have shown a wide frequency of neuroleptic usage ranging from 70% to 30% of the hospital population (Fischbacher, 1987; Lynch, 1989).

Eighty-two per cent of the population with psychiatric disorders used neuroleptics compared with 62% of the behaviourally disordered population. There is obviously not indiscriminate usage of neuroleptics in behaviourally disturbed people in this hospital.

It has been stated that a higher proportion of males (Fischbacher, 1987) and a higher proportion of females (Lynch, 1989) have been using neuroleptics. Our survey does not show any difference between males and females in neuroleptic usage (Table II). Neuroleptic use decreases in older people (Jacobsen, 1988). This finding is replicated in our population where significantly fewer people over 50 are on neuroleptics.

Good practice dictates that antiparkinsonian drugs should not be automatically prescribed to everybody on neuroleptics. In this survey less than half of the population with psychiatric disorder, and only one fourth of the population with behaviour disorders are on antiparkinsonian drugs.

In our mentally handicapped hospital population only 2.7% ($n = 14$) have been prescribed antidepressants. This seems to be lower than many community studies and it will be worth studying if depression is under diagnosed in the severely and profoundly handicapped population with limited or no verbal communication.

Lithium salts have been used as antiaggressive agents as well as mood stabilisers in a small number of people. The antiaggressive effect needs to be reconsidered for the behaviourally disturbed and self injurious population.

Benzodiazepines are largely used as antiepileptics to prevent status epilepticus. Only a small number of people in this hospital are on regular benzodiazepines as compared to an adult general population report. Over-prescription, which may be followed by dependency, does not seem to be a problem.

This survey has given us insight into the present use of different types of psychotropic medication. Some have predicted that as hospitals shrink in size only the psychiatrically unwell in need of pharmacological treatment will continue to reside in hospitals or health units, and hence will account for a very large percentage of medication usage. Others predict that, once losing the security and safety of the hospital, mental handicapped people in the community may be given larger amounts of psychotropics to prevent any possible crisis. Longitudinal and follow-up studies looking at the same or similar populations in the community will answer these questions.

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A full list of references is available on request from Dr Kohen.

Continuing medical education, clinical audit and the Mental Health Act

The Public Policy Committee is concerned that psychiatrists should keep up to date, and keep under review, their knowledge of Mental Health Act procedures, particularly in light of the recent changes to the Code of Practice issued under the Mental Health Act 1983, s. 118. An example of recent changes is the amendment to para 2.6 of the Code to the effect that a doctor needs to consider the health *or* safety of the patient, or the prevention of harm to others, rather than the health *and* safety, as previously implied by the Code (*Psychiatric Bulletin*, 1992, **16**, 586).

There are likely to be further amendments to the Code of Practice in due course. In light of this the Public Policy Committee recommends that members seek opportunities to focus clinical audit activity on and develop continuing medical education initiatives in this area.

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