Violence and sudden death

SIR: I read with great interest the paper on "Suicide and unexpected deaths among psychiatric in-patients" by Morgan & Priest (*Journal*, March 1991, **158**, 368–375). They have raised some very important issues.

Drs Morgan & Priest indicated that communication difficulties, low levels of available staff, or absence on leave may have been important in some cases of their series of suicides. Our work on violence (including self-harm) has already demonstrated this quantitatively (e.g. James *et al*, 1990). Of particular interest is the positive relationship between levels of agency (temporary) nursing staff and violence, and a negative relationship between levels of permanent nursing staff and violence. Other studies of in-patient suicides have indicated authoritarian attitudes and under-involvement of medical staff (Langley & Bayatti, 1984) and increased vulnerability among nursing staff in conflict (Morgan & Priest, 1984) as contributory factors. All these studies indicate that adequate provision of well trained staff with an appropriate hierarchical support structure is vital, particularly in the modern era of community psychiatry, cost cutting and audit.

In a further study of violence on a high-dependency mental handicap ward (Shah & Piachaud, 1988), 620 violent incidents over a 21-month period were identified. Four patients accounted for 74% of this violence, and two of these four most violent patients suffered sudden unexpected deaths during the study period. Both these patients were in their early twenties and physically well. In one case the cause of death was spontaneous jejunal rupture with peritonitis and in the other case, dissecting aneurysm of the thoracic aorta. Both these causes of death are rare even in the surgical literature. Shortly after completion of the study, a third violent patient died suddenly from acute pneumonia. Although the numbers were small for statistical analysis, this apparent relationship between violent behaviour and sudden death is of interest. It could be argued that these sudden deaths could be avoided if strategies to reduce violent behaviour were available. This is another area that needs systematic exploration and I would be interested to hear of such cases.

JAMES, D. V., FINBERG, N. A., SHAH, A. K., *et al* (1990) An increase in violence on an acute psychiatric ward: a study of associated factors. *British Journal of Psychiatry*, **156**, 846–852.

LANGLEY, G. E. & BAYATTI, N. N. (1984) Suicides in Exe Vale Hospital 1972–1981. *British Journal of Psychiatry*, **145**, 463–467.

MORGAN, H. G. & PRIEST, P. (1984) Assessment of suicide risks in psychiatric in-patients. *British Journal of Psychiatry*, **145**, 467–472.

SHAH, A. K. & PIACHAUD, J. (1988) Violence, nursing and in-patient psychiatry. *Lancet*, *i*, 940.

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Treatment-resistant depression

SIR: We noted the letter by Malizia (*Journal*, July 1990, **157**, 145). Regarding the Tyrer & Murphy article also published in the *Journal* (January 1990, **156**, 115–118) on a case of treatment-resistant depression, we are in agreement with Dr Malizia. However, we believe that the following issues deserve further comment. Treatment resistance must be clearly defined. Adequate duration of treatment, dose, and blood levels must be established. The differential efficacy within the same individual of one antidepressant over another must be determined.

The issues of diagnostic criteria, comorbidity and personality disorders are increasingly complex. The pharmacological factors may be simplest to define. It would seem appropriate, then, to work towards the establishment of a common system, regarding duration of treatment, dose, and blood levels, lest the important and painstaking work of investigators such as Drs Tyrer & Murphy and others be marred by vague concepts of treatment resistance.

Ayd (1983) highlighted the problem of treatment resistant depression, noting the recommendations of the World Psychiatric Association. He discusses the distinction of absolute and relative treatment resistance, the former being defined as failure to respond to 150 mg per day of imipramine, or its equivalent, for four to six weeks, and the latter as failure to respond to an inadequate course of treatment. This clarification fails to consider well established findings of the 'relative' efficacy of the 150 mg per day dose of imipramine. Simpson *et al* (1976) report that 300 mg of imipramine is clearly superior to 150 mg per day. The same effect has been demonstrated for other antidepressants.

It is imperative that we arrive at a consensus opinion regarding criteria to define the adequacy of a treatment trial. It has been relatively well established, at least for imipramine and nortriptyline, that blood levels may be used to guide therapy. In cases where blood levels are not available, it is increasingly advisable to use imipramine at 300 mg per day, or