Table 1—Family members' views (n = 100) on telling the diagnosis of Alzheimer's disease

	Yes		No
Should the patient be told?			
Patient is aware that he/she is ill	7	Diagnosis would depress/agitate patient	51
Patient's right to know	5	Patient has a dread of developing Alzheimer's disease	12
Patient would cope better	4	Would not understand diagnosis	8
Informed consent for drug trials	1	No benefit in knowing	5
		Would not want to be told of any illness	4
		Stigma of the diagnosis	2
		Patient might commit suicide	1
Should you be told?			
My right to know	36	Diagnosis would depress/agitate me	13
Make provisions for my future	26	Would not want to be told of any illness	10
Commit suicide	6	No benefit in knowing	3
Explore treatment options	3	Commit suicide	2
		Stigma of the diagnosis	1
Would you make use of a predictive test?			
Make provisions for my future	42	No benefit in knowing	15
Explore treatment options	18	Diagnosis would depress/agitate me	5
My right to know	8	Would not want to be told of any illness	3
To help research into the disease	5	Not now, but at an older age	2
Commit suicide	2		

bers said that they would consider committing suicide if they were diagnosed as having Alzheimer's disease.

In 1961, 90% of doctors expressed a preference for not telling cancer patients their diagnosis. By 1977 a complete reversal of opinion had occurred, with 97% of doctors favouring disclosure of the diagnosis.⁵ The reasons for not telling cancer patients their diagnosis in 1961 were similar to those now given for not telling patients with Alzheimer's disease their diagnosis. The change in policy among doctors coincided with advances in the management and treatment of cancer. Similar advances are being made with Alzheimer's disease today, so clinicians must decide whether to respect the wishes of family members not to tell patients their diagnosis, or to respect individual autonomy, inform patients, and involve them in the management of their condition.

A recent review which advocated disclosure of diagnosis emphasised that clinicians must evaluate each situation individually.¹ Family members as well as

patients respond in various ways to the psychological threats presented by the diagnosis of Alzheimer's disease, and the issue of disclosure needs to be dealt with on a patient by patient basis.

Funding: Health Research Board of Ireland and Mercer's Institute for Research on Ageing.

Conflict of interest: None.

- 1 Drickamer MA, Lachs MS. Should patients with Alzheimer's disease be told their diagnosis? *N Engl J Med* 1992;326:947-51.
- 2 Bahro M, Silber E, Sunderland T. How do patients with Alzheimer's disease cope with their illness? A clinical experience report. *J Am Geriatr Soc* 1995;43:41-6.
- 3 Michon A, Deweer B, Pillon B, Agid Y, Dubois B. Relation of anosognosia to frontal lobe dysfunction in Alzheimer's disease. *J Neurol Neurosurg Psychiatry* 1994;57:805-9.
- 4 Rohde K, Peskind ER, Raskind MA. Suicide in two patients with Alzheimer's disease. *J Am Geriatr Soc* 1995;43:187-9.
- 5 Novack DH, Plumer R, Smith RL, Ochitill H, Morrow GR, Bennett JM. Changes in physicians' attitudes toward telling the cancer patient. *JAMA* 1979;241:897-900.

(Accepted 24 May 1995)

Can adverse drug reactions be detected earlier? A comparison of reports by patients and professionals

Toine C G Egberts, Maartje Smulders, Fred H P de Koning, Ronald H B Meyboom, Hubert G M Leufkens

The occurrence of previously unknown adverse reactions after the marketing of a new drug is inevitable given the limitations of preregistration clinical trials. Nevertheless, their impact on public health should be minimised by ensuring that reactions are detected as early as possible. The reporting of suspected adverse drug reactions by health care professionals to monitoring agencies¹ and to medical journals² has been important in alerting doctors to drug safety problems, but Mitchell *et al* suggested that the time lag to the first reports of adverse reactions might be shortened if patients themselves reported adverse events.³ For a newly introduced antidepressant we compared the time to reporting of adverse drug reactions by patients and by health care professionals.

Methods and results

A telephone medicines information service was started in 1990 by the Dutch Ministry of Health and the Royal Dutch Association for the Advancement of Pharmacy to promote the correct use of drugs and identify problems related to drug use. Anonymously and free of charge, patients can consult a pharmacist. The pharmacist summarises each call on a standard form. All reports produced by the service in 1992-4 were searched for those indicating an adverse reaction associated with the antidepressant paroxetine. This drug was introduced just before the study (September 1991) and has been prescribed in considerable volume. The time lag between marketing of paroxetine and the date of the phone calls was calculated and compared with the time lag between marketing of paroxetine and the date of suspected reactions reported by health professionals to the Netherlands Pharmacovigilance Foundation. This is a typical spontaneous adverse drug reaction reporting system, which in 1994 covered a population of about two million people in seven regions of the Netherlands. We analysed separately the time lag in both systems for those drug reactions that were not mentioned in the patient information leaflet at the time of the study.

Out of 23 625 calls to the telephone service 120 suggested an adverse reaction to paroxetine. Of the 7665 suspected adverse reactions reported to the Nether-

Correspondence to: Dr Egberts.

