columns

any simple term that could describe 'strange' speech.

Currently there are terms that only partly describe what we wanted to be included in a single general term. For example, schizophrenic speech is composed of unusual oral creations which cannot be considered as a language as the latter is nothing if it is not creative.[1] The term 'schizophasia' designates, specifically, at least two forms of unconventional surface speech behaviours – 'glossomanic behaviour' and 'glossolalic behaviour' – that can be observed in certain patients who experience a psychotic episode.[2] Both can be spectacular. The essential characteristics of 'glossomanic schizophasia' is the production of utterances the linguistic components of which – be they phonemes, words or more complex units – are selected and combined on the basis of superficial or semantic kinships rather than an immediately shareable topic. The main characteristic of 'glossolalic schizophasia' is an entirely or nearly entirely neologistic discourse.[1]

However, the Greek term *xenophonia* describes what we are looking for. The exact definition for *xenophonia* is any strange/odd/paradoxical voice or speech[3,4] and *xenophonic* is one who speaks or sounds strange. Following a thorough research of all available databases, including EMBASE, MEDLINE and PsycINFO, without any language restriction, the term *xenophonia* has been referred to in only one paper, a non-psychiatric study. It is being used there to describe a vocal abnormality during and after the sound variation stage; the main symptoms are high tone, low voice, short breath and unstable sound control, which are usually a functional variation, a habitual vocal defect.[5]

As the term *xenophonia* has never been mentioned in our fields of interest we would like to propose it as a new psychiatric term which describes the phenomena of generally 'strange speech'.

1 Sims A. *Speech and Language Disorders in Psychiatry.* Gaskell, 1995.

2 Lecours AR, Navet M, Ross A. Langage et pensée du schizophase. *Confrontations Psychiatriques* 1981; **19**: 109–44.

3 Liddell HG, Scott R, Jones HS, McKenzie R. *A Greek–English Lexicon.* Clarendon Press, 1940.

4 Dimitrakou D. *Grand Dictionary of the Greek Language*, Vol. 10, 1964.

5 Zhiqing W, Wenjun Y, Yiting C. Tratment of xenophonia in male youths by extralaryngeal massage and language training. *J Tradit Chin Med* 1993; **13**: 221–2.

***Panagiotis Zis** PhD student in neurology, University of Athens, CT2 in Psychiatry, London Deanery, University of Athens, 22–26 Daskalaki Street, 11526 Athens, Greece, email: takiszis@gmail.com, **Bryan C. Timmins** Consultant Neuropsychiatrist, Northamptonshire Healthcare NHS Trust

doi: 10.1192/pb.33.7.275b

ECT: there is more than just unilateral or bilateral selection!

The assumption that all doctors are well informed about the latest arguments regarding the pros and cons of unilateral or bilateral electroconvulsive therapy (ECT) may not be right. We would like to take this opportunity to update readers of current developments that may potentially revolutionise or even significantly modify our thinking about this controversial treatment.

As the author says, the UK ECT review group in 2003 had an important shortcoming of inclusion of all stimulus intensities, leading to a dubious conclusion in favour of the advantages of bilateral ECT.[1] Although we do believe that the uncertainty in evidence exists, the emerging evidence base, particularly in the USA and Australia, may tilt the balance of opinion and attitudes, more in favour of right unilateral (RUL) ECT with the ultra-brief type of pulse width.

Sackeim *et al*[2] and Loo *et al*[3] have in 2008 published research indicating that ultra-brief pulse width right unilateral ECT is likely as effective as the conventional one (brief pulse RUL), in addition to being significantly better in terms of cognitive disability. This is an exciting new development as we believe cognitive disability has consistently been underplayed in studies on ECT over the years. Robertson & Pryor[4] as well as Mangaoang & Lucey[5] cite extensive relevant body of research suggesting a lot more cognitive damage and disability, undetected by conventional testing. Additionally, if the patients were to be made aware of a potential modality of treatment with significantly less cognitive disability, they may actually make a more completely informed decision.

Although it is not difficult to adapt current practice to using ultra-brief pulse width RUL ECT by slight modification of the 'programmes' settings available on current machines in the UK, this detail is clearly beyond the scope of this letter.

In conclusion, we posit that the need for faster recovery by using bilateral ECT may be more than balanced by the need to deliver the treatment that is less disabling (in terms of cognitive disability) and possibly equally effective.

1 The UK ECT Review Group. Electroconvulsive therapy: systematic review and meta-analysis of efficacy and safetly in depressive disorders. *Lancet* 2003; **361**: 799–808.

2 Sackeim HA, Prudic P, Nobler MS, Fitzsimmons L, Lisanby SH, Payne N, et al. Effects of pulse width and electrode placement on the efficacy and cognitive effects of electroconvulsive therapy. *Brain Stimulat* 2008; **1**: 71–83.

