

medication compliance. Home care schedules had not been specifically arranged for the supervision of medication taking specifically for any patients and when this had occurred it was at the initiative of the home carer or by chance. Eight patients had their medication changed by the general practitioner without the awareness of psychiatric services.

Comment

This was a small study and it is possible that several of the non significant results were type 2 errors. This might explain why neither day labelled blister packs nor the number of prescribed medication had a significant impact on compliance. The study, however, suggests that several commonsense factors such as tailoring medication regimes to allow supervision, avoiding unnecessary changes in medication and a good communication between the GP and psychogeriatric services play a major part in enhancing compliance. Interestingly, the overall level of compliance for the psychogeriatric sample was similar to that found in a community sample of elderly people (Cartwright, 1988).

Several potentially dangerous situations were highlighted which included unclear labelling of bottles, the failure to renew prescriptions and

patients continuing to take discontinued medication. This latter situation could only be prevented by physical removal of discontinued prescriptions from patients' houses.

Difficulties such as these are widespread and indicate that this is an important area for audit.

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A full list of references is available from Dr Ballard on request.

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Clinical audit effects a reduction in routine prescribing of benzodiazepine hypnotics

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The Edith Morgan Centre is a 60-bedded acute psychiatric in-patient unit on a DGH site, now open for three and a half years, following the closure of a nearby psychiatric hospital.

Each academic term for the last three terms there has been a session each week devoted to clinical audit, primarily involving medical staff, but on occasions other disciplines. Two such sessions involved the auditing of prescribing policies.

The study

Before the first audit meeting, a cross-sectional survey of the prescription charts for each in-patient was

undertaken randomly and without the prescribers' prior knowledge. Two months later a second such survey was performed, again randomly and without the knowledge of the prescribers. The medical staff did not know that after the first survey there would be a second survey.

The name, dose, timing and duration of all benzodiazepines received by each patient were noted. Where the prescriptions were written as 'PRN', nursing administration sheets were consulted to determine how often the patients were receiving the benzodiazepines. Although all benzodiazepine prescriptions were considered, hypnotic usage was particularly being examined. Patients who were

TABLE I
Results of both cross-sectional surveys

	Survey 1	Survey 2
Number of patients in unit	56	52
Number receiving benzodiazepines	20 (35.7%)	13 (25%)
Number receiving hypnotics	18 (32%)	10 (19%)
Number of non-benzodiazepine hypnotics	1	1
Number of patients on more than one benzodiazepine	2	2 (One patient on three)
Number of patients on withdrawal/detoxification regimen	1	2
Male:female ratio	7:13	8:5
Psychotic:neurotic ratio	12:8	9:4

undergoing detoxification or withdrawal regimens were noted. The results were tabulated with regard to sex and to psychotic or neurotic disorder, determined by review of the notes or discussion with relevant medical staff.

Findings

It can be seen that there has been a considerable decrease in the number of patients receiving hypnotics in the second survey (see Table I). Initially more female patients were receiving benzodiazepines, but this had reversed by the second survey. The majority of patients receiving benzodiazepines were psychotic patients, who had been long-standing, and proving difficult to place. This was somewhat surprising as it had been thought neurotic patients were more likely to be prescribed hypnotics.

It appeared that when patients were written up for hypnotics on a 'PRN' basis, a high proportion were receiving them. PRN medications at the unit are those medications prescribed by a doctor which can be administered to a patient by nursing staff should they feel that the patient requires that medication (up to a stated limit).

Comment

What factors identified by the audit process were important in reducing the prescribing of hypnotics? At the initial audit meeting the medical staff expressed surprise and disquiet at the high number of patients receiving benzodiazepine hypnotics. Some consultants stated they did not realise their patients had been receiving hypnotics and said they did not regularly review their patients medication charts even at ward rounds. If they did, it seemed hypnotics were "missed" compared to other, perhaps more striking psychotropics.

