PTSD among our forces should not blind us to the devastating effects on the Iraqi troops.

JACQUELINE M. ATKINSON
University of Glasgow
Glasgow G12 8RZ

DEAR SIRS

The two highly topical articles on factors contributing to military casualty rates and the demand for psychiatric services as a result of the Gulf War (*Psychiatric Bulletin*, April 1991, **51**, 199–203) are noted with great interest.

In this connection the facilities of the Ex-Services Mental Welfare Society are relevant. They are available as a contribution to the overall community care of ex-Service personnel to which all such patients are entitled to be considered.

The Society was formed in 1919. The record shows that it has cared for almost 50,000 former Service men and women in its 72 year history. Some 3,000 veterans of World War II and of the several campaigns since 1945, are currently provided for by the Society which has a network of eight Regional Welfare Officers and two Rehabilitation/Treatment units at Leatherhead, Surrey and Scotland respectively. In addition, we have a Veterans Home at Kingswood Grange, Surrey.

Referrals should be made direct to me and further administrative information about the Society can be obtained from the Director (081 543 6333).

E. G. LUCAS
Ex-Services Mental Welfare Society
Broadway House
Wimbledon Broadway
London SW19 1RL

Management of violent incidents

DEAR SIRS

As psychiatrists in higher training, we welcome the recent report of the Collegiate Trainees' Committee Working Party on the training of junior psychiatrists with respect to violent incidents (*Psychiatric Bulletin*, April 1991, **15**, 243–246).

The report mentions that an informal survey of trainees in two regions showed that formal training in the management of violent incidents was almost universally absent. This observation is extended by our own survey conducted approximately 18 months ago in which we sent questionnaires to 37 members of the Collegiate Trainees' Committee. The questionnaires asked about training received in several aspects of the management of violence. We received 27 replies which provided information about 28 training schemes throughout the whole United Kingdom. The replies indicated that in three schemes there was no formal training in the assessment of dangerousness, in 12 schemes there was no training in the emergency use of medication, in 15 schemes there was no training in talking with aggressive patients, in 21 schemes there was no teaching in the use of physical restraint and in 22 schemes there was no formal training in the use of seclusion. Several respondents commented that they had been expected to learn about these management approaches simply through "experience".

It is obvious from our survey that the interventions least well covered in psychiatric training are the more physical interventions which are, of course, those used in the most dangerous and difficult situations. Appropriate use of these interventions requires an accurate (and often speedy) assessment of the situation, a knowledge of the available management options and, importantly, confidence on the part of the psychiatrist making the decisions. Unfortunately, training for junior psychiatrists in the use of these "physical" interventions comes almost exclusively from having to deal with violent emergencies while on call. While it is important to obtain this type of practical experience, it would be of great benefit to patients, junior psychiatrists and other staff if the junior psychiatrists were given better preparation to deal with such emergencies.

We believe that every hospital should organise an induction course for new junior psychiatrists in which there is teaching about and discussion of practical aspects of managing psychiatric emergencies. All too often hospital managers content themselves with handing out a pile of operational policies which may satisfy their solicitors but make no contribution to improving patient management or to training junior doctors. We hope that the College report will help to bring about major improvements in this neglected but vital aspect of psychiatric training.

NICK CRADDOCK
BRIDGET CRADDOCK
University of Birmingham
Queen Elizabeth Hospital
Birmingham B15 2TH

DEAR SIRS

In response to the 'Report of the Collegiate Trainees' Committee Working Party on training of junior psychiatrists with respect to violent incidents' (*Psychiatric Bulletin*, April1991, **15**, 243–246), I would like to detail a training course recently made available to junior psychiatrists in Nottingham entitled 'Coping with Violence and Aggression at Work'. It concentrated on practical breakaway and self-defence techniques for use in violent situations in and out of hospital. The course, covered by the Department of Health guidelines, was developed from the control and restraint training designed for the Prison Service and extended by way of the Special Hospitals to the NHS psychiatric services. The moves and holds are intended to allow one to quickly and effectively break