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High dose neuroleptics

Sir: Wilkie et al's (*Psychiatric Bulletin*, May 2001, **25**, 179–183) study of high dose

neuroleptics was timely and informative. However, it is surprising to note that they consider haloperidol 10 mg to be equivalent to chlorpromazine 100 mg. It is generally regarded that 2 mg of haloperidol is equivalent to 100 mg of chlorpromazine (King, 1995). Moreover, the highest recommended dose of haloperidol in schizophrenia is 30 mg (British Medical Association & Royal Pharmaceutical Society of Great Britain, 2001) and not 200 mg as the authors suggest. It is well known that doses of haloperidol higher than 12 mg do not produce any additional clinical benefits while causing increasing side-effects. The findings of the present study suggest that high dose neuroleptic prescribing is not based on sound pharmacological principles. Despite the high profile of pharmacological treatments in

psychiatry, psychopharmacology does not appear to have a similar status in the psychiatric trainee's curriculum. I hope that the newfound Psychopharmacology Special Interest Group of the College will rectify this anomaly.

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the college

Guidance for the preparation of medical reports for mental health review tribunals

The following guidance has been approved by the Royal College of Psychiatrists, Home Office, Department of Health and The National Assembly for Wales.

This guidance, given in clarification of the requirements under Part B, Schedule 1 Mental Health Rules, 1983, is designed to help the authors of medical reports for tribunals know what the mental health review tribunal (MHRT) finds useful in reports.

Reports should include the following information:

- date of report
- patient's name
- Section of Mental Health Act under which detained and expiry date
- name of responsible medical officer (RMO) and name of doctor making report and job title (if not RMO)
- name of patient's keyworker
- copies of any earlier reports referred to in the current report
- in making this report doctors should specify, whenever appropriate, whether their statements derive from sources outside their personal experience. If this is the case, the source should be named.

Reasons for detention

- (a) What were the circumstances that gave rise to the patient's detention?
- (b) Considering the criteria in the Act, into which category does the patient's

mental disorder fall? If there is an established diagnosis (diagnoses) please name it (them) with reference to the ICD–10. Please give the length of time the patient has been considered to suffer from it (them).

- (c) Highlight the characteristics (including the nature and degree) of the disorder that warrant detention. Explain why it is not possible to provide care and/or treatment outside hospital or in a less restrictive setting.
- (d) Is the patient being detained in the interests of his/her own health and/or in the interests of his/her own safety, or for the protection of others? If the patient has a long term or recurring disorder, explain the impact that it has or has had on the patient's life and the likely course of events if he/she were not cared for compulsorily.
- (e) Other relevant and significant history.
- (f) Details of progress since admission – current mental state and residual symptomatology:
 - insight
 - compliance (and detail unapproved absences, if any)
 - response to leave (if any granted).
- (g) What current medication is the patient receiving, and are there any problems arising from it?
- (h) Details of other forms of treatment tried or currently being delivered.

Care plan, compliance, risk and aftercare

- (1) What future treatment is planned? Please provide details (or a copy, if available) of the care plan. What is the response to it of the patient, carers and relatives?

- (2) What is the patient's attitude to treatment and his/her likely compliance to it in the future? Is this likely to vary if his/her insight changes?
- (3) What is your assessment of outstanding risk factors regarding the patient's own health and safety and the protection of others? What do you consider may happen if the patient is discharged from compulsory detention? In particular, how will any outstanding risk factors be managed in any environment that you are considering or that you believe the tribunal will be asked to order or recommend?
- (4) Please provide a brief note of the patient's unmet needs, what specific services are required to meet them and why the needs remain unmet.
- (5) If you are considering aftercare (as opposed to current care in hospital) please set out what provision you would like for the patient and indicate whether problems in such provision would be caused by immediate discharge/release from detention.

For restricted patients

- (6) If your report relates to a restricted patient, please deal with the issues set out on the attached Home Office list (if not already addressed).
- (7) Where a conditional discharge is a possibility, please set out what would be the foreseeable consequences of failing to provide any of the elements of the proposed package of conditions.

NB Remember to send your report also to the Home Office mental health unit!



Note regarding confidential material not to be disclosed to the patient

If you wish to add a section to your report that you ask not to be disclosed to the patient, this is possible under Rule 12 of the MHRT rules if the information would adversely affect the health or welfare of the patient or others in the opinion of the tribunal.

The procedure is:

- (1) You have the confidential material typed onto a separate page and clearly marked 'not to be disclosed to the patient'.
- (2) You write a covering letter explaining why you believe the material would adversely affect the health or welfare of the patient or others.
- (3) The tribunal will then consider the application not to disclose the material to the patient as a preliminary issue before the tribunal hearing; you may have to answer questions on the non-disclosure request at this stage. The patient's legal representative will still receive a copy even if the material is withheld from the patient.