Factors identified in the unit itself, which might lead to high levels of prescribing were that several (indeed many) patients were regularly asleep during the mornings, some not rising before mid-day. There were only limited opportunities for occupational therapy, exercise or physiotherapy; the main area for patient congregation had little natural light and in that area coffee was served regularly during the day and a coffee machine was available at all times.

Patient factors identified included differing sleep expectations and desire for night sedation, the opportunity to discuss the benefits of "sleeping pills" with others and whether or not the patient was already receiving, or dependent upon hypnotics from his or her GP. It was noted that for non-dependent patients to leave the unit dependent was to be deprecated. Some general practitioners were probably more likely to dispense hypnotics and repeat prescriptions than others.

Staff factors were of primary importance. These included awareness of the problems of hypnotic dependency and the likelihood of a particular doctor prescribing hypnotics for certain groups of patients. Most prescribing was carried out by the most junior, inexperienced doctors. Many of the medical staff felt that some members of the night nursing staff were more likely to dispense medication written PRN than others, but as previously noted, most patients prescribed such medication received it on a regular basis anyway.

Attention was then focused on formulating methods likely to reduce the level of prescribing. All doctors were exhorted to bear in mind the advice given in the BNF (1990) regarding the use of hypnotics. Patients were to be advised as to steps likely to improve sleep pattern (nighttime milky non-caffeinated drink, use of earplugs, exercise, ventilation of room, etc) and to consider reducing or stopping their hypnotics and the help available to do so.

The need for occupational therapy, physiotherapy, exercise and other therapies was voiced and by the time of the second survey these had been instituted (although not as a direct result of the audit process). Patients were to receive an individual programme of activities intended to promote early rising. The need for better liaison with general practitioners with regard to hypnotics was highlighted and the possibility of changing the coffee supply to a decaffeinated variety mentioned.

The effects of these ideas, together with the changes in the unit mentioned, has been of great benefit to most patients. Several were able to reduce and, in some cases, stop completely their hypnotics. Most now rise earlier and take part in daytime activities provided. Taken over a year, the reduced number of prescriptions represents a saving in prescription charges.

A third cross-sectional survey undertaken two months after the second has confirmed that the prescribing level remains low, although it appears that the non-benzodiazepine hypnotic Zopiclone is being increasingly prescribed. I suggest monitoring of this compound to avoid over-usage and potential patient dependency.

There are several shortcomings to this study. Firstly the in-patient population of the Edith Morgan Centre is a rapidly changing one and it might be that people not already taking benzodiazepine hypnotics had simply been admitted, replacing those who were. This seems unlikely, particularly as the psychotic population, who made up the majority of people receiving hypnotics, changes less quickly. Secondly, the overall figures concerned are small. Thirdly, between the first and second survey, activities were instituted, which although proposed by the audit meeting, were independent of it.

Conclusion

I suggest that audit is an effective process and that substantial improvements can be effected if the use of hypnotics is reviewed, discussed and attention paid to reducing the high levels of prescribing, which may exist in in-patient psychiatric units. I would recommend regular audit of prescribing and further, larger studies to demonstrate its apparent effectiveness.

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Letter from . . .

Chengdu (China)

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In this personal review we discuss the contemporary issues in Chinese psychiatry, the main themes in recent Chinese literature, and current psychiatric practice in China.

Contemporary issues in Chinese psychiatry

Western psychiatry was first introduced into China at the end of the 19th century, mainly by missionaries and charities.

It is commonly acknowledged that modern Chinese psychiatry began in 1906 when the first Chinese psychiatric hospital was established. However, by 1950, it is estimated that there were only about ten psychiatric hospitals and 1100 psychiatric beds in the whole country^{1,2}. At that time the total population was about 500 million. Although by the end of the 1980s there were about 7000 psychiatrists and 80,000 psychiatric beds, this provision was far less than that in developed countries, in terms of the total population served³. From 1980 to 1984 an epidemiological