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service users and facilitate their recovery from a mental illness. Psychiatry does not hold all the answers and other professions, agencies and individuals have different distinctive roles. Within psychiatry, we have to struggle with the internal threat of crude biological reductionism. Equally, if we break the boundaries of our legitimate expertise and become generic healers, we will have lost all usefulness and legitimacy.

Declaration of interest

The authors have a range of personal convictions including atheist, Buddhist, Methodist, Roman Catholic and non-denominational faith.

HOLLINS, S. (2008) Understanding religious beliefs is our business. Invited commentary on . . . Religion and mental health. *Psychiatric Bulletin*, **32**, 204.

KOENIG, H.G. (2008) Religion and mental health: what should psychiatrists do? *Psychiatric Bulletin*, **32**, 201–203.

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Koenig (2008) discusses important principles for working therapeutically with the spiritual dimensions for our service users' well-being. However, several points need highlighting.

Of course one should respect religious beliefs. As an old age psychiatrist in London seeing people at home, I have to be aware of what to do if offered coffee in a Muslim home during Ramadan, who looks after the *mandir* in Hindu households and of the dates and social impact of Jewish holidays. I have had to respond to letters from Catholic priests 'she needs a psychiatrist, not an exorcist' and avoid sending Muslims appointments for midday on Friday. In a multi-faith society there is much to learn to avoid pitfalls which could be interpreted as lack of respect.

Most of us have little experience of taking a spiritual history as distinct from asking about religion. Neither Koenig nor Hollins (2008) direct us to Sarah Eagger's guidance on the College website saying just how to do this (www.rcpsych.ac.uk/PDF/DrSEaggeGuide.pdf).

We cannot work with mental health trained chaplains in our area; there aren't any. Recent guidance (Department of Health, 2003) details specific provision for mental health. However, the first stage of implementation is related to numbers of beds. In this age of community care and bed reductions, this is unrealistic. If the first stage has to be implemented before the community-focused second stage, we still have a long wait for an essential service.

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KOENIG, H.G. (2008) Religion and mental health: what should psychiatrists do? *Psychiatric Bulletin*, **32**, 201–203.

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I was amazed and alarmed to read Koenig's article on religion and mental health (Koenig, 2008), and the President's lukewarm support of the article (Hollins, 2008), as it presents no scientific evidence that any of the suggested working practices improve patient care. The few figures it uses are not supported by other studies. Koenig claims that only 1.4% of the British population are atheists. His source is the World Christian Database, hardly an unbiased source of information. This low figure has no face validity to anyone working in this country. A recent study (Huber & Klein, 2008) funded by the conservative Bertelsmann Institute looked at religious beliefs in 18 countries (eight of them European) across both high-income and low- and middle-income countries. It used a very broad definition of religion and spirituality focusing on Pollack's work on the belief in the transcendence as the core of substantial spirituality (Pollack, 2000). In other words, it looks for the belief in something spiritual that may or may not be related to formal religion. They professionally polled tens of thousands of people in the 18 countries making it by far the largest and most comprehensive study into the subject so far.

Their findings confirms Britain to be among the least spiritual countries of the 18 examined, across a wide range of factors including prayer, church attendance, personal religious experience, religious reflection, pantheistic influence, etc. It finds that across European Christians more than 10% of those who formally belong to a church do not believe in anything spiritual at all. This makes census data potentially quite unreliable when it comes to assessing people's real religious believes. In Britain, 19% of those polled were classed to be highly religious, 43% as religious and 38% as non-religious using a broad definition of spirituality; 55% of Britons consider prayer to be non-significant for their lives and only 33% have personal religious experiences.

Far from religion being pervasive throughout the majority of society, in Britain at least the opposite seems to be the case. Moreover, there is already a well-organised provision of support for people who follow organised religion in all hospitals with easy access to religious elders and prayer rooms. However, no provision exists for non-believers who look at questions of meaning of life and morality in a non-spiritual way. It is this group that is disadvantaged rather than those who follow organised religion. It follows that rather than insisting on getting a 'spiritual history' of each service user we should show respect to those who can discuss the meaning of life without spirituality and find a solution to identify and facilitate their needs in an increasingly secular society.

HOLLINS, S. (2008) Understanding religious beliefs is our business. Invited commentary on . . . Religion and mental health. *Psychiatric Bulletin*, **32**, 204.

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Koenig's attention to the topic of religion and psychiatry is welcome (Koenig, 2008). That the minority of psychiatrists have a religious affiliation is evidently beyond the scope of any intervention or policy. However, I worry that the studies quoted do not accurately reflect the situation. Although they confirm that religion is

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more important to service users than their psychiatrists, this does not tell us what happens in practice.

The real question which we should be asking is to service users themselves and how *they* feel religion has been accounted for in treatment. I worry that the answers might be even more demoralising.

Taking a spiritual history is both an easy and important task to be undertaken by any professional. It can substantially help a service user feel understood and hence engaged in treatment. The Spirituality Special Interest Group provides several tools which should surely become routine practice for all mental health professionals, at the very least in screening (www.rcpsych.ac.uk/PDF/DrSEaggeGuide.pdf).

