columns

patients' confidence and trust. The concern is that those who pose the greatest danger to others, may be the ones who become most motivated to avoid contact with services.

DEPARTMENT OF HEALTH (2000) *Reforming the Mental Health Act*. London: Stationery Office.

TAYLOR, P. J. & GUNN, J. (1999) Homicides by people with mental illness: myth and reality. *British Journal of Psychiatry*, **174**, 9–14.

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## In-patient adolescent services

Sir: I was interested to read the report of Worrell and O'Herlihy (*Psychiatric Bulletin*, June 2001, **25**, 219–222) summarising the views of psychiatrists on in-patient child and adolescent provision. I have completed a similar survey in Wales, with a response rate of 96% (25/26 responses).

In Wales no psychiatrist has access to an adolescent psychiatric in-patient bed for emergency admissions. Eighty per cent ($n$=20) usually use a bed 'borrowed' from adult services and 20% ($n$=5) use paediatric beds either primarily, or equally to adult psychiatric beds.

Eighty-eight per cent ($n$=22) believe appropriate in-patient care is delayed for adolescents with mental illness because of inadequate provision. All believe this is primarily because of insufficient beds. Sixty-eight per cent ($n$=17) identify the lack of specialist adolescent provision, particularly adolescent psychiatric intensive care and adolescent forensic mental health provision.

Forty per cent of psychiatrists ($n$=10) feel the regional adolescent units are frequently unable to offer a bed within an acceptable time. Those patients are managed locally in adult psychiatric (24%) or paediatric (16%) beds or referred out of area largely to beds within the independent sector.

The response rate of >95% suggests the views expressed are representative of opinion in Wales. In my study higher percentages report delayed in-patient care (88% *v.* 36%) and inadequate specialist provision (68% *v.* 17%).

Regional differences in current provision may influence the level of concern expressed in Wales. My findings indicate the themes raised by Worrell and O'Herlihy are not only representative of opinion within the specialty but that experiences in Wales may be more extreme than those in England.

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## Mental health problems of asylum seekers

Sir: Derek Summerfield's editorial (*Psychiatric Bulletin*, May 2001, **25**, 161–163) shows how apparent mental health problems of asylum seekers/refugees must be seen in the context of disrupted social lives, and the importance of such practical issues as employment.

One practical issue not mentioned was housing. Those with no established right of abode experience special difficulties in securing accommodation.

For the hospital, this causes a danger of bed blocking if the patient ought not be discharged without an address to allow appropriate follow-up. Normally referrals are made to social services or to the Salvation Army. However, the social services has no duty to house an illegal immigrant, and the Salvation Army cannot help as it cannot recover costs via the benefits system. The Home Office does have a duty to house immigrants whose status is being investigated. However, faced with a detention centre, the patient may withhold consent to inform the Home Office. The stand-off can persist until a stage is reached in an asylum application when the applicant becomes eligible for benefits, and can be brought into the normal support system.

Even for an experienced doctor knowing the system, the process is difficult and extremely frustrating. How much harder must this be for someone trying to deal with a foreign language. As Derek Summerfield and others (for example, see Burnett & Peel, 2001) note, symptoms of psychological distress are common among refugees but may not signify clinical mental illness. Other cultural and social factors may contribute to psychological distress (for a recent analysis see Bhugra & Jones, 2001). Surely, the difficulties of finding accommodation must be one such contributing factor.

BHUGRA, D. & JONES, P. (2001) Migration and mental illness. *Advances in Psychiatric Treatment*, **7**, 216–223.

BURNETT, A. & PEEL, M. (2001) Asylum seekers and refugees in Britain: health needs of asylum seekers and refugees. *BMJ*, **322**, 544–547.

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## Hyperglycaemia and myoclonus with clozapine

Sir: Hyperglycaemia and myoclonus have been reported as uncommon adverse events with clozapine treatment. We report two cases in which they occurred together in close temporal association.

### Case 1

A 42-year-old African–Caribbean man with a history of severe, treatment-resistant schizophrenia developed myoclonic jerks while taking clozapine 700 mg/day. Eight weeks later he developed diabetic ketoacidosis with a blood glucose of 44 mmol/l, for which he required intensive care treatment. Clozapine treatment was subsequently stopped. Following recovery he was reinstated on clozapine, has not developed further myoclonus and his glucose tolerance is not impaired.

### Case 2

A 58-year-old White British man with a history of clozapine-induced hyperglycaemia was restarted on clozapine 400 mg/day. After 2 weeks he developed severe myoclonus and deterioration of glycaemic control with random serum glucose as high as 21.5 mmol/l. Clozapine treatment was withdrawn. Within 7 days control of his blood sugar was re-established and myoclonus resolved.

Myoclonus has been reported in 0.2% of 24 000 clozapine treated patients on the UK Clozaril Patient Monitoring Service (CPMS) database. Results from case series suggest the incidence may be as high as 2.0% (Safferman *et al*, 1991) to 2.7% (Sajatovic & Meltzer, 1996).

Impaired glucose tolerance with clozapine treatment is also probably more common than the 0.4% quoted by the UK CPMS (Linda Annan, Advisor, CPMS, personal communication). In a case-note study of 82 patients, 36.6% were considered to have developed diabetes (Henderson *et al*, 2000). The true prevalence of these adverse events remains to be established.

The association between hyperglycaemia and movement disorders, including myoclonus, has been well documented (Moores & Dire, 1989). Hyperglycaemia is the commonest metabolic disorder to be associated with clonic activities of the extremities and other focal motor phenomena. Correction of the underlying metabolic disturbance prevents further focal seizures or movement abnormalities (Berkovic *et al*, 1982).

Since uncontrolled hyperglycaemia is potentially life threatening, the presence of myoclonus in clozapine treated patients may be of use in alerting clinicians to the presence of impaired glucose tolerance.

BERKOVIC, S., JOHNS, J. & BLADIN, P. (1982) Focal seizures and systemic metabolic disorders. *Australian and New Zealand Journal of Medicine*, **12**, 620–623.

HENDERSON, D., CAGLIERO, E., GRAY, C., *et al* (2000) Clozapine, diabetes mellitus, weight gain, and lipid abnormalities: a five year naturalistic study. *American Journal of Psychiatry*, **157**, 975–981.



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MOORES, C. & DIRE, D. (1989) Movement disorders as a manifestation of nonketotic hyperglycaemia. *Journal of Emergency Medicine*, **7**, 359–364.

SAFFERMAN, A., LIEBERMAN, J., KANE, J., *et al* (1991) Update of the clinical efficacy and side effects of clozapine. *Schizophrenia Bulletin*, **17**, 247–261.

SAJATOVIC, M. & MELTZER, H. (1996) Clozapine-induced myoclonus and generalized seizures. *Biological Psychiatry*, **39**, 367–370.

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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.

BRITISH MEDICAL ASSOCIATION & ROYAL PHARMACEUTICAL SOCIETY OF GREAT BRITAIN (2001) *British National Formulary*. London & Wallingford: BMJ Books & Pharmaceutical Press.

KING, D. J. (1995) Neuroleptics and the treatment of schizophrenia. In *Seminars in Psychopharmacology* (ed. D. J. King), pp. 259–327. London: Royal College of Psychiatrists.

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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!



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