Bulletin, April 1991, **15**, 199–203) which if not cleared up might cause unnecessary alarm.

In the first she states that "overall psychiatric casualties are approximately 30%" and in the second "Overall . . . an incidence of psychiatric casualties of about 20–30% could be expected". The question is 30% of what? What is not clear is that these projections from historical data obtained from a variety of nations and wars in this century refer to percentages of surviving casualties and not to percentages of personnel involved. If the 30% yardstick were applied to the Gulf War in which 43 were injured, the estimated number of psychiatric casualties would be 19 not 13,500 (that is 30% of the total force of 45,000).

In her second article, the author asserts that "it is clear that military services cannot deal with all the current problems". If this taken to mean "deal with all the problems remaining from all the wars of this century" she is of course right, although your readers may be surprised to learn how many ex-service personnel, ranging from veterans of the Falklands conflict to Far East prisoners of war from the 1939–45 War, have in fact received help from the military psychiatric services. If, however, she means "deal with the problems of those currently entitled to military care" or "deal with the problems currently arising from the Gulf War", the statement is quite simply not true. We can and we do. Provision was made for dealing with 100 times the number of casualties evacuated, had the war taken a greater toll of our forces.

Finally, under the heading Service provision the author says: "The NHS's role will be determined, at least in part, by the adequacy and availability of front-line CRS treatment." Your readers will be glad to learn that Field Psychiatric Teams were deployed for the first time in support of the Armed Forces of the Crown in War. They were seen at work during the BBC/ITN news bulletins of 23 January 1991. As a result of education and training the number and quality of psychiatrically trained personnel involved, and the system of deployment used, the adequacy and availability of front-line treatment was unrivalled. Happily it was scarcely tested.

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DEAR SIRS

I have recently returned from the Gulf War and have been catching up on a backlog of journals. It was with interest that I read the trilogy of articles about psychiatry and war (*Psychiatric Bulletin*, April 1991, **15**, 199–204), and in particular Jacqueline Atkinson's article 'The demand for psychiatric services as a result of the Gulf War'.

I was a psychiatrist in a Field Psychiatric Team (FPT) travelling in support of the British Division as it prepared for war and as it fought through southern Iraq and eastward into Kuwait. This FPT was the most forward element of a comprehensive Psychiatric Service supporting Servicemen and women in the Middle East Theatre of Operations.

I disagree with Jacqueline Atkinson where she states that "Current mental health services in the field are unlikely to be able to deal with all those requiring assistance". I am confident that the Service would have dealt admirably with the theoretical maximum estimate of battleshock casualties, had this occurred. That this did not occur (no casualties were referred to our team during and after the ground battles) was due to two main factors. First, the nature of the battles – fast, successful, minimal physical casualties – precluded the development of large numbers of acute cases. Second, military units were well prepared for prevention, recognition and management of the problem within their own lines. In the transition-to-war phase the psychiatric service was involved in the education of all troops, and especially commanders, in this respect. Units knew to refer cases only when they could not manage them themselves. The other teams coped easily with the relatively small number of combat-related stress casualties which came to them from the rear areas.

Jacqueline Atkinson also writes that "The NHS's role will be determined, at least in part, by the adequacy and availability of front-line CRS treatment". I trust that the NHS will have little to do in the wake of this war. So far the Psychiatry Division of the Army Medical Services has seen but a very small number of cases of a chronic nature.

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DEAR SIRS

In response to Brigadier Abraham and Major Gamble, I would point out that these articles were written during the height of the Gulf War when there was speculation about a protracted land war and when provision was being made by NHS hospitals to receive psychiatric casualties. The first sentence was changed as the *Bulletin* went to press and hostilities ceased. That there was not a prolonged war means there will be fewer people suffering PTSD but does not negate the arguments for potential problems under other conditions as outlined in the articles. With no clear epidemiological data from the Falklands War, it is difficult to estimate how many people will suffer PTSD in the years to come. That Britain has been fortunate in the military conditions (including the use of Field Psychiatric Teams) being likely to contribute to lower incidence of

PTSD among our forces should not blind us to the devastating effects on the Iraqi troops.

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DEAR SIRS

The two highly topical articles on factors contributing to military casualty rates and the demand for psychiatric services as a result of the Gulf War (*Psychiatric Bulletin*, April 1991, **51**, 199–203) are noted with great interest.

In this connection the facilities of the Ex-Services Mental Welfare Society are relevant. They are available as a contribution to the overall community care of ex-Service personnel to which all such patients are entitled to be considered.

The Society was formed in 1919. The record shows that it has cared for almost 50,000 former Service men and women in its 72 year history. Some 3,000 veterans of World War II and of the several campaigns since 1945, are currently provided for by the Society which has a network of eight Regional Welfare Officers and two Rehabilitation/Treatment units at Leatherhead, Surrey and Scotland respectively. In addition, we have a Veterans Home at Kingswood Grange, Surrey.

Referrals should be made direct to me and further administrative information about the Society can be obtained from the Director (081 543 6333).

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Management of violent incidents

DEAR SIRS

As psychiatrists in higher training, we welcome the recent report of the Collegiate Trainees' Committee Working Party on the training of junior psychiatrists with respect to violent incidents (*Psychiatric Bulletin*, April 1991, **15**, 243–246).

The report mentions that an informal survey of trainees in two regions showed that formal training in the management of violent incidents was almost universally absent. This observation is extended by our own survey conducted approximately 18 months ago in which we sent questionnaires to 37 members of the Collegiate Trainees' Committee. The questionnaires asked about training received in several aspects of the management of violence. We received 27 replies which provided information about 28 training schemes throughout the whole United Kingdom. The replies indicated that in three schemes there was no formal training in the assessment of dangerousness, in 12 schemes there was no training in the emergency use of medication, in 15 schemes there was no training in talking with aggressive patients, in 21 schemes there was no teaching in the use of physical restraint and in 22 schemes there was no formal training in the use of seclusion. Several respondents commented that they had been expected to learn about these management approaches simply through "experience".

It is obvious from our survey that the interventions least well covered in psychiatric training are the more physical interventions which are, of course, those used in the most dangerous and difficult situations. Appropriate use of these interventions requires an accurate (and often speedy) assessment of the situation, a knowledge of the available management options and, importantly, confidence on the part of the psychiatrist making the decisions. Unfortunately, training for junior psychiatrists in the use of these "physical" interventions comes almost exclusively from having to deal with violent emergencies while on call. While it is important to obtain this type of practical experience, it would be of great benefit to patients, junior psychiatrists and other staff if the junior psychiatrists were given better preparation to deal with such emergencies.

We believe that every hospital should organise an induction course for new junior psychiatrists in which there is teaching about and discussion of practical aspects of managing psychiatric emergencies. All too often hospital managers content themselves with handing out a pile of operational policies which may satisfy their solicitors but make no contribution to improving patient management or to training junior doctors. We hope that the College report will help to bring about major improvements in this neglected but vital aspect of psychiatric training.

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DEAR SIRS

In response to the 'Report of the Collegiate Trainees' Committee Working Party on training of junior psychiatrists with respect to violent incidents' (*Psychiatric Bulletin*, April1991, **15**, 243–246), I would like to detail a training course recently made available to junior psychiatrists in Nottingham entitled 'Coping with Violence and Aggression at Work'. It concentrated on practical breakaway and self-defence techniques for use in violent situations in and out of hospital. The course, covered by the Department of Health guidelines, was developed from the control and restraint training designed for the Prison Service and extended by way of the Special Hospitals to the NHS psychiatric services. The moves and holds are intended to allow one to quickly and effectively break