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Shared care of people with major mental illness

EDITOR—Tony Kendrick and Tom Burns (a general practitioner and a psychiatrist) argue that family doctors should take back the sole continuing care of stable and compliant patients with psychotic disorders.[1] However, we stand by our assertion that it is the job of multidisciplinary community teams to oversee the care of almost everybody with a major mental disorder,[2] although always in collaboration with general practitioners. This debate is at least a healthy sign amid concerns about the failure of community care and in the light of recent guidance from the General Medical Services Committee which could greatly limit general practitioners' role in the management of major mental illness.[3]

No matter who takes primary responsibility, the monitoring of seriously mentally ill patients should lead to adequate recognition of their needs and the appropriate responses. Several studies, including our own, indicate that routine psychiatric services often fail in this task.[2 4] Our subjects who had returned to the sole care of their general practitioner also had important unidentified needs, although Kendrick and Burns are right to criticise our failure to study the important group of psychotic patients who have never been in touch with specialists.[1]

Continuing care of patients with major mental diseases is dominated by the fact that many do not seek help when their condition deteriorates. This is why we now insist that even patients whose condition is stable require systematic review, usually in their own homes. Our work in Lanarkshire and an ongoing investigation by one of us (HW) in the Scottish borders suggests that a rolling survey of all patients with identified psychotic disorders can be undertaken without prohibitive additional costs. Several standardised schedules have been developed which could guide this clinical process.[5] Further research is required to show whether this routine needs assessment will help specialists and general practitioners to prioritise mental health care according to need rather than demand. This will probably lead to increased input to the least vocal and most vulnerable psychiatric patients—that is, those with schizophrenia, manic depressive illness, and other brain disorders. This will inevitably divert services from patients with milder acute conditions, but it is for each area to establish comprehensive services within available resources. Potential shortfalls in healthcare provision will not be avoided by leaving general practitioners to provide all community care once patients recover from the acute phase of major psychotic illness.

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People may become psychologically dependent on antidepressants

EDITOR—Robert G Priest and colleagues advocate educating patients that discontinuing antidepressant treatment will not be a problem but remarkably do not cite any evidence to support their recommendation.[1] They also complain that many lay people regard antidepressants as addictive. They suggest that people may be extrapolating from what they have heard about benzodiazopines. This may be, but it is also common sense to believe that discontinuing taking a drug that is thought to improve mood may be difficult. I think that the general public understands this issue better than the Royal Colleges of Psychiatrists and General Practitioners, which are responsible for the Defeat Depression Campaign.

Of course what Priest and colleagues mean is that there is little evidence of physical dependence caused by antidepressants, but this is not what they say. There are, however, case reports of a withdrawal syndrome.[2] Clinical experience is that it can be difficult to withdraw treatment with antidepressants for various reasons. The general public might reasonably expect psychiatrists specialising in disorders of the mind to recognise psychological dependence, base their advice on clinical experience, and use their common sense.

Randomised controlled trials of discontinuation of antidepressant treatment have a relapse rate varying from 92%[3] to 36%[4] in the placebo group. Relapse rate is significantly reduced by continuing antidepressant treatment. Some patients therefore do maintain their therapeutic gains when antidepressants are withdrawn, but the relapse rate is not insubstantial and seems to support the general public's commonsense view rather than the Defeat Depression Campaign's purist scientific statement. Perhaps the public needs to be suspicious of the motives of a campaign that encourages them to seek medical treatment and also tries to help doctors recognise depression. Patronising misinformation is not constructive.

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Afghanistan: a biased report

EDITOR—Robert Ivker's news story about medical supplies to Afghanistan publicised the good work of the International Red Cross but was factually incorrect and made inadequate reference to the World Health Organisation.[1]

He writes: "In the past four years nearly 50 000 people have died in the conflict between the Taliban authority and a coalition of ethnic minority groups that is fighting against it." Taliban started its comparatively peaceful takeover of large areas of Afghanistan early in 1995, putting an end to the fighting and bringing safety and peace wherever it came; the opposing coalition formed only late in 1996. Statistics for deaths from fighting among the Mujahedin followers before the time of the Taliban are not available.

We at the WHO have staff constantly in nine suboffices throughout the country, and we know of no case of men being executed because they do not have a beard. Women doctors and nurses at all health facilities in Kabul are working normally. The WHO is not only "primarily concerned with basic nutritional support and the immunisation of children." [1] In the past few years staff from the Ministry of Public Health were not able to visit all parts of the country, but the WHO has always been welcomed everywhere because of its strict neutrality; in practice it has acted on behalf of the ministry. As an impartial United Nations agency, we as the WHO provide some medical supplies, tools, and instruments to nearly all hospitals. We have national and international experts; conduct short term training courses, seminars, and workshops for doctors, nurses, health workers, and traditional birth attendants; and sponsor fellowships for Afghan doctors and paramedics all over the world.

At Qandahar in the south, in remote Faizabad in the north east, and in Jalalabad and Ghazni we have reinstated water supply networks. Together with Unicef and non-government organisations we have vaccinated millions of mothers and children. Two batches of medical students from Kabul and Jalalabad have been able to graduate with