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.

Alicia Etchegoyen Consultant Child and Family Psychiatrist, Chelsea and Westminster Hospital, 869 Fulham Road, London SW10 9NH

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.

David Abrahamson Consultant Psychiatrist, Community Mental Health Rehabilitation Team, 313 Shrewsbury Road, London E7 8QU

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.

Roger Howells Consultant Psychiatrist, Maudsley Hospital, Denmark Hill, London SE5 8AZ; e-mail: roger.howells@slam-tr.nhs.uk

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.

Daniel J. Smith Registrar in Psychiatry, North West Crisis Assessment and Treatment Team, 200 Sydney Road, Brunswick, Melbourne 3056, Victoria, Australia; e-mail: daniel.smith@nwhcn.org.au

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

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their own is to ask us to imagine that an aeroplane with a mind of its own decided not to follow the pilot's landing instructions. But I do not think the analogy is very valid in relation to homicide inquiries. One will surely agree that when a plane crashes, the inquiry will have to look at what part or parts failed and why. If there was wear and tear, why was this not identified and rectified prior to the flight, and more important was this oversight a negligent act? If the plane had a structural defect due to a 'harsh' landing the previous day, which was not corrected prior to the next flight, surely some one was culpable and possibly negligent? Equating a crash enquiry with a homicide inquiry is oversimplifying a very complex and quite understandably an emotional issue. Maybe if we had civil suits of negligence in homicide cases instead of inquiries, we would not feel so aggrieved, as the team would have its chance to defend its practices (which should in any case be within standards of reasonable care adopted by the profession).

Sameer P. Sarkar Specialist Registrar in Forensic Psychiatry, Ashen Hill, The Drive, Hellingly, Hailsham, East Sussex BN27 4ER

Split posts register for psychotherapy

Sir: At the recent Psychotherapy Faculty meeting in Bristol some consultants working both as psychotherapists and as general psychiatrists felt it would be helpful to liaise with others who also hold 'split' posts. I have been asked to coordinate an informal register of such individuals which would form the basis of a future network. I would like to invite anyone in a substantive split post involving psychotherapy to contact me with their details: who they are, where they work and what the designated split is in terms of specalisms and sessions.

Sally Mitchison Consultant Psychiatrist with Special Responsibility for Psychotherapy, Cherry Knowle Hospital, Ryhope, Sunderland S22 0NB

the college

Proposal for a Special Interest Group in Neuropsychiatry

Procedure for establishing a Special Interest Group:

(a) Any member wishing to establish a Special Interest Group shall write to the Registrar with relevant details.
(b) The Registrar shall forward the application to Council.
(c) If Council approves the principle of establishing such a Special Interest Group, then it will direct the Registrar to place a notice in the *Psychiatric Bulletin*, or its equivalent, asking members of the College to write in support of such a Group and expressing willingness to participate in its activities.
(d) If at least 120 members reply to this notice, then Council shall formally approve the establishment of the Special Interest Group.

In accordance with this procedure, Council has approved the establishment of a Special Interest Group in Neuropsychiatry, to provide a focus within the College in relation to this area of practice.

Members are invited to write in support of this Group and express willingness to participate in its activities. Interested members should write to Miss Sue Duncan at the College. If 120 members reply to this notice, then Council shall formally approve the establishment of this Special Interest Group.

Mike Shooter Registrar, Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG

New College policies

The College has always been committed to providing a supportive working environment for all of its employees. Council has recently approved a formal College policy providing protection from harassment in employment. The policy specifically covers sexual and racial harassment and bullying in the context of working relationships, not only between employees of the College, but also between College Members and employees.

Sexual and racial harassment

Harassment may be defined as inappropriate behaviour, actions, comments or physical contact that is objectionable or causes offence. Harassment can take many forms, from that which may appear relatively minor (e.g. a single insensitive comment) to the more serious (e.g. persistent offensive remarks, physical contact or abuse). What is acceptable to one person may not be to another, so the issue is not one of intention, but of the effect the actions or behaviour of an individual or individuals have on another individual or group.

Bullying

Bullying is persistent, abusive, intimidating, malicious or offensive behaviour and/or abuse of power which makes the target feel upset, threatened, humiliated or vulnerable and which undermines their self-confidence. While it is unpleasant to be the recipient of someone's occasional aggressive behaviour, such behaviour would normally be considered to fall outside the definition of bullying or harassment.

Resolution

(a) If an employee feels that he or she has been the victim of harassment, they are advised to make it clear to the harasser either verbally or in writing, explaining the distress which the unacceptable behaviour is causing and that it must stop.
(b) Where informal methods fail or where serious harassment occurs, employees are advised to seek the assistance of the Head of Central Secretariat and Personnel who may be able to resolve the matter or who can assist in invoking the College's grievance procedure.
(c) The College will treat seriously any breaches of this policy and all instances of actual or alleged inappropriate behaviour will be fully investigated and appropriate action taken. If an allegation is made by a College employee against a College member, the Registrar will be involved in any investigation.

This is a summary of the main provisions of the policy. Further information is available from the Head of Central Secretariat and Personnel.

Roberta Wheeler Head of Central Secretariat and Personnel, Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG

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