many in management to our chaos and loss was less than impressive, regarding it as a serious nuisance in financial terms and haggling over which budget resources may be squeezed from. On the day after the fire, the patients had to be met outside the unit, the situation explained to them, and they were then escorted to the general psychiatric unit where we were allowed to borrow a room for a couple of days. On requesting tea and coffee for the patients, the charge nurse said "Is this authorised?; which budget is it from; you'll have to pay for this". Maybe we need to learn a lesson in humanity from our patients: I rang a number of out-patients to cancel their appointments and explain what had happened; typically the response was "How dreadful, thank goodness no one was hurt, is there anything that would help?" I know which response I prefer.

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Community care in England and Wales – an Eastern perspective

DEAR SIRS

We have noted a marked contrast in the care of mentally ill and mentally handicapped people in India and the United Kingdom over the past 12 years. In India, a tiny minority of these patients have institutional care as most are looked after by their families in their own homes, usually in the setting of extended/joint families.

In the United Kingdom mental hospitals have cared for an otherwise difficult to care for group by the development of a subculture, a community in itself within the walls of the hospital where each ward could be compared to a large extended family house of an eastern society. If we visualise a traditional large hospital from this perspective, the transition from "hospital to community" becomes a misnomer. It is a mere change from one community setting to another, from a large extended family to a small nuclear family.

One may argue for and against the two types of family settings. One system may have greater independence, freedom of movement, less hierarchy and greater opportunity while the other has inbuilt social support harbouring interdependence. When it comes to caring for disabled persons, a nuclear family system will fail as it lacks cohesion and sharing of the task in hand. Such care can only be provided in a setting comparable to an eastern extended family.

In a society where the majority of people live in small nuclear family units, the existence of large hospitals seems a paradox. The two tier system then becomes unbearable to society at large.

The care of the people with learning disabilities in small ordinary houses has seemed acceptable to the non-disabled section of the population, the planners and the carers. It is debatable, in our view, whether it offers the best environment for care as perceived by those at the receiving end.

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'Di Pietro syndrome': psychopathology, mass media, and the Italian bribes scandal

DEAR SIRS

D. N. Protheroe (*Psychiatric Bulletin*, 1992, **16**, 807) reported on a case where a mass media event such as the Wimbledon Tennis Championship was incorporated into a patient's psychopathology.

We would like to describe a similar case related to the mass media coverage of the Italian bribes scandal, the most ambitious political corruption clean-up ever, described by international newspapers since the beginning of 1992 (Phillips, 1992; Bannon, 1992). Antonio Di Pietro, the magistrate leading the investigation, discovered a wide network of illegal kickbacks and bribes on state-funded projects and nearly every day politicians and businessmen have been jailed and hundreds questioned. This situation has created a public climate of suspicion which has flavoured pre-existing psychopathogical states in local public service workers and administrators, as illustrated by five local managers who committed suicide after having being questioned.

Our patient, a 35-year-old health worker, employed in a major Milanese hospital, attempted suicide by jumping in front of a train. He was then admitted to hospital for minor bone injuries in an orthopaedic ward, where a psychiatric consultation was requested. At interview, he appeared over-sensitive and suspicious, and described meticulously his predicament, later coloured by delusional ideas with persecutory features and auditory hallucinations which led to a DSM-III-R Axis I diagnosis of delusional disorder (297.10), persecutory type.

The delusional ideas had appeared about two months earlier with associated anxiety, depression, insomnia and feelings of guilt about imagined shortcomings in his performance at work. Self-harm took place after reading a report of the arrest by Di Pietro of managers of the local health care system, which