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Correspondence

Prescription charges

DEAR SIRS

Any person, regardless of financial means, who suffers from one of nine physical conditions requiring maintenance medication is entitled to free prescriptions. People disabled by severe mental illness, on the other hand, are excluded from this concession. The majority of the patients cared for by the Netherne Rehabilitation Service, for example, are not entitled to exemption from charges since they neither have a qualifying physical disorder nor receive income support or family credit. They do, however, have long-term, disabling conditions, mainly schizophrenia and affective illnesses, and they need to be maintained on long-term medication. The increase in prescription charges, for them, is an intolerable burden and very few can afford the prepayment certificates, which are beyond their limited weekly budgets. The hardest hit are those who have been successfully resettled in employment; one said that he is being penalised for working.

Three main arguments have been rehearsed against exempting people with a psychiatric diagnosis.

(a) There are too many long-term psychiatric disorders; however, two groups of patients, those with chronic schizophrenia and those with recurrent affective illness, are known to require maintenance medication for many years, in the same way as diabetic and epileptic patients.
(b) Such exemptions would be based on stigmatising diagnostic labelling; most patients in receipt of maintenance medication are aware, or should be aware, of the reasons. It is more stigmatising to discriminate against long-term disabled psychiatric patients by making them pay.
(c) The case of hardship has not been clearly demonstrated; there is no evidence that such a case has ever been made for the exemption of patients with physical conditions, and, in any case, disabled psychiatric patients rarely complain loudly enough. It would also be unrealistic to carry out means tests on those who might qualify.

One 'solution' adopted by some of the patients is to soften the blow by requesting larger supplies of medication, which may not be a safe practice in some cases. Another, of course, is non-compliance which may have serious and expensive consequences. Surely, the only rational solution is to treat people with psychiatric disability fairly by including them in the exemption category.

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The right to treatment

DEAR SIRS

Most general psychiatrists have had the distressing experience of seeing their patients discharged from a treatment order just because they are not suicidal or homicidal on the day of the hearing of the MHRT or Member's Appeal. This has happened to me six times and each time patients have turned up for treatment again because their illness was no better or because they had stopped taking medication, which had been predicted at the hearing. To get them back into treatment often means a struggle to get them on another section, which one does in despair, knowing the whole thing will happen all over again. I am particularly impressed by the problems facing CPNs trying to implement a community care order which involves medication given against the patient's wishes or understanding in his home, and by the willingness of some patients to have medication once they understand there is no alternative. This willingness disappears once they are outside hospital. I would make a proposal to stop these patients with long term illness from suffering too much.

When it is clear that a patient's illness is going to be long term, and that the patient is unable to cooperate with treatment, then a Treatment Tribunal will be called by the RMO. This Tribunal will have the same general set-up as the MHRT, i.e. the lawyer, the outside consultant psychiatrist, the lay person. The persons called to give evidence would be the same. The patient, his solicitor, his family or carer, the RMO, the CPN and social worker involved in his management, perhaps the centre manager of a mental health resource centre where the patient attends, plus other interested persons.

The community treatment section. This would be a long-term section, say one year in the first instance, and two years at the second hearing, and so forth. It would empower the professional persons dealing with the case to require the person to return to hospital if his illness relapses so that his medication can be reviewed. This removes any idea of the CPN trying to

give a patient medication in his own home against his wishes, which I do not think is feasible. Before the professional staff can call such a Tribunal, it will be necessary to demonstrate that the patient's illness has been in existence for a minimum of three years and that it has been impossible to persuade him to take medication voluntarily.

The right to be medicated properly. I am amazed at the huge doses of neuroleptic drugs used by some colleagues and concerned that such a treatment section should not become a rogue's charter for over-prescribing. I think that the amount of medication given and its regularity should be monitored by a second opinion doctor, as happens now when a patient is given medication against his wishes. It could be that over a period of time we could discover some upper limit to the injectable neuroleptics.

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Social work liaison: facing a challenge

DEAR SIRS

Recent government papers have suggested an integrated approach by local authorities and the health service to the care of the mentally ill outside hospitals. In the light of this, I would like to describe my experience, as a senior registrar, of providing a liaison group in a local authority social work team office which I ran for just over a year until September 1989.

The suggestion of some form of joint work originated from staff in the office and was discussed initially with the consultant psychiatrist at the nearby Day Hospital. Uncertainty surrounded the process of referral to the psychiatric service. The consultant suggested that urgent referrals could be seen at the day hospital within office hours. Less urgent cases may be suitable for discussion in a fortnightly liaison meeting which would discuss cases or issues of psychiatric relevance.

From an early stage, trained staff expressed difficulties in attending the meetings at the time specified and were often called out to other meetings, phone calls or to urgent difficulties in the office. Despite this, several interesting cases were brought to the meetings and discussed at length. However, as time went on, the problem of attendance worsened and it became clear that dissemination of information within the office was difficult.

New arrangements were made. The meeting times were changed and contact was made with the office ahead of the meeting. However, the new time was disastrous and we quickly reverted to the original time. Attempts to recruit from adjoining social work offices failed and after six months, the only regular attenders were trainees without a caseload of their own. Educational talks on issues such as ethnic minorities, violence, drug and alcohol abuse, etc. became the norm. The only trained staff member who attended began to use the meetings to discuss mental health officer work and the trainees, with little experience of the Mental Health Act, became increasingly excluded. In September 1989, I resigned from my commitment to the social work office, at the time of a move to another hospital. The psychiatrist registrar from the Day Hospital took over the meetings and has continued the link by providing regular seminars.

The White Paper on Community Care emphasises that effective liaison is necessary between local authorities and health services, particularly in areas where the distinction between health and social care is blurred. In the light of this, a regular link with an area social work office seems an ideal first step to develop relationships and to provide information on psychiatric illness and treatment, often a focus of concern to social workers. This link may also help to heal the philosophical and political rift so often felt to exist between the two professions. The difficulties experienced during this liaison group, despite enthusiasm on both sides, are worthy of comment. I became aware over the course of the year of the enormous pressure of work on trained social workers and the huge organisational problems within the office. Staff meetings had been abandoned and little in the way of timetabling and regular commitments could be achieved. One staff member explained that priorities were heaped on top of priorities and another described very long working days which were inadequately recognised or remunerated. In this setting, psychiatric aspects of social work were recognised and staff were keen to attend meetings but it proved impossible to find time to do so. Even the recognition of the meeting's importance by their regional manager produced no change. Crises could now be attended to by links with the local day hospital but a liaison meeting did not deal with crises and therefore other priorities took its place.

It was felt that a senior registrar in psychiatry could provide an autonomous service to a social work office and could offer flexibility of meeting times because of the supernumerary nature of the post. However, the provision of lectures and seminars under the auspices of a liaison meeting does not seem appropriate, nor does the informal supervision of a mental health officer.

Very little relevant literature exists on this approach to joint working. Grant & Richardson (1988) and in *Community Care* (22.9.88) described a similar social work liaison group in Newcastle. The senior registrar involved fulfilled a wider role, taking part in joint evaluations of direct and urgent referrals. In the