

UKPPG Newsletter

August, 2008



Chairman's letter

Hello all,

Welcome to my third newsletter as Chair of the UKPPG. Since the last newsletter we have held two committee meetings including a very successful joint meeting with the College of Mental Health Pharmacy in Belfast on the 25th April. The UKPPG committee also met on the 13th June at Ullswater. Probably the most important outcome of the meetings was that the College and the UKPPG, building on the Waterloo agreement, identified the need to work closely with the Transcom chaired by Nigel Clarke (www.transitionalcommittee.com). Stephen Guy, President of the College, has taken the lead on this piece of work and has developed a joint UKPPG/CMHP position statement and written formally to Nigel Clarke.

This major external development within the Royal Pharmaceutical Society will also help to inform the future development of the UKPPG and CMHP. Dawn Price and David Branford are currently producing an option appraisal, which will encompass the sustainability of the present format and the future direction for both groups. We hope to present options towards the autumn. Dave and Dawn have also streamlined the manner in which we respond to requests to comment on guidelines and protocols; we have produced a formalised procedure and will access expertise within the wider membership for certain consultations.

At recent committee meetings we have also discussed future developments on the membership database, developing research capacity within the group and the corporate partnership programme. Dawn has been developing a proposed corporate partnership programme following last year's conference resolution. In anticipation of a formal resolution at this year's conference, Dawn will be aiming to send out details of the final options to all members.

Bev Faulkner has been the lead technician on a New Ways of Working (NWW) document for pharmacy technicians, which was released at the recent NWW conference in Leeds on the 23rd June. One of the clear outcomes from the recent workforce survey was that there needs to be a significant investment in the pharmacy technician workforce. The document is featured relatively highly in the pharmacy white paper and Bev is also working with the NWW team to ensure that the document has a high profile within mental health trusts. The document will shortly be available on the UKPPG web-site.

On the 25th May, the UKPPG ran a joint study day on 'Consent and the new mental health law' with the College of Mental Health Pharmacy and the Pharmacy Law and Ethics Association. Speakers included Joy Wingfield, Professor of Pharmacy Law and Ethics, and Peter Bartlett, Professor of Mental Health Law, both from the University of Nottingham, in addition to Anthony Oxley and David Branford. As a follow-up to the day, we may run something on a similar topic at conference 2009.

The committee have been working hard developing the programme for the 33rd Annual (15th International) UKPPG conference from the 10-12th of October at Wokefield Park. The conference will include the market-place, which was well received last year; look at less common conditions and feature an international flavour with speakers from around the world.

The committee would like to acknowledge the valuable support of the following people; Denny Humphries for her role in organising the conference, Graham Newton for his work on conference sponsorship and Katherine Delargy for her work with Graham Parton in developing the conference programme. For up-to-date details of the programme please check our web site at the following address: <http://www.ukppg.org.uk/conference.htm>

Finally, I would like to wish everyone a happy autumn, look forward to meeting you at the conference.

Regards,

Ian
ian.maidment@nhs.net

Creating mental wealth

You would be forgiven for labelling this a misprint. Mental wealth refers to a state of mental health and wellbeing not just of the individual but, more ubiquitously, a societal state. This was to be the subject of the joint Primary Care Mental Health Education (PRIMHE) and Wales Mental Health in Primary Care Network (WaMH in PC) conference.

Gambling people's future

Dr Julian Tudor Hart opened the proceedings by answering the question: 'What are people for?' from his unique standpoint; a mixture of epidemiology, socioeconomic observations and heartfelt expression of the repercussions of industrial decline. Enter the casino, the international money markets, where a relative handful of multimillionaires place their chips on the next good investment. Significant sums are moved from developed to developing economies and a whole generation of labourer's children face a bleak or prosperous future at the whim of those gambling. The bleak future: communities of coal miners and production workers who were previously defined by their productivity, now no longer possess a definition, or a standing. With such vocational abyss being a fertile breeding ground for ill health and deprivation, it is simple to understand how hard industrial decline has hit mental wealth. Logically then, is the use of medicine to address ill health the answer? 'Probably not', contested Dr Tudor Hart. Sound economic policy and having a true understanding of the implications of the casino on the value of people was required.

