However, why *did* the College (both Council and Court of Electors) change its mind and make basic psychotherapy training mandatory? Not, I think, because they were occupied with issues of 'status', or a wish to resolve half-forgotten battles from the past, but because most psychiatrists working with multi-professional teams regarded this as a *sine qua non* for good practice, and for maintaining professional self-esteem.

Certainly the somewhat precocious influence of the General Psychiatry Section, which endorsed multi-model psychiatry, was undoubtedly a major explanation as to why these formerly controversial issues caused such little dissent (or debate) when the *Guidelines for Psychotherapy Training as Part of General Professional Training* (Royal College of Psychiatrists, 1993) were proposed; although influential academics correctly endeavoured to see that the psychotherapy recommendations were realistic and achievable. To that extent the most difficult decisions for the Court of Electors are yet to come, i.e. when training programmes are being revisited in two to three years time and the psychotherapy training requirements for SHOs reviewed, how will the Court respond to requirements that have not been *fully* implemented?

No doubt consultant psychotherapists and the Psychotherapy Section were appropriate advocates for these changes but the challenge for these specialist psychotherapists is equally great. Will they indeed direct their energies to the training of psychiatrists in their first years of training, and provide a menu of clinically relevant supervision sessions across the broad range of psychotherapeutic treatment?

I indeed hope, using the Holmes' metaphor, to remain a 'footsoldier' of psychiatry and certainly there is plenty of room in the trenches for a psychotherapist familiar with the rigours of trench warface including the ability to adopt strategies to meet unexpected demands.

The *Guidelines* were of course written by a general psychiatrist (James Watson), a psychotherapist (Sandra Grant), and that notable hybrid now from North Devon whose pungent writings have as usual sparked off this less eloquent, but hopefully relevant, historical response.

ROYAL COLLEGE OF PSYCHIATRISTS (1993) *Guidelines for Psychotherapy Training as Part of General Professional Training* (CR 27). London: RCPsych.

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Warning signs at a discharge meeting

Sir: The patient was subject to Section 117, Level 3 Care Programme Approach and the Supervision Register. There had been full agreement on the care plan until we came to warning signs. The patient agreed that 'stopping medication' was a warning sign. That was why he was in hospital now. 'Suicidal thoughts' were also a warning sign. He was well aware that he might kill himself one day and did not object to being on the Supervision Register.

However, he strongly disagreed with 'social withdrawal', included because he had been admitted to hospital in a catatonic state. He felt he had the right to silence like anyone else and became suspicious and upset having previously been very positive about the care plan. It was agreed that social withdrawal would have to be accompanied by self neglect to qualify as a warning sign. The sheaf of relevant forms were amended and he was asked to sign them.

He wanted to know whether signing the forms meant he was making a future commitment or just a current one. Would it make a difference to him if he did not sign? We reassured him it would make no difference to his care, and he should only sign if he agreed.

Trust had evaporated, and he now decided he wanted to appeal against his inclusion on the Supervision Register. He was on the Supervision Register because he had made several serious suicide attempts in the past which always occurred without warning, when he had no psychotic symptoms and was taking medication. Only when he was well did he fully realise how much his illness had frustrated his progress through life.

The meeting, witnessed by a baffled nearest relative, was unavoidably stressful and protracted. Later I was recalled to the ward to fill in the Early Notification of Discharge Form for the general practitioner which I had forgotten. Only that night did I remember that I had also forgotten to sign the most important form of all. It was presumably designed in 1983 because it was the size of a postcard and merely required the name of the patient, the date and my signature to discharge him from Section 3.

With the advent of the Supervised Discharge Order which adds another 20 pages of documentation to the discharge procedure, I wonder whether it is the profusion of paperwork that is the warning sign for our profession – the gradual change from doctor to discredited public official continues.

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Plasma levels of tricyclics and related antidepressants

Sir: I was interested in reading the opinion by Taylor & Duncan (*Psychiatric Bulletin*, September 1995, **19**, 548–550) that "...tricyclic serum levels

should be used only to assure patient compliance or to confirm toxicity due to overdose or adverse interaction". The following case is paradigmatic of the reasons why I find the previous statement too restrictive.

