questions about compliance that will add bias to the results.

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Author's reply Dr Agell rightly points out that seven of the nursing women in our study were taking paroxetine and sertraline at doses lower than are usually recommended for the treatment of major depression. We disagree, however, with his conclusion that these mother–infant pairs were not valid subjects for the study. These women are representative of many new mothers who choose to take the lowest dosage of medication that will benefit them for the duration of their nursing. Further, we considered the range of subjects' doses in our correlation analyses of the relationship between maternal dosage of antidepressant and infant serum concentration of medication. In fact, one of the primary goals of our study was to identify the dosage of medication that was likely to produce a detectable level of medication in the infants.

Dr Agell also points out that fluvoxamine cannot be deemed safe in the same manner as paroxetine and sertraline, given the smaller number of fluvoxamine exposures. We agree with this observation and recommend that, whenever possible, nursing women be prescribed antidepressants for which the most extensive safety data are available.

Declaration of interest

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Reforming the Mental Health Act – recruitment and retention issues

Having recently read the Royal College of Psychiatrists' response (see http://www.rcpsych.ac.uk/college/parliament/wp.htm) to the Government White Paper on the reform of the Mental Health Act (Department of Health, 2000), there were a number of issues I felt needed raising. First, I believe that the College's response to the white paper would broadly be welcomed as helpful by my junior colleagues. However, there are some additional points I would like to comment on from the perspective of a junior doctor working on a busy general psychiatry ward. These include the matters of recruitment and retention of junior grade doctors, the erosion of the autonomy of the profession, the changes required for junior doctor training and the implications for the use of 'holding orders' by senior house officers (SHOs).

The College expresses concern that recruitment to the profession may be adversely affected by the implementation of the Government's proposals. Early retirement of consultant grade staff is also mentioned. In addition, I would like to draw attention to the increasing problem of retention of junior doctors at SHO grades who do not complete training and are lost to psychiatry, or to medicine generally.

Arguably, junior doctors will feel the greatest impact from the changes proposed. The prospect of working with a new Mental Health Act that is considered contentious, on both ethical and legal grounds, is bound to lower morale. This is equally true of the Government's further emphasis on the coercive aspects of patient management and the erosion of the rights of confidentiality for patients. The inevitable deterioration in the relationship between doctors, patients and user groups will further reduce job satisfaction.

Psychiatry, unlike any other medical speciality, is affected on a day-to-day basis by changes to statute law. At the same time, SHOs are perhaps more aware of their counterparts in other disciplines. Recently, the divide between psychiatry and the rest of medicine has seemed to be shrinking. However, this is likely to be reversed by legislation that separates physical illness and mental disorder so completely in terms of individual capacity and patients' best interests.

The College's views are so evidently at odds with the Government's plans and yet it appears that the Government is driven predominantly by media opinion and public fears. Despite widespread misgivings it appears that psychiatrists will have to grudgingly embrace risk-management and 'dangerous and severe personality disorder' (DSPD). It seems psychiatry is unable to resist the external pressure to move from dealing with mental disorder to policing the population for social deviancy. Junior doctors will become increasingly aware that the job they chose and trained for may be radically different in the future.

There are questions that need to be answered regarding SHOs' role in the management of DSPD patients. If they are to be involved in the day-to-day management and assessment of such patients, who are widely regarded as unmanageable and disruptive on general wards, then a great deal of thought needs to be given to appropriate training. Currently, there are few placements specialising in the management of people with personality disorders. More emphasis will also have to be given to training in group therapies and therapeutic communities and this will require considerable time and resources. It could also be argued that time spent managing but not 'treating' DSPD patients will necessarily dilute trainees' experience of 'treatable' mental illness. A massive expansion in all grades of post, including SHOs, will be required. It is doubtful how achievable this is given current recruitment difficulties.

Further clarification is required regarding the role of trainees in the emergency detainment of informal in-patients under any new legislation. If similar measures remain to those currently prevailing under section 5(2), more rigorous policies for emergency detention will need to be made. It is likely that the perception of detainment will change significantly – from the viewpoints of staff, patients and the community at large. Further, the consequences of applying a holding order will need to be considered, especially if this leads to a chain of events that may not be in the best interests of the patient.

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