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Correspondence

Correspondents should note that space is limited and shorter letters have a greater chance of publication. The Editors reserve the right to cut letters and also to eliminate multitudinous references. Please try to be concise, strictly relevant and interesting to the reader, and check the accuracy of all **references in Journal style.**

WHOSE DILEMMA? THE CRISIS OF THE MENTAL HEALTH SERVICES

DEAR SIR,

I understand that you are unwilling to allow lengthy debates or polemics in the pages of the *Journal.* However, I should like to respond, albeit briefly, to a few points raised by Professor Jones' recent commentary on my work (*Journal,* September 1982, **141,** 221–26).

Those who are concerned with the future of the mental health services confront, as Professor Jones rightly suggests, a dilemma: "if it is wrong to get patients out of the mental hospital, and wrong to keep them in, what are we to do with them?" In seeking a way out of this double-blind, we must, it seems to me, remain sceptical of the painless solutions we are usually offered in the guise of "reforms". No informed person, least of all myself, could view with equanimity the prospect of once more consigning chronic psychotics to the Victorian bins in which they were traditionally stored. There are clearly a substantial number, however, for whom some form of more or less permanent sheltered environment is abolutely essential. For the still larger proportion for whom non-institutional forms of care are in principle preferable, the central requirement is for adequate community-based support and care: the kind of infrastructure which is presently all but entirely absent. Bitter experience ought by now to have taught us to scorn millennial claims that adoption or rejection of the asylum will substantially ameliorate the mental patient's situation. We must recognize instead that neither institutional treatment nor community care is in any sense a panacea; and that both, if inadequately funded, provide ample opportunity for, and plenty of concrete examples of squalor, neglect, abuse, and inhumanity.

Pace Professor Jones' bizarre suggestion that I am a "radical non-interventionist", the whole thrust of my critique of contemporary policies is towards a condemnation of dressing up malign neglect as humanitarian concern. So far from sharing the naive romanticism of many of my sociological colleagues, who assume that the mental patient's difficulties flow more or less exclusively from the application of pernicious psychiatric labels, I would insist that serious discussion of this subject must begin with a recognition of the disturbance, disorder, and profound alienation that constitute serious forms of madness. It is precisely these features of the condition that make provision of good communal *and* institutional care so essential. It is precisely the powerlessness of those who require help and the structural biases of the social system in which we live that make it so unlikely that either will be forthcoming.

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NEUROLEPTIC-INDUCED CATATONIC SYMPTOMS

DEAR SIR,

Neuroleptic drugs can cause a syndrome very similar to catatonia with withdrawal, mutism, posturing, rigidity, immobility and waxy flexibility, but although several cases have been reported over the last twenty years this phenomenon does not appear to be widely known (Brenner and Rheuban, 1972; De, 1973; Gelenberg and Mandel, 1977; May, 1959; Regenstein, Alpert and Reich, 1977; Weinberger and Kelley, 1977; Weinberger and Wyatt, 1978).

It may be very difficult to distinguish schizophrenic catatonia from this reaction, and often the final diagnosis arrived at is one of catatonic schizophrenia. However Ayd suggests in 'Haloperidol Update 1958–80' that nowadays catatonia as a side-effect of neuroleptic drugs is actually a commoner phenomenon than catatonic schizophrenia, and he advises that clinicians should presume that neuroleptic drugs are responsible whenever catatonic symptoms appear shortly after the start of neuroleptic therapy (Ayd, 1981). Since potentially fatal medical complications may follow, he advises that neuroleptic therapy be stopped immediately, although the catatonic symptoms may continue for a while due to the long elimination half-life of neuroleptics such as haloperidol.

Another case of catatonia which appears to be neuroleptic-induced is now reported:

The patient was a sixteen-year-old girl of Chinese-

Vietnamese origin who was admitted to the South Western Hospital in January 1982 following a period of "strange behaviour" at school, which included an attempt to jump out of a window, emotional lability, anorexia and insomnia. There was no relevant family history. There was however a previous history of a similar episode during a period of emotional stress three years previously, which was said to have been cured by a Chinese healer using water. This episode again occurred during a period of severe emotional stress associated with bullying at school.

On admission the patient was almost mute, giggled inappropriately, and was observed to talk to herself, often expressing suicidal ideas. She was treated with an injection of haloperidol 10 mg intramuscularly, and the following day she suddenly developed acute catatonic symptoms including posturing and waxy flexibility, which were accompanied by oculogyric crises and torticollis. She continued to appear unperturbed and to smile inappropriately. These symptoms disappeared spontaneously approximately fifteen minutes later, but returned on a further occasion later that day. On this occasion she was given an injection of diazepam 7.5 mg intravenously which quickly abolished both the catatonic and schizophrenic symptoms. Since her behaviour continued to be disturbed, she was observed carefully and her medication changed to oral haloperidol 5 mg qds and oral procyclidine 5 mg tds. Her behaviour gradually returned to normal over the next few days, all physical investigations were normal, and haloperidol was discontinued five days later. She was discharged from hospital eighteen days after admission, on a small dose of amitriptyline, and followed up in the out-patient clinic; she has remained well for almost nine months. A diagnosis of depression with hysterical dissociative reaction under stressful conditions was made, together with an uncommon catatonic reaction to neuroleptic agents.

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HAZARDS OF LITHIUM AND NEUROLEPTICS IN SCHIZO-AFFECTIVE DISORDER

DEAR SIR,

I read with interest Delva and Letemendia's review of lithium treatment in schizophrenia and schizo-affective disorder (*Journal,* October 1982, **141,** 387–400), and I share their concern about the combining of lithium and neuroleptics in treating these conditions. As the authors point out this is a topic which so far has received little attention. This combination of lithium and neuroleptics, especially when both are used in high doses, can sometimes have unexpected results as the following two brief case histories illustrate.

Case 1. A 22-year-old female patient on her first admission to hospital showed paranoid delusions, feelings of being possessed by the Devil, thought disorder, bizarre posturing, along with great hyperactivity, disinhibition, and total insomnia for the previous week. A provisional diagnosis of schizo-affective illness, schizomanic type, was made and she was commenced on lithium carbonate and chlorpromazine. She reached a peak daily dose of 2000 mg lithium and 800 mg chlorpromazine after eight days. Serum lithium levels were done every two days and these were 0.54, 1.24 and 1.52 respectively. On the tenth day when the serum lithium was 1.52 there was a dramatic change in the clinical picture. The patient developed extra-pyramidal side-effects (EPSE: pseudo-parkinsonism and dystonia) along with confusion, disorientation for time and place, and an ataxia which caused her to fall several times. Simultaneous with this the original psychotic symptoms disappeared. All drugs were stopped and benztropine added. Rapid improvement then followed with no long term sequelae.

Case 2. A 35-year-old female was admitted for the fourth time for schizo-affective illness, schizomanic type. She showed paranoid delusions, auditory hallucinations but also great hyperactivity, pressure of speech and nearly total insomnia. She was treated with a peak dosage of lithium carbonate (Priadel) 1600 mg and chlorpromazine 800 mg. Serum lithium levels were done every two days and showed levels of 0.59, 1.28, and 1.42. At the 1.42 level, on the eighth day of treatment, a similar sudden clinical change took place