upon the application of the definition laid down by the Homicide Act 1959, in practice juries may be more influenced by various intangibles, such as their emotional reactions to the circumstances, the skill and persuasiveness of defence and prosecution counsel, the attitudes of the Judge presiding etc. The final question is whether or not this process is a 'just' one. I have my doubts. I would be interested to hear the views of other forensic psychiatrists.

CHRIS GREEN

AMI Stockton Hall Hospital
Stockton-on-the-Forest
York YO3 9UN

The use of old and new antidepressants

DEAR SIRS

At a recent conference on the economic evaluation of antidepressant drugs, virtually all the speakers felt that the new antidepressants, being safer in overdose, should be prescribed in preference to the older tricyclic drugs which should no longer be considered a first line treatment for depression. One speaker highlighted the number of litigation cases in the United States against psychiatrists whose patients had committed suicide using these drugs.

What is being said? Is it now negligence to prescribe amitryptiline instead of say, lofepramine or fluoxetine? The professor of psychopharmacology believed that the new antidepressants were a safer alternative. The poisons expert said that there were almost 400 deaths per year associated with tricyclic overdosage and only a very small number associated with the newer antidepressants. The senior lecturer replied that there was overwhelming evidence that the new antidepressants were as efficacious as tricyclics and also safer. Only the professor of general practice disagreed and said there were many situations in which a sedative tricyclic would be his first choice.

The professor of psychiatry stated that it was for the courts to decide negligence. But, as opinion leaders, all the above speakers carry tremendous weight as it is they who are called as expert witnesses and their views will shape the law. I am happy to prescribe the new antidepressants but there are situations in which I would prescribe a tricyclic in preference. To imply negligence because one writes such a prescription is a very serious issue.

The grounds for concern over the tricyclic related deaths per million prescriptions seem vastly oversimplified. Who are these patients? What is their diagnosis? How careful was the prescription? Was a proper assessment of suicide risk made? Do patients who fail to kill themselves by taking an overdose of a new antidepressant go onto kill themselves by another method?

I would suggest it is time for the College to produce a consensus statement on the indications for the use of old and new antidepressants. It is too important an issue to be left to the courts to decide. Depression is our bread and butter and I for one do not wish to be that meat in the sandwich.

RICHARD CAPLAN

The Peter Hodgkinson Centre
County Hospital
Lincoln LN2 5QY

Community homes run by untrained staff

DEAR SIRS

Increasing numbers of people suffering from chronic mental illness live in staffed private homes, often in seaside towns, run either for profit or by voluntary organisations. These homes are registered under the Residential Homes Act (1984), some of which have received criticism.

The failure of this legislation to address the standards of care has been often stated (National Institute for Social Work, 1988). The scandals of abuse and neglect in homes for the elderly and the ineffectiveness of the statutory supervision have been reported by the media.

An extraordinary home, where adults suffering from schizophrenia wore nappies, were fed baby bottles by the staff and stood in the corner when 'naughty' was the subject of a Radio 4 documentary (Face the Facts, 10 February 1992). Professor Leff stated that this environment was likely to provoke acute relapses in those residents suffering from schizophrenia.

Dr Graham Thornicroft and I recently surveyed a sample of staffed homes registered for the under 65s, in Southend-on-Sea (submitted for publication) and found them to be of a good physical standard. It was my impression that the staff in the homes were well motivated to care for their residents. However, care homes where none of the staff had had previous psychiatric nursing experience tended to allow their residents less autonomy than homes run by carers with psychiatric nursing qualifications. Environments where residents are allowed comparatively little autonomy, may tend to worsen patients' disabilities and were present in some hospitals 30 years ago (Wing & Brown, 1970). I would contend that since appropriate training has not been offered to lay carers in privately run staffed homes by the local psychiatric services, they have not assimilated the positive changes of psychiatric in-patient care, which over the last 30 years have led to increasingly less restrictive ward environments (Curson *et al*, 1991).