3 Loo CK, Sainsbury K, Sheehan P, Lyndon B. A comparison of RUL ultrabrief pulse (0.3 ms) ECT and standard RUL ECT. *Int J Neuropsychopharmacol* 2008; **11**: 883–90.

4 Robertson H, Pryor R. Memory and cognitive effects of ECT: informing and assessing patients. *Advan Psychiatr Treat* 2006; **12**: 228–37.

5 Mangaoang MA, Lucey JV. Cognitive rehabilitation: assessment and treatment of persistent memory impairments following ECT. *Advan Psychiatr Treat* 2007; **13**: 90–100.

***Mukesh Kripalani** Specialist Registrar in Adult Psychiatry, Northern Deanery, Tees, Esk and Wear Valleys NHS Foundation Trust, email: drmukesh@doctors.org.uk, **Vinod Chaugule** Consultant Psychiatrist and ECT Lead for Tees, Esk and Wear Valleys NHS Foundation Trust

doi: 10.1192/pb.33.7.276

A survey on takeaways in a secure unit

Physical health monitoring of long-term detained psychiatric patients in secure care has attracted much attention in the past few years.[1] The rate of coronary heart disease in patients with schizophrenia is almost three times higher than in the general population and is thought to be a greater contributor to mortality in this group of patients than suicide.[2] Patients on antipsychotic medication seem to have a worse metabolic profile.[3] Metabolic syndrome has been described as a risk factor associated with the development of coronary heart disease and includes central obesity, impaired glucose tolerance, hypertriglyceridaemia, hypercholesterolaemia and hypertension.

For long-stay patients in secure hospitals a combination of antipsychotic medication, poor diet, sedentary lifestyle, lack of exercise and leave, smoking and illness effects are all likely to contribute to weight gain and metabolic syndrome.

As part of a wider consultation exercise promoting healthy lifestyles, concern has been raised about the number of takeaways ordered by detained patients within a National Health Service (NHS) medium secure unit and how this may contribute to metabolic syndrome. A survey monitored the number of takeaways delivered to the unit over a 21-day period.

In total, 326 individual takeaways at the overall cost of £2736 were consumed at an average of £8.40 per order (range £3–23). The figures included 'group bookings' from two wards within the learning disability directorate that have two designated takeaway nights per week.

It was estimated that around three-quarters of patients ordered a takeaway during the study period: 29 patients consumed at least one takeaway a week and 16 patients consumed at least

https://doi.org/10.1192/pb.33.7.276a Published online by Cambridge University Press

two per week; 4 patients consumed a takeaway every other day and 1 patient consumed 15 takeaways in total. There was no clear distribution between acute and rehabilitation wards and there were no obvious gender differences. The mean number of takeaways per ordering patient was five. At least half of the takeaways were curries.

The wide range of cost and high average cost probably reflected group bookings registered to a patient and so underestimated the total number of takeaways. This was confirmed at a unit meeting with patient representatives who felt that a takeaway should on average cost around £5 and that sharing takeaways or group bookings registered to a patient occurred frequently. If extrapolated over a year, a patient would spend on average £727 on takeaways. The annual cost for all patients in the unit would be £47 423.

Possible ways of reducing 'excessive takeaways,' though this amount is undefined, include individual care plans or designated 'takeaway nights,' which is the current policy within the learning disability directorate. Although the average number of takeaways per patient was five within a 21-day period and could potentially increase to six if takeaways were ordered twice a week, as per the learning disability model, it was felt that the average number of takeaways calculated was a gross underestimation. An outright ban could be enforced on security grounds. The issue of restricting patient choice, patient autonomy, poor-quality hospital food and infringement on human rights have been raised as counterarguments.

1 Osborn DP, Levy G, Nazareth I, Petersen I, Islam A, King MB. Relative risk of cardiovascular and cancer mortality in people with severe mental illness from the United Kingdom's general practice research database. *Arch Gen Psychiatry* 2007; **64**: 242–9.

2 Lawrence DM, Holman CDJ, Jablensky AV, Hobbs MST. Death rate from ischaemic heart disease in Western Australian psychiatric patients 1980–1998. *Br J Psychiatry* 2003; **182**: 31–6.

3 Mackin P, Bishop D, Watkinson H, Gallagher P, Ferrier IN. Metabolic disease and cardiovascular risk in people treated with antipsychotics in the community. *Br J Psychiatry* 2007; **191**: 23–9.

