Correspondence

EDITED BY MATTHEW HOTOPF

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Hospitalisation and adolescent anorexia nervosa

Gowers et al’s (2000) study of the impact of hospitalisation on the outcome of anorexia nervosa in adolescence is a useful and important contribution to a debate that is difficult to resolve meaningfully, because of lack of useful evidence. As the authors note, randomised controlled trials are both lacking and extremely difficult to perform, for both practical and ethical reasons. However, the significant mortality and morbidity associated with these disorders is such that this problem must not be ignored.

Although the paper raises some very important questions, we are concerned that the suggestion that in-patient treatment is associated with a poor outcome is premature, and may be taken by some to mean that in-patient treatment should not be considered. This view would be particularly worrying if adopted by cash-strapped health authorities that are already often reluctant to finance treatment of what is still sometimes seen as a trivial condition.

We believe that three questions need to be answered before making any general pronouncement on the appropriateness of in-patient treatment; (a) what factors lead to admission? (b) what is the relationship between these factors and outcome? and (c) what constitutes in-patient treatment, and is it a uniform concept?

Our experience of over 500 admissions of young people suffering from anorexia nervosa leads us to the view that many of the factors which lead to admission, but which are also predictive of poor outcome, are systemic. They will not therefore be measured by the Morgan–Russell Assessment Schedule (Morgan & Hayward, 1988) or other individual-based predictor variables. Such systemic variables include major psychosocial stresses within the family, and the health and strength of the professional network, but we have found it hard to find instruments that adequately measure these factors.

In other words, the measures used to assess severity in this study are all individual to the patient and do not sufficiently take account of the complex network of relationships within which anorexia nervosa takes root and either flourishes or dies. In our experience, the severity of symptoms such as weight loss does not bear a linear relationship to outcome because of highly complex intervening contextual variables, which need to be addressed by any outcome study.

We certainly share the view that in-patient treatment is not the only response, and that we need to be continually reflecting on the style and content of such treatment. However, we think it highly premature to conclude that it should be discouraged. It should be remembered that at present it is often a life-saver for many young people who are seriously ill.


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Author’s reply: We are grateful to Drs Wood & Flower for contributing to the debate on treatment setting in adolescent anorexia nervosa. Our aim was indeed to open rather than close discussion.

We agree that it is of paramount importance that anorexia nervosa is seen for the serious condition with high morbidity and mortality that we know it to be, rather than the trivial disorder sometimes portrayed by the media. It is right, however, for commissioners to expect an evidence-based case for expensive treatments. Despite the questions raised in our paper, our service treats a large number of adolescents as in-patients and continues to make and support significant numbers of referrals to specialist eating disorder in-patient services.

Nevertheless, it is extraordinary that the following questions are so rarely addressed:

(a) Could it be that in-patient treatment has negative (side-)effects?

(b) Could there be some intrinsic features of anorexia nervosa, such as ineffectiveness, low self-esteem or past history of abuse, which might make those with anorexia nervosa particularly vulnerable to these negative effects?

(c) Might these negative effects sometimes outweigh the benefits?

We would take these questions for granted in evaluating a new drug therapy.

The point Drs Wood & Flower make about systemic factors as predictors of outcome is an important one that our group has previously researched (Gowers & North, 1999). Where there is family or social difficulty, however, does this mean that the adolescent is better treated within or outwith the family home? Does this difficulty add to the case for admission or the case against? In view of the high rates of relapse after weight restoration in hospital, we contest that one could form testable hypotheses either way.

The National Health Service Executive has rightly judged that further evidence of the effectiveness of treatment in different settings is required. We are pleased to report that our group was awarded a Health Technology Assessment grant to conduct a randomised controlled trial of treatment setting covering the north-west of England. We hope in the course of the 4-year pragmatic study to contribute to the debate on when specialist eating disorder in-patient units may be helpful and for whom. We are also examining family satisfaction and acceptability. Of course, this large study will not provide the last word on the issue, but we must avoid the negativism which suggests it is better not to carry out research in case the results are misinterpreted.

Almost certainly in-patient admission sometimes saves lives. Nevertheless, almost all series show high rates of relapse after discharge (Crisp et al, 1991; Eisler et al, 1997) and however loaded with poor
Possible causes of catatonia in autistic spectrum disorders

I read with interest the paper by Wing & Shah (2000) on catatonia in autistic spectrum disorders. The authors quite correctly make the point that catatonia, although a useful clinical concept, is a description of a number of behaviours. However, they have not attempted to investigate the aetiology of catatonia in their sample of 40 patients. Three other possible causes for their observations spring to mind.

