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.

ALAN B. EPPEL

Community Mental Health Clinic
147 Delhi Street,
Guelph, Ontario, Canada

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

need or demand for the facility from the patients and their carers who are not in crisis. Continuing care beds provide a final home for very disabled patients and ideally should not be serving the acute needs of the elderly demented patients in the district. The realities of a very under-resourced service are very different. The striking finding was that if one has no continuing care beds to offer in the foreseeable future people stop asking for them. The placement of the 34 patients is summarised in the table below.

Placement	*Number of patients*
Home	10
Part III OPH	6
Other wards	7
Other hospitals	1
Left district	2
Deceased	8
Total	34

Three of the patients in Part III Homes were coping very badly and the other three were being cared for only because of the devotion of the care staff. One case illustrates the problems all too clearly. This lady had been on the waiting list since October 1986, when it was said by the visiting consultant psychiatrist that the home could not be expected to cope with her incontinence and wandering. The head of the home said that further help had not been requested because she felt there was no prospect of a hospital bed for this lady. This was in spite of her occasional aggressive outbursts to other frail residents.

Of the patients on other wards, two were in acute geriatric beds and two had been very kindly accepted by the geriatricians for long-term care. Although both these patients were profoundly demented they had been on our waiting list for so long, (one since December 1984 and one since August 1985) that they had been overtaken by physical frailty.

Five of the deaths had occurred on the waiting lists while the patients were on a medical ward. One of the two patients on the acute psychiatric ward had a pre-senile dementia and the other was on our own functional acute ward. The ten patients who were being cared for at home were all supported by a devoted family member. These carers felt strongly that they could not allow their demented relatives to enter long-stay care. They were all, except one who is too frail to attend, supported by the Psychogeriatric Day Hospital in the district. This facility can only be offered even in the most severe cases two days a week because of the limited number of places available.

While I would agree with Dr Blessed that hospital care may not be ideal, it does fulfil some of this need. There is no reason why hospital could not be made more comfortable and attractive for patients and their relatives. It may indeed have some advantages, particularly as these most severely ill patients have access to 24 hour medical cover and are often nursed by dedicated staff. Unfortunately, I fear the stigma attached to long-stay hospital wards will follow the patients into the nursing homes. Relatives will again be reluctant to place their demented family member in such a setting.

CLAIRE LAWTON

Homerton Hospital
London E9

Psychiatry of mental handicap in Ontario

DEAR SIRS

I wish to comment on the article by Dr Evans 'Visits to Centres of Excellence in Mental Handicap' (*Bulletin*, May 1988, **12**, 191–193).

Dr Evans commented on the scarcity and lack of understanding of the role of psychiatrists in Ontario in relationship to the mentally handicappd. I wish to point out that three medical schools out of five in Ontario (Queens, University of Toronto and the University of Western Ontario) have chairs of mental 'retardation' within the respective departments of psychiatry. Out of 1000 psychiatrists in Ontario, approximately 20 (within institutions and in the community) have expressed special interest in working with both mentally handicapped children and adults.

I agree with Dr Evans that with the current impetus for deinstitutionalisation of emotionally and behaviourally disturbed mentally handicapped individuals there is an even greater need for psychiatric manpower in Ontario and throughout the world. There is considerable encouragement through the University, the Canadian Academy of Child Psychiatry and the Royal College to develop greater expertise in developmental neuro-psychiatry.

Ontario psychiatrists have, however, distinguished themselves in the American Association on Mental Retardation and the International Society for the Scientific Study of Mental Handicap. It is also unfortunate that in Dr Evans' search for centres of excellence she was not directed to the Children's Psychiatric Research Institute in London, Ontario. This institute achieved the highest honour of the *American* Psychiatric Association, the Gold Award, for its achievements in developing comprehensive programs in service delivery, teaching and research in the field of mental handicap.

In terms of Dr Evans' observations about the use of physical restraint in Ontario, I would direct her to