
Correspondence

Needs of carers

Sir: We agree with Cohen *et al* (*Psychiatric Bulletin*, March 1996, **20**, 131–133) that the needs of informal carers are neglected and that this is an under researched area. We conducted a literature search in Medline (1985–95) and PsycLIT (1990–95) for the terms informal carers and care. We identified 118 main articles. The majority of these concerned informal carers of patients suffering from dementia. There was little information on carers of patients under the care of adult general psychiatrists.

We would like to report on our experience of liaising with informal carers of patients within our catchment area of Barnet, in outer London. All carers named by current patients of our sectorised service team (total population circa 50 000) were sent a letter inviting them to an initial evening meeting. The meeting was organised and chaired under the joint auspices of the local branch of the Carers National Association (Ruth Pitter House, 20/25 Glasshouse Yard, London EC1A 4JS) and ourselves. Twenty-three people attended. They wanted to bypass the GP and have 24-hour direct access to the psychiatric team, reasoning that as they (the carers) had noticed a change in their relatives' mental state it might be possible to abort a full blown relapse by early treatment.

We are concerned that bypassing the primary care filter would deskill GPs, lead to unnecessary contacts with secondary services, and possibly overload these already stretched services.

The carers' group now meets each month, with at least one team member present. "Care in the Community" had neglected the needs of carers. Carers need support, advice and respite. Good communication between professional carers and informal carers without breaching medical confidentiality is important, but difficult to achieve.

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Highly specialised services

Sir: Regarding the survey of highly specialised psychiatric services (Beasley *et al*, *Psychiatric Bulletin*, March 1996, **20**, 129–130), I was extremely astonished to see no mention of the psychiatry of learning disability, which requires skills beyond the experience of general psychiatrists. Psychiatrists in learning disability have been providing specialised psychiatric services,

including neuropsychiatry, for many years with few resources and scant recognition, developing community care successfully and earlier than colleagues in other branches of psychiatry. I look forward to when the psychiatry of learning disability will be resourced and recognised properly and when we will not have to endure the unkindest cut of non-recognition of the speciality.

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Authors' reply: We have every sympathy with Dr Chakraborti's view of the importance of psychiatry of learning disabilities. However, we deliberately confined our study to those highly specialised services which are not formally and nationally recognised and necessarily provided in every locality. For this reason we did not include forensic psychiatry, the psychiatry of addiction, child and adolescent psychiatry, the psychiatry of learning disabilities, etc. which are already fully covered by Sections of the College. This distinction between the specialised and highly specialised services was identified in an earlier and related article in the *Bulletin* (Crisp, *Psychiatric Bulletin*, November 1995, **19**, 657–659).

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Fitness to be interviewed?

Sir: Protheroe & Roney (*Psychiatric Bulletin*, February 1996, **20**, 104–105) report the findings of their survey of senior registrars in Yorkshire concerning assessments of 'fitness to be interviewed' in police stations. Unfortunately they do not report all their findings. They cite criteria used by senior registrars to assess 'fitness to be interviewed', report that the majority had been asked to make such an assessment and comment on the lack of formal training on this matter. However, they beg the question as to whether or not it is appropriate that such a judgement should be made by senior registrars. I know that at least one of their respondents argued that it is not.

Senior registrars in Yorkshire, when on duty, attend police stations at the request of police surgeons. This is not a contractual duty. The purpose of this arrangement is to assist the police surgeon in the assessment and disposal of detainees who may be psychiatrically disordered. Except for forensic trainees, senior registrars may know little about the law apart from the Mental Health Act. It is often the custody officer rather than the police surgeon (who will often no longer be present) who raises the question of 'fitness to be interviewed'. Custody officers not infrequently raise matters that are beyond the remit of psychiatric training: these include 'fitness to be interviewed', questions of reoffending and the likelihood of breaching police bail. It is in recognition of areas such as these which bridge medicine and the law that police surgeons are recruited and trained. 'Fitness to be interviewed' must remain the police surgeon's decision. Psychiatrists may inform and assist police surgeons, but should not substitute for them.

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Authors' reply: We are surprised by Dr Mitchison's views. Most assessments of 'fitness to be interviewed' are performed by police officers and police surgeons. Police surgeons, who may have minimal psychiatric training have the right to ask for specialist help after assessing a detainee who may be mentally disordered. Detainees should not be denied access to specialist services. We would suggest that discussion of the case between police surgeon and psychiatrist constitutes good practice. The issue of contractual duty is irrelevant to this complex and important subject.

Dr Mitchison suggests that psychiatrists should only offer advice but not make decisions on fitness to be interviewed. We believe that psychiatrists offering advice should take responsibility for their own assessments and recommendations, in the same way that they do elsewhere. This is particularly important as the issue will be open to debate later on in any future trial and the court will be interested to hear evidence at first hand.

It remains our opinion that psychiatrists should receive training on 'fitness to be interviewed'.

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Gastrointestinal side-effects

Sir: We report that nausea, vomiting and indigestion are more common in schizophrenic patients

being treated with clozapine than those treated by the usual antipsychotic drugs. When the drug charts of the 31 in-patients suffering from schizophrenia at Llanarth Court Hospital were scrutinised on 15 January 1996 there were 11 patients on clozapine and 20 patients on the usual antipsychotics. Of the latter only one patient was on an antacid (Gaviscon) and none on ulcer healing drugs (ranitidine and omeprazole). However, six of the patients on clozapine (i.e. 55%) were on ulcer healing drugs and none on antacids.

On further scrutiny all four patients on clozapine for over one year were also on ranitidine. Two of the four patients who had been on clozapine for over 18 weeks and under one year were on ranitidine and omeprazole respectively. The three patients who had been started on clozapine recently (i.e. under 18 weeks), were not on ulcer healers. When the patients on ranitidine or omeprazole were asked why they had suffered from nausea, vomiting and indigestion all believed these symptoms were due to the clozapine as this was the only drug they were on. They also mentioned that on stopping the ulcer healers the symptoms recurred quickly.

Sandoz have had reports of cases of oesophagitis caused by clozapine as it influences the lower oesophageal sphincter pressure due to its anticholinergic properties. Can this be happening to a large number of patients on clozapine, but not being reported?

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Women in psychiatry

Sir: It is encouraging to read the Manpower Committee's recommendation that we need to "take every opportunity to make our speciality more attractive so that we can retain our current trainees and stimulate more undergraduates and newly qualified doctors into an interest in psychiatry" (*Psychiatric Bulletin*, March 1996, 20, 177). These efforts should include making a career in psychiatry more attractive for women doctors, as over 50% of entrants to British medical schools are now female. Eighty per cent of these women are likely to marry and take on additional domestic responsibilities and the opportunity for part-time working must therefore be an important factor in encouraging women doctors to carry on working. Job-sharing is a relatively new solution to the problem but finding a local person at the same level and in the same speciality can be very difficult. The newly formed Special Interest Group for Women in Psychiatry is hoping to keep a job-share register which may make this task easier. There are no doubt other