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# Correspondence

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## **Tardive dyskinesia: risk disclosure and informed consent in the Netherlands**

Sir: We read with interest the article of Chaplin & Potter (*Psychiatric Bulletin*, December 1996, **20**, 714–716) on the practice of screening and risk disclosure in patients at risk of developing tardive dyskinesia in the UK. We have conducted a similar study in the Netherlands. A questionnaire was sent to 200 consultant psychiatrists on the Central College mailing list, enquiring about their current practice towards informing their patients on neuroleptic medication about the long-term risks of tardive dyskinesia. One hundred and six (56%) questionnaires were returned, 90% from general psychiatrists. Of the respondents, 20% always and 75% sometimes discuss the risk of tardive dyskinesia with patients being commenced on neuroleptic treatment, despite the fact that 65% believe it not to be in the patient's best interests to know about the risk of tardive dyskinesia.

It was agreed by 75% of respondents that most psychotic patients receiving ongoing treatment with neuroleptic drugs are capable of informed decisions regarding their medication. Possible future litigation was a concern for 60% of those responding, while only 40% would support using a standardised consent form.

Our study shows that Dutch psychiatrists are less reluctant to discuss the risk of tardive dyskinesia with their patients, although they share similar concerns regarding this issue with their British counterparts.

Clearly patients need to know the likely effects and side-effects of medication and possible options. There is evidence that many patients want more information than they currently receive (Rogers *et al*, 1993).

Brabbins *et al* (1996) felt that the use of a pro-forma would facilitate the process of informed consent. The majority of respondents in our survey do not favour the use of a consent form informing patients of the risk of tardive dyskinesia. This is in line with the recommendations of the American Psychiatric Association (1992) which argue that the use of a consent form could militate against the ongoing process of informed consent.

Whether in practice conditions conducive to a process of ongoing informed consent are created for these patients and accurately documented is more doubtful.

AMERICAN PSYCHIATRIC ASSOCIATION (1992) *Tardive Dyskinesia: A Task Force Report of the American Psychiatric Association*. Washington, DC: American Psychiatric Press.

BRABBINS, C., BUTLER, J. & BENTALL, R. (1996) Consent to neuroleptic medication for schizophrenia: clinical, ethical and legal issues. *British Journal of Psychiatry*, **168**, 540–544.

ROGERS, A., PILGRIM, D. & LACEY, R. (1993) *Experiencing Psychiatry: Users' Views of Services*. London: Macmillan/MIND Publications.

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## **Evidence based medicine**

Sir: Schmidt *et al* (*Psychiatric Bulletin*, December 1996, **20**, 705–707) outlined the growing influence of evidence based medicine (EBM) in medical practice and its implications for psychiatry. EBM has the potential to offer some hope in rationalising the current ad hoc chaos of the publication paper chase. Bearing in mind that 80% of all published scientific papers are never cited more than once and 5–20% of citations are authors citing themselves (Institute for Scientific Information, 1990), emphasising training in research appraisal seems entirely appropriate. Successfully integrating the art of medicine with its psychosocial and philosophical facets with the rigours of scientific methodology is a training challenge in which EBM may have a place.

Higher psychiatric training, in providing protected research time and special interest sessions, leads the way in facilitating the incorporation of new knowledge into the expertise of SpR grades. Should purchasing and other new NHS structures seek to reduce our training freedom to become familiar with tools such as EBM, such pressure must be vigorously resisted. As a result, I hope to continue to be informed on diverse topics such as recruitment to drug trials (Skerrit *et al*, 1996) and the benefits of poetry (Holmes, 1996), both of which I consider will improve my clinical practice.

HOLMES, J. (1996) Can poetry help us become better psychiatrists? *Psychiatric Bulletin*, **20**, 722–725.

INSTITUTE FOR SCIENTIFIC INFORMATION IN PHILADELPHIA (1990) *Science*, **250**, 1331–1332.

