



# the columns

## correspondence

### Liaison services – collaborative working

We read with interest Kewley & Bolton's survey on liaison psychiatry (*Psychiatric Bulletin*, July 2006, **30**, 260–263) and the related correspondence of Pitman & Catalán (*Psychiatric Bulletin*, January 2007, **31**, 33). In the wake of threats to close or merge liaison service with crisis resolution teams, it is imperative not to compromise patient care. The liaison psychiatry service in Birmingham Heartlands Hospital has developed a way of working to adhere to the time targets in accident and emergency (A & E) departments which neither compromises psychosocial assessment (National Institute for Clinical Excellence, 2004) nor overburdens the existing psychiatric services.

The protocol for psychiatric assessment is based on the SAD PERSONS scale (Juhnke, 1994) and has been devised in consultation with the A & E department. The A & E department is responsible for initiating the psychosocial assessment and classifying patients either as high or low priority, based on needs and risks. The majority of psychiatric patients attending A & E departments out of hours are needing assessment and treatment for self-harm. The patients who are deemed high priority are referred to the local crisis resolution teams for emergency assessment. Low-priority patients are referred after medical assessment to the psychiatry clinic in the A & E department on the next working day. This efficient collaboration reduces the number of 'did not wait' patients and possibly avoids breaching A & E waiting time targets.

In a 6-month period, 46% of psychiatric patients attending the A & E department out of hours have been referred to the clinic. If this way of collaborative working can be adapted to meet local hospital needs, it might address some of the concerns raised by Kewley & Bolton.

JUHNKE, G. (1994) SAD PERSONS Scale review. Measurement and evaluation. *Counselling and Development*, **27**, 325–327.

NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE (2004) *Self-Harm. The Short-Term Physical and Psychological Management and Secondary Prevention of Self-Harm in Primary and Secondary*

Care. NICE. <http://www.nice.org.uk/pdf/CG016NICEguideline.pdf>

**Sathish Masil** Specialist Registrar, General Adult Psychiatry, New Bridge House, 130 Hobmoor Road, Birmingham B10 9JH, email [gmasih@yahoo.co.uk](mailto:gmasih@yahoo.co.uk), **Dhruva Bagchi** Consultant in Liaison Psychiatry, New Bridge House, Birmingham

doi: 10.1192/pb.31.5.191

### Clozapine-induced speech dysfluency: further cases

Lyall *et al* (*Psychiatric Bulletin*, January 2007, **31**, 16–18) presented two cases of clozapine-induced speech dysfluency and suggest that there are only four cases in the British and American literature. However, we do not think that their literature search was comprehensive. Begum (2005) reported stuttering, facial tics and myoclonic seizures, which developed a few days after initiation of clozapine for treatment-resistant schizophrenia. Furthermore, Bär *et al* (2004) examined the hospital records of about 6000 German patients receiving antipsychotic treatment over 3 years for evidence of stuttering as a possible side-effect. They described seven patients with stuttering induced by the atypical antipsychotics olanzapine (six cases), and clozapine (one case).

We also observed a man in his early 40s who developed stuttering when his clozapine was increased from 400 mg/day to 450 mg/day. This was also associated with a marked increase in seizure activity which necessitated reducing and stopping clozapine.

We suggest that future case reports in the *Psychiatric Bulletin* should describe a systematic search of standard databases for other case reports and the time period covered by such a search. This would be beneficial to the *Psychiatric Bulletin* and the wider readership.

BÄR, K. J., HÄGER, F. & SAUER, H. (2004) Olanzapine- and clozapine-induced stuttering: a case series. *Pharmacopsychiatry*, **37**, 131–134.

BEGUM, M. (2005) Clozapine-induced stuttering, facial tics and myoclonic seizures: a case report. *Australian and New Zealand Journal of Psychiatry*, **39**, 202.

