1 Thompson AE. 'You are instructed to prepare a report . . .': How to make sound decisions about whether to accept or decline medico-legal work. *Psychiatrist* 2011; **35**: 269–72.

2 Rix KJB. Medico-legal work of psychiatrists: direction, not drift. Commentary on . . . 'You are instructed to prepare a report'. *Psychiatrist* 2011; **35**: 272–4.

3 *Jones v. Kaney* [2011] UKSC 13.

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The psychiatrist as expert witness

Thompson[1] and Rix[2] make particularly interesting statements regarding continuing professional education in the area of providing expert reports. I generally agree with the requirements listed by Thompson, with the exception of expecting the psychiatrist to have had specific training in being an expert witness. It seems to me that, although advice about conduct in court is prudent, the requirement of specific training is redundant. The competence and expertise of the witness should rapidly become apparent to the court during the process of giving evidence and being cross-examined.

The testing of a witness's competence is strictly a matter for the court. Indeed, one of the attractions of my medico-legal work over the past 40 years has been that my knowledge and competence are examined in a very rigorous manner by counsel in the course of giving evidence. I would be concerned if our own professional body were to suggest that an answer in court that one had met the accepted requirements of training as a witness were to replace this.

If the courts were to need such support from our College, it would imply that the general level of competence at the Bar is insufficient and our colleagues at the Inns of Court may need to reconsider their training. For ourselves, our expertise resides in psychiatry with an understanding of the law, not being experts at the law.

1 Thompson AE. 'You are instructed to prepare a report . . .': How to make sound decisions about whether to accept or decline medico-legal work. *Psychiatrist* 2011; **35**: 269–72.

2 Rix KJB. Medico-legal work of psychiatrists: direction, not drift. Commentary on . . . 'You are instructed to prepare a report'. *Psychiatrist* 2011; **35**: 272–4.

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Psychiatric reports: a must for all psychiatrists

Thompson's article[1] about preparing psychiatric reports for courts contains some useful advice, but we were left wondering why she had taken the time to write it, given that she suggests such reticence in taking on this work.

Criminal and other courts rely on psychiatric evidence on occasion and, at least in the UK jurisdiction, where dual loyalties to the court and to the patient are tolerated,[2] a report for a criminal court is often best prepared by the psychiatrist who knows the patient and will be treating them. Sometimes, for that very reason, a psychiatrist will prefer not to be involved in a court case, but equally, there are cases where they really should be involved, because they will be carrying out the treatment that sentencing might support or enable.

It may be better for a consultant who does not do such work regularly to seek supervision from a more experienced colleague, rather than simply refuse to provide it, as Thompson suggests. There are many other situations in which courts need expert psychiatric evidence, either to meet statutory requirements or on higher court guidance. It is essential that there is a body of psychiatrists available that is willing and able to provide this, and there is no reason why it should come, as Thompson implies, exclusively from the ranks of forensic psychiatrists or clinicians who do not work for the NHS.

Training then becomes crucial, and Rix[3] has – much more encouragingly – discussed some of the ways in which it can be acquired. However, he does not address some of the associated matters that Thompson rightly raises. In particular, matters of probity relating to payment for work done and the interface between providing fee-paying services (category 2 work, as it was) and one's contractual NHS duties are important, and perhaps are not given the explicit attention in training and supervision that they deserve.

In the West Midlands we have prepared explicit guidelines for forensic trainees who are required to engage in this work. This covers matters such as the requirements for supervision and how best to acknowledge this within the report, the arrangements agreed with local employing trusts in relation to office support, guidance on providing estimates of costs and on what aspects of the work are chargeable, the requirements of Part 33 of the Criminal Procedure Rules 2010, and issues of consent, confidentiality and information governance. Although some of these matters are complex and may encompass some variety of practice, the principles are generally clear enough and need to be established openly.

In particular, when preparing a court report, a series of aims or outcomes may be conflated, including the (in category 2 terms) primary outcome of assisting a third party (the court) to meet its objectives (by dealing with the case justly), but also including preparing for the assessment and treatment of the patient in hospital (category 1 work as was), and personal learning and development for the clinician. The amount of time charged for should properly reflect this. Dealing with money may be sensitive, but a trainee's court report work must be explicitly supervised in terms of probity as well as clinical quality.

We agree with Rix that it would be a shame if psychiatrists were put off gaining competencies in this potentially rewarding, but also necessary, area of work. Many of Thompson's concerns can be successfully addressed by a more open attitude to the complex probity issues that are involved, rather than simply deciding 'not to undertake this work at all'.

Declaration interest
Both authors have provided expert reports for the courts in criminal proceedings of varying degrees of seriousness and complexity.

1 Thompson AE. 'You are instructed to prepare a report . . .': How to make sound decisions about whether to accept or decline medico-legal work. *Psychiatrist* 2011; **35**: 269–72.

