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.

Acknowledgements
We would like to thank Dr A. W. T. McDowall (Medical Director, Walsgrave Hospital, Coventry) for his helpful comments in preparing the manuscript.

References


A full list of references is available from Dr Ballard on request.
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 (nightime milky non-cafeinated 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.
Clinical audit effects a reduction in routine prescribing of benzodiazepine hypnotics

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.

Acknowledgement
My thanks are due to Dr Jeanette Smith for help and advice.

Reference

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. 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 served. From 1980 to 1984 an epidemiological
Clinical audit effects a reduction in routine prescribing of benzodiazepine hypnotics

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Access the most recent version at DOI: 10.1192/pb.15.10.625