then, like suicide, the second attempt becomes much more likely.

The College could encourage this activity by publishing an Annual Bumper Book of Coarse Psychiatric Research which would contain selected synopses of these works. What a joy to read short accounts of all ideas pursued by our bright young doctors!

The only good research is coarse research. 'Good' research is the mopping up of the successful ideas generated by coarse research. The encouragement of original thinking is a prime educational responsibility of our College.

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Support and stay

DEAR SIRS

The interesting article by Whitby and his colleagues 'Support and stay: an innovative community service for the elderly confused' (*Psychiatric Bulletin*, December 1990, **14**, 708–710) illustrates marked differences in the balance between health and social services provision for the demented elderly across the country. In our own health district the sort of activities described by Whitby are entirely the province of social services: now the subject of a pilot project involving budget-holding case managers who can arrange an even more flexible package of care than that provided by the "Sas" service reported by Whitby. My main question is this: in what way does a psychogeriatric service differ from a social service? There is nothing in Whitby's article that suggests that the "Sas" service should not be available to *all* clients with a dementia, rather than only those referred to a specialist service.

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Personal experience with clozapine

DEAR SIRS

Clozapine is a dibenzodiazepine derivative. In 1975, granulocytopaenia developed in 16 patients taking clozapine in Finland. Subsequently 13 of these developed agranulocytosis and eight died from secondary infection (Griffith & Saameli, 1975). A multi-centre trial in the USA involving 319 patients (Kane *et al*, 1988) and a study in Germany involving 387 patients (Naber *et al*, 1989) produced only one death; a causal relationship between clozapine and the fatality could not be excluded but was not probable. The present risk rate of white cell problems has been summarised at 1–2% which should be taken with a comparable risk of 0.01–0.1% of agranulocytosis with phenothiazines.

The current prescribing regulations in the UK demand weekly white cell counts for 18 weeks, which is the high risk period, and fortnightly white cell counts thereafter. Worldwide experience suggests that if this is strictly adhered to, and tablets are supplied only on receipt of normal white cell results, then all cases of agranulocytopaenia will recover solely on rapid cessation of the drug.

Clozapine was introduced in the spring of 1990 to the UK and marketed to consultant psychiatrists in NHS practice. Currently only 10% have used it and most have given it to only one or two patients. There are only about 500 patients who have experienced the drug in this country. Because of the above difficulties, Sandoz UK have suggested that the drug is used for schizophrenic patients who are resistant to conventional antipsychotic therapy or who do not tolerate these drugs.

I have prescribed clozapine for a total of 13 patients for a maximum of eight months and all but one are still on the drug. In two cases I had to discontinue the drug due to lack of response and in one case the patient refused to take the drug due to his paranoid state. All three of these cases were recommenced with some improvement. The one case that was not recommenced suffered a severe extra-pyramidal reaction as he had done with conventional drugs but recovered with anti-parkinson drugs and discontinuation of the clozapine. There were no cases of agranulocytopaenia that were serious enough to cause a 'red alert' and stop the drug but several cases triggered an 'amber alert' occasionally due to a damaged sample.

There were eight males and five females, all caucasian, and the age range was from 20–52. Seven out of the eight males had spent time on an interim secure unit. The dose range of clozapine was from 300–900 mg daily with some on a single nightly dose and others on split dosage. All the patients had been on oral and depot phenothiazines and most had been on at least three different depots in doses up to 1000 mg fluphenazine decanoate weekly or equivalent. The duration of illness ranged from two to 17 years and all but three had been admitted to hospital before the start of the clozapine.

The side effects seen most commonly were hypersalivation and morning drowsiness, but one case suffered tachycardia and three cases had a total of five *grand mal* fits. Two of these were being withdrawn simultaneously from benzodiazepines. Most of the patients were left on anti-parkinson medication and two were left on lithium carbonate but other anti-psychotic drugs were used in only three patients.

I have rated the change in mental state according to the scale 1 worse, 2 no change, 3 marginally improved, 4 clear improvement, 5 marked improvement. Seven were ranked at 5, four were ranked at 4, one was ranked at 3 and one was ranked at 1.

Thirteen patients were started on clozapine after long intractible schizophrenic conditions. There were no problems with the white cell counts sufficient to cause the drug to be stopped and such side effects as there were settled, except for one severe extrapyramidal reaction. Most of the patients improved either clearly or markedy with regard to level of disturbance and emotional warmth. Seven of these patients now spend most of their time out of hospital and only return for the white cell counts and dispensing of the clozapine. Six of the patients had actually requested clozapine, and all of the patients and relatives were fully counselled on the side-effects before the drug was considered.

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Benzodiazepines as night sedation

DEAR SIRS

Various studies have shown that pharmacological dependence and tolerance to benzodiazepines occur with therapeutic dosages. Alternative ways of dealing with insomnia exist and it can be asked if benzodiazepines should ever be used to manage these conditions. The *British National Formulary* (1990) (BNF) states that "routine use of benzodiazepines as hypnotics, especially in hospitals, is undesirable and ideally they should be reserved for short treatment in acute distress". The Royal College of Psychiatrists (1988) statement on benzodiazepine prescribing for insomnia states that their use should be limited to cases where the condition is severe, disabling, or subjecting the individual to extreme distress.

Little is known about the prescribing habits or knowledge of new medical graduates on this topic. We surveyed 97 graduates of a single medical school in pre-registration house jobs, using a telephone questionnaire; 93 responded.

In the month prior to the study 92 of the doctors prescribed night sedation, 82 (92.5%) prescribing only benzodiazepines. One-third estimated that more than 50% of their patients received night sedation and 12 stated that more than 80% received it. One-half of the doctors stated that they prescribed night sedation in response to nursing requests or pressure, but 14 said they commenced patients on benzodiazepines routinely. The first choice of sedative for almost all of the respondents was temazepam. Just over 10% did not know that tolerance developed to benzodiazepines with the same number being unsure. Less than 5% did not know that the patient can become dependent on benzodiazepines and 2% were not sure. Approximately 9% of the doctors would discharge patients on benzodiazepines even if the patient was not taking these prior to admission.

The majority of the doctors surveyed were aware of the occurrence of tolerance and dependence with benzodiazepines, but this did not seem to influence their prescribing practice. Our figures highlight a need for more teaching about safe prescribing of benzodiazepines as night sedation to medical and nursing staff. Formal prescribing policies may protect inexperienced doctors from undue pressure to commence patients on night sedation. On a more optimistic note, only 9% of the doctors surveyed would continue benzodiazepines after discharge if the patient was not on them on admission. Although not strictly comparable, this contrasts well with 72.2% of patients on benzodiazepines after discharge from psychiatric hospital (Fry, 1989). This group of graduates are taught to use the BNF as a source of reference for drug dosages but its guidelines on prescribing practices do not seem to be followed. Of those surveyed, 10% asked our advice on prescribing benzodiazepines, possibly indicating a need for more direct guidance from senior doctors.

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A full list of references is available on request to the authors.

Section 5(2) audit

DEAR SIRS

The visiting Mental Health Act Commissioners in August 1990 commented that Section 5(2) was