the area. However, we stand by our conclusions. It is precisely because we wished to understand the heterogeneity of results from good services and good studies that we undertook our work. We examined 20 components of home-based care in experimental and control services of published studies. These included, but were not restricted to, ACT studies. Our results (Burns et al, 2001; Catty et al, 2002) show that the clear distinction between ACT and other forms of intensive home-based care that Professor Stein and colleagues insist on, and which Marshall and colleagues (Marshall et al, 1997; Marshall & Lockwood, 1998) used, simply will not withstand scrutiny. Many of the ACT teams did not have all the ‘ACT’ characteristics and many of the ‘non-ACT’ teams had more of them. In short, the groups overlap. It is for this reason that we conducted our regression analysis to determine which components are associated with outcome. Many of these effective ingredients were present in earlier study control services. We would argue that this is why big differences are no longer being found in US or European studies.

None of this is to take away from the epoch-making impact of Stein and Test’s original study. If we are to progress in our understanding of community care, however, we must be prepared to test more sharply-focused questions with increasingly well-designed studies.

Dr Mahapatra is correct in his assertion that the method of ECT administration in the audit described was common practice at that time. Indeed in one survey (Robertson et al, 1997), 58% of clinics in Scotland did not use the cuff technique.

One of the purposes of audit was to examine the effects of different ECT machine and further training on rates of missed fits. A significant reduction in missed fits was observed. As discussed in my paper, stimulus titration and EEG monitoring could be considered in future practice and further audit could be carried out.

Audit of antipsychotic and anticholinergic prescribing: Leeds CMHT 2000–1

We read with interest the paper by Harrington et al (Psychiatric Bulletin, November 2002, 26, 414–418). It mirrored the results of a recent audit we did on atypical, high dose and co-prescribing of antipsychotics, as well as concurrent anticholinergic prescribing. Drug card information on all general adult inpatients, aged 18–65, prescribed an antipsychotic on a regular basis was collected during a single visit in April 2000. Re-audit occurred in June 2001, and on this occasion adult day hospital patients were included.

Overall, 231 inpatients received a regular prescription for an antipsychotic drug in 2000 and 321 patients in 2001 (213 in-patients and 99 day hospital patients). There were high levels of atypical antipsychotic prescribing (49%, 95% confidence interval (CI) 42–55 in 2000 and 52%, 95% CI 46–57 in 2001), co-prescribing (20%, 95% CI 15–26 in 2000 and 25%, 95% CI 20–30 in 2001) and also a British National Formulary (2002) limits prescribing (15%, 95% CI 11–20 in 2000 and 17%, 95% CI 12–21 in 2001) when compared to total antipsychotic prescribing. Furthermore, there were high levels of anticholinergic prescribing with atypical antipsychotics alone (21, 95% CI 13–31 in 2000 and 18%, 95% CI 12–26 in 2001).

These prescribing patterns increase the risk of side-effects and negate the cost benefits of atypical antipsychotics. They also run counter to 1993 Royal College of Psychiatrists guidelines on antipsychotic prescribing and World Health Organization anticholinergic prescribing guidelines (World Health Organization, 1990; Barnes, 1990). This audit appears to indicate problems in dissemination and a lack of widespread knowledge of current guidelines.

From couch to coach

The Football Association (FA) launched its strategy “Psychology for Football” at the Pride Park Stadium, Derby, on...
prevention in psychiatry

7 November 2002. The meeting was a call to football professionals to endorse the use of sports psychologists.

Psychologists have received a cautious reception from sports professionals (Martin et al, 1997). Countries like Australia and the USA have been using psychologists in sports for decades. In the UK, developments have been slower, with important changes, such as the accreditation of the British Association of Sports and Exercise Sciences, happening in the late 80s.

The involvement of psychiatrists in sports has been more anonymous, as psychiatry not only carries a stigma but is also the antithesis of Mens sana in corpore sano (Carranza, 1999). Society perpetuates the problem by seeing sportsmen as highly-skilled entities, rather than primarily as human beings with strengths and weaknesses. Because of this, sports professionals in need of psychiatric help usually approach services as a last resort, during the final stages of their problem.

The FA strategy should be made extensive to other sports, and, ideally, implemented at all levels. It would also be desirable to consider the inclusion in the strategy of professionals such as psychiatrists, who could play not only a role in the promotion of mental health and the care of people with mental illnesses with an evidence-based approach to preventive interventions.

It begins with a background section, introducing concepts related to mental health promotion and the prevention of psychiatric disorders. Prevention is then considered in relation to the different stages of the life cycle, beginning in the womb and ending with the approach of death. Life cycle chapters are provided for the prenatal period and infancy; childhood, puberty and early adolescence; late adolescence and young adulthood; adulthood; older people; and the stage of approaching death. Account is taken of the fact that the influences acting at one stage of the life cycle will impact on the rates of disorder in later stages. Further, traumatic events such as physical or sexual abuse will impact not only on the individual concerned throughout the life cycle, but on subsequent generations.

Preventive activities are then considered in relation to the different settings in which they can take place. Settings considered include the neighbourhood and the community; early years provision, school and higher education; the workplace; residential care settings; the criminal justice system and prisons; primary care settings; the general hospital; and specialist psychiatric settings. In all of these, preventive activities relevant to psychiatric disorders need to be placed and maintained on the agenda, and the report provides practical, evidence-based information on how this may be achieved.

The Working Party has tried to keep the report brief and clear. To make the material more accessible, some information has been summarised and presented in the form of bullet points. A small number of key references to each section are provided for those readers wishing to pursue the subject further.

Domestic violence


This policy statement on domestic violence was produced by a working group under the chairmanship of Dr Gill Mezey. The following are the key points:

- Psychiatrists need to have a working knowledge of the aetiology, effects and range of interventions available for victims of domestic violence.
- Domestic violence, that is the physical, sexual or emotional abuse of an adult victim by an adult perpetrator in the context of an intimate relationship, occurs in around 23% of women and 15% of men over their lifetime.
- Women are more likely to sustain physical injuries than male victims, they are more likely to experience repeated assaults and they are more likely to report emotional distress or fear as a result of the violence.
- Domestic violence is associated with psychiatric illness, including depressive...