It is imperative, however, that the benefits of such a facility should be available to all trainees and not only centrally based units by virtue of personal contact or proximity.

(4) The Examinations Department should consider making a condition of taking up the research option of the MRCPsych, that weekly research sessions are allocated.

(5) The College should be encouraging the appointment at senior registrar level of those who are suitable to subsequently become appointed as consultants. Although assessment of research experience may be a simple way to decide appointments, the clinical and organisational skills of the applicant should carry more weight with the appointing committee.

S. J. JOHNSTON, *Convenor*
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Copies of the seven Figures giving demographic details, etc, are available from Jean Wales at the College.

Psychiatric Bulletin (1991), **15**, 243–246

Report of the Collegiate Trainees' Committee Working Party on training of junior psychiatrists with respect to violent incidents

In September 1989, a working party of the Collegiate Trainees' Committee (CTC) was set up to examine issues in relation to the involvement of trainee psychiatrists in dealing with actual or threatened violence.

Background

The CTC had become concerned about the issue of the personal safety of junior psychiatrists as a result of incidents known to members of the Committee when trainees had been assaulted during the course of their work or had been pestered or threatened by patients when off duty. The aim of the working party was to explore the problem and, as quickly as possible, to develop some recommendations which might be readily implemented by the College and which would have a significant impact in improving the safety and training of junior psychiatrists.

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However, it was recognised that employing authorities have a responsibility for the personal safety of staff and that a safe working environment depends on the provision of appropriate resources in terms of staff, buildings, communication systems and so on. The working party did not specifically address these matters, but such issues were frequently identified as a source of concern by trainees consulted for information by members of the working party. Clearly, consultation should occur with general managers to consider service provision in relation to junior doctors' safety.

Safety of junior psychiatrists

It is well recognised that the nursing staff on psychiatric wards are most commonly involved in violent incidents and are thus most at risk of sustaining injury. Although junior doctors may not be the most frequent victims of physical violence to staff, it seems from informal enquiries that most junior doctors are assaulted at least once in their training, and that a significant minority have been assaulted several times. The issue of physical violence towards psychiatric trainees has received little attention in the literature in Britain, but there have been some publications about violence towards GPs (Harris, 1989). Women doctors may be more at risk than their male counterparts of suffering physical and sexual assault and pregnant doctors are likely to be particularly vulnerable. Clearly every effort should be made to protect junior doctors from assault, as even only minor or trivial physical injury may have a marked psychological impact. Furthermore, to minimise harm, help should be available to trainees who become victims; at present there is no established mechanism for offering advice and support to psychiatrists who have been assaulted in connection with their work.

Existing training for junior doctors

While junior psychiatrists are attacked only occasionally, they are almost invariably involved in any episode of violence within the psychiatric service in that they are called upon to make decisions about the management of patients presenting with physically aggressive behaviour in hospital wards and casualty departments. It is usually junior trainees, rather than senior trainees or consultants, who personally encounter violent incidents yet they may have had little, if any, previous experience in psychiatry. Furthermore, few psychiatrists in training have had any specific instruction concerning the management of violent incidents. An informal survey of committee members and of trainees in various training schemes in two regions showed that formal training of this kind was almost universally absent. One training scheme had a useful booklet which is given to all trainees on arrival on that scheme. However, this was not coupled with any formal teaching on the subject, and its inclusion amongst a variety of other handouts given to trainees on that scheme had resulted in its being largely ignored by our informant, who only later realised he had it in his possession.

Most textbooks of psychiatry include a section about the management of a violent or potentially violent patient, but practical advice about protection of personal safety is in short supply, although this is less of a failing in books from the USA. A small survey of senior trainees in one higher training scheme revealed perceived deficiencies in training in recognition of potentially dangerous situations, in techniques of defusing violence, in self defence, and in the use of physical restraint.

Different settings

Trainees may be at risk on hospital sites in buildings which are poorly designed or isolated. With increasing community work, junior doctors may also be involved in violent incidents in community settings where there are few, if any, immediately available resources with which to manage such episodes. The particular problems encountered in this setting are described clearly in a recent article by two senior psychiatric trainees (Black & Guthrie, 1990).

Acute and chronic risks

Most of the occasions when junior psychiatrists may be in personal danger are in acute situations when a patient is in a temporarily disturbed state and doctors are put at risk by virtue of being involved in dealing with emergencies of this kind. However, there is a different kind of risk which involves a patient seeking contact with a psychiatrist outside the work situation. Inexperienced psychiatrists may not be aware of such a risk until it is too late and, for example, a patient has been able to obtain a doctor's home address from the *Medical Directory*.

Conclusions

The working party of the Collegiate Trainees' Committee concludes that, at present, insufficient attention is being given to the issue of training of junior psychiatrists with respect to their personal safety and the management of violent incidents. The College should give consideration urgently to action which it could take to improve standards of safety and training of psychiatric trainees.

We are of the opinion that there should be mandatory requirements for training schemes in terms of adequate formal training for all trainees at the

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beginning of their careers in psychiatry to enable them to cope with violent or potentially violent patients and situations. There should also be mechanisms established locally to help doctors who have been the victims of violence.

Recommendations

(1) We recommend that the Central Approval Panel considers the inclusion of the following points in the requirements for Approval of General Professional Training Schemes and that Clinical Tutors be made aware of them at the earliest opportunity.

