Reply

DEAR SIRS

We read with interest the above letter by Dr Palin on the use of selective serotonin reuptake inhibitors.

He seems to be surprised that a significant number of his profession still "believe" in the use of tricyclic antidepressants. "Belief" usually comes from working with a particular group of drugs over a long period and results from a knowledge of their therapeutic efficacy as well as their potential dangers. It is to be remembered that until recently these drugs were the yardstick against which new drugs competed in clinical trials to establish their therapeutic status. The CSM would not have licensed the SSRIs unless they had been shown to have the same therapeutic benefits as those of the tricyclics.

Our article attempted to give a broad and balanced view of the introduction of the SSRIs. There are, of course, pharmacological arguments, not presented in this article, for the continued prescription of the tricyclics. Amitriptyline is equipotent in blocking the reuptake of noradrenaline and 5HT and similarly, as we mentioned in our article, the clomipramine metabolite desmethylclomipramine is a potent noradrenaline reuptake inhibitor. Recent studies (Seth *et al*, 1992; Nelson *et al*, 1991) have proposed the joint administration of an SSRI and a noradrenergic uptake inhibitor in patients with relative treatment resistance.

It is well known to drug firms and their marketing staff that whether doctors prescribe new drugs depends not only on the science they present the doctor with but also the doctor's own personality profile. Some always prescribe new drugs, some never. There is currently a place for taking the middle ground of using the new drugs in one's own clinical practice to find their place in the armamentarium of antidepressants. Treatment of all, particularly the more difficult, patients is likely to be by a single group of drugs. In patients who have failed to respond to a SSRI (and in psychiatric practice this may be as high as 40% of patients) prescribing of a tricyclic with attention to detail remains a necessary option. We indicated that some of the newer tricyclics have significantly lower toxicity in overdose than some of the first line tricyclics. Time will tell as to whether the SSRIs constitute a completely acceptable replacement for the tricyclic antidepressants or whether they simply increase the range of drugs available to us.

I. N. FERRIER
D. ECCLESTON

University Division of Psychiatry
The Royal Victoria Infirmary
Newcastle upon Tyne NE1 4LP

References

NELSON, J. C., MAZURE, C. M., BOWERS, M. B. & JATLOW, P. I. (1991) A preliminary, open study of the combination of fluoxetine and desipramine for rapid treatment of major depression. *Archives of General Psychiatry*, **48**, 303–307.

SETH, R., JENNINGS, A. L., BINDMAN, J., PHILLIPS, J. & BERGMAN, K. (1992) Combination treatment with noradrenaline and serotonin reuptake inhibitors in resistant depression. *British Journal of Psychiatry*, **161**, 562–565.

Audit of above BNF dosage medication

DEAR SIRS

A recent study of Broadmoor has looked at prescribing habits for patients in special hospitals (Fraser & Heppel, 1992). This showed that 38% of men and over 60% of women received over 1 gram of psychotropic medication in chlorpromazine equivalents.

At the Reaside Clinic, the West Midland regional secure unit, a point prevalence study was carried out looking at patients who were receiving psychotropic medication greater than 1 gram of chlorpromazine equivalents (Wressell *et al*, 1990). On the day of the census there were 77 in-patients. Of these, five patients (6.5%) were on psychotropic medication at above the *British National Formulary* recommended dosage. Only one of the patients was on an acute admission ward; the rest were on the rehabilitation wards. All five patients were on depot medication; three of these (4%) were at a dosage above the BNF limits. All the patients had reasons for their high dosage clearly stated in the notes. All patients had a second opinion consent to treatment, because of their inability to give informed consent, which allowed medication to be given in excess of BNF limits. The improvements to the patients' mental health while on the high doses of medication were clearly stated. We noted no ethnic differences in the dosage of the medication compared with the population of the clinic as a whole (of the five patients one [20%] was Afro-Caribbean, one mixed race Afro-Caribbean and Asian compared with a 40% Afro-Caribbean population for the clinic as a whole).

Most of the patients who were on high doses had been on large doses of medication for some months. All of the patients were relatively young, mean age 34, range 22–58 years. There is little in the literature about prescribing above BNF limits although concern has been expressed about excessive dosages (Edwards & Kumar, 1984). None of this group of patients had evidence of side effects, including tardive dyskinesia.

