

Van Praag (1992) cautioned against "a system of diagnosing mainly grounded on symptoms detached from aetiology". The failure to consider aetiology when making a clinical diagnosis is common. In the case of schizophrenia, the error is both common and costly. The cost of the unnecessary treatment must be enormous in drugs, manpower and to the community services, the patients suffer from unnecessary side-effects and often cannot work, and, by doctors purporting to offer 'treatment', they are actually prevented from getting well, since they are not confronted by the fact that their fearsome experiences are self-induced, that they will get well if they stop taking the substance responsible, and that appropriate help is available for them to do this if they wish. As I wrote once before (Cohen, 1992), "The problem is common . . . and perhaps it is time the College tackled it . . ."

COHEN, S. I. (1992) Patients repeatedly admitted to psychiatric wards. *Psychiatric Bulletin*, **16**, 664.

VAN PRAAG, H. (1992) Reconquest of the subjective. *British Journal of Psychiatry*, **160**, 266–271.

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Cocaine, psychiatric admissions, and HIV

SIR: Gossop *et al* (*BJP*, May 1994, **164**, 660–664) suggest that there may be a relationship between cocaine use and HIV infection. Psychiatric patients have been identified as a potentially high-risk population for HIV infection because of their likely impairments in judgement and an increased exposure risk (Cournos *et al*, 1991).

In Trinidad and Tobago, smoking crack is the predominant mode of cocaine use, with no intravenous use reported. In a two-year review of HIV testing in St Ann's Hospital, the sole psychiatric hospital there (Infection Control Unit, 1993), it was found 6.8% of those tested were HIV positive (53 of 782). Of the HIV-positive patients, however, 31 (58.5%) were admitted with cocaine-related problems. This suggests that cocaine use in psychiatric admissions may further increase the risk for HIV infection.

With crack cocaine use increasing in the UK, particularly among the Caribbean population, there is some cause for concern, and preventive strategies for both cocaine abuse and HIV infection should be developed for this group.

COURNOS, F., EMPFIELD, M., HOWARTH, E., *et al* (1991) Seroprevalence among patients admitted to two psychiatric hospitals. *American Journal of Psychiatry*, **148**, 11225–11230.

INFECTION CONTROL UNIT (1993) *HIV Testing in St Ann's Hospital. Psychiatric Update*. Trinidad: St Ann's Hospital.

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SIR: I have worked at the Substance Abuse Prevention and Treatment Centre (SAPTC) in Trinidad, West Indies (population 1.2 million). This facility offers patients using cocaine a six-week in-patient treatment programme.

I reviewed the notes of new admissions for 1986 and 1987. There were 125 admissions in 1986 and 127 admissions in 1987 which met the DSM-III-R criteria (American Psychiatric Association, 1987) for cocaine dependence. All of them listed smoking as their most recent mode of intake, and while a few had used the intranasal route, virtually none had ever injected. (There has never been a culture of intravenous drug use in Trinidad.)

It is impossible to make direct comparisons with the findings of Gossop *et al*, given what is effectively a single route of administration in a cohort presenting to a specialised treatment facility. However, although Gossop *et al* report low dependency in their sample of crack smokers in the community, the SAPTC experience does suggest that using crack cocaine by smoking alone can result in severe dependence. Indeed, in each year there were many patients who were seen but not admitted simply because of a lack of beds, and the figures above thus underestimate the dependency problem.

Cocaine use in Trinidad was not an issue until about the 1980s when a ready supply of cocaine became available, and the problem has since mushroomed. Whatever the pattern of use in the community in the UK now, with the targeting of Europe by suppliers of crack cocaine as reported in the press and increasing availability, there is likely to be the emergence of a large group with severe problems of dependence. A major issue will be the nature of services offered to them.

AMERICAN PSYCHIATRIC ASSOCIATION (1987) *Diagnostic and Statistical Manual of Mental Disorders* (3rd edn, revised) (DSM-III-R). Washington, DC: APA.

