Although the funding source of a research finding should be considered when reviewing and interpreting the results of a study, hopefully our field has not become so jaded or cynical that all such work is rejected out of hand.

Freemantle, N., Anderson, I. M. & Young, P. (2000) Predictive value of pharmacological activity for the relative efficacy of antidepressant drugs. Meta-regression analysis. *British Journal of Psychiatry*, **177**, 292–302.

Thase, M. E., Entsuah, A. R. & Rudolph, R. L. (2001) Remission rates during treatment with venlafaxine or selective serotonin reuptake inhibitors. *British Journal of Psychiatry*, **178**, 234–241.

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Declaration of interest

M.E.T. is a paid consultant to Wyeth–Ayerst Laboratories.

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Response from Neurolink: The members of Neurolink were particularly disturbed by Dr Wright's accusation that the materials produced by Neurolink are unbalanced and favour venlafaxine, manufactured by Wyeth.

Neurolink is a well-established board of 14 mental health experts who pride themselves on their unbiased, professional expertise in anxiety and depression, and their ability, as a multi-disciplinary group of health care professionals, to produce materials of practical value to other health care professionals and patients.

Neurolink is indeed supported by an educational grant from Wyeth Laboratories, and has been since 1995. Board members receive an honorarium for their attendance at Advisory Board meetings and working parties, where production of materials is discussed and agreed in the light of the existing evidence base and consensus of the members of the Board.

We would like to emphasise that the materials produced by Neurolink are balanced items that review all treatment options – including drug and non-drug options – and we would refute all claims that materials give prominence to venlafaxine, or any other drug or treatment, unless there is a body of significant evidence that supports it. In the 6 years that we have been in existence, we have never previously received comments to suggest that Neurolink materials are not impartial, practical resource items.

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A. Kirby Health Media Ltd, Cardiff, UK
S. Koppel Glan Rhyd Hospital, Bridgend, UK
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Editor's response The *Journal* is committed to openness and I was pleased several years ago to introduce a requirement for authors to make a declaration of their interests with regard to publication of their papers. Last year this requirement was extended to include editorials and items of correspondence (Wilkinson, 2001).

As an elected Honorary Officer (not a paid employee) of the Royal College of Psychiatrists I am required regularly to complete a Declaration of Competing Interests form. My form states that I have an annual renewal of a consultancy with Neurolink, sponsored by Wyeth (£2000 per annum). These forms are available to members of the College, and to non-members of the College at the discretion of the President, Registrar and the College Secretary.

The issues raised by Dr Wright were discussed by the Editorial Board in June 2001. To quote from the minutes of that meeting:

> "It was not felt that the Editor had acted at all improperly. . . . It was agreed that a general policy of openness was desirable, but it was generally felt that a detailed on-line register of interests for all staff, referees and authors such as that suggested by Dr Wright was impractical. . . . The 'Recommendations for publication' form sent to all assessors would [be amended to] give the assessor the opportunity to declare an interest in the publication of the paper."

Following that decision, since October 2001, referees have been required to state explicitly if they have an interest in the publication of any paper they are asked to assess. If that is the case, they are required to return the manuscript without assessment.

It has always been the case that when I have an interest in a paper's publication by virtue of being a co-author, another nominated member of the Editorial Board acts as Editor for that paper. That person's identity is not divulged to me, and I am kept blind to the peer-review process as it applies to that manuscript. Since receipt of Dr Wright's letter (in April 2001, subsequent to the acceptance of another paper reporting work funded by Wyeth; Allgulander *et al*, 2001), the same procedure has been extended to any submission connected with Wyeth. Finally, in keeping with these developments, I am beginning the evaluation of open peer review as a policy from this month (i.e. all assessors will be required to identify themselves to authors).

I am doing what I can to address these important issues, and I am grateful to Dr Wright for this opportunity to clarify our procedures to our readers.

Allgulander, C., Hackett, D. & Salinas, E. (2001) Venlafaxine extended release (ER) in the treatment of generalised anxiety disorder. Twenty-four-week placebo-controlled dose-ranging study. *British Journal of Psychiatry*, **179**, 15–22.

Wilkinson, G. (2001) Declaration of interest. Editor's response (letter). *British Journal of Psychiatry*, **179**, 175.

Greg Wilkinson Editor, *British Journal of Psychiatry*, 17 Belgrave Square, London SWIX 8PG, UK

Risk of pregnancy when changing to atypical antipsychotics

We have become aware of a number of pregnancies which have occurred in women with chronic psychotic illnesses whose medication has been changed from traditional oral or depot antipsychotics to atypical drugs. This can be explained by the loss of the contraceptive side-effects produced by drug-induced hyperprolactinaemia in these women. Most atypical antipsychotic drugs (e.g. olanzapine, quetiapine, clozapine) have a negligible effect on prolactin levels, whereas older drugs such as chlorpromazine and haloperidol, as well as sulpiride, amisulpride and risperidone, can cause significant hyperprolactinaemia in some women. Although these should not be considered as contraceptives, there is undeniably a contraceptive effect.

