developing standardised multi-dimensional outcome measures remains a long-term goal.

SHAUN GRAVESTOCK
NICK BOURAS

*United Medical and Dental Schools*
*Guy's Hospital*
*London SE1 9RT*

*Reference*

GRAVESTOCK, S., BOURAS, N. & HOLT, G. (1991) Outcome indicators in mental handicap. *British Journal of Psychiatry*, **159**, 294–295.

## *NHS reforms*

DEAR SIRS

I enjoyed the article by Harrison (*Psychiatric Bulletin*, January 1993, **17**, 29–31) and share some of her concerns. To determine whether the new reforms are leading to improvements over the 'old NHS', it is necessary to specify their objectives of improving efficiency and equity, and more scope for consumer choice (Culyer *et al*, 1990). The consumer-patient plays a slight role in the reformed NHS and it is the purchaser guardians of the patients' interest (GPs and DGMs) and providers who shall be held accountable.

One principle of the reforms is to create a situation in which need is better assessed at the community level with the delivery of care responding to this expressed need more efficiently. The author failed to underscore the problems with needs assessment. Was she refering to the total needs of psychiatric patients when discussing the issue of significant unmet need? I hope not! Resources are scarce and I expect public health departments to use their influence with purchasers to concentrate on the costs and benefits of marginal changes in what we are already doing. It is important that the morality of recognising that need is not absolute and cannot be met in full is accepted (Mooney, 1986). By highlighting the choices to be made, and the opportunity costs involved, Goldberg & Gater (1991) are at the cutting edge of this form of decision making.

I agree that psychiatric services face many challenges but I would caution against alarmist overreaction. It may be appropriate that our profession concentrate on the more severely ill! Audit of the effectiveness of our inputs and linking these to output and costs can be enlightening. In the short-term competition between provider units may introduce discrepancies in negotiating terms and conditions of service. However, because the NHS is highly labour intensive it is particularly sensitive to wage cost inflation (Culyer *et al*, 1990). Any sensible manager will recognise the need to manage capital resources effectively with the appropriate skilled labour.

Once contracting as a process is fully understood, it is probable that contracts will become longterm relationships permitting the purchaser to acquire economies of scale and influence service quality (Culyer *et al*, 1990). Self interest may lose out and be replaced by mutual inter-dependence and a sense of duty. My fear is the use to which data on costs will be used. Decisions based on quantifiable financial criteria may lead to neglect of quality of care which is much more difficult to measure.

Any good options appraisal will consider the 'what if we do nothing' scenario and must remind the author that standing on the sidelines will remain an option for some. However I intend to comply with her prescription and wonder if she had any depot preparations due out before April for my more recalcitrant colleagues!

RAYMOND TRAVERS

*The Scott Clinic*
*St Helens*
*Merseyside WA9 5DR*

*References*

CULYER, A. J., MAYNARD, A. & POSNETT, J. (eds.) (1990) *Competition in Health Care. Reforming the NHS* (1st edn). London: Macmillan Scientific and Medical.

GOLDBERG, D. P. & GATER, R. (1991) Estimates of need. *Psychiatric Bulletin*, **15**, 593–595.

MOONEY, G. H. (1986) *Economics, Medicine and Health Care* (1st edn). Bodmin: The Harvester Press Group.

## *Reply*

DEAR SIRS

Since I wrote this article with the hope of stimulating debate about the impact of the NHS reforms on psychiatry, I welcome the opportunity to respond to Dr Travers' comments.

I agree that mental health needs are complex and diverse, and that, as yet, the methodology required to assess such needs is not sufficiently developed. However, having recently worked in a purchasing department for 18 months, I am very aware that purchasers are pressing ahead with such assessments, whether or not local service providers are working with them. This has two unfortunate consequences. The first is a very real danger of re-inventing the wheel, as researchers with little experience in mental health expend significant time and money on methodologically flawed prevalence studies, only to find that much of the work has been done before. The second, and perhaps more serious difficulty, is that where such assessments have not been undertaken collaboratively, neither side will be able to agree on the service implications arising from the results. Such conflicts are unlikely to be productive, but district service providers ignore, at their peril, the reality that purchasers can and will take their money elsewhere. But

it is not all doom and gloom. As I tried to point out in my article, there are opportunities here to demand more resources. Of course psychiatry cannot be expected to be all things to all people, but every time an acute bed is blocked because of a lack of community facilities, or members of the multidisciplinary team cannot be accessed because of staff shortages, we are experiencing unmet need. The cry from the purchasing departments would be to stop complaining about it, and start measuring it.