Addressing inequalities

Edwina Hart AM, the Welsh Assembly Government Minister for Health and Social Services, discussed the importance of wellbeing and social care. Tim Loughton MP, Shadow Minister for Children, Schools and Families, echoed such sentiments and delivered a stout warning that ignoring the needs of future generations, by shelving investment in services targeted at early intervention and children/adolescents, would represent the biggest threat to mental wealth thus far. There was unified recognition that mental health services were too often the 'Cinderella service of all Cinderella services', and historically queued last in line for funds and first in line for cuts to spare the blushes of other sectors. It was suggested that in order to create mental wealth there would need to be more equitable division of funds to address the apparent inequalities.

Phil Chick, the Director of Mental Health within the Welsh Assembly Government, introduced outline plans for the Welsh gold standard in mental health care. A rallying cry to promote good mental wealth for Wales through the recovery model; enabled by world class commissioning and delivered by services with appropriate values and evidence base. The importance of engaging with individuals and carers, and the need to remain patient-centred was underlined.

Good working relationships

Further speakers included Dr Ian Walton, Dr Huw Lloyd and Dr Tony Downes. Perhaps for me, as a mental health pharmacist, the most poignant matter was that at the core of all services, the ability to form human relationships and communicate effectively would be the most fundamental of factors. With many mental health services

being provided by an ever-increasing range of community based teams, silos have developed. The need for all services to work together closely, understand each other and have good relationships was explored. Without this the service user would be moved from silo to silo subject to repetition and unnecessary change, or lost in limbo betwixt services.

Projects to create mental wealth

The afternoon session included examples of how people from different services (schools, health, and the voluntary sector) had worked in new, innovative ways to tackle issues and made ordinary services extraordinary. The projects showed a genuine desire to create mental wealth, be it by tackling underachievement and lack of ambition in school pupils, by providing excellent support for people with mental health disorders/dementia in the community or by imparting means for communities to actively shape their own future. PRIMHE are looking to endorse similar projects by awarding quality marks to participating services and developing a forum for sharing the wisdom.

Dr Phil Hammond was a superb chair, and kept the day flowing with wit and insight, his summing-up tipped more than a wink to the (often negative) role that the press can play in creating or destabilising mental wealth. Perhaps dealing in this area is one of the biggest challenges that will be faced by healthcare organisations over the years to come.

Matthew Elswood

Mental Health Pharmacist, Campbell Centre, Milton Keynes.

The Servier Annual Psychiatry meeting, neuropotential, 20 May 2008



Those of you who were unable to take up the invitation to the Servier Annual Psychiatry meeting missed a rare treat, not least of which was the venue. It was held at the Royal Institution of Great Britain, the week before Her Majesty the Queen re-opened it following its multi-million pound refurbishment.

The lectures took place in the main lecture theatre, familiar to many as the location for the annual Christmas lectures initiated by Michael Faraday, held there since 1825 and televised for decades. Many world famous scientists have given the lectures, including Baroness Susan Greenfield (the current Director of the Royal Institution), naturalist Sir David Attenborough and Richard Dawkins. Of particular historical interest were the paintings adorning the corridors. These showed eminent scientist from days gone by, such as Faraday and Rutherford demonstrating basic principles of physics and chemistry to a captivated audience. The actual lecture theatre seemed to have changed little since those days and the digital projector and laptop podium appeared to be somewhat incongruous.

Notwithstanding the venue, we were treated to a galaxy of speakers. The sessions were chaired by Professor Guy Goodwin who in his address gave an overview of the current situation regarding the diagnosis and treatment of mental illness. He described the important diseases as largely genetic in origin, arising as a result of complex phenotypes. The reasons for their high rate of recurrence and chronicity remain part of our current lack of understanding of the disease process. He ended with the reflection that only four of the forty-two members of the reference group for the National Service Framework (NSF) for Mental Health were psychiatrists. The challenge, he went on, is to apply either science or sociology. We must apply science he stressed; the real challenge is mental illness not mental disorder.

Professor David Nutt followed with a review of the development of antidepressants over the past fifty years. This was a fascinating romp through the aetiology of depression and the pharmacological principles of its treatment, with an in-depth look at neurotransmission and the efficacy and side-effect profiles of the various treatments available.

Professor Sidney Kennedy from Canada discussed remission and 'quality' remission. The latter implies an outcome characterised not only by symptom resolution but also by return to optimal functioning with minimum side-effect burden. Risks and benefits of treatment should be carefully assessed with the benefits to patients during maintenance treatment, depending upon patient risk factors and medicine tolerability.