First, the onset of catatonic symptoms in adolescence or early adulthood, in this largely male sample, could be related to the development of schizophrenia, although it may be difficult to diagnose. It has presumably been excluded as no patients had first-rank symptoms according to the accounts of relatives or carers, although in Table 3 (p.359), the heading “bizarre-psychotic” catatonic manifestations were found in 40% of their patients. The fact that ‘Others had occasional visual hallucinations or paranoid ideas’ suggests that they may qualify for an additional diagnosis of schizophrenia according to the ICD–10 (World Health Organization, 1992). The authors have not specifically stated whether the patients had been assessed for a diagnosis of schizophrenia.

Although the patients may be difficult to interview on account of communication disorders or cognitive problems, nearly half did not have impaired language and the number of mute patients is not stated. Furthermore, 70% of the patients had a level of cognitive ability within the range from mild learning disability to average intellectual ability, not incompatible with a diagnosis of schizophrenia.

Second, the possible explanation for catatonic symptoms is the development of an affective disorder. In 13 of the 30 patients, precipitating factors included bereavement, pressure at school, lack of structure after leaving school and lack of occupation, which are more commonly associated with a depressive illness. Central to the diagnosis of catatonia are increased slowness, difficulty in initiating and completing actions and lack of motivation, among others, possibly symptoms of depression.

Third, and most importantly, catatonic symptoms may be difficult to distinguish from the extrapyramidal side-effects of antipsychotic drugs (American Psychiatric Association, 1992). In Wing & Shah’s description of the criteria for catatonia, a secondary feature listed was “Parkinsonian features: tremor, eye-rolling, dystonia, odd stiff posture, freezing in postures, etc.”. Although the patients are fairly young, they are also a tertiary referral group and it is likely that they would have received other, previous treatments. Recent estimates of prescriptions of psychotropic medication to adolescents and adults with developmental disabilities vary from 12 to 40% (Connor & Posever, 1998). There was no record of previous treatment and, more specifically, a history of current or prior exposure to antipsychotics is omitted.

It is helpful to know that catatonia can complicate autistic spectrum disorders and that individuals who present with catatonia may have an undiagnosed autistic spectrum disorder. However, although recognition is necessary to institute appropriate management, this paper offers only limited help in this direction. There would have been a greater clinical impact if it had addressed the possible causes of catatonia or the other associated psychopathology. The study also raises the question of whether catatonia represents the expression of other, more common mental disorders in those with limited communication skills.


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Authors’ reply: Dr Chaplin notes that neither the possible causes nor the treatment of catatonia were discussed in our paper. As the Journal requires papers to be 3000–5000 words long, we decided to focus on the clinical picture of catatonia and its prevalence. We have written and intend to publish a second paper dealing with causes and treatment and are grateful to Dr Chaplin for providing us with the opportunity to write a few more words on these subjects.

The individuals in the study had all been seen by one or more clinicians before the tertiary referral to Elliot House. During the course of the multiple assessments, possible underlying causes, including schizophrenia, depression, obsessive-compulsive disorder and identifiable brain pathology such as parkinsonism, would have been considered. These conditions, together with autistic spectrum disorders and catatonia, are defined and diagnosed only on history and clinical picture and there is overlap of clinical features among them all. In the individuals in our study, the developmental history and clinical picture, including the “bizarre/psychotic” behaviour in some people, fitted best with autistic spectrum disorders. We do not argue that psychiatric conditions, such as schizophrenia, cannot occur in association with autistic disorders. The point of our paper is that catatonia can occur as a complication of autistic spectrum disorders alone.

Twenty-one individuals in our study had received psychotropic medication for possible psychiatric conditions, and two people were treated with electroconvulsive therapy, all without useful effect on the catatonic features. The side-effects of neuroleptic medication were considered as possible causes of the catatonia. Of the 21 individuals who were medicated 10 were given drugs only after the onset of catatonia. The temporal relationships were
difficult to establish for the other 11, but there was no clear evidence for cause and effect.

When considering aetiology, an important point is that many of the features described in discussions of catatonic phenomena are also characteristic of autistic disorders. This has interesting implications for the nature of autism and catatonia, and their relationship to each other and to other psychiatric conditions associated with impairments of motor function. This will be the subject of a separate paper.

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In-patient detoxification after GHB dependence


A 43-year-old male reported using GHB for 2.5 years. The effects of use were reported as feelings of relaxation, inner well-being, increased appetite and short, restful periods of sleep. Starting doses of GHB were difficult to quantify as it is generally taken in liquid form. The patient said his dose was originally 15 ml irregularly, but had increased to 30 ml every 3 hours by the beginning of 1999. The patient reported withdrawal experiences such as feelings of panic, terror and anxiety, often with a tremor. Other autonomic features included diarrhoea. Adverse effects of GHB were reported, including accidental injury when intoxicated and episodes of bizarre behaviour. In-patient detoxification was thought necessary as both patients were unable to stop using GHB at home.