\***Nasser Abdelmawla** Brandon Mental Health Unit, Leicester General Hospital, Gwendolen Road, Leicester LE5 4PW, email: [Nasser.Abdelmawla@leics.part.nhs.uk](mailto:Nasser.Abdelmawla@leics.part.nhs.uk)

[leics.part.nhs.uk](mailto:leics.part.nhs.uk), **Stephen J. Frost** Brandon Mental Health Unit, Leicester General Hospital

doi: 10.1192/pb.31.5.191a

We read with interest the report by Lyall *et al* (*Psychiatric Bulletin*, January 2007, **31**, 16–18) of speech dysfluency associated with clozapine and would like to report our experience in a patient we are treating. Our patient is currently 44 and experienced his initial episode of psychosis when he was 23. Aged 27 he was diagnosed with schizophrenia and maintenance typical antipsychotic medication was prescribed, with initial good effect. However, he continued to have low-grade positive symptoms and the negative syndrome also became apparent. Over the subsequent 10 years he had many changes of medication with little positive effect. At the age of 38 he was commenced on clozapine and his positive symptoms rapidly receded. At a dose of 200 mg he developed a stutter (he had not had this problem as a child), but the dose was increased to 350 mg daily because of its overall positive effect. However, the stutter was so disabling that clozapine optimisation strategies were employed and the clozapine dose was gradually reduced. Owing to a lack of local speech therapy services our patient was referred to a neurologist, who confirmed our findings and supported our medication strategy. Amisulpride and low-dose benzodiazepines were added and the dose of clozapine was reduced. The stutter reduced with these changes and disappeared when the clozapine was stopped. His illness is currently well controlled and his current prescription is amisulpride 400 mg twice daily with clonazepam 0.5 mg twice daily.

**Laki Kranidiotis** Consultant Psychiatrist, Kidderminster Hospital, Kidderminster DY11 6RJ, email: [Laki.Kranidiotis@worcsh-tr.wmids.nhs.uk](mailto:Laki.Kranidiotis@worcsh-tr.wmids.nhs.uk), **Sheila Thomas** Community Psychiatric Nurse, Kidderminster Hospital

doi: 10.1192/pb.31.5.191b

### Medication side-effects – informing the MHRA

Lyall *et al* (*Psychiatric Bulletin*, January 2007, **31**, 16–18) described how two



patients with psychotic illnesses developed stuttering while being treated with clozapine. The Government's Medicines and Healthcare Products Regulatory Agency (MHRA) is responsible for ensuring that medicines are acceptably safe. It takes action in relation to safety concerns and changes in the balances of risks and benefits. There is no mention by Lyall *et al* of informing the MHRA about the stuttering side-effect. I would like to urge readers of *Psychiatric Bulletin* to report to the MHRA any side-effects, suspected or otherwise, caused by a medicine through the Yellow Card Scheme. This scheme plays an essential role in protecting public health by helping the MHRA to monitor the safety of medicines on the market. Psychiatrists and other healthcare professionals can complete a form online at [www.yellowcard.gov.uk](http://www.yellowcard.gov.uk), or on a Yellow Card available in the *British National Formulary*, or directly from the MHRA (by telephoning 0800 731 6789). I would also urge readers to encourage patients to report any side-effects. With these reports, we can actively look for signs of potential safety issues requiring further investigation.

Reporting of adverse drug reactions is the professional duty of all healthcare professionals. The continued success of the Yellow Card Scheme depends on the continued support of health professionals and patients in completing Yellow Cards. We encourage Yellow Card reports from patients, but it is also vitally important that we continue to receive reports from psychiatrists and other health professionals.

**June Raine** Director of Vigilance and Risk Management of Medicines, Medicines and Healthcare Products Regulatory Agency (MHRA), London SW8 5NQ, email: [press.office@mhra.gsi.gov.uk](mailto:press.office@mhra.gsi.gov.uk)

doi: 10.1192/pb.31.5.191c

## Work-related stress in psychiatry

I read with admiration Dr Harrison's report on work-related stress (*Psychiatric Bulletin*, October 2006, **30**, 385–387) but I felt a sense of disappointment that we as psychiatrists and the wider medical profession continue to deny our health needs and general fallibility, and that our employers exhibit similar impotence.

Our training focuses our energies on succeeding both academically and later clinically. We are a competitive breed, entering our working life with high personal expectations of our performance on a day-to-day basis. The effect of daily consultation with morbidity and mortality on ourselves has to be addressed somehow. Denial becomes a handy defence mechanism.

As a profession we are more likely to develop alcohol misuse and dependence

problems, as well as having a higher suicide rate. Yet how often do the precursors to these go unchecked or unnoticed. Taking time off sick is often accompanied by guilt and a sense of failure. We seem to believe that it shouldn't happen to us.