Professor Koen Demyttenaere continued the theme of tolerability in his presentation on the importance of adherence. He has researched the area extensively and published widely. He commented on the variety of terms used to describe medicine-taking behaviour, which, he said, was influenced by a variety of characteristics including the disorder, its treatment, the patient as well as the doctor. The first known example of non-adherence occurred in the Garden of Eden where the role of the doctor was 'played' by God. He concluded by saying that the most expensive medicine was the one that had not been taken.

Professor Goran Hajak was the final speaker of the day. He described depression as a 'circadian disorder' which affected the whole 24-hour period, not just the night. Sleep disturbance is a core symptom of depression and poor sleep is a risk factor for depression. The question arises, which comes first? In most cases he said it is insomnia. Poor sleep is also a common residual symptom as well as a predictor of relapse.

Throughout the day there was ample opportunity for discussion and a question and answer session with the experts at the end. This enabled me, as one of only a couple of pharmacists present, to mention the role of the pharmacist in encouraging and promoting adherence. The stroll back down Albermarle Street in the sunshine to the tube station, past the design shops of Viscount Linley and Paul Smith and the many galleries and boutiques, was the final treat in a day which had been both stimulating and enriching.

Celiam Feetam

Ten publications to tickle your transmitters

Aggression in learning disabilities

In aggressive challenging behaviour in learning disabilities, a trial of haloperidol vs risperidone vs placebo, showed that aggression decreased substantially over four weeks in all three groups, with no differences between the groups, and the placebo group at no point showed a worse

response than the antipsychotic drugs. The authors thus concluding that antipsychotics should no longer be accepted routine therapy for aggressive behaviour in LD (n=86, RCT, d/b, p/c, 26/52, Tyrer *et al*, *Lancet* 2008;**371**:57–63). Perhaps Dave Branford might like to comment?

Alcohol dependence

A meta-analysis of alcohol dependence studies concluded that naltrexone has significant effect on abstinence and prevention of heavy drinking, but that acamprosate only supports abstinence by preventing a lapse, whereas naltrexone is better at preventing a lapse becoming a relapse (Rösner *et al*, *J Psychopharmacol* 2008;**22**:11–23).

Modafinil in ADHD

Using pooled data from three studies, modafinil seems to improve attention deficit hyperactivity disorder (ADHD) symptoms and behaviours compared to placebo (s=3, n=638, d/b, p/c, <9/52, Biederman and Pliszka, *J Pediatr* 2008; **152**:394–9).

Memantine in BPSD

A systematic meta-analysis suggested that memantine decreases NPI (neuropsychiatric inventory) scores and may have a role in managing BPSD (behavioural and psychiatric symptoms of dementia), although the effect size was relatively small (s=5, n=1750, RCT, d/b, p/c, Maidment *et al*, *Ann Pharmacother* 2008;**42**:32–8).

Adolescent depression

In adolescents with SSRI-resistant depression, switching to another SSRI and adding CBT was effective and well-tolerated, and that switching to venlafaxine was as effective but with more ADRs (TORDIA trial, n=334, RCT, 12/52, Brent *et al*, *JAMA* 2008; **299**:901–13).

Escitalopram in obsessive compulsive disorder (OCD)

High-dose escitalopram (up to 50mg/d, mean 34mg/d) was very well tolerated and seemed very effective in resistant OCD (n=67 [c=64], open, 16/52, Rabinowitz *et al*, *Int Clin Psychopharmacol* 2008;**23**:49–53).

SSRIs in social anxiety

A meta-analysis of effect sizes from 15 studies (including all six UK SSRIs) concluded that SSRIs are more effective than placebo, also with improvements in social and occupational functioning (s=15, n=3527, RCT, d/b, p/c, 10–24/52, Hansen *et al*, *Int Clin Psychopharmacol* 2008;**23**:170–9).

Aripiprazole and alcohol

Aripiprazole 2.5–10mg/d increases sedation from alcohol, a relatively new finding (n=18, p/c, Kranzler *et al*, *Alcohol Clin Exp Res* 2008;**32**:573–9).

Olanzapine-induced weight gain

Addition of sibutramine (10–20mg/d) to metformin (850–1700mg/d) was no more effective than metformin alone for reducing olanzapine-induced weight gain (n=28, d/b, p/c, 12/52, Baptista *et al*, *Psychiatry Res* 2008; **159**:250–3).

Naltrexone

In an interesting secondary analysis of another study, naltrexone appeared more effective for improving alcohol-related outcomes if prescribed with an antidepressant compared to when used as monotherapy (n=627, Krystal *et al*, *Alcohol Clin Exp Res* 2008;**32**:85–91).

