Glasgow group, referrals were directed to the appropriate medical staff as necessary. When the Newcastle group ended, in September 1988, there was concern that media interest in child abuse might cause difficulties. This was when our group started. I left as community care proposals were beginning to be discussed at local level.

In future, government policy may provide the impetus to effective liaison between local authorities and health service staff. Each will need the services and skills of the other. Joint meetings will no longer be seen as a valuable option but as a priority. This may be enhanced by the media turning from its focus on child abuse to that of community neglect of the mentally ill.

HELEN ANDERSON

Clackmannan County Hospital
Alloa FK10 2BE

Reference

GRANT, W. & RICHARDSON, A. (1988) A psychiatric liaison service for a social service office: an unmet need, a useful innovation or an unnecessary inconvenience? *Psychiatric Bulletin*, **12**, 481–483.

A social network in a psychogeriatric day hospital

DEAR SIRS

I would like to describe the development of social network in a new psychogeriatric Day Hospital since its inception. Patients developed close ties with other patients or staff while in-patients which continued when they attended the day hospital.

The patients developed a small closely knit group at the day hospital and later kept in telephone contact, began to visit each other, and perform activities such as shopping, entertainment etc. together. If geographically separated they maintained letter or telephone contact. Despite the concept of confidentiality, a lot was learnt about patients who declined in their mental state or who defaulted from attendance, from other patients in this network.

Once discharged, patients often dropped in to visit fellow patients and staff. If a patient was readmitted to a psychiatric bed or elsewhere for medical reasons, other patients would visit him/her. The whole phenomenon evolved to include patient's relatives who often became closely involved in this network.

As many of the patients are single, separated or widowed, this social network, which was supportive and stabilising, persisted after discharge, perhaps indefinitely. It also enhanced compliance with treatment and made it easier to refer patients to other facilities away from the day hospital if their friends were already attending there.

Although the development of such a social network in a psychiatric day hospital has been reported (MacMillan & Shaw, 1966) it appears to have been forgotten and not used to its fullest advantage.

A. K. SHAH

Whittington Hospital
Dartmouth Park Hill
London N19 5HT

References

MACMILLAN, D. & SHAW, P. (1966) Senile breakdown in standards of personal and environmental cleanliness. *British Medical Journal, ii*, 1032–1037.

Psychiatrists in potentially dangerous situations

DEAR SIRS

Dr Philip Marshall is to be congratulated on his courageous attempt to "talk down" a potential suicide threatening to jump from a high building (*Psychiatric Bulletin*, March 1991, **15**, 147–148). I was quite horrified that Dr Marshall did not appear to be attached to the fire service platform, except by holding on to the rail "like grim death". Surely the fire service could have fitted him with a harness, such as is used by rock climbers, and belayed (secured) Dr Marshall to the platform with rope slings, karabiners, etc.

Had I been in Dr Marshall's position (literally and metaphorically), there is no way that I would have agreed to be lifted to lethal heights without such protection, even if I had to go home and collect my own rock climbing gear first!

Dr Marshall's account raises important questions about the extent to which psychiatrists should put themselves in physical danger at the request of outside agencies. I recently received a request from a GP to go to the home of a paranoid schizophrenic patient who was at the time threatening his brother and the police with a large knife. Not having the bravery of Dr Marshall, I am afraid I refused to attend the patient until he was disarmed and safely in police custody. Fortunately, the GP accepted my view that we should not put ourselves at risk unnecessarily; before our conversation, he had been willing to attend himself, taking with him his GP trainee.

It seems that from the first day at medical school, doctors are inculcated with the belief that they must offer help, whatever the circumstances, at whatever cost to themselves, their family and friends. The longer I practise medicine, the more inappropriate this seems, especially in a branch

https://doi.org/10.1192/pb.15.7.453-a Published online by Cambridge University Press

where one can no longer assume oneself to be safe with a patient.

