

MANAGEMENT OF SUICIDE RISK

DEAR SIR,

The view of Professor H. G. Morgan, (Book Reviews, *Journal*, April 1980, 136, 405–6) that it is “rightly so” that “psychiatrists cannot be regarded as more expert than others in the management of suicide risk” is of concern. Certainly there has been literature which has questioned whether or not psychiatrists are the most appropriate persons to assess and manage suicidal subjects. However, a recent review of these studies (Goldney and Burvill, 1980) has noted that this debate is by no means conclusive, and on the basis of published reports it was suggested that “for the present time, it would appear to be in the patient’s best interest to be assessed by the most experienced psychiatric clinician available”.

Professor Morgan’s view would also appear to be at odds with an earlier observation of his own research team (Morgan *et al*, 1975). In commenting on the stereotype of the self-harming patient as being “a histrionic young woman who is making a nuisance of herself and who merely needs to pull herself together, preferably without psychiatric intervention”, they noted: “the view does not conform to the high degree of psychological distress which we have found”. It is accepted that one cannot precisely equate “psychological distress” with psychiatric illness, but one could hardly postulate that they were unrelated.

There appears to be ample documentation of psychiatric illness in those who have committed or attempted suicide (Barraclough *et al*, 1974; Kreitman 1977), and to express the view noted above appears to be, at the best, effecting premature closure on a complex issue, or, at the worst, abdicating psychiatric responsibility.

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ABUSE OF KETAMINE

DEAR SIR,

Ketamine hydrochloride is a rapid-acting general anaesthetic for medical and veterinary use, with the formula 2-(chlorophenyl)-2-(methylamino) cyclohexanone hydrochloride, given intravenously (about 2 mg/kg for 5–10 minutes of surgical anaesthesia) or intramuscularly. Physiologically, as well as inducing anaesthesia and analgesia, it raises the pulse rate and blood pressure for a few minutes. Disturbed psychological states have been reported during emergence from anaesthesia. There have been reports of ‘street’ use in the USA.

We wish to draw attention to illicit ‘experimentation’ with this drug, which in Sydney appears to have been confined to medical circles. A 30-year-old doctor with no personal or family history of functional psychosis had been involved in drug abuse for several years. In November 1977, after discussion with drug-abusing medical colleagues, he took 100 mg of ketamine intravenously. He remained alert in an altered state of consciousness for the next 3½ hours, experiencing numbness and a feeling of immobilization yet travelling into space mentally at a rapid speed. He had colourful visual hallucinations and a feeling of being part of a cosmic orchestra. He reported that the experiences were similar to those after LSD but with some subtle differences.

We would be interested to know of any instances of ketamine abuse in other countries.

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PSILOCYBIN INTOXICATION

DEAR SIR,

In the lowest economic strata of illicit drug users an indigenous mushroom, *psilocybin semilanceata* (the Liberty cap), found in large quantities in the autumn, is now frequently ingested on account of its hallucinogenic properties. The ingestion of between 20–30 mushrooms is the usual number required for a ‘trip’ lasting 4–6 hours. The active principles, psilocybin and psilocin (4 hydroxy-tryptamine derivatives), induce subjective sensations similar to those of LSD. Another common mushroom *panaeolus foenisecii*, regarded as a ‘latent psilocybin’ as hallucinogens are not always present, has caused euphoria, excitement and hallucinations of colour and speed of movements (Cooles, 1980).

A 25-year-old man with no previous psychiatric history, but a frequent user of cannabis, LSD and