Update on POMH-UK

The national Prescribing Observatory for Mental Health (POMH-UK) was launched in 2005 and its aim is to help specialist mental health services improve prescribing practice. Most programmes comprise a cycle of clinical audit against evidence-based standards and bespoke change interventions, including the provision of benchmarked data that allow trusts to compare their prescribing practice with other participating trusts. A total of 43 mental health trusts have signed up to participate in the 2008 POMH programme.

The story so far:

1. Twelve trusts participated in the benchmarking of high-dose and combined antipsychotics in acute adult wards. Seven of these trusts participated in all three audits (the original quality improvement [QI] cycle in January 2006 and 2007 and the further benchmarking in Jan 2008) and of these, five have seen prescribing practice moving closer to the standards. These results suggest that it is possible to change practice in this area but that this takes time. The main audit cycle is reported in the June edition of the *British Journal of Psychiatry*.
2. Sixteen trusts participated in monthly benchmarking of high-dose and combined antipsychotics in acute adult wards. Data were collected over twelve consecutive months. Although practice moved towards the standards in a small number of trusts, this was not reflected at national level. These findings would seem to reinforce the conclusions above, that it takes time to change practice with respect to the prescribing of high-dose and combined antipsychotics. In order to meet demand from member trusts, monthly benchmarking will continue for a second year and data collection for this cycle has started.
3. Twenty-one trusts participated in the re-audit of high-dose and combined antipsychotics in forensic settings. Again, findings are that overall, change is slow and difficult to achieve but possible.
4. Forty trusts are participating in a QI cycle addressing the quality of assessment of side effects in patients prescribed depot antipsychotics. This programme is an ambitious one that we hope will help all clinicians reflect on their practice with respect to assessing side effects. Final reports are awaited.

Still to come to come this year:

- A further opportunity to benchmark practice with respect to screening for aspects of the metabolic syndrome in patients treated with antipsychotics and under the care of Assertive Outreach Teams.
- A new QI cycle that will address the quality of monitoring in patients prescribed lithium.

The central POMH team recognises that pharmacists in our member trusts are very supportive of the work that we do and that many pharmacists go the extra mile to lead their local POMH team, and ensure that data are collected and submitted on time. Without you, POMH would not be the success that it is. In return, we hope that the benchmarked data you receive is useful in stimulating reflective practice in your trust and keeping medicines management on your trust board agenda.

We are in the process of consulting with member trusts about next year's programme, so please let the POMH team know if you

have any strong preferences. We have a finite resource and are keen to use this in the most effective way. This means getting the balance right between continuing previous topics and offering new ones. Your views are essential.

Further details about POMH can be found on our website: <http://www.rcpsych.ac.uk/researchandtrainingunit/centreforqualityimprovement/prescribingobservatory.aspx>

Details about how to join can be obtained from: Amber Shingleton-Smith, the POMH project manager ashingleton.
Email: smith@cru.rcpsych.ac.uk

Carol Paton

Principal Pharmacist, Oxleas NHS foundation Trust

Presenting at the MHRN Conference

The UK Mental Health Research Network (MHRN) is part of, and funded by the National Institute of Health Research (NIHR). The network provides the NHS infrastructure to support commercial and non-commercial large-scale research in mental health, including clinical trials. A pharmacy arm of the network was formed last year by chairman, David Taylor:

The annual conference is a multidisciplinary event bridging basic and clinical science through to public health. The focus this year was to showcase high quality international research in mental health. The conference was held over three days at the impressive Royal College of Physicians in central London. The list of speakers read like a who's who of psychiatry; David Nutt, Peter Tyrer and Til Wykes to name but a few. As one would expect, the lectures and plenary sessions were of the highest quality and highlighted some of the most contemporary issues in psychiatry today. The session on addiction was one of the best I attended, especially John Strang's talk on the injectable opiate study. The pharmacy session was chaired by David Taylor and other speakers included Carol Paton of Oxleas and Justine Raynsford from Leeds. David outlined the research that the prolific research team at the Maudsley pharmacy have conducted recently, including as yet unpublished data on clozapine and mortality. Carol discussed the latest results from the exciting POM-UK project and Justine gave an excellent talk on improving the information that service users receive about their medicines.

