DEAR SIRS

I wish to comment on some of the extremely important issues raised by Dr Tufnell in her letter and to offer further information about the endeavours made to secure media coverage for the meeting of the European Society of Child and Adolescent Psychiatry (ESCAP) in London in September 1991.

Dr Tufnell suggests that psychiatrists should adopt public relations strategies and harness the media to make purchasers, managers, our patients and the public more effectively aware of the scope and value of what psychiatry and psychiatrists have to offer. I agree entirely.

The Royal College of Psychiatrists has a small but active, and increasingly effective, Public Education Department which has adopted the strategic awareness which Dr Tufnell espouses.

The ESCAP meeting was administratively supported in a major way by the staff and the Departments of the Royal College of Psychiatrists. This included the Public Education Department. Both the College staff member who runs this Department and I, a professional member of its staff, were involved in providing this support.

Prior to the conference a large number of media people were offered details of the press conferences which were held twice daily throughout the conference. The large volume of publicity which followed the opening speech given by the Princess of Wales was not surprising and this did indeed give the Conference a high profile. It is true that the press conferences were sparsely attended. However, the College Public Education staff did create a considerable number of informal contacts between individual speakers and members of the press. Dr Tufnell points out that the BPS has worked very hard over the last 15 years to create its successful public image and that need for cultivation over an extended period is endorsed by the experiences of the College Public Education Department.

Perhaps this has a bearing on the apparently restricted volume of press coverage which resulted from the ESCAP conference. ESCAP meets at a different venue in Europe once every four years. I was therefore not unduly surprised to find that the immediate press coverage was thin but, nonetheless, believe that the exercise of providing the Public Education Department's support for the ESCAP meeting was worthwhile. The individual contacts made between the press and psychiatrists may yet yield positive results and contribute to positive impressions of the specialty.

In short, the College has got the message! The Public Education Department is working hard to challenge stigma and create a positive image of psychiatry. Its members have embarked upon the task of encouraging College Divisions and Sections to create relationships with the media through their Public Education Officers. The support of more members with Dr Tufnell's positive attitude to public relations would be very welcome.

Dr RICHARD WILLIAMS
Consultant Child and Adolescent Psychiatrist
Member of the Public Education Committee of
The Royal College of Psychiatrists

Harassment by patients

DEAR SIRS

A number of clinical syndromes have been recognised in which an individual becomes unduly attracted to, or hostile towards, their medical attendants and may subject them to unwarranted attention which, at times, amounts to serious harassment. There is little information on the frequency of such harassment, the remedies which can be applied and the attitudes of colleagues and employing authorities towards the victim.

In order to offer advice to psychiatrists and employing authorities, the College have asked me to collate available information and prepare a report. I would be very grateful if psychiatrists aware of such incidents, now or in the past, would write to me in confidence providing as much information as is possible about individual instances.

Details of clinical diagnosis, the use of the Mental Health Act or other legal remedies and any general advice would be useful. It would be of particular interest to hear of action by or support from employing authorities.

S. BRANDON
University of Leicester
School of Medicine
Leicester Royal Infirmary
Leicester LE2 7LX

Manic depression psychosis

DEAR SIRS

The College's Patients' Liaison Group has received a letter from a man suffering from manic depression who states that he is occasionally in hospital suffering from delusions of grandeur. However on his Lithium Tests form he finds the diagnosis of 'Manic Depressive Psychosis' even when discharged and long out of hospital. He points out that he is psychotic for only a few weeks every year or two and asks: "Surely psychosis is a state of mind, not a potential state of mind, nor a condition of the mind that might give rise to a psychotic episode? What I want to know is why I am called a madman, permanently, when I am only a part-time madman?"

The Patients' Liaison Committee felt that he made a very cogent point and that the use of the term

'Manic Depression Psychosis' should be confined to the times when patients are psychotic and that on other occasions such terms as 'bi-affective disorder' or 'manic depression' would be more appropriate.

