delay and attention-deficit hyperactivity disorder (Hart-Santora & Hart, 1992; Steingard *et al*, 1993; Singer *et al*, 1995), there is a need for a safe protocol that highlights the need for gradual withdrawal.

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columns

the college

Prison psychiatry: adult prisons in England and Wales

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The prison environment is radically different from that with which most psychiatrists are familiar. Doctors may have limited control over health facilities in prisons and the delivery of services follows a radically different philosophy, being principally centred on security and control. Resources are also likely to be limited both in quantity and diversity. The epidemiology of mental disorder and the nature of the prison environment result in the role of the psychiatrist in prison being a particularly challenging one.

This report concerns itself with the development of psychiatric services in adult prisons in England and Wales. It is hoped that the guidance will be of relevance to other jurisdictions (it is not applicable to people under the age of 21 in prison establishments). It concentrates on generic services in prisons, and so does not generate recommendations on the needs of prisoners with special needs, nor on the particular needs of women or people from Black or minority ethnic groups with mental health problems in prison.

The report makes 26 recommendations to improve mental healthcare in prisons. These cover the areas of:

- role of the consultant psychiatrist in prison
- commissioning mental health services in prisons
- addiction services in prisons
- learning disability services in prison
- female prisoners
- old age psychiatry in prisons
- rehabilitation psychiatry in prison
- psychotherapy services in prison
- training

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Use of licensed medicines for unlicensed applications in psychiatric practice

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Drug treatment is an essential part of much of psychiatric practice in patients from a wide age range and across many diagnostic groups. Despite the availability of many classes of psychotropic drugs, a substantial proportion of patients will remain troubled by persistent, distressing and impairing symptoms, even after a succession of licensed pharmacological treatments. In this situation, many psychiatrists will consider the prescription of psychotropic drugs outside the narrow terms of their licence, as part of an overall plan of management.

As this aspect of clinical practice in psychiatry has recently come under some scrutiny, a working group of the Special Interest Group in Psychopharmacology (SIGP) of the Royal College of Psychiatrists was convened to examine the nature and extent of the use of licensed psychotropic drugs for unlicensed applications in psychiatric practice, to consider any potential benefits and risks associated with this aspect of clinical practice, to outline when this may be an appropriate part of the management of individual patients, and to make balanced recommendations for a suggested procedure when prescribing licensed medication for unlicensed applications.

This College Report summarises the discussions and conclusions of the working group, and incorporates feedback from the wider membership of the SIGP. It is recommended that unlicensed prescribing should only occur when licensed treatments have been used or excluded on clinical grounds; and when the prescriber is familiar with any possible benefits and risks of the medication being considered, and feels confident with the proposed treatment. Whenever possible the agreement of the patient should be obtained; but if not possible, this should be noted. Prescriptions should be started cautiously, and the subsequent progress of the patient should be monitored closely. If the treatment proves ineffective it should be withdrawn carefully and if effective, the patient should be reviewed regularly. This aspect of prescribing practice may be a suitable area for review within continuous professional development peer groups and for clinical audit within mental health services.

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