A. M. Mortimer

St Luke's Hospital
Huddersfield HD4 5RQ

See Report of the CTC Working Party on training of junior psychiatrists with respect to violent incidents. (*Psychiatric Bulletin*, April 1991, **15**, 243–246).

Support groups for women psychiatrists

Dear Sirs

The paper 'A support group for women psychiatrists' (*Psychiatric Bulletin*, September 1990, **14**, 531–533) was published at a time when a number of trainees on the Plymouth rotation were discussing the need for, and the setting up of, a support group for junior staff in psychiatry.

We convened an initial meeting in October 1990 and following considerable discussion decided to run a group for women only and to include our female clinical assistant colleagues and women working in psychiatry as part of a GP training scheme. We agreed at this time that the group should be open to new female staff in these grades if and when they joined the department.

We started with a group of seven women and decided to meet at three weekly intervals. We meet in the evening and are at present running without external consultation. Of the initial seven group members, four have been regular attenders.

I read Dr Griffin's letter (*Psychiatric Bulletin*, March 1991, **15**, 171–172) with considerable interest as our group is undergoing its first transition following a change of junior staff in February. We have said goodbye to two members and have invited three new members to join. Although we are still a relatively new group this change will undoubtedly alter the group process and it is therefore a time of uncertainty. However, we are confident in our decision to run an open group and Dr Griffin's letter highlights some of our concerns about a closed group.

The ease with which new members are able to join an existing group remains to be seen but I feel the onus is on the remaining members of the 'original' group to be flexible in accommodating changing needs and perhaps alternative ways of group functioning.

S. Walker

Moorhaven Hospital
Bittaford
Ivybridge, S. Devon

A register for Munchausen's cases?

Dear Sirs

I read with interest the letter on a register for Munchhausen's cases from Dr Davey (*Psychiatric Bulletin*, March 1991, **15**, 167). Although a register may be beneficial, there may be a tendency towards anger and resentment on the part of the staff on finding out that the patient had given them inaccurate information (Shah, 1990). This may lead to hastily developed management decisions and possible discharge. The purpose of the register should be to identify this group of patients who are much in need of help and be used to plan their long term care. This point needs emphasis, otherwise there is a risk of its misuse. Other advantages of a case register have been described elsewhere (Jones & Horrocks, 1987; Shah, 1990).

Where the register should be held is open to debate. Both the Royal College of Psychiatrists (Markantonakis & Lee, 1988) and the Department of Health (Jones, 1988) have been suggested. Clear guidelines as to who should feed information and have reciprocal access to the register should also exist.

A. K. Shah

Whittington Hospital
London N19 5HT

References

Jones, J. R. (1988) Psychiatric Munchausen's Syndrome: a college register? *British Journal of Psychiatry*, **153**, 403.

——, Horrocks, F. A. (1987) Fictitious epilepsy associated with amnesia. *British Journal of Psychiatry*, **150**, 257–258.

Markantonakis, A. & Lee, A. S. (1988) Psychiatric Munchausen's Syndrome. A College Register? (letter) *British Journal of Psychiatry*, **152**, 867.

Shah, A. K. (1990) Psychiatric Munchausen's Syndrome. *British Journal of Clinical and Social Psychiatry*, **7**, 143–144.

Future of psychotherapy services

Dear Sirs

I read the article on the future of psychotherapy services (*Psychiatric Bulletin*, March 1991, **15**, 174–179) with great interest and some sorrow.

In the district where I work it has taken us a number of years to get staffing levels for general psychiatry up to the College recommendations. We have now just about achieved this and we felt that a consultant psychotherapist would be a valuable addition to the service. I have now discussed this with the managers, who told me that psychotherapy is provided by clinical psychologists, that the general practitioners like this service and that patients would rather be seen by a psychologist than a psychiatrist because it is less stigmatising. Finally it was pointed out to me that post for post psychologists are cheaper than psychiatrists.

The managers went on to tell me that now there are purchasers and providers it would be up to us to

https://doi.org/10.1192/pb.15.7.453-a Published online by Cambridge University Press