Correspondence

Use of benzodiazepines

DEAR SIRS

The College statement on benzodiazepines and dependence (*Bulletin*, March 1988, **12**, 107–109) and subsequent correspondence illustrates how difficult it is to develop firm prescribing guidelines for these medications. The College statement draws attention to the many, now well-known, adverse effects of benzodiazepines. However, the prescription of such medications, like others, must be based on the careful analysis of the risks versus the benefits, the risks of alternate treatments, the risks of no treatment, and the patient's own views regarding proposed treatment options. In this context, there still remains a very important place for the use of benzodiazepines; for instance, the treatment of panic disorder with clonazepam for patients who are intolerant of antidepressants or for whom there are medical contraindications to their use. There is a small percentage of patients who may develop depression or worsening depressive symptoms on clonazepam, but most do not.

Patients with severe agitated depressions often benefit enormously with the adjunctive prescription of lorazepam during the early weeks while awaiting response to antidepressant medication. In these cases, the reduction of agitation reduces risk of suicide. Prescription of a phenothiazine appears less effective and is not without hazard.

There are some patients with schizophrenia who develop classical panic symptoms; treatment with antidepressants may be inappropriate (possibility of worsening the psychosis; potential drug interaction with antipsychotic and anticholinergic medications). Such patients respond well to high potency benzodiazepines.

Some patients with severe obsessional symptoms are unresponsive to or intolerant of clomipramine. Such patients may experience some small relief from the use of high potency benzodiazepines, sufficient to permit continued functioning at work or to prevent suicide in response to intractable symptoms.

Perhaps the greatest danger with benzodiazepines is the production or exacerbation of depression with potential suicidal behaviour. This appears to be very variable from drug to drug within each individual and some patients report a definite improvement of mood. Careful monitoring is required.

Dependence potential appears to be in part a function of half life. It is now known that the shorter acting compounds are much more liable to induce tolerance and dependence. Ironically, this means that many of the newer substances are much more problematic than the older ones. Withdrawal is effected much more easily under 'cover' of a long-acting benzodiazepine.

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Services for the elderly mentally ill

DEAR SIRS

I was very interested to read Dr Blessed's discussion on "Long-stay beds for the elderly severely mentally ill" in the *Bulletin* (June 1988, **12**, 250–252). I would like to describe the situation in the City and Hackney Health District where there are about 30,000 residents over the age of 65. Services for the elderly mentally ill have been organised separately from the adult services since 1986. There has been no large mental hospital back-up for the acute services in the district since 1972. All the psychogeriatric continuing care beds are therefore within the district and currently on the Hackney Hospital site. There are 58 beds providing care both for patients with advanced dementia and severe functional illness.

Hackney is a poor and deprived area with few resources to offer. There are at present no local authority old people's homes specifically designated for the elderly mentally ill. All the Part III homes cope with residents who have some degree of dementia. Such individuals may already be incontinent and have some of the behavioural disturbances associated with dementia even on first admission to the homes. To their credit, the homes have been prepared to care for such frail people in spite of staffing difficulties. There are very few places provided by the private and voluntary sector in this district and little funding available for such places outside it. In this social context the number of beds provided is inadequate if we consider the norm suggested by the DHSS in 1972 of 2.5 to 3 beds per thousand population over 65.

In January of this year, I looked at the waiting list for our continuing care beds. There were 34 names on this list and I undertook to follow them up to find out where they had subsequently been placed. Although the continuing care beds are easy to fill with patients in crisis, it is very difficult to assess either the level of