Correspondence

Advertising in psychopharmacology

Sir: A glossy, beautifully produced pamphlet entitled *Highlights, Managing Depression with the Whole Patient in Mind*, arrived with my usual collection of postal freebies. It reports on a conference on this topic, the audience including 350 UK psychiatrists, sponsored by Lundbeck, the Danish CNS pharmaceutical company. The views of individual participants were invited on "the management of depression and the likely role of a new SSRI, Cipramil (citalopram) in the treatment of the condition".

This pamphlet raises important questions in relation to advertising.

Each of the 13 pages quotes an authority on depression, medical or non-medical. Eight of the 13 are from the UK, six of these professors; the remainder are from other European countries. Cipramil is mentioned by six contributors and prescribing information for the preparation is given at the back of the pamphlet.

Like many non-generalists I try to keep up with developments in psychopharmacology and am helped by advertising material. However, I expect this material to be orientated around the results of published research together with references so that the reader is in a position to judge the comparative effectiveness and unwanted effects, in the present example, between different SSRIs.

I appreciate it is difficult for those attending sponsored meetings to know how their views are to be represented. However, this example strongly suggests that participants should insist that an outline should be given to speakers as to how the papers are to be reported, especially in material aimed at a wide distribution.

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Driving, insurance and SSRIs

Sir: Since the serotonin-specific reuptake inhibitor drugs (SSRIs) have less potential for interfering with driving ability than tricyclic drugs (TCAs) (Kerr & Hindmarsh, 1995), it might be expected that a patient on an SSRI would represent a lesser risk for motor vehicle insurance and pay a reduced amount.

I contacted five insurance companies on four separate occasions, requesting quotes which differed only in medical details. In the first, no medical problem was mentioned; in the second, a recent history of depressive illness with no treatment; in the third, treatment with amitriptyline; and in the fourth, treatment with fluoxetine.

All four companies were happy to give a quote under the initial criteria, though at very different cost. For the second quote each company wanted to know whether the driver had any restriction placed on their driving by the Driving and Vehicle Licensing Agency. Only one would insure a restricted driver.

Two companies would not insure an unrestricted driver with a history of mental illness whether treated or not. An approximately 15% increase in quote was given by a further two companies for an unrestricted depressed driver and presence or nature of treatment made no difference. Only one company made no change in quote for a depressed driver provided their licence was not restricted. No company made a reduced quote for patients on fluoxetine rather than amitriptyline.

This brief survey suggests that insurance companies do not feel that drugs with less potential for causing cognitive impairment reduce the risk of accidents, or are unaware of any differences. This is in spite of evidence for reduced accidents from the Medical Commission on Accident Prevention (Taylor, 1995).

This is unfortunate as, while by prescribing SSRI drugs we aid our patients' abilities, we do not save them money.

EDWARDS, J. G. (1995) Depression, antidepressants and accidents. *British Medical Journal*, **311**, 887–888.
KERR, J. & HINDMARSH, I. (1995) Antidepressants and RTAs. *Psychiatry in Practice*, July/August, 6–8.
TAYLOR, J. F. (ed.) (1995) *Medical Aspects of Fitness to Drive*. London: The Medical Commission on Accident Prevention.

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Missing, possibly moribund, 'IQ'

Sir: I should be grateful if older psychiatrists and psychologists who remember 'IQ' would search their premises to try and ascertain his whereabouts. He was a valued colleague in the past and helped greatly in understanding intellectual functioning. His guidance was invaluable in legal issues and in such concepts as mental impairment.

I saw him recently in DSM–IV but younger psychologist colleagues who were entrusted with his care seem to have forgotten about him and have little desire to ensure his whereabouts or condition. I am informed that most cannot recognise him, having been led astray by more alluring upstarts.

If he is found but is too ill to recover it might be that those of us who valued him greatly could ensure a worthy memorial.

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Depot clinics

Sir: Singh *et al*'s (*Psychiatric Bulletin*, December 1995, **19**, 728–730) conclusive findings showed that consumers preferred to receive their depot medication at the traditional psychiatric depot clinic setting. I studied an inner city sector (population 100 000) in Nottingham where there is a well developed community mental health service. We looked at the prescribing pattern to the population receiving depot medication.

We had 106 patients receiving their depot medication at this clinic. The diagnosis of our patient group was very similar: diagnostic breakdown (90%); schizophrenia (6%); bipolar disorder and schizoaffective disorder (4%). We also issued a questionnaire to the sector's 58 general practitioners (GPs) to see whether they were prescribing and administering a depot to any patient not attending the clinic: 75% replied and none was prescribing or administering a depot at a GP surgery.

It is essential that the future of the depot clinic survives within the mental health setting, be it hospital or community psychiatric base. These patients have a serious mental illness diagnosis. To ensure care and contact with this vulnerable group who usually relapse without medication the depot clinic remains a valuable resource.

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Audit and psychiatry of learning disability

Sir: Successful audit depends on active participation by a peer group working in the same speciality. As psychiatrists specialising in learning disability, we find that some clinical topics can be audited locally with the multidisciplinary team of the learning disability service, or with other psychiatric specialities, but there are some topics that can be usefully audited only with specialist peers.

Psychiatry of learning disability is a small speciality with very low staffing levels in the former North Western region. There are only nine whole-time equivalent consultants, whereas the minimum number recommended by the College is 21 (for a population of around 4.2 million). Very few Trusts employ more than one consultant in the speciality. With the progress towards closure of the mental handicap hospitals and development of local services, doctors in the speciality have little daily contact with each other, and it is difficult to establish a peer group.

An organisational framework is required for audit, including a person to coordinate audit and administrative support, access to case notes, and information technology. It is not feasible to have an audit coordinator dedicated to the speciality in each district. If other psychiatric specialities have an audit coordinator, that person could provide some time, but it is difficult to secure a fair share of time, and the person is unlikely to be familiar with the speciality. Another option is for one service to take responsibility for coordinating audit in the speciality for several services.

There are also significant problems of gaining access to case notes. We have considered three options: case notes could be moved temporarily to a central place for audit, they could be scrutinised at their base by a person employed by the service which produced them, or they could be scrutinised by a person employed by another service.

The first of these is undesirable because of the risk of losing records, or needing them for clinical purposes during the period of the audit. The second is undesirable because of the need to validate the data. The third might be regarded by some Trusts as intrusion into their business by competitors.

There is a need to devise improved systems for enabling audit in psychiatry of learning disability in areas where consultants are single-handed in a service. We would welcome the views and suggestions of colleagues who have similar difficulties.

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Imbalance in the purchasing of drug services

Sir: Another tranche of grants was recently issued by the National Lottery Charity Commissions and Merseyside received £1.5 million to help good causes in the area. One voluntary drug