It is ironic that in the rush towards deinstitutionalisation, the impoverished social environments of

30 years ago may be recreated to some extent in community homes run by untrained staff, in seaside areas where perhaps insufficient resources have been devoted to a comprehensive re-provision programme.

The opportunity may exist for mental health professionals to train the lay staff, to enable them to further improve the quality of care given in their homes.

It would be interesting to read of the experience of clinicians in other districts.

JOHN BARNES

The London & Runwell Hospitals
Runwell Hospital
Wickford Essex
SS11 7QE

References

CURSON, D. A. *et al* (1992) Institutionalism and schizophrenia 30 years on. *The British Journal of Psychiatry*, **160**, 230–240.

NATIONAL INSTITUTE FOR SOCIAL WORK (1988) *The Wagner Report: Residential Care and Positive Choice*. HMSO.

WING, J. & BROWN G. (1970) *Institutionalism and Schizophrenia*. Cambridge University Press.

"Black" issues in Mental Health Practice (Dr Azuonye) "Cannabis psychosis" (Dr Eva)

DEAR SIRS

I agree with Professor Sims' comment on Dr Azuonye's letter (*Psychiatric Bulletin*, May 1992, **16**, 310–311). I have treated large numbers of white patients with exactly the same problem, also in the Royal London Hospital, for the past 30 years. It is not a "black" issue, it is a drug abuse issue. I would like to know how Dr Azuonye makes the diagnosis of schizophrenia and drug abuse. One cannot repeat too often that no diagnosis is possible in anyone taking drugs until after they have stopped taking them. When they do the symptoms usually disappear rapidly and the diagnosis becomes obvious. Schizophrenia is often strongly diagnosed in these circumstances and neuroleptic drugs are given with all the accompanying disability to the patient and cost to the service and to the community. Indeed this error perpetuates the problem since it purports to offer a "treatment" other than the *only* one that will help, namely stopping the poison that is affecting the brain. As I recently wrote: "If cannabis continues to be used then major tranquillizers are not effective and if it ceases they are not necessary".

Dr Eva's letter in the same issue touches on this subject too. Last year I visited Australia and New Zealand and found the misdiagnosis of schizophrenia when patients were taking cannabis and other drugs as common there as here. As far as nosological status of 'cannabis psychosis' is concerned there are commonly organic, schizophreniform and manic pictures. The important thing is not what you call it but what you do, i.e. stop cannabis.

A national research study on patients attending depot injection clinics to ascertain the extent of drinking or cannabis abuse might pay enormous dividends by removing the schizophrenic label from many patients. This question is of particular importance with the issue of the legalisation of cannabis being raised again.

SAMUEL I. COHEN

Emeritus Professor of Psychiatry
University of London

Reference

COHEN, S. I. (1991) Cannabis psychosis. *Psychiatric Bulletin*, **15**, 706.

Primary care psychiatry

DEAR SIRS

Dr Strathdee *et al* described a six stage plan in establishing psychiatric attachments to general practice (*Psychiatric Bulletin*, May 1992, **16**, 284–286) and expressed interest in other approaches used in strategic planning in this field. While Strathdee *et al*'s stages focused on formal organisational arrangements of objectives, location and response, in West Lancashire, we phased our project (GPs, CPNs and psychiatrists) into two phases of service delivery. Phase one comprises out-patient, joint consultation model and regular meetings (modified Balint) to discuss management of selected patients. This is to be followed by phase two of team case conferences and the tripartite community assessment at the patient's location, home/hostel or elsewhere. Both approaches, the Maudsley and ours, aspire to a good working alliance with the clients being the beneficiaries.

G. K. GAD

Ormskirk and District General Hospital
Ormskirk, Lancs. L39 2AZ

Relatives who refuse to give consent

DEAR SIRS

Regarding Dr Jane O'Dwyer's letter concerning relatives who refuse to give consent (*Psychiatric Bulletin*, April 1992, **16**, 232) I feel I must object. I believe it wrong to dismiss the rights of the next of kin under the act as merely a complicating factor whatever the circumstances. Further, if the treating psychiatrist has done all he/she possibly can why then should