I have been involved in observational studies on antipsychotics in Cardiff (Whitchurch Hospital) and London (Maudsley Hospital) over the past five years. I was invited to present the results of our studies on risperidone long-acting injection (RLAI) and aripiprazole. This was the most intimidating audience I had ever lectured to and I was quite nervous beforehand. I had prepared rigorously and practised the talk many times in front of my very bored family. When I'm nervous I tend to talk quickly, so I was careful not to sound rushed. Although I felt the talk was generally well received, my 'calmness' meant I overran. Despite this misjudgement, the entire experience was excellent and has whetted my appetite for presenting at more conferences. The other highlight was the opportunity to network with researchers during the relaxed evening events. I can thoroughly recommend the MHRN conference to all pharmacists with an interest in research and hope to be invited again one day. Next time I will be more careful to look at the clock!

Arwel Thomas

Mental Health Pharmacist

PLEA Conference: Consent and the new mental health law. May 21st 2008

When an email was sent in April advertising a study day on 'consent and the new mental health law', I decided it was about time I learnt about the proposed changes to the mental health law from the experts instead of the press and so I signed myself up. I was apprehensive of what the day was to hold and the swish London offices of Beechcroft PLC made me think that I was maybe at the wrong event for a novice. However, I was put at ease after a coffee and chat with the chairman of Pharmacy Law and Ethics Association (PLEA). Approximately forty people attended the day and there was a mixture of pharmacists, lawyers and some that have qualifications in both roles. Some had little knowledge of the mental health law and others were well informed and had been involved in the consultation process.

The day started off with a very entertaining talk by Peter Bartlett, Professor of Law at the School of Law, Nottingham. He explained the mental capacity act in simple English, which was a major relief. He linked the act to everyday scenarios that pharmacists may face. His presentation was very thought-provoking and led to an interesting debate which most of us continued over lunch.

After lunch it was our time to do some work. Anthony Oxley did a workshop which applied what we had learnt from Peter's presentation to possible work scenarios. Working in mixed groups of lawyers and pharmacists allowed us to see the law not only from the mental healthcare professional's side, but also from the lawyer's side, which both parties found beneficial.

It was then on to Dr David Branford to explain the proposed changes of the new mental health law. He explained the background to the changes before discussing what the implications for pharmacists are with the new proposed act. The proposed new act is certainly quite mind boggling but, by the end of the presentation, it all seemed clearer and I came away with a better understanding of what it will mean to pharmacists working in mental health.

Overall the day was very informative, it translated the mental capacity act and the new proposed mental health law into a language that I could digest and understand. What I learned has allowed me to present a couple of lunchtime sessions on the mental capacity act to the pharmacy department and I am in the process of organising sessions on the new proposed mental health law. I would like to thank all those who organised the day and attended. I feel I now know more than the *Daily Mail* readers do.

Dawn Swainson.
Mental Health Pharmacist, Leeds PFT

UKPPG email Group

Here are a few statistics for you. The email group has been going since April 2000 — over eight years and 17,000 emails (which may explain why our inboxes are always full!). Many, many shared documents, many adverts for specialist mental health pharmacy jobs, many UKPPG communications — I don't count them! For anyone who isn't aware of what an email group entails, it is a mechanism for forwarding an email from a subscriber to all email addresses subscribed to the email group. It isn't a chat room, or a blog, or one of those web-based discussion forums. It's a way for members of the UKPPG, and the occasional very helpful guest, to share questions, advice, documents, knowledge and support.

It is open to all UKPPG members so we have subscribers in the UK, New Zealand and Australia, from mainly secondary care but also other healthcare settings, research and industry, pharmacists and technicians,

doctors, nurses and specialists in TDM and pathology. Everyone can contribute and there is no editorial process. The more people contribute their knowledge, expertise and experience, the more the members of the UKPPG can get out of it.

There is no spam and the group, as a whole, is remarkably well behaved and on-topic. Speaking of which, recent topics have included incident reporting, Medusa monographs, multiple job opportunities all over the country, terms of reference for D&TC, switching between antidepressants and... well, a broad range of topics. Some are almost cyclical — someone somewhere is looking to answer a question not easily answered by the standard texts and they keep cropping up. Whether it's an example of a document, a system issue around service delivery, a clinical problem such as an interaction, risk monitoring, switching medication or side effects there have been a lot of helpful responses over the years.

Did you know that bruxism can be caused by SSRI's?