On admission to the unit physical examination was unremarkable apart from some features of anxiety. Physical investigations were normal. The patient was commenced on a diazepam reducing regime from 20 mg over 11 days. Detoxification was uneventful. The patient was engaged in relapse prevention and referred to psychotherapy services.

Gamma-hydroxybutyrate has adverse effects but also produces euphoria and relaxation; GHB has abuse and dependence potential and so educational campaigns for the public may be important.


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Suicide in psychiatric hospital in-patients in Ireland

We were interested in the paper by Powell et al (2000) concerning suicide in psychiatric hospital in-patients. We conducted a 10-year review of the same phenomenon in Irish psychiatric hospitals (Corcoran & Walsh, 1999). Although this was not a case-control study in the sense of Powell et al, the findings were very similar, particularly in respect of the high proportion of suicides (70%) among in-patients who died ‘off the premises’ although ‘on the books’. The Irish suicide rate among acute in-patients (i.e. those in hospital for less than one year), at 319 per 100,000 of population (v. 118 per 100,000 for long-stay patients), is higher than that reported by Powell et al (137 per 100,000 admissions).

However, the validity of calculating in-patient suicide rates on the basis of an admissions denominator is questionable. It ignores the length of time during which each individual is at risk during a hospital year, and is based on admissions rather than on the individuals contributing to these admissions. Many patients may have had several admissions in any given year. We approached the problem by the person-year method which takes into account not only the number of admissions, but also their mean length of stay and other data which were available to us from the National Psychiatric In-Patient Reporting System. Our paper discusses the imperfections of this approach.


Low blood pressure and depression in the elderly

Paterniti et al (2000) report welcome prospective data showing that low blood pressure precedes depression in older people rather than vice versa. However, important alternative explanations for this effect require consideration before conclusions can be drawn regarding causality.

Poor physical health and disablement have been shown to be strong risk factors for incident depression in older people (Prince et al, 1997). A large prospective community study showed that low blood pressure was associated with raised mortality but that this effect was eliminated after adjustment for comorbid physical illness (Booshuizen et al, 1998). The same may be true for depression. Paterniti et al comment that the number of chronic diseases was measured in participants and was not associated with depressive symptoms or low blood pressure. However, it is the severity of individual conditions and resulting functional limitation which are likely to be most important in depression rather than the number of different conditions. Important confounding effects may therefore have been missed. Both depression and low blood pressure may also be secondary to early cognitive decline, although this is less likely to explain results in the age range of participants for this study.

In order to develop effective strategies for the prevention of depression in later life,
further research will be required to clarify causal pathways: in particular: (a) whether low blood pressure causes depression through one of the organic mechanisms discussed by the authors; (b) whether low blood pressure and depression are both secondary to early cognitive decline; and/or (c) whether low blood pressure is a marker for other, more psychological risk factors for depression, such as the impact of poor physical health and functional limitation.


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Complex medical roles in mental health review tribunals

Gibson (2000) makes a thoughtful rejoinder to the suggestion by Richardson & Machin (2000) that the dual nature of the roles exercised by the mental health review tribunal (MHRT) medical member precludes open-mindedness. That this need not be the case was demonstrated some years ago by Langley (1990, 1993) and Brockman (1993). Gibson suggests that the role of the MHRT doctor was introduced in the 1959 Act to facilitate examination of the “hospital notes without ruffling medical feathers”. In reality, the role of the medical member’s role was more complex than this. During the parliamentary debates on the 1959 Act there were very conflicting views expressed as to who was best fitted to make judgments concerning the need for detention, bearing in mind the then current legislation which involved a purely judicial decision. A compromise appears to have been reached by the introduction of the present three-member MHRT panel.

Gibson’s remedy, which would involve tribunal members reading the medical notes for half an hour prior to the hearing, has two serious weaknesses. First, in many cases the notes are too voluminous and complicated to make this possible in the time-scale suggested. Second, medical notes sometimes require a certain degree of medical interpretation for the benefit of the two non-medical members of the panel. However, these issues may turn out to be academic in the light of the current Government’s proposals for reform of the 1983 Act (Department of Health, 1999) involving a considerably more complicated (and, most likely, more costly) system than we have at present; a system which also comes very close to infringing the European Convention on Human Rights’ mandates. It is also very clear that the Government’s proposals have not found favour with some members of the Scoping Study Review Team (Peay, 2000). There is an old adage ‘marry in haste, repent at leisure’. Maybe in this case it would be appropriate to substitute for this phrase, ‘legislate in haste’ (on the basis of a pre-determined and heavily constrained remit and timescale by Government) and we will be most certain to ‘repent at leisure’.


