six month attachment to a learning disabilities unit. Monitoring was by means of written records of all clinical contracts. Specially designed forms were used which encouraged a problem-orientated approach, recording interventions made and outcome. Evaluation occurred during consultant and pharmacist supervision, allowing changes in clinical approach to be introduced. The limitation of too close an adherence to a medical model were highlighted and the benefits felt of an outsider commenting on prescribing habits. Inter-disciplinary discussions were facilitated by the audit forms (in the community setting case notes are often absent) and the desire to measure outcome of medical interventions led to requests for information about client behaviour from nursing staff in an objective form, such as the charting of events or the use of rating scales. The audit highlighted differences in multidisciplinary involvement between long-stay in-patient and hostel patients. A medication review confirmed a large reduction in the use of neuroleptics for behaviour control had been achieved without deterioration in behaviour. Appraisal of the range of experience gained by the trainee was facilitated, so that deficiencies in training could be rectified. The benefits of a self-audit exercise merits advertisement to colleagues.

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Environmental change and violent incidents

DEAR SIRS

I read with great interest the paper on environmental change and violent incidents (*Psychiatric Bulletin*, 1992, **16,** 489–490). The conclusion that "the reduction in violent incidents ... was primarily due to change of environment" needs to be challenged. The definition of violent incidents was not specified. Data on the validity and reporting reliability of violent incidents were not provided. For example, it may be that fewer staff in hostels or only 14 hour staffing in homes may result in a poor reporting reliability for violent incidents. A number of other factors need to be considered and have been summarised elsewhere (Shah *et al*, 1991). These include demographic characteristics of nonviolent patients, activity patterns (admission rates, length of stay and bed occupancy) and staff attitude, training and nature (temporary or permanent) in all three settings. Unless consideration is given to the above array of factors the conclusion becomes weak. Having said this, the study in question has attempted to address the important issue of changing environment for our patients, which is occurring at increasing frequency in the modern era of community care.

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References

SHAH, A. K., FINEBERG, N. A. & JAMES, D. V. (1991) Violence among psychiatric inpatients. *Acta Psychiatrica Scandinavica*, **84,** 304–309.

Reply

DEAR SIRS

I thank Dr Shah for his comments, but disagree that the conclusion is weak. Violent incidents are documented when an act causes or is intended to cause physical harm to a third party. Although validity and reporting reliability were not specified, the same staff rated incidents before and after transfer. There is no reason to suppose that their criteria or reporting reliability suddenly changed. Within the houses/hostels the average staff/patient ratio remained comparable to that of the ward. Houses are unstaffed between the hours of 21.00 to 07.00 hrs; this is the period when very little violence occurs, which is also acknowledged by Dr Shah, and is unlikely to significantly reduce reporting reliability.

The study suggested the reduction in violent incidents was due to the change of environment. The other factors mentioned by Dr Shah fall within the definition of environment. A number of interrelated variables were considered in the original paper, but I am grateful to Dr Shah for emphasising the huge array of factors, which obviously, require consideration. Quantifying the myriad of influencing factors appertaining to "the environment" would require an abundance of data which was not available.

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Use of antidepressants by child psychiatrists

DEAR SIRS

I was interested to read Bramble & Dunkley's article about the prescribing habits of child psychiatrists (*Psychiatric Bulletin*, 1992, **16,** 396–398), but was perplexed by their apparently interchangeable use of the terms "antidepressant" and "tricyclic antidepressant" (TCA). In their opening discussion they state that there has never been a survey looking "specifically" at TCA use; the description of their