Section 37 Hospital Order

Sir: I write in reply to H. Mathew (*Psychiatric Bulletin*, June 1996, **20**, 375) asking why Section 37 patients cannot apply to a Mental Health Review Tribunal (MHRT) in the first six months of detention. Patients detained on a Section 3 or a Section 37, both of which allow treatment to be given, are given the right to a review of their detention by an independent body with professional members once in the first six months of detention. Thus, those on a Section 3 can apply to a MHRT within the first six months. In the case of a Section 37, the order is imposed by the court, which is regarded as an independent body and therefore the patient is not entitled to a further review by an equivalent body (i.e. a MHRT) within the first six months of detention under the Mental Health Act.

I share the concern at the seemingly anomalous situation which H. Mathew describes.

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College guidelines on psychotherapy training

Sir: The Royal College of Psychiatrists in November 1993 issued new guidelines on psychotherapy training (Grant *et al*, 1993). I would like to report on progress made towards meeting the guidelines with regard to individual psychotherapy training.

A questionnaire was posted to all 44 registrars on a London-based general psychiatric training scheme. Twenty (64%) of the 31 career registrars responded compared with only five (38%) visiting registrars, giving a total response rate of 57%.

It was disappointing to find that only 8% of the respondents had attended Balint-type seminars, but 17 (68%) reported training with video technology. More encouraging were the findings that 23 (92%) reported psychotherapy casework experience, with 13 (52%) successfully continuing therapy with the same patient despite a change of postings. The majority of respondents (72%) satisfy the guidelines' requirements for casework experience of at least one long case and two short cases. On the whole, career registrars satisfied the requirements more than visiting registrars.

Regarding supervision, 16 (72%) received an average of one hour supervision per week, with the majority, i.e. 12 (54%), being supervised within groups. The result is that 95% of the respondents presented their cases for supervision after two or more sessions with the patients. It is perhaps not surprising therefore that 13 (59%) wished for individual as well as group supervision. Surprising, however, is that 64% of the respondents felt they were receiving adequate supervision. This suggests an inadequate understanding of the purpose and process of supervision.

Despite the many reported difficulties with pursuing a training in psychotherapy (poor consultant support, rotating posts, inadequate time and other logistic problems etc.), 52% reported satisfaction with the overall training.

GRANT, S., HOLMES, J. & WATSON, J. (1993) Guidelines for psychotherapy training as part of general professional psychiatric training. *Psychiatric Bulletin*, **17**, 695–698.

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High dose antipsychotic prescribing

Sir: Hillam and colleagues (*Psychiatric Bulletin*, February 1996, **20**, 82–84) and Haw & Morgan (*Psychiatric Bulletin*, May 1996, **20**, 311) both debate the merits and demerits of calculating neuroleptic dosages in terms of chlorpromazine equivalence, but they do not proceed to use the consensus statement to set standards in such prescribing.

We have examined antipsychotic prescribing in our Forensic Unit by point prevalence survey. Bed occupancy on the day of the survey in April 1996 was 98% (n=42). A chlorpromazine equivalence figure was calculated for all regularly prescribed oral and depot drugs using data from the *Psychotropic Drug Directory* (Bazire, 1995). We identified 13 patients (31%) who were receiving prescription for "high dose" antipsychotic drugs.

Following the initial survey, we have adopted the following practical approach to comply with concensus guidelines.

(1) All patients identified in our survey and those prospectively identified in 2 (see below) have the drug prescription kardex marked with a fluorescent orange "high dose antipsychotic prescription" marker with the date of instigation of such prescribing.
(2) At the weekly ward round, the team pharmacist identifies any new or current patient who has entered this category.
(3) At the above review patients highlighted as being in receipt of a high dose prescription have duration of treatment and its efficacy monitored. Surveillance for co-prescription of QT interval prolonging drugs as defined by the CSM is included here.
(4) All patients on high dose regimes are offered ECG examination and those remaining on such regimes beyond three

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months have this repeated at three monthly intervals.

(5) The resuscitation training of medical and nursing staff will now be on a compulsory rather than voluntary basis.

BAZIRE, (1995) *The Psychotropic Drug Directory*. Salisbury: Quay Books.

THOMPSON, C. (1994) Consensus Statement: the use of high dose antipsychotic medication. *British Journal of Psychiatry*, **164**, 448–458.

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The research option for MRCPsych examination

Sir: Candidates for the MRCPsych Part II examination may, subject to certain conditions, submit a dissertation describing a research project carried out by themselves or jointly. This dissertation, if successful, will replace the essay paper of the examinations. The College is undoubtedly aware of the under-usage of the research option by trainees. Obviously the College's aim in encouraging trainees to acquire a more searching and critical approach and to foster interest in clinical data, literature, the teaching of psychiatric practice and research (The Royal College of Psychiatrists, 1995) is not met.

A title and brief outline of the proposed research project must be submitted to the Court of Electors at least 15 months before the examination. This period could be reduced. According to the College regulations, candidates will be informed prior to the date of written papers whether their dissertation has reached the required standard, but no time limit is given. This decision will affect the candidates' preparation so they would like to be informed at specific times prior to the examination. Finally, publishing abstracts of accepted research will encourage other trainees and give them an idea about standards accepted by the College.

THE ROYAL COLLEGE OF PSYCHIATRISTS (1995) *General Information and Regulations for the MRCPsych Examination*. London: RCP.

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Sir: Your correspondent rightly asserts that the research option for candidates for Membership of the College by examination has been very infrequently taken up. The research option has not been effective in requiring trainees to acquaint themselves with research methodology and to develop a critical and balanced approach to the psychiatric literature. Partly on this account the Examinations Sub-Committee of the Court of Electors is developing a "Critical Review" paper to test these abilities. This is likely to be introduced in the Autumn of 1997 or the Spring of 1998. The paper is currently being developed, using experiences of this kind of paper in other Colleges and in Universities. The new paper will replace the Short Answer paper which principally examines factual knowledge and in this respect overlaps the areas examined by the Multiple Choice Question paper.

As yet, no decision has been made about the future of the research option in the examinations for the MRCPsych. Preparing a dissertation engages the trainee in research procedures in a very direct way which is impossible to replace by a written paper. Probably the most important requirement for the preparation of a dissertation as training in research is that satisfactory arrangements are made for supervision. This and other aspects of research training are very difficult to arrange on a national, or even international basis, and it seems unlikely that a dissertation will ever become a compulsory part of the requirements for Membership of the College. The development of Masters degrees in Psychiatry which require a dissertation probably provide a more satisfactory way of making this experience available to psychiatric trainees; universities have staff with suitable experience to act as supervisors.

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Terminology; learning difficulties or mental retardation

Sir: One can emphathise with R. Denson (*Psychiatric Bulletin*, May 1996, **20**, 309–310). The attempt to use appropriate and understandable terminology in this field can leave one speechless. As clinicians we must use terminology that is acceptable to our patients, yet allows internationally comparative data to accrue which enhances clinical practice. Efforts to be politically correct often fail on both accounts.

In Ireland, advocates with the disability in question prefer the term learning disability. However, this term is either meaningless or conveys the wrong meaning when used in conversations with other groups or with colleagues from outside these islands. Mental handicap is the term used by the national umbrella organisation of service providers and parents and friends groups (NAMHI). However, the docu-

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