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Prescribing in mental handicap hospitals

SIR: Wressell *et al*'s study (*Journal*, July 1990, **157**, 101–106) has highlighted the common problems of drug prescription in mental handicap institutions, namely overprescription, polypharmacy, irrational prescription practice (e.g. antipsychotics prescribed to those with a diagnosis of neurosis) and inadequate review leading to unnecessarily prolonged drug treatment. However, I wondered why they restricted their survey to the antipsychotic drugs, ignoring other psychoactive drugs such as sedatives, anticonvulsants, antiparkinsonian drugs and antidepressants, etc. All these drugs are frequently prescribed for the mentally handicapped and they share many common side-effects. Furthermore, improper drug use like prolonged use of anticholinergic drugs, which is due to inadequate review, is known to expose the mentally handicapped population to higher risk of tardive dyskinesia.

Also, why did they not study all patients on antipsychotic drugs in 1982? Although they have shown that there was significant reduction in the dosage and polypharmacy of those patients who were given drugs in both 1982 and 1986, one important indicator of the overall improvement in drug-prescription practices would be the number of patients who could be successfully weaned off their drug treatment. Hence the authors have not provided us with adequate proof of the improvement in overall drug prescription.

A similar study (Fan, 1988) in Hong Kong yielded very similar results. A survey of all drug prescriptions for the 200 inmates of the Siu Lam Hospital who were moderately or severely mentally handicapped revealed that 69 (34.5%) were on antipsychotic drugs, 73 (36.5%) on anticonvulsants and 20 (10%) on both; 34 (17%) were on antiparkinsonian drugs, 14 (7%) on depot preparation and one on lithium. Polypharmacy was noted in 14% of inmates on antipsychotics and in 15% of inmates on anticonvulsants. In all except one case, antipsychotic drugs were prescribed for behaviour problems without any formal psychiatric diagnosis. Too frequent drug administration and inadequate review were also noted.

Comparing the findings of these two studies reveals a few points of interest. Fan found that significantly more male inmates (43%) received antipsychotic drug prescriptions than female inmates (26%) ($P<0.01$). This is compatible with the finding of Dr Wressell *et al*, and is probably related to the significantly higher prevalence of behaviour problems in the male sex ($P<0.0005$).

Secondly, although the mean daily dosage of antipsychotic drugs for the female patients (568 mg, s.d. = 777) is also higher than that of the male patients (303 mg, s.d. = 374), again compatible with Dr Wressell *et al*'s finding, it is not statistically significant (analysis of variance, $F=3.512$). When Dr Wressell *et al*'s claim of significant difference between the mean daily antipsychotic dosages of the male and female patients was subject to more critical examination, it turned out that they had miscalculated the result of the analysis of variance and hence wrongly stated the result. Recalculation of the analysis of variance with the provided data shows that the variance ratio (F) was 1.562 and hence is not statistically significant. This is not unexpected, as the standard deviations of the daily dosages are very great in both studies, especially in the case of the female patients. Therefore the apparent difference in the mean daily dosages between the male and female patients is not any greater than the chance variation between any two patients of the same sex. Another point of interest worthy of further consideration and study may be the much greater variation in the daily dosage of antipsychotic drugs in the female patients compared with the males as noted in both studies.

Notwithstanding the above comments, I believe that such studies on drug-prescription practices in

mental handicap institutions serve the important function of increasing the psychiatrists' awareness of the inadequacy of the current practice and motivating them to seek improvement via the emphasis on more rational prescription guidelines, increase of medical input, introducing regular drug review, and alternative treatment approaches. Prescribing psychoactive drugs for the mentally handicapped patients in long-stay institutions requires extra care and consideration, and the dictum to follow is: "When in doubt, don't!" (Kirman, 1975).

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References

FAN, T. W. (1988) Drug prescription in a local mental handicap hospital. *Journal of Hong Kong Psychiatric Association*, **8**, 22–36.

KIRMAN, B. (1975) Drug therapy in mental handicap. *British Journal of Psychiatry*, **127**, 545–549.

AUTHORS' REPLY: We were interested to read Dr Fan's letter and see that his findings with regard to the prescription of antipyschotic drugs in the mentally handicapped are very similar to our own, despite differences in the ethnic and cultural background of his subjects. We would like to reply to the queries that he has raised.

We chose the use of antipsychotic medication in our study rather than other psychotropic drugs because we believe that antipsychotic drugs are prescribed too readily in mental handicap with insufficient pharmacological indications. Furthermore, the adverse effects of long-term prescription of these drugs are more serious than erroneous administration of alternative psychotropic agents.

We agree that it would have been helpful to look at all patients who received antipsychotic drugs four years before our investigation. However, the logistic task of identifying all patients in the hospital in 1982 and perusing their files was considered too major an exercise and, because of problems arising with patients who had died or who had left hospital in the four years before our study, it was likely that any enquiry of this nature would have been incomplete. We are now undertaking a further study examining the cohort of our 1986 sample to see what drugs they are at present receiving.

Dr Fan is quite right to point out our error in stating that female patients in our study received a significantly higher mean daily dose of chlorpromazine equivalents compared with that of the male patients. We agree that the considerable variation in dosage in the female patients is of interest and shows that there are some female mentally handicapped patients who receive very high doses of antipsychotic drugs. Examination of our data indicates that a group of these patients have a history of frequent disturbed behaviour and/or aggression.

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Buspirone in benzodiazepine withdrawal

SIR: Beeley & Hammersley (*Journal*, November 1990, **157**, 777) comment indignantly that our study of buspirone in benzodiazepine withdrawal (*Journal*, August 1990, **157**, 232–238) was clinically irrelevant and unethical. They castigate us for ignoring the "generally accepted" view that "gradual dosage reduction with appropriate psychological treatment is the best way to manage benzodiazepine withdrawal", and for perpetuating "the search down a blind alley for pharmacological short-cuts".

In Newcastle we have long advocated gradual dosage reduction in benzodiazepine withdrawal, which is individually tailored and combined with psychological support (Ashton, 1987, 1989). We have emphasised the distress that benzodiazepine withdrawal can cause in some patients and have drawn attention to the need for psychological help and for tranquilliser support groups (Ashton, 1984). For the past seven years we have conducted a benzodiazepine withdrawal clinic which operates in close liaison with clinical psychologists and with a tranquilliser advice and support group which we helped to establish. Our general policy has been to involve the patients closely in decisions about their own withdrawal regimes.

After experience with over 200 patients at the clinic (and many more at the support group) it is clear that present methods are not ideal. Although 90% of our patients have achieved and maintained benzodiazepine withdrawal (Ashton, 1987), the clinical course has not always been easy and we have learned that some patients do require additional pharmacological support. For example there is a real risk of suicide in withdrawal and a proportion of patients develop major depression requiring treatment with antidepressants (Ashton, 1987).

Hence we felt that it was (and still is) important to evaluate the effect of pharmacological and other