SKERRITT, U., PITT, B., ARMSTRONG, S., *et al* (1996) Recruiting patients for drug trials: a difficult task. *Psychiatric Bulletin*, **20**, 708-710.

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### GPs and the Care Programme Approach

Sir: To gain a more up-to-date picture of GPs' awareness of the care programme approach (CPA) we replicated the Grace *et al* study (*Psychiatric Bulletin*, **20**, 634-644) but added questions to determine GPs' knowledge of the different levels of the CPA and modified one question to ascertain GPs' thoughts on the worth of their input to CPA meetings. Two hundred GPs were surveyed in the Doncaster area and 64% replied. Of those, 67% knew of the CPA, 93% via the local services. Of those who knew, 91% knew there were different levels of CPA, but only 14% knew the inclusion criteria; 28% were aware they were invited to reviews but only 50% thought they would attend, with 24% saying they would attend less than half the reviews and 26% saying they would attend none. The majority, 60%, of those aware of the CPA felt they would have little to contribute to such meetings.

These findings suggest firstly, in the two years since the previous study, GPs' knowledge of the CPA has improved due to communication with the local psychiatric services, DoH guidelines playing little part. Secondly, although most GPs aware of CPA were aware of there being different levels of CPA, very few were aware of the basis for allocation despite the fact that we expect GPs to become involved with patients on levels two and above. We include the criteria in our discharge letters, but they are tucked away in small print at the page bottom. Thirdly, although our policy is to invite GPs to reviews we have not monitored this; with the result that only a third of GPs are receiving invitations, a subject for future audit. Lastly, the majority of GPs feel unable to attend meetings and believe they would have little to contribute if present. This is unsurprising as the role of the GP here has been poorly defined, there are intense pressures on GP time, and care of the mentally ill requiring specialist services has recently been defined as a non-core service.

GRACE, J., STEELS, M. & BARUAH, R. (1996) General practitioners' knowledge of and views on the care programme approach. *Psychiatric Bulletin*, **20**, 643-644.

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### Non-attendance at clinics

Sir: We were interested to read Potter & Darwish's article regarding out-patient non-attendance in children and adolescents (*Psychiatric Bulletin*, December 1996, **20**, 717-718). The authors have demonstrated the aphorism, 'there is nothing like behaviour to predict behaviour'. To describe the pattern of out-patient non-attendance at a child and adolescent psychiatry clinic in Birmingham, we undertook a retrospective case note study. All such defaulters were identified during one calendar year (1991). Of 462 referrals received by the then Heathlands Clinic, 56 (12%) did not attend for their initial appointment. Of these, 28 (50%) were offered a second appointment, of whom 12 (43%) subsequently attended. When those offered a second chance were scrutinised, being younger ( $P < 0.001$ ) and male ( $P < 0.01$ ) predicted subsequent attendance. Those that were offered a second appointment following an initial non-attendance were also on the waiting list for a significantly longer period of time: a mean of 58.5 days compared with 39 ( $P < 0.05$ ). This study is consistent with that of Bowman *et al* (1996) who found a highly significant relationship between length of time from referral to appointment and subsequent attendance among paediatric ophthalmology out-patients.

One variable not addressed by either study is the fact that clinicians offer subsequent appointments often on the basis of professional concern, for example child protection issues, rather than the probability of future attendance. Cottrell and colleagues (1988) studied 100 consecutive referrals of which 16% failed to attend at all. This was significantly associated with parental opposition to referral.

BOWMAN, R. J. C., BENNETT, H. G. B., HOUSTON, C. A., *et al* (1996) Waiting times for and attendance at paediatric ophthalmology outpatient appointments. *British Medical Journal*, **313**, 1244.

COTTRELL, D., HILL, P., WALK, D., *et al* (1988). Factors influencing non-attendance at child psychiatry outpatient appointments. *British Journal of Psychiatry*, **152**, 201-204.

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