Yasir Kasmi Specialist Registrar in Forensic Psychiatry, Newton Lodge, Yorkshire Centre for Forensic Psychiatry, Ouchthorpe Lane, Wakefield WF1 3SP, email: yasirkasmi@hotmail.com

doi: 10.1192/pb.33.7.276a

Injectable opioid prescribing in Oxfordshire

We sought to replicate in the Specialist Community Addiction Service that covers the county of Oxfordshire the audit on the prescribing of injectable opiates undertaken by White & Shearman in Cornwall.[1] We identified 19 patients (14 males and 5 females) on regular injectable opioid prescriptions: 10 on diamorphine (53%), 5 on methadone (26%), 2 on pethidine (11%) and 1 on morphine (5%); 1 person dropped out of the service and was not further included in the study. Of these, 17 were interviewed using a slightly modified version of the audit tool kindly provided by White & Shearman. Only one person had been started on a script in the past 4 years while others had been on this type of treatment for an average of 9.5 years (s.d. = 4.1). Three patients, all females, had been dependent on prescribed injectable opioid analgesics. The other 14 had been heroin users for an average of 15.8 years (s.d. = 6.3) before being started on an injectable prescription. Compared with Cornwall, our audit reveals an older group of users who had been started on injectable scripts after lengthy periods of oral substitution treatment (average 9.2 years, s.d. = 6.1). The Oxfordshire cohort was also relatively more stable with no reports of overdoses while using the prescribed drug or additional opiate use in the previous month. Alcohol consumption was also low, with only two clients reporting problematic levels of drinking. When asked, 47% said they had no intention to ever come off the script; 29% would consider it in 5 years and 24% in 1 year. The clients, regardless of the drug injected, were approximately evenly split between almost exclusive intramuscular or intravenous use with little crossover. Around half the patients reported experiencing any harmful physical consequences from prescribed injectable opiates. Occasional abscesses were the main problem faced by those injecting intramuscularly, whereas those who practised intravenous injections reported abscesses, deep vein thrombosis and cellulitis. All had found access to medical care when needed. The overwhelming majority claimed to consistently use clean needles but the answers were more equivocal with regard to sterile injecting technique. Direct supervision of injecting techniques was minimal with only two clients (11%) remembering having been observed on one occasion by their general practitioner or another health professional. In conclusion, we found interesting similarities between the client groups in Oxford and Cornwall, which might indicate that a clinical rationale for providing injectable opiates to a niche population exists and that it transcends geographical and social regional differences.

1 White R, Shearman L. Injectable opiate prescribing in Cornwall. *Psychiatr Bull* 2008; **32**: 387–90.

***Joseph El-Khoury** Specialty Registrar in Adult Psychiatry, Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust, Oxford Specialist Community Addiction Service, The Rectory Centre, Rectory Road, Oxford OX4 1DU, email: Josephelkhoury@doctors.org.uk, **Andrew McBride** Consultant in Addiction Psychiatry, Oxfordshire and Buckinghamshire Mental Health NHS Foundation NHS Trust, The Rectory Centre, Oxford

doi: 10.1192/pb.33.7.277

Prevalence of challenging behaviour among older in-patients: a pilot study

Older people occupy two-thirds of in-patient beds in acute general hospitals. Pre-existing mental health disorders are independent predictors of poor outcomes such as increased mortality and length of stay, loss of independent function and higher rates of institutionalisation.[1] Disruptive behaviour can have a negative effect on the nursing and other healthcare staff and can affect the quality of care provided to other patients on the ward.[2] There are no published studies on the prevalence of behavioural problems in older in-patients in the UK.

We conducted a pilot study to determine the prevalence of challenging behaviour in older people on two care of the elderly wards in an acute general hospital. Patients aged 65 years and older were included. The Crichton Royal Behavioural Rating Scale (CRBRS)[3] was used to identify patients with challenging behaviour. The CRBRS is a descriptive scale designed to assess patients on psychogeriatric wards. The main scale items are mobility, orientation, communication, cooperation, restlessness, dressing, feeding, mood and continence. Each modality has a score of between 1 and 5, where 1 is normal and 5 is the most abnormal. The scores for cooperation, restlessness and sleep are those that provide information on the prevalence of challenging behaviour. Patients with a score of 2 or more for restlessness or sleep, or 4 or more for cooperation are considered to have a challenging behaviour.

The scale was completed separately for daytime and night-time by interviewing nursing staff completing the respective shifts. Medical notes were examined to identify any previous mental health problems and to determine whether the patients were on psychiatric medication. The study was approved by the trust's clinical governance department.

In total, 58 patients were studied (47 males). Mean age was 81 years (range 66–96). Challenging behaviour was identified in 16 patients (29%) according to the CRBRS criteria: 5 scored for restlessness only; 3 for restlessness, sleep disturbance and cooperation; 1 scored for sleep disturbance and cooperation, and 1 for

https://doi.org/10.1192/pb.33.7.276a Published online by Cambridge University Press