Appendix – Checklist of points considered by the Home Office in examining the cases of restricted patients

The role of the Home Office in the management of restricted patients is to protect the public from serious harm. To carry this out effectively, the Home Office needs to know:

- (a) why a patient has been dangerous in the past
- (b) whether he or she is still dangerous (if so, why; if not, why not and in what circumstances he or she might be dangerous again)
- (c) what the treatment plan is.

The following list is not exhaustive, but is intended to cover some of the points that may need to be addressed when reporting to the Home Office. Not all points will apply to all patients; but all sections (not just those covering the main diagnosis) that apply to a particular patient should be completed. Attaching relevant reports is always encouraged.

Reports to the Home Office should reflect the views of the multi-disciplinary team. Please indicate whether the team has been consulted.

For all patients

- (1) Should the patient still be detained and for what reasons?

- (2) If yes, which level of security does the patient need?
- (3) What is the team's current understanding of the factors underpinning the index offence and previous dangerous behaviour?
- (4) What change has taken place in respect of those factors (i.e. to affect the perceived level of dangerousness)?
- (5) What are the potential risk factors in the future (e.g. compliance with medication, substance misuse, potential future circumstances, etc.)
- (6) What are the patients' current attitudes to the index offence, other dangerous behaviour and any previous victims?
- (7) What is the outward evidence of change (i.e. behaviour in hospital or on leave, attitudes towards staff and patients and potential victim groups?) How has the patient responded to stressful situations? Describe any physical violence or verbal aggression?
- (8) Have alcohol or illicit drugs affected the patient in the past and did either contribute to the offending behaviour? If so, is this still a problem in hospital and what are the patient's current attitudes to drugs and alcohol? What specific therapeutic approaches have there been towards substance misuse?
- (9) Which issues still need to be addressed, and what are the short- and long-term treatment plans?
- (10) What is known about circumstances of the victim, or victim's family?
- (11) How is the patient's dangerous behaviour related to his/her mental illness?
- (12) Which symptoms of mental illness remain?
- (13) Has stability been maintained under differing circumstances? Under what circumstances might stability be threatened?
- (14) Has medication helped and how important is it in maintaining the patient's stability?
- (15) To what extent does the patient have insight into his/her illness and the need for medication?
- (16) Does the patient comply with medication in hospital? Is there any reluctance? Would he/she be likely to comply outside?
- (17) What are the individual characteristics of the personality disorder?
- (18) What have been the treatment approaches to specific problem areas?
- (19) Is the patient now more mature, predictable and concerned about others? Please give evidence.
- (20) Is he/she more tolerant of frustration and stress? Please give evidence.
- (21) Does the patient now take into account the consequences of his or her actions and learn from experience? Please give evidence.
- (22) How has the patient benefited from treatment/training?
- (23) Is his/her behaviour more acceptable? Please give evidence.
- (24) Is the patient's behaviour explosive or impulsive? Please give evidence.
- (25) Does the patient now learn from experience and take into account the consequences of his/her actions? Please give evidence.
- (26) Does the patient still show undesirable interest in the victim type?
- (27) Describe any access to the victim type and the patient's attitude towards this group
- (28) What form has sexual activity in hospital taken?
- (29) What do psychological tests or other evaluation indicate?
- (30) What is the current content of fantasy material?

Patients with mental impairment

- (22) How has the patient benefited from treatment/training?
- (23) Is his/her behaviour more acceptable? Please give evidence.
- (24) Is the patient's behaviour explosive or impulsive? Please give evidence.
- (25) Does the patient now learn from experience and take into account the consequences of his/her actions? Please give evidence.

Patients with dangerous sexual behaviour (all forms of mental disorder)

- (26) Does the patient still show undesirable interest in the victim type?
- (27) Describe any access to the victim type and the patient's attitude towards this group
- (28) What form has sexual activity in hospital taken?
- (29) What do psychological tests or other evaluation indicate?
- (30) What is the current content of fantasy material?

Patients who set fires (all forms of mental disorder)

- (31) What interest does the patient still have in fires?
- (32) Has he/she set fires in hospital?
- (33) What access does he/she have to a lighter or matches?
- (34) In what way do fires appear in current fantasy material?
- (35) Does the patient have insight into previous fire setting behaviour?

And, finally

- (36) Please give any other relevant information that would be useful to the Home Office.



Changes to the MRCPsych examination – an update

The proposed changes to the MRCPsych examinations were published in the *Bulletin* in July 2000 (Katona *et al*, July 2000, **24**, 276–278). The timetable for the changes to the examination were indicated in the article.

After further discussions by the Implementation Working Group, the body that is concerned with the logistics of implementing the changes to the MRCPsych examination, two changes have been recommended of which candidates and examiners should be aware.

