

clozapine. Clearly there is a problem with compliance with regards to blood tests and Meltzer, who participated in some of the original studies (Kane *et al.*, 1988) has confirmed that around 10% of intractable schizophrenics who meet the criteria for clozapine will refuse to have blood taken.

I think it is important that this number is minimised and there are several measures that can be taken to achieve this. The question of refusal of consent is dealt with by pre-clozapine counselling, involving not just the patient but also relatives and staff. If a patient is detained under Section 3 within the first three months, there is no reason why this patient should not be given clozapine against his or her will. If, in fact, the patient has been detained over three months then the Mental Health Act Commission has recently sent a circular to all Second Opinion doctors, referred to by Bingley's letter (*Psychiatric Bulletin*, 1991, 15, 645), which makes it clear that a special second opinion for clozapine must be requested.

With reference to epileptic seizures, certainly in my experience of over 18 months of using clozapine I have seen patients with epileptic seizures and at least two of them now currently also take anticonvulsants in the form of sodium valproate. However, recent research in the USA (Haller & Binder, 1990) has shown that it is commonly, although not always, described with patients who receive clozapine in a dosage in excess of 600 mg and this can be resolved by adding anticonvulsants and/or reducing the clozapine dosage.

It is important with regard to all these problems that the patients and relatives are counselled, not only pre-treatment but also during treatment and post-treatment. We have therefore set up relatives' groups and are about to set up both patient groups and staff groups to enable patients to continue on this rather unique preparation which, as Lipsedge & Ball mention, has so many potential benefits.

With nearly 25 patients on the drug, we have found that the only reason for discontinuing patients, apart from the difficulty with neutropenia, would be non-response after prolonged treatment. However, clozapine can be combined with conventional neuroleptics, apart from depot injections, and this is, in fact, the case in many European countries. Sometimes it is necessary to do this in order for patients to achieve at least 12 months on the drug, which is again described by Meltzer, as a watershed after which patients can continue to improve who have not responded in the first six weeks.

I am convinced that with the counselling that must go on from an early stage both pre-treatment and throughout the treatment period, most patients can continue to take clozapine and also there are fewer patients who are reluctant to take it for either delusional or prejudicial reasons. Certainly

staff who have seen patients improve are more willing to counsel both patients and relatives with regards to overcoming the difficulty of consent to blood tests and the patients themselves, after they begin to improve, certainly, in my experience, are more likely to change their views from non-consent as a by-product of their improved mental state.

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### *Will Columbus succeed in discovering the computer? Floppy disc psychiatry in Italy*

DEAR SIRS

The Italian people define "Columbus' egg" as a simple but clever solution to a reputedly difficult or insoluble problem. This idiom refers to the anecdotal report about the lively and witty intelligence of Christopher Columbus, who, when challenged to make an egg stand upright, succeeded simply by flattening the base with a light touch (you can try it, it works!).

A lot of problems in psychiatry should be solved through a similar approach. So, when we tackled the problem of finding an efficient and feasible screening instrument for psychiatric morbidity in a difficult setting such as in general practice, our response "computerise!" struck us as being a true "Columbus' egg". Moreover authoritative literature, particularly about the use of the computerised version of the General Health Questionnaire (GHQ), gave us a strong theoretical support to this solution (Hughes *et al.*, 1986; Lewis *et al.*, 1988).

Confident in our knowledge of informix and emerging computer technology we computerised the Italian version of GHQ. This was proposed for all the subjects consecutively referred to our psychiatric out-patient unit prior to visiting either for bureaucratic reasons (shooting-licence, licence to carry firearms, attitude to special jobs, etc.) or routine examinations. The software requested the subject to answer to the screen by using only three specially-coloured keys on the keyboard ("Enter" and two arrows). The remaining keys were out of use in order to avoid errors.

The subject was politely requested to answer the questionnaire by a research resident (A.C.) who neutrally remained present during the assessment. Twenty-seven subjects (17 male and 10 female) underwent the computerised screening test and then were interviewed by a senior psychiatrist (M.C. or P.S.). The mean age of the sample enrolled was  $35.08 \pm 10.25$  (SD) years, the educational level was  $10.62 \pm 3.33$  (SD) years.

Problems arose right from the first subject. Performance time was more than ten minutes and all but two subjects (regardless of being a legitimate psychiatric case or not) repeatedly asked for help in spite of the exhaustive computer suggestions. The subjects, when asked to comment on the procedure, showed frustration and anxiety about their performance (23 subjects: "I don't know; I didn't manage"; "I'm afraid of having made mistakes"; "It is embarrassing") or refusal (two subjects: "It's stupid"; "useless") and they couldn't wait to finish the test. The two remaining subjects (one with a high school diploma in computer sciences and one airline pilot) performed without any problems. Examining the data of the questionnaire, the GHQ threshold score of 4/5 offered identification as "cases" of 50% of the patients and 100% of the controls.

Apart from the fact that almost all of our subjects had never seen or utilised a computer, the problem did not seem to be the understanding of the programme instructions, but the response to an interface (the screen) by another interface (the keyboard) and the co-ordination between the two.

Perhaps the subjects of our sample have never known how "interesting and sometimes enjoyable" (Hughes *et al*, 1986), "very easy" or "very acceptable" (Lewis *et al*, 1988) a computerised assessment could be as reported by perhaps a little too optimistic view.

We know about the important utilisations of computerised procedures in patients without any informix knowledge and sometimes severely disabled patients but perhaps more regard for computer-patient interface patterns is needed in settings where an immediate understanding of the procedure without extensive explanations is necessary. Perhaps Italian knowledge about informix, or that of our sample, is not as widespread and high as in some countries, nevertheless it is probably no less so than in others. And yet there is a whiff of problems in the acceptability of computerised assessments in other reports (Lewis *et al*, 1988).

We feel sure that computer usefulness lies in simplifying and facilitating screening procedures in general practice but probably a different kind of interface such as a "touch-screen" system or an extremely simplified keyboard could give more accessibility in such a setting. This is a matter for our present ongoing search.

"... and the computer said: talk to me about your mother ..." perhaps does not belong to the near future of our patients after all.

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### Psychiatry in Australia

DEAR SIRS

Andrews (*Psychiatric Bulletin*, July 1991, **15**, 446-449) contrasts Australia's 74 specialist psychiatric beds per 100,000 with England's 142 beds per 100,000. He adds together the costs of psychiatrists' and hospital beds, and reckons that the total costs of psychiatric services in Australia and England are, respectively, \$5.17 million and \$8.23 million per 100,000 population. Andrews attributes the greater costs in England to "continuing reliance on admission to hospital as the primary means of service delivery". He states that Australia appears to have one of the lowest bed ratios of any developed nation.

It is surprising that Professor Andrews does not draw attention to the difference between age distributions of Australian and English in-patients, while comparing costs. In Australia, the number of beds per 100,000 occupied by those under 65 years of age is about 66; in England, the corresponding number estimated for 1991 is about 67 (Wing, 1986). Andrews' figures can be explained by the difference in costs attributable to care of elderly people. The lesser number of elderly people in psychiatric hospitals and units in Australia (when compared to England) is partly because our population is younger (about