean wait in July–December 1991 was 21.6 days, which fell to a mean of 12.6 days during the same period in 1992 ($P=0.023$), and the waiting became much less variable ($P=0.0036$). Overall in the preceding 2.5 years, 5.1% of patients waited over seven weeks for contact (if they received any advice at all) whereas none waited as long as seven weeks after July 1992. Before outreach, the majority of in-patients did not have access to this service. The rate of contact rose with outreach, until by 30 December the active caseload was 430, compared with a bed occupancy of 372 on Christmas day. Achieving this contact, in excess of 100% of the in-patients, was due in part to the active follow-up users who had just been discharged over the recent holiday period. A satisfaction survey of in-patient wards had shown that 73 out of 90, 81% of patients found the welfare officers "helpful" or "very helpful" (compared to 644 out of 868 [74%] of responses about the helpfulness of nine other mental health professions in the hospital). An objective corollary of this reported helpfulness to users was the identification of needs. Monthly rates of arranging support increased (e.g. clothing grants averaged 212% and loans 202% of last year's levels). Backed by a training programme, welfare workers now have clearer expectations of their roles (e.g. in planning ahead for discharges) and time can be freed for, say, the qualified social workers' specific mental health roles.

In conclusion, many patients had previously "slipped through the net" of welfare help. This may apply to other psychiatric hospitals and figure prominently in the hierarchy of needs during mental