- (a) The new extended matching items (EMI) questions will be introduced into the MRCPsych Part I examination in Spring 2003 as planned. It has been demonstrated that EMI questions test a wider range of clinical skills than the multiple choice question (MCQ) format. In a recent pilot examination of EMI questions in Part I of the examination in Autumn 2000, these questions were found to have good psychometric properties in terms of distinguishing between good and bad candidates, and were acceptable to the candidates. EMI questions will therefore replace part of the MCQ examination so that in future the written section of the Part I examination will consist of both MCQ and EMI questions. Examples are to be found on the College website (<http://www.rcpsych.ac.uk/traindev/exams/regulation/emisamp.htm>). Alternative formats are being developed in a further pilot examination in Spring 2002 for both parts of the examination and examples of these will be posted on the website. However, EMI questions will not be included in the Part II examination until Autumn 2003.
- (b) The revised curriculum for basic specialist psychiatry training and for the MRCPsych examination is scheduled for publication within the next 3 months. In the Autumn 2001 MRCPsych examinations candidates should be aware that the questions set in both parts of the examinations will be based on the old curriculum. Sufficient time will therefore be available for candidates to examine the revised curriculum, which will be used as a basis for the questions set in both the written and clinical papers in the Spring 2002 examination.

Stephen Tyrer Chief Examiner, **Simon Fleming** Chairman, EMI Working Group

Election of Sub-Deans

Council will be electing Sub-Deans at its meeting on Wednesday 31 October 2001.

There are currently four Sub-Deans, three of whom are eligible for re-election. The Sub-Deans work closely with the Dean, Professor Cornelius Katona, and it is likely that the successful candidate will work in the area of examinations.

If you would like further information please contact Professor Cornelius Katona by 1 October 2001 (e-mail: ckatona@rcpsych.ac.uk).

Vanessa Cameron Secretary, Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG

Royal College of Psychiatrists' Board of International Affairs

Just as in the 19th century, when it was realised that public health – or ill health – was often the product of poor social conditions requiring municipal and national action to address it, so in the 21st century it is evident that many of the factors that determine health now require international action. The immediate threats to global health include over-consumption, environmental damage and misuse of medicines, and many international forums have focused on the consequences for physical health. However, as countries address these more tangible problems and improve the physical health of their population, their mental health needs become more apparent and more pressing. In many countries these needs are acknowledged and appropriate training for health care professionals is provided and/or is being developed. However, with the growing gulf in prosperity between rich countries and poor, it is important that mental health services in the latter do not become – or do not continue to be – the Cinderella services that they were for so many years in the UK.

Our College, with its tradition and reputation of experience in postgraduate education and its historical links with many countries, is well placed to play a role in the direct provision of training that should be appropriate to the needs of the country concerned and should not seek to exploit its workforce to remedy service deficiencies in the UK.

A continuing contribution to international education, although an important responsibility, should be seen as the starting point for the College's future global role, rather than an end-point. As a starting point it allows the development of relationships with the people likely to become leaders of the discipline within different countries, and it also offers the College – and through the College, the profession as a whole – the opportunity

to learn from other countries' experiences about cultural differences, different pathologies, different treatment approaches and so on. This development of genuine partnerships between equals, benefiting all parties, is of fundamental importance for the College's international role. The decline in the number of overseas trainees in recent years is evidence and warning that the old ways are no longer sufficient.

Instead, the College must reach out and become involved not just with the English-speaking Commonwealth countries, but increasingly with the countries in the European Economic Area. This will require the College to be wholeheartedly committed to organisations such as the World Psychiatric Association, the Association of European Psychiatrists and the World Health Organization, as well as developing strong links with sister organisations in other countries.

We appreciate that any such efforts require significant investment of precious time and money. This investment is essential, not just for the College's continued international prestige, but also because of our responsibility to advocate actively equality of mental health worldwide. Our concern must be for the mental health of all the world's citizens, not just the 'mental health of the nation'.

Finally, remembering the not too distant history of the use of psychiatry for political purposes, the Royal College of Psychiatrists should lead the way in advocacy of human rights, individual freedom and ethical and moral issues, which are fundamental to good mental health.

Hamid Ghodse Vice-President and Director of International Affairs

Invitation

The Board of International Affairs has been set up by Council with a specific remit to make recommendations and comment on recommendations or decisions by other College committees whenever these have international implications. The Board will meet at least four times a year. It has its own office and the administrative support at the College. But this is just a beginning.

You are hereby invited to help us to define specific issues that, in the light of the above article, you think we should be concentrating on, by applying for one of the posts of Appointed Member of the Board of International Affairs.

This is an honorary post and it is probable that you will need to devote