Professor BRICE PITT

Chairman
Patients' Liaison Group

Patients' access to medical records

DEAR SIRS

Regarding Dr D.H. Thomas' letter (*Psychiatric Bulletin*, 1991, **15**, 647), could the problem of patients' access to records be solved by creating several records – one confidential to the medical staff and the others for patients, etc. In the best training setting I have known (Professor Adolf Meyer's Henry Phipps Psychiatric Clinic for decades until the 1940s) he insisted that five formulations be written within a week of admission summarising the relevant facts for:

(a) the clinical director
(b) the referring physician
(c) the paramedical staff
(d) the family
(e) and most relevant for our topic, the patient.

Unless the problems of records is solved other than by full access, many aspects of examination and treatment will never be recorded. Eventually no significant record of any psychoanalytic treatment of patients could be recorded in hospital.

W. CLIFFORD
M. SCOTT

488 Mount Pleasant Avenue
Westmount, Quebec
Canada H3Y 3H3

Clozapine: a worm's eye view

DEAR SIRS

We would like to comment on the article 'Expert Opinion, Clozapine' by Drs Cutting & Reveley (*Psychiatric Bulletin*, 1991, **15**, 617). We have had experience of the use of clozapine in 20 treatment-resistant schizophrenic patients over a period of six months. Of these, 11 remain on the drug, in most cases with considerable benefit (dramatic in some cases). As general trainees, rather than experts, we are involved in the day to day monitoring of these patients. This includes regular blood tests as well as dealing with side effects and other problems which may arise. We feel that it would be useful to complement the article from a trainee's point of view.

Perhaps the most surprising aspect of clozapine therapy is that once a patient has accepted the need for regular follow-up and blood tests, compliance is exceptionally good. This may suggest that other factors are at work in addition to the undoubted pharmacological effects of the drug, and we think that the intensity of follow-up is a motivator in some patients. While sharing Cutting & Reveley's enthusiasm for the drug, we believe that there can be difficulties involved in its use which should be taken into consideration. Apart from agranulocytosis, which in theory should be covered by Sandoz's "no blood, no drug" policy, other side-effects are apparent in some patients. They are very variable. Some report only mild or no side-effects. Others may experience considerable sedation at anti-psychotic doses or weight gain of greater than 10% (in practice this has been tolerated because of improvement in mental state). Increased extrapyramidal side-effects can appear, of which drooling is the most common, requiring the use of high doses of anti-cholinergic drugs. In addition, several patients stopped their medication after unprecedented periods of stability only to relapse extraordinarily quickly over a matter of a few days. Presumably, these are examples of the "supersensitivity" psychosis described by Chouinard *et al* (1978). It is worth noting that because conventional treatment has previously failed these rebound phenomena may be extremely difficult to treat. Clozapine blood levels are not monitored and so compliance is judged by mental state alone. In this regard, one of our patients overdosed having stored several week's supply of clozapine even though he had attended for weekly follow-up and blood tests. This dangerous overdose led to a 2 day admission to intensive care. Pyrexia and cardiovascular instability persisted for a further three days and these were worrying complications to deal with on a psychiatric ward.

Other problems in our experience include a wide variation in maintenance dose (as much as tenfold) and restrictions of the patient's mobility – several of our patients have had to return from holiday for monitoring and Sandoz recommend discontinuation of the drug before travelling abroad.

Despite these reservations, our impression is that clozapine does work and is a considerable advance in the treatment of neuroleptic resistant schizophrenia. The improvement seen in a significant number of patients would seem to justify its wider use.

M.F. RIGBY
H. PANG

Charing Cross Hospital
Fulham Palace Road
London SW6 8RP

Reference

CHOUINARD, G., JONES B. D., & ANNABLE, L. (1978) Neuroleptic induced supersensitivity psychosis *American Journal of Psychiatry* **135**, 1409–1410.