mental handicap institutions serve the important function of increasing the psychiatrists' awareness of the inadequacy of the current practice and motivating them to seek improvement via the emphasis on more rational prescription guidelines, increase of medical input, introducing regular drug review, and alternative treatment approaches. Prescribing psychoactive drugs for the mentally handicapped patients in long-stay institutions requires extra care and consideration, and the dictum to follow is: "When in doubt, don't!" (Kirman, 1975).

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AUTHORS' REPLY: We were interested to read Dr Fan's letter and see that his findings with regard to the prescription of antipyschotic drugs in the mentally handicapped are very similar to our own, despite differences in the ethnic and cultural background of his subjects. We would like to reply to the queries that he has raised.

We chose the use of antipsychotic medication in our study rather than other psychotropic drugs because we believe that antipsychotic drugs are prescribed too readily in mental handicap with insufficient pharmacological indications. Furthermore, the adverse effects of long-term prescription of these drugs are more serious than erroneous administration of alternative psychotropic agents.

We agree that it would have been helpful to look at all patients who received antipsychotic drugs four years before our investigation. However, the logistic task of identifying all patients in the hospital in 1982 and perusing their files was considered too major an exercise and, because of problems arising with patients who had died or who had left hospital in the four years before our study, it was likely that any enquiry of this nature would have been incomplete. We are now undertaking a further study examining the cohort of our 1986 sample to see what drugs they are at present receiving.

Dr Fan is quite right to point out our error in stating that female patients in our study received a significantly higher mean daily dose of chlorpromazine equivalents compared with that of the male patients. We agree that the considerable variation in dosage in the female patients is of interest and shows that there are some female mentally handicapped patients who receive very high doses of antipsychotic drugs. Examination of our data indicates that a group of these patients have a history of frequent disturbed behaviour and/or aggression.

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Buspirone in benzodiazepine withdrawal

SIR: Beeley & Hammersley (*Journal*, November 1990, **157**, 777) comment indignantly that our study of buspirone in benzodiazepine withdrawal (*Journal*, August 1990, **157**, 232–238) was clinically irrelevant and unethical. They castigate us for ignoring the "generally accepted" view that "gradual dosage reduction with appropriate psychological treatment is the best way to manage benzodiazepine withdrawal", and for perpetuating "the search down a blind alley for pharmacological short-cuts".

In Newcastle we have long advocated gradual dosage reduction in benzodiazepine withdrawal, which is individually tailored and combined with psychological support (Ashton, 1987, 1989). We have emphasised the distress that benzodiazepine withdrawal can cause in some patients and have drawn attention to the need for psychological help and for tranquilliser support groups (Ashton, 1984). For the past seven years we have conducted a benzodiazepine withdrawal clinic which operates in close liaison with clinical psychologists and with a tranquilliser advice and support group which we helped to establish. Our general policy has been to involve the patients closely in decisions about their own withdrawal regimes.

After experience with over 200 patients at the clinic (and many more at the support group) it is clear that present methods are not ideal. Although 90% of our patients have achieved and maintained benzodiazepine withdrawal (Ashton, 1987), the clinical course has not always been easy and we have learned that some patients do require additional pharmacological support. For example there is a real risk of suicide in withdrawal and a proportion of patients develop major depression requiring treatment with antidepressants (Ashton, 1987).

Hence we felt that it was (and still is) important to evaluate the effect of pharmacological and other

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