

detention) or another consultant at the hospital concerned, preferably one who does not share a ward with the patient's RMO.

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Breakaway techniques

DEAR SIRs

In response to the recent Report of the Collegiate Trainees' Committee Working Party on training of junior psychiatrists with respect to violent incidents (*Psychiatric Bulletin*, 1991, **15**, 243–246) we would like to share our experience at York.

Several measures have been implemented to help ensure safety, including written information regarding the management of potential violence on joining the training scheme, installation of emergency bells in consulting rooms and the formalised reporting of violent incidents. In addition, occasional guest lectures on the assessment and management of violent patients have been arranged.

The most useful measure, however, has been the Breakaway Techniques Course which we have arranged for trainee and senior medical staff. The breakaway techniques are designed to enable the professional working in isolation to safely remove themselves from the following form of attack: hair pulling, strangulation, grasping of clothing, 'bear hugs', and wrist grips.

We have attended one course comprising two half days so far. The course instructors were Home Office approved nursing colleagues who also teach control and restraint for the nursing staff. Originally, the junior doctors felt that training in control and restraint would be useful as often they are present at potentially dangerous situations on the ward. The junior doctors feel helpless while nursing colleagues are trying to restrain physically aggressive or violent patients on the Ward. However, due to the time commitment necessary for the Control and Restraint Course, the Breakaway Techniques Course was the best next alternative. However, we had difficulty in organising breakaway techniques due to the intransigence of senior nurse management with regard to releasing the instructors from their ward duties without reimbursement for their time. After protracted negotiation with the nursing hierarchy we were able to overcome this hurdle without any financial implications.

Once arranged, the course proved a success. Besides learning breakaway techniques, we gained confidence in our ability to deal with the potentially difficult situation and believe that this confidence in itself may prevent 'potential' developing into 'actual'.

It is planned to repeat the course six-monthly so that the new trainees joining the scheme will benefit

early in their training and for others it will be a 'refresher'. If the number of medical staff is too small, it may be possible in future for them to join the courses arranged for nurses. We think it is possible for other psychiatric training schemes to organise similar courses with the help of trained nursing colleagues. We gather that other training schemes have also organised such courses and we would strongly suggest still more did so.

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Training in neurology

DEAR SIRs

I was most interested to read Dr Hughes' article on the value of the physical examination in psychiatry (*Psychiatric Bulletin*, 1991, **15**, 615–616). I am concerned about his findings, in particular with regard to the poor way in which the neurological examination was carried out. I agree with him that it is very important to exclude treatable pathology in the nervous system in psychiatric patients.

I would like to propose two ways of improving the situation.

More emphasis should be placed on training in neurology during postgraduate training for psychiatrists. Perhaps rotational training schemes should include a six month period in a department of neurology. This would also improve the management of psychiatric patients with chronic neurological problems.

The quality of neurological examination would improve if psychiatric units used detailed standardised neurological examination forms, with adequate spaces to note the findings. This is done in many neurology units. The forms I have seen used in psychiatric hospitals to record the physical examination leave very little space to record nervous system findings. (The ones I have seen allowed a quarter of one side of A4 paper for this.)

I feel that the detection of treatable neurological disease is a vital part of the psychiatric evaluation. Perhaps more units should audit this area of practice and changes could then be implemented.

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Use of clozapine

DEAR SIRs

I refer to the letter by Ball & Lipsedge (*Psychiatric Bulletin*, 1991, **15**, 645–646), concerning the use of

clozapine. Clearly there is a problem with compliance with regards to blood tests and Meltzer, who participated in some of the original studies (Kane *et al.*, 1988) has confirmed that around 10% of intractable schizophrenics who meet the criteria for clozapine will refuse to have blood taken.

I think it is important that this number is minimised and there are several measures that can be taken to achieve this. The question of refusal of consent is dealt with by pre-clozapine counselling, involving not just the patient but also relatives and staff. If a patient is detained under Section 3 within the first three months, there is no reason why this patient should not be given clozapine against his or her will. If, in fact, the patient has been detained over three months then the Mental Health Act Commission has recently sent a circular to all Second Opinion doctors, referred to by Bingley's letter (*Psychiatric Bulletin*, 1991, 15, 645), which makes it clear that a special second opinion for clozapine must be requested.

With reference to epileptic seizures, certainly in my experience of over 18 months of using clozapine I have seen patients with epileptic seizures and at least two of them now currently also take anticonvulsants in the form of sodium valproate. However, recent research in the USA (Haller & Binder, 1990) has shown that it is commonly, although not always, described with patients who receive clozapine in a dosage in excess of 600 mg and this can be resolved by adding anticonvulsants and/or reducing the clozapine dosage.

It is important with regard to all these problems that the patients and relatives are counselled, not only pre-treatment but also during treatment and post-treatment. We have therefore set up relatives' groups and are about to set up both patient groups and staff groups to enable patients to continue on this rather unique preparation which, as Lipsedge & Ball mention, has so many potential benefits.

With nearly 25 patients on the drug, we have found that the only reason for discontinuing patients, apart from the difficulty with neutropenia, would be non-response after prolonged treatment. However, clozapine can be combined with conventional neuroleptics, apart from depot injections, and this is, in fact, the case in many European countries. Sometimes it is necessary to do this in order for patients to achieve at least 12 months on the drug, which is again described by Meltzer, as a watershed after which patients can continue to improve who have not responded in the first six weeks.

I am convinced that with the counselling that must go on from an early stage both pre-treatment and throughout the treatment period, most patients can continue to take clozapine and also there are fewer patients who are reluctant to take it for either delusional or prejudicial reasons. Certainly

staff who have seen patients improve are more willing to counsel both patients and relatives with regards to overcoming the difficulty of consent to blood tests and the patients themselves, after they begin to improve, certainly, in my experience, are more likely to change their views from non-consent as a by-product of their improved mental state.

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References

- HALLER, E. & BINDER, R. L. (1990) Clozapine and seizures. *American Journal of Psychiatry*, **147**, 1069–1071.
KANE, J., HONIGFELD, G., SINGER, J. & MELTZER, H. (1988) Clozapine for treatment-resistant schizophrenia: a double blind comparison with chlorpromazine. *Archives of General Psychiatry*, **45**, 789–796.

Will Columbus succeed in discovering the computer? Floppy disc psychiatry in Italy

DEAR SIRS

The Italian people define "Columbus' egg" as a simple but clever solution to a reputedly difficult or insoluble problem. This idiom refers to the anecdotal report about the lively and witty intelligence of Christopher Columbus, who, when challenged to make an egg stand upright, succeeded simply by flattening the base with a light touch (you can try it, it works!).

A lot of problems in psychiatry should be solved through a similar approach. So, when we tackled the problem of finding an efficient and feasible screening instrument for psychiatric morbidity in a difficult setting such as in general practice, our response "computerise!" struck us as being a true "Columbus' egg". Moreover authoritative literature, particularly about the use of the computerised version of the General Health Questionnaire (GHQ), gave us a strong theoretical support to this solution (Hughes *et al.*, 1986; Lewis *et al.*, 1988).

Confident in our knowledge of informix and emerging computer technology we computerised the Italian version of GHQ. This was proposed for all the subjects consecutively referred to our psychiatric out-patient unit prior to visiting either for bureaucratic reasons (shooting-licence, licence to carry firearms, attitude to special jobs, etc.) or routine examinations. The software requested the subject to answer to the screen by using only three specially-coloured keys on the keyboard ("Enter" and two arrows). The remaining keys were out of use in order to avoid errors.