Correspondence

Benzodiazepine use

DEAR SIRS

We very much welcome the College Statement on benzodiazepine use (*Bulletin*, March 1988, **12**, 107–109). We would like to reinforce the suggestions made in Section 4 (Possible Research Topics) with particular reference to (i) the development of alternatives to benzodiazepines, and (ii) collaboration with other professionals, in particular general practitioners, in the development of such alternatives.

Research in general practice has shown the value of at least three psychological alternatives to anxiolytics. First, brief counselling (listening, explanation and advice) given by GPs was as effective as anxiolytic medication in the treatment of minor affective disorders of recent onset.[1,2] Second, problem-solving treatment given by a research psychiatrist was more effective than the usual GP treatment for emotional disorders likely to persist.[3,4] Third, anxiety management given by a research psychologist was an effective treatment for persistent severe anxiety disorders and led to a reduction in anxiolytic use.[5] Anxiety management is described in a booklet which can be used in general practice.[6] Problem-solving and anxiety management are intended to enable patients to deal with future as well as present problems, thereby reducing their need for anxiolytics.

We would like to suggest that the next step in research is to train a group of GPs and other primary care workers in problem-solving and/or anxiety management, and to evaluate the results of treatment in their hands. If these treatments proved effective, they could be recommended for wide use in primary care.

We would also like to endorse the College's view that benzodiazepines are of value only for the treatment of severe disorders and not for the disorders usually seen in general practice[7] – a point to bear in mind now, when new anxiolytics are being introduced and marketed.

JOSE CATALAN
GILLIAN BUTLER

Warneford Hospital, Oxford

References

[1]CATALAN, J., GATH, D., EDMONDS, G. & ENNIS, J. (1984) The effects of non-prescribing of anxiolytics in general practice: I–Controlled evaluation of psychiatric and social outcome. *British Journal of Psychiatry*, **144**, 593–602.

[2]——, ——, BOND, A. & MARTIN, P. (1984) The effects of non-prescribing of anxiolytics in general practice: II–Factors associated with outcome. *British Journal of Psychiatry*, **144**, 603–610.

[3]GATH, D. & CATALAN, J. (1986) The treatment of emotional disorders in general practice: psychological methods versus medication. *Journal of Psychosomatic Research*, **30**, 381–386.

[4]CATALAN, J. & GATH, D. Evaluation of a problem-solving approach in the treatment of emotional disorders in general practice (in preparation).

[5]BUTLER, G., CULLINGTON, A., HIBBERT, G., KLIMES, I. & GELDER, M. (1987) Anxiety management for persistent generalised anxiety. *British Journal of Psychiatry*, **151**, 135–142.

[6]BUTLER, G. (1985) *Anxiety Management*, Oxford University Department of Psychiatry (copies available from author).

[7]CATALAN, J. & GATH, D. Benzodiazepines in general practice: time for a decision. *British Medical Journal*, **290**, 1374–1376.

Enduring Power of Attorney

DEAR SIRS

It is always useful to see articles such as Mrs McFarlane's (*Bulletin*, May 1988, **12**, 181–182) outlining clearly the procedure for the management of the affairs of the mentally ill. I write, however, to express my growing concern at possible misuse or abuse of the Enduring Power of Attorney (EPA) in the absence of a compulsory medical opinion at the time of signing.

I have already seen a case where an EPA has been signed without a medical opinion being sought when there is no doubt the donor concerned was unfit to sign. The Power was registered and irreversible action, i.e. the sale of property, took place before the donor came to medical attention. I have also seen several cases where but for an incidental medical intervention EPAs would have been signed totally inappropriately.

The reasons this can happen would seem to be as follows:

(1) the appointee genuinely fails to appreciate how confused the donor is – perhaps due to the retained social skills of the donor and/or due to the defence of denial on the part of the appointee;

(2) solicitors rightly point out to relatives the much greater expense of asking the Court of

https://doi.org/10.1192/S0140078900021039 Published online by Cambridge University Press