(a) Trainees should receive adequate formal training in all aspects of the psychiatric management of violent incidents at an early stage in their careers.

(b) Trainees must have safe working conditions. They should not be expected to interview patients in isolated rooms. In particular, when there is a potential for violence or when a patient is unknown, there should always be ready access to immediate assistance. Offices and on call accommodation should not be sited in such a way that personal safety is compromised.

(c) Trainees should receive appropriate induction when starting work on a new site, with respect to the facilities available there for managing violent incidents. This should include a copy of the local operational policy for violent incidents, a tour of the relevant parts of the building and an introduction to procedures for involving additional staff when an incident occurs or is anticipated.

(d) Trainees should be given basic guidance about the protection of personal safety. Additional attention should be devoted to the vulnerability of women doctors and especially those who are pregnant. Advice should be given with respect to situations where violence is occurring or imminent; this should include the use of breakaway and self defence techniques. There should be particular safeguards for the protection of personal safety where community visits are made by trainees. Trainees should also be informed about the need to consider protection of their private lives, for example in having ex-directory telephone numbers and not listing a personal address in the *Medical Directory*.

(e) Trainees should be offered guidance beforehand about what to do after an incident in which they have been assaulted. Each training scheme should have an identified individual, either the clinical tutor or someone appointed by him or her, to counsel trainees who have been subject to an assault. There should be consideration in advance of how to help with sensitivity doctors who are victims of sexual assault. Help should be available regarding the appropriate course of action to take from a legal point of view. Trainees should also have access to counselling to help them deal with the psychological effects of an assault. In the event of an assault such assistance should be automatically offered to a trainee:it should not be necessary for the trainee to seek it out.

(f) All training schemes should monitor violent incidents with respect to the role of trainees in such incidents, and there should be regular review of local arrangements regarding training and supervision. Information about the number and nature of incidents should be available for visiting approval teams.

(2) The JCHPT should consider aspects of training appropriate at senior registar level, and points (b) to (f) above should be requirements for approval of Higher Training Schemes.

(3) Basic information concerning personal safety should be included in the *Inceptors' Handbook*.

(4) The College should include in its reading list a specific list of references regarding: the assessment and management of violent and dangerous behaviour; issues related to safety of staff.

(5) Consideration should be given to aspects of assessment and management of immediate violence and long-term dangerousness which can be given more prominence than at present in the examination for MRCPsych.

(6) The issue of assessment and management of immediate or threatened violence should be considered as a topic for College meetings.

(7) The College might consider producing a booklet concerning good practice in managing violent or potentially violent behaviour.

(8) All aspects of the involvement of junior psychiatrists in situations of actual or threatened violence should continue to be given attention by the Collegiate Trainees' Committee. Various topics from this central theme would be suitable for consideration at Trainees' Days.

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The College Library

We wish to express our thanks to those Members of the College who have donated copies of their works to the Library. During the past six months books have been received from the following:

Dr J. Bancroft *Adolescence and Puberty*

Dr B. Barraclough *Suicide: clinical and epidemiological studies*

Dr C. M. Bass *Somatization: physical symptoms and psychological illness*

Dr P. E. Bebbington *Working in Partnership*

Dr D. Bhugra *SAQs in Psychiatry*

Dr P. Casey *A Guide to Psychiatry in Primary Care*

Dr A. J. Coppen *The Hamilton Scales*

Dr M. J. Crowe *Therapy with Couples*

Dr J. C. Cutting *The Right Cerebral Hemisphere and Psychiatric Disorders*

Professor W. I. Fraser *Key Issues in Mental Retardation Research*

Professor S. Gershon *Biological Basis of Psychiatric Treatment*

Professor L. S. Gillis *Human Behaviour in Illness*

Dr S. E. Greben *Office Treatment of Schizophrenia*

Dr K. Hawton and Dr P. J. Cohen *Dilemmas and Difficulties in the Management of Psychiatric Patients*

Dr J. A. Holmes *The Values of Psychotherapy*

Dr J. Jancar *Stoke Park publications 1939–90: Mental handicap*

Professor J. P. Leff *Psychiatric Examination in Clinical Practice*. 3rd ed.

Dr J. E. B. Lindesay *Delirium in the Elderly*

Dr S. A. MacKeith *The Development of Imagination: the private worlds of childhood*

Professor I. M. Marks *Mental Health Care Delivery*

Professor E. S. Paykel *Depression: an integrative approach*

Mr H. A. Prins *Bizarre Behaviours: boundaries of psychiatric disorder*

Dr N. Sartorius *Anxiety: psychobiological and clinical perspectives*

Dr D. A. Spencer *The Evolution of NHS Provision for Mental Handicap in Yorkshire Health Region: the nosocomial period*

Dr C. A. Storr *The Art of Psychotherapy*. 2nd ed.

Dr D. P. Wheatley *The Anxiolytic Jungle: where next?*

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Obituary

Editor: Henry R. Rollin

SYDNEY CATTERALL, formerly Consultant Psychiatrist, Royal Dundee Liff Hospital

Sydney Catterall, who died recently, was born in 1917 in Preston, Lancashire. He received his medical education at Aberdeen University where he qualified MB, ChB in 1940 and proceeded to the MD in 1954. Having decided on a career in psychiatry he obtained the DPM in 1948. He was elected to the fellowship of the College in 1972. He became interested in psychoanalysis and underwent a personal analysis: in due

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