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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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columns

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!

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