Graham Parton
Chief Pharmacist for Avon & Wiltshire Mental Health Care Partnership
NHS Trust and UKPPG Yahoo Group Moderator

Coming soon — managed entry template

Several members of the UKPPG have been working with Servier Laboratories Ltd to produce a managed entry template. It is proposed that the template be used to gather essential information and pose, as well as answer, some vital questions about any new medicines. The idea is that an individual will populate the template which would then be posted on a protected area of the UKPPG website for all to see, use and amend as they see fit, no point in us all re-inventing the wheel. The completed template would then provide consistent, appropriate, evidence-based information to a D&T committee or PCT considering the introduction of the new medicine to the local health economy. I am sure many of us already do this in a variety of ways but why not cut down our workload and centralise such information for all UKPPG members to access? The finalised template, populated with an example will be available soon on the UKPPG website.

Diary

Please let the editor know of any dates to be added to the UKPPG events and diary listings, either by post (Stephen Bazire, Chief Pharmacist, Hellesdon Hospital, Norwich NR6 5BE) or e-mail: sbazire@ukppg.org.uk.

Friday 26th September: UKPPG committee meeting

Please let Ian Maidment (ian.maidment@nhs.net) or Marina Davidson (marinadavidson@sky.com) know of any item you would like to raise.

Thursday 9th October, vivas for college membership: If you would like to be considered for a particular viva date then your completed portfolio needs to be received by the registrar at least three months before the date that you would like to attend. If you wish to apply for College membership then the application form needs to be completed and sent to the registrar at the address given on the top of the form. Steve Bleakley, Principal Pharmacist, The Beeches, St James' Hospital, Locksway Road, Portsmouth PO4 8LD, stephen.bleakley@ports.nhs.uk

Friday–Sunday, 10–12th October, 33rd Annual (15th International) Psychiatric Pharmacy Conference, venue Wokefield Park, Reading

Monday 13th October: South East Pharmacy Network meeting, Psychiatric Classroom 4th floor Guys Tower, Guys hospital.

Friday 21st November: UKPPG committee meeting

Please let Ian Maidment (ian.maidment@nhs.net) or Marina Davidson (marinadavidson@sky.com) know of any item you would like to raise.

List of useful names/addresses

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Treasurer and Membership Secretary: Mick Marven, Clinical Pharmacy Support Unit, Unit 46, Sandford Lane Business Park, Kennington, Oxford OX1 5RW; e-mail: Michael.Marven@oxmhc-trnhs.uk

Membership details and application form available from the website: www.ukppg.org.uk

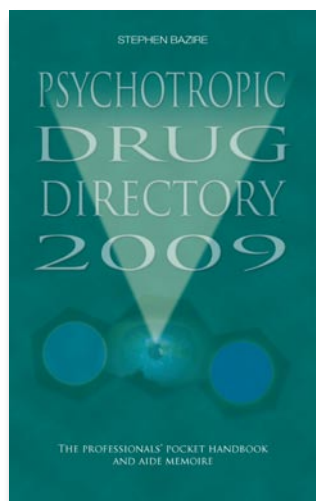
College of Mental Health Pharmacists (CMHP) contacts:

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Secretary: Cathy Mortimer, Pharmacy Manager, Princess Marina Hospital, Upton, Northampton NN5 6UH; email: cathy.mortimer@nht.northants.nhs.uk

Special offer to UKPPG members

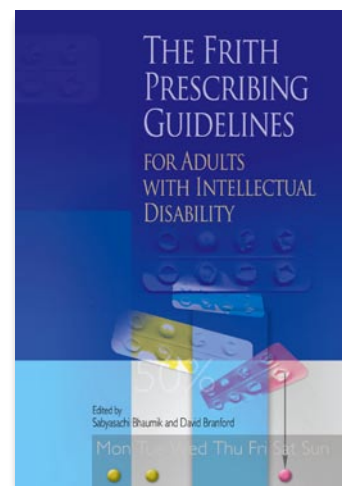


Psychotropic Drug Directory, 2009

The new 2009 edition of the *Psychotropic Drug Directory* continues its aim to provide for professional practicing clinicians a source of rapidly accessible information, advice and references on psychiatric drugs and to act as an aide memoire.

Frith Prescribing Guidelines for Adults with Intellectual Disability

People with intellectual disability (ID) have significant developmental intellectual impairment (IQ <70) and deficits in adaptive functioning, included in this group are people with Down syndrome and many of those with autism spectrum disorders and cerebral palsy. People with ID have high levels of physical and psychiatric health problems. About 40% of adults with ID have a major psychiatric or behaviour problem and 25% have active epilepsy. In this population, the diagnostic and treatment process may need a different approach from that used in the general population, in particular it is essential to take account of the impact of communication difficulties.



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