The suggestion of prayer with service users is a troubling one with the potential to lead to transgression of boundaries through sharing such an intimate act. It leads to duplicity of the psychiatrist's role, erosion of the purpose of treatment and in my mind is best avoided.

Declaration of interest

P.C. is an atheist.

KOENIG, H.G. (2008) Religion and mental health: what should psychiatrists do? *Psychiatric Bulletin*, **32**, 201–203.

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Medication for side-effects under the Mental Health Act

The need to authorise the use of hyoscine to counter hypersalivation caused by antipsychotics has been recently debated by Woochit & Husain (2008). They question the logic of the Mental Health Act Commission in suggesting that authorisation needs to be sought on Forms 38 or 39 for detained individuals to receive such medication. They propose a corollary of the Commission's position that all medication used for possible side-effects should similarly be specified, such as senna for constipation and metformin for diabetes.

The Mental Health Act 1983 nowhere defines 'medication for mental disorder' in relation to its consent to treatment powers and the courts have never ruled on the question, although the case of *B v. Croydon Health Authority* [1995] is often cited as a precedent for the contention that a treatment ancillary to the administration of medication for mental disorder can fall within section 58 of the Act (Jones, 2006) and therefore requires certification. It is a long accepted practice, for example, that antimuscarinic drugs should be named on the legal forms. Of course this approach could be taken to absurd lengths, meaning that a statutory second opinion might be required to administer a laxative or an indigestion tablet to an incapacitated detained individual.

The Mental Health Act Commission seeks to ensure that forms should provide a clear indication of the limits of any authorisation, both for clinical teams and for the service user, while remaining practical. We therefore seek to distinguish between ancillary treatments that are an essential adjunct to the core treatment, without which the latter could not be reasonably given, and treatments of more widespread physical complaints that may or may not be related to the core treatment.

Hyoscine is a good example of how this distinction should work in practice. Idiopathic sialorrhoea is exceptionally rare. Where it occurs with antipsychotics, in particular but not exclusively with clozapine, it can be said to be almost certainly one of the side-effects of that drug and nothing else. Contrast this with, for example, constipation or indigestion: both are known to be side-effects of psychotropic medication, but are also common intermittent or chronic problems in the general population, often with no exact known cause. From such pragmatic distinctions we have drawn up a list of ancillary treatments requiring certification including, for example, antimuscarinics used in parkinsonism and other motor effects of antipsychotics and hyoscine used for hypersalivation but excluding laxatives, indigestion remedies, or antidiabetics (Mental Health Act Commission, 2002). Our guidance is under review and we would welcome comments and responses to the correspondence address below.

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MENTAL HEALTH ACT COMMISSSION (2002) *Guidance for Commissioners on Consent to Treatment and Section 58 of the Mental Health Act 1983*. MHAC.

WOOCHIT, V. & HUSAIN, S. (2008) Does hyoscine need to be 'legally' prescribed? *Psychiatric Bulletin*, **32**, 196–197.

B v. Croydon Health Authority [1995] 1 All E.R. 683, CA.

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Discharge delays

Many elderly psychiatric wards are currently experiencing problems with delayed discharges (Hanif & Rathod, 2008). It is interesting to note that mental health patients were initially included in the Community Care Act 2003. They were only excluded in a late House of Lords amendment after lobbying by mental health groups, particularly MIND.

As with New Ways of Working, we reap what we sow.

HANIF, I. & RATHOD, B. (2008) Delays in discharging elderly psychiatric in-patients. *Psychiatric Bulletin*, **32**, 211–213.

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Depot risperidone, hyperprolactinaemia and prolactin-associated side-effects

Hyperprolactinaemia is a significant adverse effect of antipsychotic treatment and is particularly associated with dopamine-blocking agents like risperidone. Hyperprolactinaemia may cause menstrual disturbance, galactorrhoea, impotence and reduced libido. These problems impair the quality of life and contribute to non-adherence to medication (Maguire, 2002). Chronic hyperprolactinaemia has been associated with osteoporosis (Naidoo *et al*, 2003).

Depot risperidone is an injectable, slow-release formulation whose prolactin-inducing properties may differ from oral risperidone. Only one previous trial assessed hyperprolactinaemia associated with the use of depot risperidone in routine clinical care (Bushe & Shaw, 2007).

In a pilot study in Renfrewshire, Scotland, we identified 37 individuals who were taking depot risperidone. Twelve individuals had medical conditions or took other drugs that may have influenced the level of prolactin and thus were excluded from our study. The remaining 25 individuals had the level of prolactin measured and they completed a questionnaire about prolactin-related side-effects. Ten individuals refused to take part in the study and it was completed by 15 participants (9 men and 6 women, mean age 48 years, mean duration of treatment with depot risperidone 15.4 months).

In 12 participants the level of prolactin has risen, with 3 individuals having levels more than four times the upper limit of