The patients who are in-patients in regional secure units in general have severe mental illness. We felt that it was encouraging that of this group only 6%

required high dose medication and that where it was prescribed the reasons were clearly given and the progress closely monitored.

ANN K. STANLEY
M. ANNE DOYLE

Reaside Clinic
Birmingham B45 9BE

References

EDWARDS, S. & KUMAR, V. (1984) A survey of prescribing drugs in a Birmingham Psychiatric Hospital. *British Journal of Psychiatry*, **145**, 502–507.

FRASER, K. & HEPPLE, J. (1992) Prescribing in a special hospital. *Journal of Forensic Psychiatry*, **3**, 311–320.

WRESSELL, S. E., TYRER, S. P. & BERNEY, T. P. (1990) Reduction in antipsychotic drug dosage in mentally handicapped patients. *British Journal of Psychiatry*, **157**, 101–106.

Treatment in secure accommodation with emergency medication (Children Act, 1989)

DEAR SIRS

A ruling to treat with emergency medications in secure conditions under Section 8 (Specific Issue Orders) of the new Children Act, 1989 was recently requested of the High Court on behalf of three young patients. Concern had arisen that use of emergency psychotropic medication for minors was not covered by this Act although parental permission had been obtained and the patients were each detained under Section 25 of the Act on a Secure Accommodation Order.

In the event, the Bench directed that they were 'Gillick incompetent' and did not need to attend Court. Also, doctors had a "duty to treat in accordance with their best clinical judgement" without impediments and that the consent of one parent was sufficient to provide a suitable "flak jacket" allowing appropriate treatments, including emergencies. A Specific Issue Order was unnecessary as the Act was seen to be clear in its intent to provide treatment. Reference was made to test cases of *Re R* and the appeal case of *Re J*, where it was ruled that the Court would not order a doctor to treat a minor contrary to clinical judgement "subject to obtaining any necessary consent" (All England Law Reports, 1992).

This recent ruling, therefore, should provide support to the treatment of disturbed young people in secure settings, when appropriate. Health professionals who avoid using the Mental Health Act for young people, may now feel able to utilise the Children Act, given informed consent by a responsible parent.

As there is little reference to the Mental Health Act or to doctors' "clinical judgement" in this extensive body of law, these might be subjects which could be incorporated in any future revisions, I would suggest.

GORDON B. BURNETT

St Andrew's Hospital
Northampton NN1 5DG

Reference

ALL ENGLAND LAW REPORTS, Re J (a Minor), 20 November 1992.

A community treatment order

DEAR SIRS

The Secretary of State for Health's proposals on the care of the mentally ill in the community (*The Guardian*, 4 January 1993) include a suggestion for a community treatment order, a subject that can be traced back to the Mental Health Act 1959. The concept of guardianship, which under the Act gave the guardian wide powers of control, has not been widely taken up because it is unenforceable. Such will be the case with a community treatment order for the same reason.

This hospital is currently evaluating its implementation of the Care Programme Approach (CPA) and it is quickly becoming evident that compulsory treatment in the community is not only difficult to enforce but unacceptable to the patient and to the clinical team. Professor Sims is correct in rejecting the vision of administering injections to patients "on the kitchen table".

This, of course, does not mean that our vulnerable patients should not be closely monitored after discharge from the hospital. The CPA notion of a keyworker system is essentially a good one and often acceptable to the patient. A good relationship between keyworker and patient will ensure that community supervision will not be intrusive to the patient but will, at the same time, ensure adequate support. However, if resources continue to trickle down slowly to these vulnerable patients, whatever legislation is introduced will be yet another attempt at window dressing.

MARIOS PIERIDES
CLAIRE CASEY

UMDS of Guy's & St Thomas'
South Western Hospital
London SW9

Appeal from Croatia

DEAR COLLEAGUES

We write to ask for your help. After a year and a half of war in Croatia our hospital is in a difficult situation, with a huge lack of medical supplies.

Our hospital is one of the biggest hospitals in Croatia for adult psychiatry and geriatrics. There are