Dr Travers' final point is that standing on the sidelines should always remain an option. I cannot agree with this. Like it or not, the NHS is changing and changing fast. Failure to engage in this process will not be without consequences.

JUDY HARRISON

*Avondale Unit, Royal Preston Hospital*
*Preston, Lancs PR2 4HT*

## *Publish or perish?*

DEAR SIRS

The paper by Professor C. L. E. Katona and Dr M. M. Robertson (*Psychiatric Bulletin*, January 1993, **17**, 27–29) stresses the importance of published research as a predictor of success for trainees applying for senior registrar posts. It is a pity that the authors did not consider the number of attempts at passing both parts of the MRC Psych examination as one of the variables. Even though it can be argued that doing research helps passing exams, I suspect that many trainees would prefer to start their projects after obtaining the membership of the College, on the understanding that, important as research may be, passing the exams is a priority and the former would be of little promotional value without the latter. I have especially in mind those overseas trainees who are well aware of their extra handicaps, cultural and linguistic, when sitting exams in the UK and have preferred to concentrate on reading, revising and practising exam techniques at the expense of research time.

It is with certain dismay that we see the philosophy of "publish or perish" rapidly impregnating psychiatry training, and research activity is being perceived by many junior doctors more as an onerous prerequisite for achieving promotion than an exciting means of acquiring knowledge and developing a critical attitude and a capacity for organisation.

JOSE FERRAN

*Sefton General Hospital*
*Liverpool L15 2LF*

## *Clozaril withdrawal syndrome*

DEAR SIRS

We would like to report the possible development of withdrawal syndrome after prolonged use of Clozaril (clozapine), when stopped abruptly. This phenomenon has not been reported although rebound psychosis and supersensitivity psychosis are recognised as rare complications of this and other neuroleptic drugs. (Adams *et al* 1991; Kirkpatrick *et al*, 1992; Chouinard *et al*, 1978). The Clozaril drug data sheet suggest a gradual withdrawal except in the cases of drug induced blood dyscrasia when Clozaril needs to be stopped immediately.

*Case report*

A 31-year-old male chronic paranoid schizophrenic patient had two periods of Clozaril ingestion; the first period of 29 weeks (5 March to 28 September 1990) up to a maximum of 600 mgm daily and second period of 87 weeks after a gap of six weeks. He had up to a maximum of 500 mgm Clozaril daily (from 5 November 1990 until 9 July 1992). There were no withdrawal phenomena when Clozaril was stopped after the first period of ingestion due to status epilepticus. As he was showing only partial recovery, the clinical decision was made to tail off Clozaril 500 mgm over the next three days. He had no epileptic fit during the second period of ingestion while receiving 500 mgm of Clozaril. He had epileptic attacks while in receipt of 600 mgm of Clozaril which was clearly dose related. From 11 July 1992 for 12 days he suffered a withdrawal state partially controlled by restarting a much smaller dose of Clozaril, 50 mgm daily. The withdrawal symptoms were as tabled and consisted of the return of previous symptoms worsening of psychosis (delusions, hallucinations); resentful, abusive and the use of foul language; overactive behaviour) but also new symptoms agitation, restlessness; shakiness; dyskinesia; confusion; sweating; aggression; suicidal; (lying on the main road); insomnia). He was transferred to an acute admission ward for 16 days, and then went missing for three days when he slept rough.

This case clearly suggests development of a withdrawal syndrome after prolonged use of Clozaril, when stopped abruptly. Adams & Essali (1991) refer to the development of rebound psychosis, "racing thoughts to a distressing degree which settled in two weeks", but do not indicate whether this was new or the return of a previous symptom. Once the drug is stopped, which is supposed to suppress psychotic symptoms, there should be a rebound return of old symptoms. They also report the development of longer lasting "bizarrely psychotic with disturbing hallucinations" not settling after three months cessation of Clozaril (supersensitivity psychosis) suggesting, as described in relation to neuroleptics "a dopamine supersensitivity that leads to both dyskinetic and psychotic symptoms" (Chouinard *et al*, 1978). However, research has not established that chronic neuroleptic treatment causes this effect, and consideration of mechanisms has not been separated from causation (Kirkpatrick *et al*, 1992).

The case reported here of withdrawal syndrome cannot be diagnosed as supersensitivity psychosis (SSP) according to Chouinard's criteria (Chouinard & Jones, 1980). This has implications in the clinical management of those patients where Clozaril is