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B. Sridharan Salford Primary Care NHS Trust, Salford, UK

P. Arshad Meadowbrook, Department of Psychological Medicine, Stott Lane, Salford M6 8HG, UK

M. Marcos Salford Primary Care NHS Trust, Salford, UK

Authors' reply: We were delighted to read that our paper was so enthusiastically discussed by Sridharan *et al* at their evidence-based journal club. They have spotted the main limitation to the study, which was included in our own list of limitations – namely, that our findings were "based upon only one service model and may have limited generalisability" (Sipos *et al*, 2001). In our paper, we cited previous work from Nottingham (Harrison *et al*, 1991), showing how the development of multi-disciplinary teams had coincided with a reduction in the proportion of patients with first-episode psychosis requiring hospitalisation at initial contact. In Sipos *et al* (2001) we went on to show that, although there is clearly a reduction in hospitalisation at first contact, the risk of admission at some point in the first 3 years after first onset has actually remained the same. Indeed, there are striking differences between those patients admitted early in the course of the disorder and those admitted later.

On reflection, we agree that the paper would have benefited from a slightly more detailed specification of service changes in Nottingham, although these have been described elsewhere and we would refer readers to Beck *et al* (1997). We would caution, however, against attempts to draw causal inferences from the presence, or absence, of particular 'community' services because our paper reported an observational study rather than a controlled one. The research community has barely begun to understand the interplay between different components of 'community-oriented' services and patient outcomes. The parameters mentioned by Sridharan *et al* are certainly pointers in the right direction but we have some way to go in describing (and measuring) factors such as the amount of 'social support' available, let alone evaluating their impact on outcomes.

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A. Sipos Division of Psychiatry, University of Bristol, 41 St Michael's Hill, Bristol BS2 8DZ, UK
G. Harrison Division of Psychiatry, University of Bristol, Bristol, UK
D. Gunnell Department of Social Medicine, University of Bristol, Bristol, UK
S. Amin Trafford General Hospital, Manchester, UK
S. P. Singh Queen's Medical Centre, Nottingham, UK

Antipsychotics and risk of venous thrombosis

The article by Thomassen *et al* (2001) relates a higher risk of venous thrombosis to the use of antipsychotic drugs. As mentioned by the authors, their data cannot consequentially link the risk of venous thrombosis to antipsychotic use as certain biases cannot be excluded from the autopsy date and case–control studies they analyse. However, their study adds to the numerous reports suggesting a link between this class of medication and venous thrombosis. In this debate, however, it should be noted that there is a lack of controlling for factors such as the dose of antipsychotics and the type of psychosis. Catatonia is typically a form of schizophrenia in which one could expect patients to have a higher risk of venous thrombosis (Morioka *et al*, 1997). Similarly, according to the dose of antipsychotic, the sedation of patients can be so intense that their movements are limited, creating predisposing conditions for venous thrombosis. It is possible that more cautious administration of antipsychotics at a dose which decreases the psychotic symptoms without inducing toxic sedation (Casey, 1997) could prevent a certain number of thrombosis cases, although low doses of antipsychotic appeared paradoxically associated with higher risk in a recent case–control study (Zornberg & Jick, 2000). Exploring the role of these potential confounding factors, particularly in cohort studies, is important to characterise the safety profile of antipsychotic drugs and to improve guidelines for the treatment of patients with psychosis.

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F. Curtin, M. Blum Intercantonal Office for the Control of Medicines, Erlachstrasse 8, 3000 Bern 9, Switzerland

Use of antidepressants by nursing mothers

Hendrick *et al* (2001) state that the findings of their study provide no reason to discourage nursing among women taking paroxetine, fluvoxamine or sertraline at standard therapeutic doses. Comparison with previous studies is difficult, owing to the research literature consisting mainly of single case reports or small samples, difference in methods and lack of key information (as reviewed by Yoshida *et al*, 1999).

While I applaud the effort of studying 50 nursing mother–infant pairs, I disagree with the inclusion of all of them as study subjects for two main reasons.

First, seven were included whose prescribed doses of antidepressant were below the recommended dose (British Medical Association & Royal Pharmaceutical Society of Great Britain, 2001) for the treatment of depression (paroxetine 5 mg (n=1), paroxetine 10 mg (n=2), sertraline 25 mg (n=4)). In the case of sertraline, where 30 pairs were included, exclusion of these subjects would increase the percentage of detection of medication, including metabolites, from 24% (8/30) to 34% (8/26).

Second, Hendrick *et al* came to the same conclusion regarding the safety of fluvoxamine, sertraline and paroxetine, but according to their Table 1 (p. 164) only one serum sample of the five taken from mother–infant pairs where the mother was taking fluvoxamine should be taken into consideration. Of the remainder, no maternal medication concentration was obtained in three cases, and in the fourth maternal medication concentration was below the detectable range of the assays, raising

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questions about compliance that will add bias to the results.