BMJ 1996;313:530-1

Department of
Pharmacoepidemiology
and Pharmacotherapy,
Utrecht Institute for
Pharmaceutical Sciences,
Utrecht University,
PO Box 80.082, 3508 TB
Utrecht, Netherlands
Toine C G Egberts, research
fellow
Hubert G M Leufkens,
associate professor of
pharmacoepidemiology

Netherlands
Pharmacovigilance
Foundation LAREB,
5026 RH Tilburg,
Netherlands
Maartje Smulders, student
Fred H P de Koning,
pharmacist
Ronald H B Meyboom,
physician

Fig 1—Cumulative number of reports of suspected adverse drug reactions associated with use of paroxetine received from patients and from health care professionals since marketing ($t = 0$).

lands Pharmacovigilance Foundation 89 were related to paroxetine. The mean time lag for all suspected reactions to paroxetine was 229 days less for the telephone service than for the Pharmacovigilance Foundation (95% confidence interval 160 to 298; Student's t test; fig 1). The proportion of new suspected reactions (those not mentioned in the patient information leaflet) was similar for both systems (21% *v* 18%). The nine new reactions identified by both systems were: rigours (first reported by a patient at 390 days, first reported by a health professional at 578 days), bleeding disorders (396, 1025), hypertension (432, 1192), mydriasis (597, 660), taste disturbance (635, 827), apathy (943, 1124), flushing (967, 1100), menstrual disorders (971, 1162), and rash (1002, 1125). The mean difference in time lag for these reactions was 273 (89 to 458) days.

Comment

Our findings show that reporting by patients may contribute to earlier detection of known and unknown adverse drug reactions. The information available from patients in the telephone service was, however, often crude and incomplete in comparison with professional adverse drug reaction reports. Therefore the telephone service cannot be relied on as an independent reporting system; it might generate too many false alarms. A combination of information from patients and health care professionals might, however, enable earlier detection. Additional information is relevant because alerts are often based on only a few cases,⁴ but too high demands on quality of the reports may impair their capacity for early warning.⁵ We suggest that patient reporting may play an additional role in pharmacovigilance.

We thank Mrs L van der Schoot, Mrs A van Berkel, and Mr H ter Steege for their help and the Royal Dutch Association for the Advancement of Pharmacy for the permission to analyse the forms of the telephone medicines information service.

Funding: Netherlands Pharmacovigilance Foundation LAREB and Department of Pharmacoepidemiology and Pharmacotherapy, Utrecht University.

Conflict of interest: None.

- Rossi AC, Knapp DE. Discovery of new adverse drug reactions. A review of the Food and Drug Administration's spontaneous reporting system. *JAMA* 1984;252:1030-3.
- Venning GR. Identification of adverse reactions to new drugs. III: Alerting processes and early warning systems. *BMJ* 1983;286:458-60.
- Mitchell AS, Henry DA, Sanson-Fisher R, O'Connell DL. Patients as a direct source of information on adverse drug reactions. *BMJ* 1988;297:891-3.
- Mann RD. Drug safety alerts. A review of "Current Problems." *Pharmacoepidemiology and Drug Safety* 1992;1:269-79.
- Haramburu F, Bégaud B, Péré JC. Comparison of 500 spontaneous and 500 published reports of adverse drug reactions. *Eur J Clin Pharmacol* 1990;39:287-8.

(Accepted 8 March 1996)

Evaluation of a psychiatric court liaison scheme in north London

Nick D Purchase, Alison K McCallum,
Harry G Kennedy

North London Forensic
Psychiatry Service,
Camlet Lodge, Enfield
Community Care Trust,
London EN2 8JL
Nick D Purchase, forensic
social work manager
Harry G Kennedy, consultant
forensic psychiatrist

Department of Primary
Care and Population
Sciences, Royal Free
Hospital School of
Medicine, London
NW3 2QG
Alison K McCallum, senior
lecturer in public health
medicine

Correspondence to:
Mr Purchase.

BMJ 1996;313:531-2

Court diversion schemes were established to ensure that people with mental illness who are brought before the courts obtain appropriate care from health and social services.¹ In July 1993 a psychiatric court liaison scheme, one of about 300 in England and Wales, was established at Tottenham Magistrates' Court in north London to cover two boroughs, or one health authority. We evaluated the outcome for all defendants attending the scheme over 18 months.

Subjects, methods, and results

Between July 1993 and December 1994, 104 defendants were seen. We report the data on the 89 local residents. Subjects were monitored by address, postcode, age, ethnic origin, previous contact with psychiatric services, criminal record, and offence. Their outcomes were measured against the rate of discharges of inpatients from the local psychiatric hospitals. The mean age of those referred was 33.1 (SD 10.9) years (range 18-67); 80 were men.

Of 87 patients with full information on accommodation, 16 were homeless, eight being in temporary accommodation. Of the remainder, 68 were owner

occupiers or tenants, one lived in a mental health hostel, and one was a traveller and did not consider himself homeless. Homeless people were no more likely to be admitted to hospital than were those who had homes. All those in temporary accommodation had local links and were not temporary residents.

The principal offence was classifiable in 86 of the 89 cases—namely, a public order offence (20 subjects), a property or driving offence (20), violence towards a person (26), a sexual offence (12), and arson (8). Schizophrenia was the most common diagnosis (29 subjects), followed by major affective disorders, mostly mania (22); organic mental illness, predominantly alcohol related disorder (13); neurotic disorders (8); and learning difficulties (2). Fifteen subjects had no mental illness. In addition, 12 subjects misused alcohol alone and nine cannabis, while 29 subjects misused several substances. Those with schizophrenia were more likely to be admitted to hospital ($\chi^2 = 15.9$, $P < 0.003$), while those with no mental illness were less likely to be admitted ($P < 0.002$). There was no association between ethnic group and likelihood of admission. Nineteen of the 89 subjects were unknown to the psychiatric services. The rest had received inpatient psychiatric care. All of those with a psychiatric history would have been eligible for inclusion in the supervision register (43 subjects had a history of violence and 61 had been previously convicted) (table 1).

Fifty four patients were admitted to hospital, of whom 36 had been discharged less than a year before. A further 17 were given outpatient appointments for the local services. All admissions were formal and all those admitted were psychotic. The 36 readmissions within a