

point out that the Nithsdale family treatments were given by "experienced practitioners, but who did not have special skills in family intervention in schizophrenia". This point is crucial if future reports along these lines are not to cast doubt on the established value of specialised family intervention.

Anyone who has worked in a team which specialises in family interventions with schizophrenia will be able to confirm that the work is both distinctive and sophisticated. They will also be able to confirm that it is not generally recognised, often even by knowledgeable and experienced colleagues, that successful family intervention requires specific training, preferably with a specialised team.

In this sense "The application of the results in a routine way to the work of the busy clinical team . . ." (Kuipers & Bebbington, 1988) is no trivial enterprise – not that these authors imply it should be.

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#### References

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#### Uraemia and mania

SIR: I wish to comment on Thomas & Neale's case report (*Journal*, January 1991, **158**, 119–121). The authors describe a case of mania "secondary to advanced uraemia" caused by polycystic disease of the kidneys in a 62-year-old woman. I question that mania was secondary to advanced uraemia, for the following reason. Their case had chronic renal failure. Nine days after the beginning of haemodialysis she became manic. At that time urea had fallen. As mania appeared after haemodialysis, when urea was falling, it seems more likely to me that haemodialysis precipitated the episode in a predisposed individual.

I have recently described a patient with chronic renal failure who developed mania following abrupt nicotine withdrawal (Benazzi, 1989). Mania worsened when haemodialysis was started for the first time.

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#### Reference

- BENAZZI, F. (1989) Severe mania following abrupt nicotine withdrawal. *American Journal of Psychiatry*, **146**, 1641.

#### The social networks of long-term patients

SIR: The finding of the TAPS project (*Journal*, December 1990, **157**, 842–852) that long-stay patients' responses to the Social Network Schedule (SNS) corresponded with observational data is reassuring. We have been using different versions of the Goodmayes Network Analysis Questionnaire (GNAQ) which is similar to, and I understand influenced the development since the early 1980s of, the SNS. As with the SNS, about two-thirds of patients on long-stay wards have been able to respond and the average size of networks has been similar; but individual variation is wide with some very large, as well as very small, networks.

The general picture from two surveys is of networks containing a substantial number – but rarely all and frequently not a majority – of the residents on the same ward as the respondent, together with an important proportion of patients from other wards who were particularly likely to be seen as friends or confidants. Some contacts had clearly been maintained for, or revived after, very long periods, despite being undermined throughout the years by moves without consideration of networks. Relationships with staff both on and off the ward were very important but in contrast there were few contacts with people outside hospital apart from relatives. It is an irrecoverable loss that relationships between patients within mental hospitals, which must have been a major factor in ameliorating the institutional experience, were not systematically explored much earlier. As a result they were undervalued as the de-institutionalisation movement developed and no account was taken of them in earlier studies of patients' attitudes to discharge (Abrahamson *et al.*, 1989).

At Goodmayes Hospital it has proved both illuminating and useful to seek to maintain existing networks and re-establish old ones, as well as fostering new contacts, during preparation for resettlement. These remain important after discharge, since merely placing long-stay patients out of hospital does not ensure a wide range of contacts 'in the community'; former relationships are the main, and often the only, feature of hospital life to be missed. Our experience of group homes over the past 19 years supports the TAPS concern that despite their other benefits the small, relatively intense networks they foster may be unsuitable for some patients.

As suggested, social clubs may compensate, and an encouraging range of relationships has developed within and around an evening club established in 1987 in Newham, in conjunction with a group-orientated out-patients clinic which has itself encouraged networks. Encouragement of social contacts