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Cost-effectiveness of antidepressants

SIR: Jönsson & Bebbington (*BJP*, May 1994, **164**, 665–673) calculate that total costs per patient for

imipramine and paroxetine treatment are similar, despite a fivefold difference in the actual costs of medication. This is because the real difference between the costs of 12-week courses of paroxetine and imipramine (£78.12) is small compared with the high drop-out rates (42% for paroxetine and 53% for imipramine) and the consequent substantial costs that a 'treatment failure' then incurs (£488 plus cost of other drug).

While the proposed model is stable despite variations in possible costings, it is worth noting that the actual choice of model is also important. For example, the central assumption that all drop-outs (no matter at what point during the 12-week course they occur) incur the full cost of a treatment failure may be difficult to justify. Early drop-outs (due to adverse effects, particularly likely with imipramine) may allow rapid switching to alternative medication and so be far less costly than drop-outs later in the course of therapy (for example due to lack of efficacy, which affects both drugs more equally). Although no model can ever be perfect, it is important to recognise that the assumptions underlying any given model will influence the results.

As the model allows for a relapse rate of 25%, perhaps some comment should be made about the place and costs of maintenance antidepressant treatment. Most clinicians would advise this after two antidepressant-responsive depressive episodes within 12 months (the time course of the model). The cost of one year's treatment with paroxetine (£412.45) is higher than that of imipramine (£73.00) and even approaches the cost of not treating the patient (a treatment failure). As drop-out rates for prophylactic treatment (once patients are stabilised) are unlikely to differ as they may for acute therapy, cost-effectiveness of maintenance therapy may be quite different from acute treatment. As more studies emerge stressing the importance of prophylactic medication in preventing relapse (e.g. Frank *et al*, 1990; Old Age Depression Interest Group, 1993), taking into account the continuing costs of such treatment will become increasingly important when deciding initial choice of medication.

Finally, one possibly minor point is that Table 2 states that only 5% of drop-outs subsequently attend out-patient departments (variable 10). However, the calculations in Table 3 suggest that all drop-outs attend for five out-patient sessions each, at a total cost of £180. Either there is a typographical error in Table 2 or the actual cost of out-patient treatment would only be 5% of figure stated, resulting in a substantially reduced cost of treatment failure of only £317. The effects of this would be to

reduce the costs of both drugs, although the effect would be greater (by some £20) on imipramine.

FRANK, E., KUPFER, D. J., PEREL, J. M., *et al* (1990) Three-year outcomes for maintenance therapies in recurrent depression. *Archives of General Psychiatry*, **47**, 1093–1099.

OLD AGE DEPRESSION INTEREST GROUP (1993) How long should the elderly take antidepressants? A double-blind placebo-controlled study of continuation/prophylaxis therapy with dothiepin. *British Journal of Psychiatry*, **162**, 175–182.

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Delusion of inanimate doubles

SIR: Castiloe & Berman (*BJP*, May 1994, **164**, 693–696) ask whether the delusional duplication of inanimate objects is an entirely separate entity from duplication of persons but, as yet, there is little reason to suppose that it is. Perception of inanimate objects appears to employ the same neuroanatomical mechanisms as perception of people (Anderson, 1988).

Substitution of inanimate objects occurs in 5–15% of reported cases of delusional misidentification (Anderson & Williams, 1994). Around 60% occur without duplication of person. Doubles are usually, but not invariably, inferior, and this may simply reflect congruence with the prevailing mood state, which is typically of a suspicious, persecutory type.

The cases reported by Castillo & Berman were all elderly women; we have found a tendency for substitution of inanimates to be associated with greater age and female sex, more so than substitution of person (Anderson & Williams, 1994). Sufferers often live alone, and this may contribute to the primacy of inanimate over animate objects, but late-life paranoid disorders without misidentification also show a preponderance of socially isolated women.

The authors correctly refer to similarities with reduplicative paramnesias, which are traditionally considered distinct neurological phenomena. This distinction may be no more than historical artefact, and there is clearly a family of overlapping recognition disorders, including reduplicative paramnesias, classic person misidentifications, substitution of inanimate objects, and visual agnosias.

We were disappointed that Castillo & Berman explained this phenomenon by psychodynamic and psychoanalytical symbolism (Anderson, 1990). If this phenomenon (it is inappropriate to call it a syndrome) has importance, it is in challenging the