



columns

We believe that protective arrangements should be negotiated for a consultant job-share, to secure the part-time position if the job-share partner leaves. In that case, it should be up to the employing trust to advertise the vacant part-time position. In fact it may be better altogether for separate part-time training contracts to be issued in all cases. If flexible training and working is to be seen as a valid and solid option, it has to be respected as such. Although job-shares may be convenient for financial or managerial reasons, they should not be binding for the incumbents to revert to full-time occupation.

The second point relates to the comment "Additional funding from the postgraduate dean's budget was arranged by our medical staffing department for us to overlap in one session per week". This is a welcome development. We are pleased to report that the Flexible Training Office Thames Region has taken the initiative to make this 'overlapping' session available for all job-share schemes. It has been pointed out that there may be financial implications, such as increased administrative costs, for trusts to employ two people. We would argue that the possible additional cost should be balanced against the possibility of recruiting and retaining well-trained doctors into the speciality.

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Social networks in 'community care'

Sir: Leff *et al's* finding (*Psychiatric Bulletin*, May 2000, **24**, 165–168) that the majority of the 'TAPS' cohort lead impoverished social lives contrasts with the original vision of community care. Their reference to the nature of severe psychiatric illness seems to imply that this is responsible. Many seriously ill former long-stay patients have shown unexpected potential for social and personal relationships in coping with a relocation that would have taxed any demographically similar population, irrespective of mental illness. Most also faced a policy of confining them to small, dispersed groups (Heginbotham, 1985) on the assumption that this would automatically spawn social networks in 'the community' and with an unpleasant implication that relationships among themselves were second best that has not been entirely avoided by TAPS.

Such impoverishment should not be accepted for de-institutionalised patients, even at this late stage, and services for other groups, including assertive outreach and home care, also need fully to incorporate social network considerations if they are not to lead to

similar disappointments. The TAPS review will hopefully stimulate debate; and I would suggest an approach based on the promotion of a network of varied relationships across a range of activities and settings (Abrahamson, 1997).

ABRAHAMSON, D. (1997) Social networks and their development in the Community. In *Communication and the Mentally Ill Patient* (eds J. France & N. Muir). London: Jessica Kingsley.

HEGINBOTHAM, C. (1985) *Good Practice in Housing for People with Long-Term Mental Illnesses*. London: Good Practices in Mental Health.

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Chlordiazepoxide dosage for alcohol withdrawal

Sir: I would like to comment on the data of Naik *et al* (*Psychiatric Bulletin*, June 2000, **24**, 214–215). The initial mean daily dose of chlordiazepoxide equivalents used by general practitioners and specialist alcohol services – namely 45.8 mg and 98.1 mg – approximates to 12 mg four times daily (q.d.s.) and 25 mg q.d.s. respectively. The former is very low, the latter low in more severe dependence.

An inadequate initial daily prescription of chlordiazepoxide can have two adverse consequences:

- (a) the emergence of aversive (e.g. agitation and/or withdrawal hallucinations) and/or dangerous (e.g. withdrawal seizures) complications;
- (b) an inability of the patient to cope with the withdrawal symptoms, resulting in the resumption of drinking.

Moderate to severely dependent individuals (as judged by the Severity of Alcohol Dependence Questionnaire, Stockwell *et al*, 1979) may require in the order of 40 mg of chlordiazepoxide q.d.s. and one or two extra 'as required' doses of 40 mg for comfortable withdrawal in the first one to two days. Patients and their carers can be given the advice to reduce the amount of chlordiazepoxide if it causes excessive sedation or ataxia. Experience suggests that the as-required medication is needed by most patients at least in the first night when withdrawal symptoms are worse.

Initial undermedication is an iatrogenic cause of non-adherence and needs to be emphasised in the training of those undertaking alcohol detoxification. Furthermore, clinicians managing a patient defaulting after the first day of detoxification should establish (by assertively seeking the patient) whether their initial daily prescription was too low.

STOCKWELL, T., MURPHY, D. & HODGSON, T. (1979) The severity of alcohol dependence questionnaire: its use reliability and validity. *British Journal of Addiction*, **78**, 145–155.

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Multi-professional training in psychiatry

Sir: I read with interest Bamforth *et al's* proposal for more multi-professional learning for psychiatry trainees (*Psychiatric Bulletin*, February 2000, **24**, 72–73).

I am a psychiatry trainee from the UK currently working in Melbourne on a Crisis Assessment and Treatment Team. Apart from the consultant and registrar, the other members of the 10-person team come from non-medical backgrounds such as nursing, social work, occupational therapy and clinical psychology. Many have over 15 years' experience of working in mental health and as a result our daily discussions of patient management make use of a broad range of expertise. I have found this experience very instructive, particularly as the hierarchy of decision-making which prevails in the UK is largely unrecognised. Furthermore, non-medically trained clinicians often bring to discussions of management their experience of having worked in the past as patient advocates and case managers.

Medical schools have begun to recognise the value of multi-agency involvement in teaching (Lennox & Peterson, 1998). I agree with the suggestion that psychiatry trainees would benefit if experienced nurses, occupational therapists, social workers and psychologists were given a more formal role in teaching.

LENNOX, L. & PETERSON, S. (1998) Development and evaluation of a community-based, multi-agency course for medical students: descriptive study. *British Medical Journal*, **316**, 595–599.

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Homicide inquiries

Sir: Not many would disagree with Szmukler's article (*Psychiatric Bulletin*, January 2000, **24**, 6–10) but I have to take issue with his interpretation of the inquiries regarding "the patient as an automaton". One of the concepts he elaborates in support of his argument that patients have feelings and a mind of