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Correspondence

Prescription charges

DEAR SIRS

Any person, regardless of financial means, who suffers from one of nine physical conditions requiring maintenance medication is entitled to free prescriptions. People disabled by severe mental illness, on the other hand, are excluded from this concession. The majority of the patients cared for by the Netherne Rehabilitation Service, for example, are not entitled to exemption from charges since they neither have a qualifying physical disorder nor receive income support or family credit. They do, however, have long-term, disabling conditions, mainly schizophrenia and affective illnesses, and they need to be maintained on long-term medication. The increase in prescription charges, for them, is an intolerable burden and very few can afford the prepayment certificates, which are beyond their limited weekly budgets. The hardest hit are those who have been successfully resettled in employment; one said that he is being penalised for working.

Three main arguments have been rehearsed against exempting people with a psychiatric diagnosis.

(a) There are too many long-term psychiatric disorders; however, two groups of patients, those with chronic schizophrenia and those with recurrent affective illness, are known to require maintenance medication for many years, in the same way as diabetic and epileptic patients.
(b) Such exemptions would be based on stigmatising diagnostic labelling; most patients in receipt of maintenance medication are aware, or should be aware, of the reasons. It is more stigmatising to discriminate against long-term disabled psychiatric patients by making them pay.
(c) The case of hardship has not been clearly demonstrated; there is no evidence that such a case has ever been made for the exemption of patients with physical conditions, and, in any case, disabled psychiatric patients rarely complain loudly enough. It would also be unrealistic to carry out means tests on those who might qualify.

One 'solution' adopted by some of the patients is to soften the blow by requesting larger supplies of medication, which may not be a safe practice in some cases. Another, of course, is non-compliance which may have serious and expensive consequences. Surely, the only rational solution is to treat people with psychiatric disability fairly by including them in the exemption category.

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The right to treatment

DEAR SIRS

Most general psychiatrists have had the distressing experience of seeing their patients discharged from a treatment order just because they are not suicidal or homicidal on the day of the hearing of the MHRT or Member's Appeal. This has happened to me six times and each time patients have turned up for treatment again because their illness was no better or because they had stopped taking medication, which had been predicted at the hearing. To get them back into treatment often means a struggle to get them on another section, which one does in despair, knowing the whole thing will happen all over again. I am particularly impressed by the problems facing CPNs trying to implement a community care order which involves medication given against the patient's wishes or understanding in his home, and by the willingness of some patients to have medication once they understand there is no alternative. This willingness disappears once they are outside hospital. I would make a proposal to stop these patients with long term illness from suffering too much.

When it is clear that a patient's illness is going to be long term, and that the patient is unable to cooperate with treatment, then a Treatment Tribunal will be called by the RMO. This Tribunal will have the same general set-up as the MHRT, i.e. the lawyer, the outside consultant psychiatrist, the lay person. The persons called to give evidence would be the same. The patient, his solicitor, his family or carer, the RMO, the CPN and social worker involved in his management, perhaps the centre manager of a mental health resource centre where the patient attends, plus other interested persons.

The community treatment section. This would be a long-term section, say one year in the first instance, and two years at the second hearing, and so forth. It would empower the professional persons dealing with the case to require the person to return to hospital if his illness relapses so that his medication can be reviewed. This removes any idea of the CPN trying to