Currently, our junior doctors are in a heightened state of performance anxiety as Modernising Medical Careers goes live. The usual anxieties related to finding a job are magnified considerably by the number of jobs being applied for. How are we and our employers protecting this vital part of the work force from the inevitable stress-related symptoms that are likely to ensue? When will we start to be honest with ourselves about our susceptibility to illness and look to prevent and manage it? When will our employers?

**Amy M. Macaskill** Specialist Registrar in General Adult Psychiatry, Royal Cornhill Hospital, 26 Cornhill Road, Aberdeen AB25 2ZH, email: [amy.macaskill@nhs.net](mailto:amy.macaskill@nhs.net)

doi: 10.1192/pb.31.5.192

## How safe are interview rooms?

Campbell & Fung (*Psychiatric Bulletin*, January 2007, **31**, 10–13) highlighted some important deficiencies in safety of patient interview rooms. We conducted a similar audit of 119 interview rooms in southern Hampshire in 2004, which was a repeat of an earlier study by local trainees in 2000. We were therefore able to look at whether interview room safety had improved and whether newly commissioned facilities had been provided in accordance with the Department of Health's advice regarding the safety of interview rooms (Department of Health, 2004).

Our results were largely similar to Campbell & Fung's but in southern Hampshire 75% of in-patient rooms were not isolated (v. 23%), 75% had a functioning panic alarm system (v. 0) and 52% had doors that opened outwards (v. 6%). Of particular concern was that rooms used in accident and emergency departments to assess acutely disturbed and unknown patients were isolated, had no viewing window, no panic button and were cluttered.

It was reassuring to note that those rooms which had been commissioned in the past 3–4 years demonstrated a higher level of adherence to the standards: 92% had an unimpeded exit, 100% had a functioning alarm and 77% had an internal inspection window. However, 67% remained isolated and 61% were cluttered.

DEPARTMENT OF HEALTH (2004) *Mental Health Policy Implementation Guide – Developing Positive Practice to Support the Safe and Therapeutic Management of Aggression and Violence in Mental Health In-Patient Settings*. Department of Health.

**Natasha Rae** Specialist Registrar in Forensic Psychiatry, Wessex Forensic Rotation, Ravenswood House Medium Secure Unit, Knowle, Fareham PO17 2NP, email: [natasha.rae@hantspt-sw.nhs.uk](mailto:natasha.rae@hantspt-sw.nhs.uk),  
**Abigail Hewitt** Specialist Registrar in Adult Psychiatry, St Anne's Hospital, Poole

doi: 10.1192/pb.31.5.192a

## BMA guidance on problem gambling

The British Medical Association (BMA) has recently published a document on problem gambling in the UK prior to the Gambling Act 2005 coming fully into force in September. The document focuses on various aspects of problem gambling and particularly emphasises the potential impact on young people (British Medical Association, 2007). Also emphasised is the need for the National Health Service to provide help for those with this problem. Two important areas that the document does not emphasise however, are the impact on the elderly and their carers.

The UK has an ageing population, with 16% of the population currently aged over 65. This is forecast to increase, with the elderly making up 19% of the population by 2021 (projected data from Office of Health Economics, 2002). The elderly can be at risk of problem gambling and are more likely to fall prey to the psychosocial consequences. It is therefore surprising that the BMA document did not make specific mention of this particularly vulnerable group of people.

The government has emphasised the importance of caring for carers (Department of Health, 1999). Carers of those with problem gambling could also suffer psychosocial distress and they require recognition and support. In the UK, where more and more elderly couples have only each other for support, this is particularly important. Again it is surprising that the BMA did not mention this in its recommendations.

BRITISH MEDICAL ASSOCIATION (2007) *Gambling Addiction and its Treatment within the NHS: A Guide for Healthcare Professionals*. BMA.

DEPARTMENT OF HEALTH (1999) *Caring about Carers: A National Strategy for Carers*. Department of Health.

**Ishaan Gosai** Specialist Registrar, Assertive Outreach Service, Plymouth, email: [ishaang@hotmail.co.uk](mailto:ishaang@hotmail.co.uk)

doi: 10.1192/pb.31.5.192b

## Modified 'mooting' should be part of psychiatric training

Naeem *et al* (*Psychiatric Bulletin*, January 2007, **31**, 29–32) describe the incorporation of simulated mental health review tribunal workshops in psychiatric