the columns

correspondence

Patient suicide

Sir: Yousaf *et al* (*Psychiatric Bulletin*, February 2002, **26**, 53–55), have added important findings to the work that Courtenay and Stephens (*Psychiatric Bulletin*, February 2001, **25**, 51–52) carried out among trainees in South Thames. In our paper 54% of respondents had experience of patient suicide compared to 43% in Yousaf's sample and 47% found by Dewar *et al* (*Psychiatric Bulletin*, January 2000, **24**, 20–23). These findings suggest that patient suicide is a relatively common occurrence during the training years of psychiatrists.

An interesting element of Yousaf's survey is the use of the Impact Events Scale (Chemtob *et al*, 1988) to measure the personal impact of patient suicide events on trainees and on their professional practice. Certain themes are shared by the findings in the papers. Many trainees related that in the aftermath of the suicide their practice was affected to the extent that they were more meticulous in assessing the level of risk that patients were presenting. In some cases patient suicide had a beneficial effect on the doctor's training and that consultant support was important in coming to terms with the event. In a positive way patient suicide can be a formative experience and potentially adaptive for the trainee.

Having experienced the suicide of patients since the paper was published has afforded me the experience to learn that patient suicide does not necessarily become easier for the doctor to bear. The reaction is largely dependent on the level of clinical interaction that the clinician had with the person. Even with help from senior mental health staff the impact on the trainee can be aggravated by the attitude of the organisation to patient suicide and to his/her employees' response to the event. Training programme directors have much to offer in shaping the expectations of trainees following the death of a patient through suicide and the responsibilities of hospital trusts towards their staff.

CHEMTOB, C. M., HAMADA, R. S., BAUER, G., *et al* (1988) Patients' suicides: frequency and impact on psychiatrists. *American Journal of Psychiatry*, **145**, 224–227.

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Amphetamine prescribing

Sir: We were interested to read of the survey by Moselhy *et al* about amphetamine prescribing (*Psychiatric Bulletin*, February 2002, **26**, 61–62). In England and Wales, dexamphetamine is the second most commonly prescribed controlled drug, accounting for 4.4% of such prescriptions, with an estimated 900–1000 people receiving the drug as a harm reduction measure (Strang & Sheridan, 1997).

There is more extensive evidence than that cited by Moselhy *et al* for the efficacy of dexamphetamine, but this is largely based on opportunistic clinical evaluation. Recognising this deficiency, the Department of Health has funded a pilot (n=60) randomised controlled trial of dexamphetamine and best available treatment in Manchester and South Wales. The strict inclusion and exclusion criteria are both pragmatic and clinically relevant. We have used a modified version of the Opiate Treatment Index (Barrowcliff *et al*, 1999) to evaluate progress, supported by urine testing for continued use of street amphetamine. We would be interested to know if the services surveyed routinely tested their patients using this technique, which has been available for some time (Tetlow & Merrill, 1996). We have prescribed tablets only, as we have no evidence that these are crushed and injected.

In the absence of trial evidence we would agree that amphetamine prescribing should be restricted to specialist services. We intend that one of the outcomes of our study should be some clearer clinical guidelines for the treatment of dependent amphetamine users.

BARROWCLIFF, A., CHAMPNEY-SMITH, J. & McBRIDE, A. J. (1999) Use of a modified version of the Opiate Treatment Index with amphetamine users: validation and pilot evaluation of a prescribing service. *Journal of Substance Use*, **4**, 98–103.

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Old age psychiatry services: long-stay care facilities in Australia and the UK

Sir: John Snowden and Tom Arie (*Psychiatric Bulletin*, January 2002, **26**, 24–26) covered a huge amount of ground, and inevitably omitted some features of service delivery in the two countries. One major difference is that hostel and nursing home care in Australia is accessed only after assessment by a geriatric medicine team, and the costs of care are largely met by the Commonwealth Government, which closely controls the number of beds it approves. Patients are funded on a sliding scale that can be viewed negatively as encouraging dependency, or positively as challenging nursing homes to tackle seriously ill patients. UK nursing homes seem not to attract additional funds for higher dependency care, which can lead to patients 'blocking' beds in acute general and psychiatric hospitals. The Australian systems of documentation of dependency can be a drain on nursing resources, directed at ensuring maximum funding rather than patient benefits.

Western Australian old age psychiatry services have suffered age based fiscal discrimination in recent years, and consequently limited community services. UK social services provide substantial support care in the home that is not available in Australia. The system of community based assessment is well developed in Western Australia and emphasises early response by assessment teams of a social worker and community mental health nurse, followed by consultant intervention as required. The UK model favours consultant assessment in the community in the first

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