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We have documented four patients in our local services who have recently had unplanned pregnancies in association with this change in medication. All four women had their medication changed from older, typical antipsychotics in an effort to improve their symptoms and reduce side-effects. Three were known to have a partner at this time. Two were also known to have hyperprolactinaemia, presumably as a result of taking typical antipsychotics. All four women had an unplanned pregnancy following the change in medication and all but one then had their atypical antipsychotic medication stopped. All four of these women decided to proceed with their pregnancies. Two women became acutely ill during their pregnancies and were admitted to psychiatric hospital. All four were admitted postnatally to a mother and baby psychiatric unit, three with acute psychotic symptoms and one with less severe symptoms but with concerns about her ability to parent her child. All four women required very high levels of input from mental health and social services; despite this, only one has been able to continue to provide care for her child.

Unwanted and unplanned pregnancies are clearly undesirable and a doctor could be deemed negligent if a pregnancy results from prescribing without appropriate advice on risk and contraception, for example, in the case of antibiotics given to women on the pill. Unwanted pregnancies are of particular concern in women with chronic psychotic illnesses. Not only does the mother have a substantially increased risk of acute relapse following childbirth, but there is also clear evidence that children of parents with mental illness suffer greater social disadvantage, increased psychological and psychiatric disturbance and higher rates of emotional, sexual and physical abuse (Gregoire, 2000).

There is relatively little information available on the sexuality, contraceptive habits, fertility or beliefs and wishes about reproduction in people with severe mental health problems. It has been suggested that fertility among people with severe mental illness is similar to that of the general population (Lane *et al*, 1992) and there can be little doubt among clinicians that the changing patterns of care from hospital to living in the community are likely to have altered behaviour and expectations of sexuality and reproduction. Advice to people with severe mental illness about contraception is likely to be poor and they are more likely to have unplanned and unwanted pregnancies (Miller & Finnerty, 1996). Sexuality is an area of patients' lives that psychiatrists tend to neglect even though they and their patients acknowledge its importance (Pinderhughes *et al*, 1972).

The cases we have been involved with illustrate what we believe to be an increased risk of pregnancy in women changing from conventional to atypical antipsychotics. The potential risks to mother and child associated with such pregnancies are clear and the lack of attention generally paid to sexuality and contraception by those caring for people with mental illnesses must therefore be a cause for concern. On the basis of current knowledge, we should assume that our patients are sexually active and need advice and assistance with contraception. We recommend that the potential effect on fertility be discussed with all patients changing from a traditional to an atypical antipsychotic and that mental health professionals be active in promoting effective contraception.

Gregoire, A. (2000) Mentally ill parents. In *Adult Severe Mental Illness* (ed. A. Gregoire). London: GMM.

Lane A., Mulvany, M., Kinsella, A., *et al* (1992) Evidence for increased fertility in married male schizophrenics. *Schizophrenia Research*, **6**, 94.

Miller, L. J. & Finnerty, M. (1996) Sexuality, pregnancy and childrearing among women with schizophrenia spectrum disorders. *Psychiatric Services*, **47**, 502–506.

Pinderhughes, C. A., Barrabee, E. & Rayna, L. J. (1972) Psychiatric disorders and sexual functioning. *American Journal of Psychiatry*, **128**, 96–102.

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Hospitalisation in first-episode psychosis

The paper by Sipos *et al* (2001) was discussed with great enthusiasm in our evidence-based journal club. We learnt that 80% of patients with first-episode psychosis were hospitalised within 3 years of first contact with specialist services. Patients with manic symptoms at presentation were admitted rapidly; those with negative symptoms and longer duration of untreated illness were admitted later. The paper concluded that community-oriented psychiatric services might only delay, rather than prevent, admission of patients with a first-episode of psychosis.

At the end of the journal club we realised that the findings from this paper cannot be generalised to our patient group without the knowledge of certain other key issues not mentioned in the paper.

(a) Availability of in-patient beds: studies have shown that the utilisation of in-patient care is determined by the supply of available beds (Saarento *et al*, 1996).

(b) Availability of assertive community psychiatric services: an assertive community treatment programme has shown to be effective in reducing hospitalisation compared with clinical case management programmes (Ziguras & Stuart, 2000).

(c) A study by Lang *et al* (1999) demonstrates that improvement in social support predicted decline in hospitalisation.

(d) History of suicidal behaviour carries a greater risk of admission in first-episode psychosis and higher readmission rates over 2-year follow-up (Verdoux *et al*, 2001).

(e) In clinical practice a patient's willingness to accept treatment as an out-patient would be a factor in deciding about in-patient treatment.

In our opinion hospitalisation in first-episode psychosis would be greatly affected by the above issues and without knowledge of these issues, the findings from Sipos *et al*'s study cannot be generalised to patient groups in other areas/services.

Lang, M. A., Davidson, L., Bailey, P., *et al* (1999) Clinicians' and clients' perspectives on the impact of assertive community treatment. *Psychiatric Services*, **50**, 1331–1340.

Saarento, O., Hanson, L., Sandlund, M., *et al* (1996) The Nordic Comparative Study on Sectorized Psychiatry. Utilisation of psychiatric hospital care related to amount and allocation of resources to psychiatric services. *Social Psychiatry and Psychiatric Epidemiology*, **31**, 327–335.

Sipos, A., Harrison, G., Gunnell, D., *et al* (2001) Patterns and predictors of hospitalisation in first-episode psychosis: prospective cohort study. *British Journal of Psychiatry*, **178**, 518–523.

Verdoux H., Liraud, F., Gonzales, B., *et al* (2001) Predictors and outcome characteristics associated with suicidal behaviour in early psychosis: a two-year follow-up of first-admitted subjects. *Acta Psychiatrica Scandinavica*, **103**, 347–354.

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