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Forensic inquiries inform the present and future

Lindqvist & Skipworth (2000) emphasised the shortage of high-quality randomised trials dealing with the treatment and rehabilitation of mentally disordered offenders and highlighted problems of undertaking such studies. Currently, we are involved in a project, funded by the UK National Health Service Research and Development Programme on Forensic Mental Health, to create a register of randomised controlled trials dealing with the management of violent or aggressive people. Initial searches identified 22,000 citations, over 2000 of which were relevant trials. We are now surveying the subset of 350 trials of most interest to the forensic mental health services. Data on content and quality are being reliably recorded and a report will be produced for publication. Already some of these trials are of sufficient quality to be included in systematic reviews (Brylewski & Duggan, 2000; Fenton et al, 2000; White et al, 2000).

It is likely that Lindqvist & Skipworth are correct to suggest that high-quality studies are rare. Many triallists, however, have used the ‘gold standard’ of mental health care evaluation (World Health Organization Scientific Group on Treatment of Psychiatric Disorders, 1991), the randomised trial, to investigate the value of interventions relevant to forensic services. Much can be learnt from such studies, even if they are of limited quality. Systematic appraisal of such work may inform practice, but certainly guides future research. Lindqvist & Skipworth listed considerable difficulties encountered by triallists of interventions relevant to forensic services. These difficulties have all, to a greater or lesser extent, been considered and addressed, and large, simple randomised trials could overcome most problems. Indeed, many of the treatments commonly used for offenders with mental disorders may be unethical outside of such trials (White et al, 2000).


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Involuntary out-patient commitment and supervised discharge
Swanson et al's (2000) paper comes at an opportune moment in the on-going debate about Community Treatment Orders (Harbour et al., 2000; Protheroe & Carroll, 2000; Turner et al., 2000). Although not described in detail in their recent article, involuntary out-patient commitment (IOC) (Swartz et al., 1999) has much in common with after-care under supervision or supervised discharge in England and Wales. In particular, medication cannot be enforced, patients can be escorted by law officers to the clinic, and sanctions for non-compliance seem non-existent in the absence of grounds for re-detention. In spite of this, and given the acknowledged limitations of the randomised controlled trial reported, there seem to be benefits in reductions in violence and in re-hospitalisation. The message is, however, more complex than simply subjecting patients to IOC; those that benefit are subject to IOC for longer periods (over 6 months) and have frequent contacts with psychiatric services (≥3 per month). Violence seems to be reduced in part by adherence to medication and decreased substance misuse. For readmission IOC was most effective in non-affective psychoses.

Our own experience following the introduction of supervised discharge in 1996 (Davies et al., 1999, 2000) of an increase in community survival after being subject to supervised discharge and longer survival to readmission. After 18–36 months of follow-up, 15 of 22 patients had not been readmitted to hospital, whereas only one patient survived for an equivalent period before supervised discharge.

The finding that effective IOC must be supported by frequent service contact may, in retrospect, provide evidence for the ambiguous assertion in the Mental Health (Patients in the Community) Act 1995, that supervised discharge “will help secure that he receives the after-care services so provided”. Mr Boateng, then Health Minister, stated at the initiation of the Review of the Mental Health Act 1983 that “non-compliance with agreed treatment programmes is not an option”. The advent of Community Treatment Orders in the UK seems inevitable; what evidence exists suggests that they will be effective for some patients with psychosis but only in conjunction with frequent contacts with effective community services.

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One hundred years ago

Egypt (from our own correspondent)

Lunatic asylums
Dr. J. Warnock’s annual report has just been issued from the one hospital for the insane which Egypt has considered sufficient for her needs since the thirteenth century when the first was established. But increasing civilisation means that fewer and fewer lunatics and idiots are kept by their friends or families, and therefore the hospital becomes more and more crowded. Perhaps the benevolence of the present day is waning, or is it that there is less wealth, or perhaps as we English would fain believe, the intelligent native now understands that under our control he may send his relative, whom he still calls “struck by the wrath of God”, to the asylum which only 15 years ago was justly called an abomination of the human race. The number of resident patients has risen from 300 to 500, not from any increase in lunatics, but from the necessary accumulation of uncured chronic patients. And yet during the year 1899 no fewer than 274 men and women had to be discharged still insane to make room for more urgent cases. This is an obvious danger to the public which the English advisers of the Egyptian Government ought to face without delay. England provides exactly 50 times as much asylum accommodation as Egypt per head of population. Another great disadvantage of the present asylum is that it is the only resort for criminal lunatics. During last year 23 men and four women were admitted charged with crimes, including six murderers. The analysis of the insane shows hasheesh as the cause of 22 per cent., pellagra as the cause of 5 per cent., and alcohol as the cause of 3 per cent., while the number of general paralytics has advanced to 6 per cent. The large towns furnished nearly all the last class and most of them are known to have had syphilis. The total admissions for the year were 598, including 17 nationalities besides Egyptians. Only one Englishman was admitted.

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Researched by Henry Rollin, Emeritus Consultant Psychiatrist, Horton Hospital, Epsom, Surrey
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