Case report. A 51-year-old Caucasian man, suffering from a moderate depressive illness, was referred to the psychiatric day hospital. On admission he had already been on clomipramine orally 150 mg daily for eight weeks with no clinical response, but at the same time no troublesome side-effects. He was otherwise healthy, with no concurrent medical problems and on no other medications.

It was agreed to increase gradually the dose of the antidepressant and after four weeks on clomipramine 250 mg daily, which is the *British National Formulary*'s (*BNF*) higher limit, the mental state was still unchanged and the only side-effect, easily tolerated, was dry mouth.

It was decided to measure the antidepressant plasma level and the result was that the combined plasma levels of clomipramine and its metabolites had reached dangerous toxic levels, 980 ng/ml, against a higher recommended level of 450 ng/ml. As a consequence the medication was discontinued; on examination there were no signs of toxicity and the electrocardiogram (ECG) resulted within normal limits.

In the review by Preskorn *et al* (1989) it is shown how the central nervous system (CNS) and cardiotoxicity are related to plasma levels. On the other hand the plasma levels reached on a certain dose in an individual are completely unpredictable: the rate at which the drug is metabolised varies greatly from person to person, with a single dose giving rise to a greater than tenfold range of plasma levels (Asberg, 1976). In the case just presented a daily dose within *BNF* limits resulted in plasma levels that in the review of Preskorn are considered of major cardiotoxic risk, this without any warning side-effects. If the authors' recommendations had been followed, the plasma level would not have been sought, this with potential serious consequences. For these reasons it is my opinion that the choice to request antidepressant plasma levels should be considered by the clinician any time *BNF* limits are approached and in every case with individual or epidemiological risk factors for cardiovascular system (CVS) or CNS toxicity.

ASBERG, M. (1976) Treatment of depression with tricyclic drugs – pharmacokinetic and pharmacodynamic aspects. *Pharmacopsychiatry and Neuropsychopharmacology*, **9**, 18–26.

BRITISH MEDICAL ASSOCIATION AND ROYAL PHARMACEUTICAL SOCIETY OF GREAT BRITAIN (1993) *British National Formulary* (No. 26). London: BMA & The Pharmaceutical Press.

PRESKORN, S. H. & FAST, G. A. (1991) Therapeutic drug monitoring for antidepressants: efficacy, safety and cost effectiveness. *Journal of Clinical Psychiatry*, **52** (suppl. 6), 23–33.

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Sir: In our article we stated that "some adverse effects (e.g. CNS and CVS toxicity) do seem... to be related to plasma levels". While this is true in general, it is also true that individuals differ greatly in their tolerance to the adverse effects of tricyclic and related antidepressants. The case described here, we feel, illustrates this point.

The patient cited was taking a high dose of clomipramine which afforded a high plasma level of clomipramine and its metabolite. The drug was stopped despite there being no signs of toxicity or ECG changes. We feel a more rational approach in patients on high dose tricyclics is simply to perform an ECG (and monitor carefully for other adverse effects). If the ECG is found to be normal then the drug may be continued.

The two approaches described here would have led to two different methods of treatment: discontinuation or continuation of clomipramine. We feel this case illustrates how plasma levels of tricyclics can be misused, provoking clinicians to assume toxicity where there is none. Our experience is that plasma levels much higher than those quoted here are often used safely and therapeutically. We have observed that high plasma levels are not always associated with CNS or CVS toxicity, making plasma level monitoring of limited value.

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Sir: Taylor and Duncan (*Psychiatric Bulletin*, September 1995, **19**, 548–550) are correct in stating that well defined therapeutic levels have only been accepted for a few tricyclics. We feel that their conclusion, that therapeutic drug monitoring is only useful for assessing compliance or confirming toxicity, neglects another major advantage: detection of asymptomatic toxicity.

While tricyclics have many side-effects, some of which can be serious and life-threatening, toxicity may also be present in the absence of clinical symptoms (Preskorn, 1993). There is a marked increase in central nervous system toxicity when levels exceed 300 μg/l (Preskorn & Jerkovich,