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I. Agell Department of General Psychiatry, Royal United Hospital, Bath BA1 3NG, UK

Author's reply Dr Agell rightly points out that seven of the nursing women in our study were taking paroxetine and sertraline at doses lower than are usually recommended for the treatment of major depression. We disagree, however, with his conclusion that these mother–infant pairs were not valid subjects for the study. These women are representative of many new mothers who choose to take the lowest dosage of medication that will benefit them for the duration of their nursing. Further, we considered the range of subjects' doses in our correlation analyses of the relationship between maternal dosage of antidepressant and infant serum concentration of medication. In fact, one of the primary goals of our study was to identify the dosage of medication that was likely to produce a detectable level of medication in the infants.

Dr Agell also points out that fluvoxamine cannot be deemed safe in the same manner as paroxetine and sertraline, given the smaller number of fluvoxamine exposures. We agree with this observation and recommend that, whenever possible, nursing women be prescribed antidepressants for which the most extensive safety data are available.

Declaration of interest

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V. Hendrick Department of Psychiatry & Biobehavioral Sciences, UCLA, 300 Medical Plaza, Los Angeles, CA 90024-6968, USA

Reforming the Mental Health Act – recruitment and retention issues

Having recently read the Royal College of Psychiatrists' response (see http://www.rcpsych.ac.uk/college/parliament/wp.htm) to the Government White Paper on the reform of the Mental Health Act (Department of Health, 2000), there were a number of issues I felt needed raising. First, I believe that the College's response to the white paper would broadly be welcomed as helpful by my junior colleagues. However, there are some additional points I would like to comment on from the perspective of a junior doctor working on a busy general psychiatry ward. These include the matters of recruitment and retention of junior grade doctors, the erosion of the autonomy of the profession, the changes required for junior doctor training and the implications for the use of 'holding orders' by senior house officers (SHOs).

The College expresses concern that recruitment to the profession may be adversely affected by the implementation of the Government's proposals. Early retirement of consultant grade staff is also mentioned. In addition, I would like to draw attention to the increasing problem of retention of junior doctors at SHO grades who do not complete training and are lost to psychiatry, or to medicine generally.

Arguably, junior doctors will feel the greatest impact from the changes proposed. The prospect of working with a new Mental Health Act that is considered contentious, on both ethical and legal grounds, is bound to lower morale. This is equally true of the Government's further emphasis on the coercive aspects of patient management and the erosion of the rights of confidentiality for patients. The inevitable deterioration in the relationship between doctors, patients and user groups will further reduce job satisfaction.

Psychiatry, unlike any other medical speciality, is affected on a day-to-day basis by changes to statute law. At the same time, SHOs are perhaps more aware of their counterparts in other disciplines. Recently, the divide between psychiatry and the rest of medicine has seemed to be shrinking. However, this is likely to be reversed by legislation that separates physical illness and mental disorder so completely in terms of individual capacity and patients' best interests.

The College's views are so evidently at odds with the Government's plans and yet it appears that the Government is driven predominantly by media opinion and public fears. Despite widespread misgivings it appears that psychiatrists will have to grudgingly embrace risk-management and 'dangerous and severe personality disorder' (DSPD). It seems psychiatry is unable to resist the external pressure to move from dealing with mental disorder to policing the population for social deviancy. Junior doctors will become increasingly aware that the job they chose and trained for may be radically different in the future.

There are questions that need to be answered regarding SHOs' role in the management of DSPD patients. If they are to be involved in the day-to-day management and assessment of such patients, who are widely regarded as unmanageable and disruptive on general wards, then a great deal of thought needs to be given to appropriate training. Currently, there are few placements specialising in the management of people with personality disorders. More emphasis will also have to be given to training in group therapies and therapeutic communities and this will require considerable time and resources. It could also be argued that time spent managing but not 'treating' DSPD patients will necessarily dilute trainees' experience of 'treatable' mental illness. A massive expansion in all grades of post, including SHOs, will be required. It is doubtful how achievable this is given current recruitment difficulties.

Further clarification is required regarding the role of trainees in the emergency detainment of informal in-patients under any new legislation. If similar measures remain to those currently prevailing under section 5(2), more rigorous policies for emergency detention will need to be made. It is likely that the perception of detainment will change significantly – from the viewpoints of staff, patients and the community at large. Further, the consequences of applying a holding order will need to be considered, especially if this leads to a chain of events that may not be in the best interests of the patient.

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J. Pyott Littlemore Mental Health Centre, Sandford Road, Littlemore, Oxford OX4 4XN, UK

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