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2 O'Grady J. Psychiatric evidence and sentencing: ethical dilemmas. *Crim Behav Ment Health* 2002; **12**: 179–84.

3 Rix KJB. Medico-legal work of psychiatrists: direction, not drift. Commentary on . . . 'You are instructed to prepare a report'. *Psychiatrist* 2011; **35**: 272–4.

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Mephedrone as a cognitive enhancer and its kinship to khat

The report on the adverse effects of mephedrone in patients presenting to an acute service in Scotland echoed many of our own findings in attendees of a service aimed at the early detection of psychotic illness based in inner-city London.[1]

In a small sample, we found that 8% of patients ($n=5$) seeking help for concerns about their mental health were using mephedrone. They reported using the drug for recreational reasons (during activities such as clubbing) and simply out of curiosity. Four out of the five patients stated that they also used mephedrone as a cognitive and performance enhancer to aid them in their studying and to help them stay awake while at university or college. They explained that it was a cheap and accessible alternative to other stimulants: one dose of 200 mg costs £2–3.

As mephedrone has now been classified as an illicit substance, it is possible that similar (currently unclassified) chemical compounds will become more widely used as cognitive enhancers in the student population. Both acute secondary and primary care mental health services should be aware of the adverse effects of this group of stimulants.

It is interesting to note that mephedrone is a semi-synthetic form of cathinone, the drug found in the East African herb khat. The chewing of khat has a long history and the drug continues to be used legally within several immigrant populations in Britain. Understanding the adverse effects of mephedrone has allowed us to appreciate the adverse consequences of khat misuse – a problem that has provoked substantial debate previously.[2]

1 Mackay K, Taylor M, Bajaj N. The adverse consequences of mephedrone use: a case series. *Psychiatrist* 2011; **35**: 203–5.

2 Warfa N, Klein A, Bhui K, Leavey G, Craig T, Stansfeld SA. Khat use and mental illness: a critical review. *Soc Sci Med* 2007; **65**: 309–18.

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If not now, when . . . ?

The contrast between the cover of the August issue of *The Psychiatrist* and the content of the related article[1] could hardly have been greater. On the outside: shocking depiction of a winged Freud in drag – women's bathing costume, high heels – flanked by the sphinx. Inside: announcement of change of job title from 'consultant psychotherapist' to 'consultant medical psychotherapist', buttressed by bland reassurance that 'the working role of most medical psychotherapists has become more like that of other consultant psychiatrists' and that warfare between different therapeutic modalities has ceased, and predictable pleas for greater recognition and investment in medical psychotherapy.

Sadly, it's the cover that gets it right. Medical psychotherapy is a chimera trying awkwardly to reconcile two currently incompatible sets of values – medical instrumentalism and psychotherapeutic humanism. A change of name will do nothing to resolve medical psychotherapy's abiding dilemma: how to stay true to psychotherapeutic values without isolationism or, claiming a spot in the mainstream, undermining its case for a separate identity.

I would like to see medical psychotherapy accepting the full irony and challenge of its chimeral status: a 'hopeful monster',[2] ensuring on the one hand that psychiatry does not become increasingly confined to pharmacology and forensics, and on the other that psychotherapists keep sight of their prime task – contributing to the effective treatment of psychological illness.

But nature abhors a chimera. Cash-strapped chief executives are unlikely to fall in with medical psychotherapy's vague promises when they can get NICE-approved therapies delivered by bureaucracy-savvy clinical psychologists and nurse specialists at half the price.

Which brings us back to Mace & Healy's seemingly proud statement that medical psychotherapy is unique among the CCT-bearing specialties in being 'not descriptive of the types of patients seen'. But therein lies its great weakness. Despite today's name-change, the rose will smell as uncompelling until the Faculty of Medical Psychotherapy becomes the Faculty of Personality Disorders and Complex Cases. Then at last the unique skills of the medical psychotherapist really will be seen as indispensable, and Mace & Healy's legacy come to fruition. Yesterday's hopeful monster may yet become tomorrow's role-model: the psychotherapeutically sensitive psychiatrist.

1 Mace C, Healy K. Medical psychotherapy: a speciality for now. *Psychiatrist* 2011; **35**: 301–4.

2 Gould SJ. *The Structure of Evolutionary Theory*. Harvard University Press, 2002.

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Psychological therapies for bipolar disorder: addressing some misunderstandings

We would like to reply to the letter published in your journal by Gupta & Brown,[1] concerning a recent British Psychological Society report on understanding bipolar disorder.[2] As authors of that report, we were pleased that it has generated debate. In the main, responses from psychiatric and other clinical colleagues have been overwhelmingly positive: MDF The Bipolar Organisation referred to the report as 'ground-breaking'[3] and Stephen Fry's tweet on the report led to 2000 downloads in one day.

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