

I would go further than Dr Hosty on his final point. Apparently familiar Judeo-Christian teachings can be revitalised through renewed reflection aided perhaps by meditation practice. No longer jaded or faded, they may again come to seem new, relevant, immediate and incontrovertible.

Sunday's Epistle (Advent Sunday; Romans XIII: "Thou shalt love thy neighbour as thyself. Love worketh no ill to his neighbour; therefore love is the fulfilling of the law") was echoed by the Buddhist monk leading Monday's meditation group who gave us teaching on loving-kindness, right conduct and compassion.

Thus there is little difficulty for me in reconciling these great spiritual traditions. I think of them as my longitude and latitude. Perhaps Islam could help fix height above (or below) sea-level! It certainly feels as if I am living a life in at least three dimensions these days.

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Services for brain injured adults

DEAR SIRS

I read with interest the conclusions of the Royal College Working Group on Services for Brain Injured Adults (15, 513-518). While I fully support the spirit of the article in this much neglected field, I feel that some of the recommendations totally lack credence in today's current NHS climate. Having spent three years unsuccessfully trying to obtain funding simply for one particular case involving head injury, I feel I can speak with some authority.

The suggestion that each district should have an identified consultant psychiatrist specifically with a responsibility in this area, even if it is not a full-time commitment, is unrealistic, given the fact that many districts are struggling with limited manpower to provide adequate services. While I welcome the notion that each region should review its existing services and evaluate service requirements, I am nevertheless somewhat sceptical about this proposition in view of the current changes in the NHS, with the potential relative demise of regions and the development of Commissioning Services and Trust Units. Unfortunately, the article does not grasp the tricky issue of funding. This is a particularly important issue in the light of the new Community Care Act and, given the fact that with the scarce resources available, funding becomes an inevitable tussle between Health and Social Services.

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DEAR SIRS

I welcome Dr Birkett's interest in the need for better services for brain injured adults. He rightly points to the difficulties facing service development for this client group. The purpose of the Working Party Report was to highlight the needs of brain injured adults and to outline a policy for service provision. The Working Party did not think it appropriate to identify strategies for implementing change given the very different health care environments throughout the UK and Ireland and the rapid changes that have been taking place since the Working Party first met.

Nevertheless the need to identify a consultant psychiatrist at district level with an interest in this client group must remain as a cornerstone of service organisation and delivery. This might well form a part of the remit of a liaison psychiatrist.

I take note of the very worrying demise of regions referred to by Dr Birkett. Nevertheless it is essential that services which are supra district in their organisation, such as forensic and brain injury services, remain the responsibility of planners at a regional level. It is also important that the voice of the College on such matters is heard at this level.

The continuing community care needs of this client group, the funding of community services and the relationships between health and social services are indeed major challenges. They must be subsumed within the purchaser-provider plans for people with chronic mental illness. Those with brain injury form a significant proportion of the most difficult patients.

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Liaison with GPs

DEAR SIRS

Following the article on liaison with GPs (Westbrook & Hawton, *Psychiatric Bulletin*, 1991, 15, 328-329), I feel it may be of interest to describe my own experience in this area. Over the six months from February to July 1991 I met fortnightly for an hour with a local group practice of four GPs. Initially, we set out with an open framework for discussion and exchange of ideas and information. We already have clinics operating on the shifted outpatient model and found that there was little opportunity to meet with the GPs in this setting and so wished to explore alternative ways of working together. At the beginning we decided that, due to time constraints, it would be best not to see patients at these sessions. Rather than imposing a rigid framework for these meetings, it was felt better to explore the usefulness of various formats as these sessions progressed. There was a tendency initially to focus on patients already referred to the psychiatric services

where the personal contact with the GP often gave valuable insights that could not easily be conveyed in a formal referral letter. This focus on individual patients led to the raising of broader issues and more general applications of points raised. As the meetings went on, a freer exchange of information evolved, with a psychiatric input being available for those patients whom the GP saw but did not consider for formal referral. Where the GP is managing a patient with psychological difficulties, we have found that discussion and elaboration of issues often serves to strengthen the GP's role in treatment. It was not the aim of these sessions to dissuade formal referral but it has become apparent that there has been a decrease in such referrals, with 12 patients being referred to the CMHT over the six months of these meetings compared with 26 in the corresponding six month period of the previous year (total number referred in previous year = 48). There has been no other change apparent to account for the fall-off and it appears reasonable to attribute this to the regular liaison meeting.

It is possible that where the GP is unsure of the management of particular patients, then a forum for discussion allows clarification of issues and it has been apparent that the GPs often prefer to continue their management of patients where possible while the security of knowing that review is possible at later meetings has enabled this to occur. It does appear that the investment of time while being a beneficial experience over the long term for both GPs and psychiatrist also has more immediate benefits.

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Working with clozapine

DEAR SIRS

Dr A. Mahmood described a 19-year-old schizophrenic patient who developed chickenpox while on clozapine (*Psychiatric Bulletin*, 1991, 15, 702). He stated that the patient's WBC and neutrophils dropped sharply. However, I wish to point out that the patient did not become neutropenic as the lowest recorded neutrophil count and WBC were 3.31×10^9 per litre and 4.66×10^9 per litre respectively during the episode. Hence the patient could be recommenced on clozapine.

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Working with clozapine – it can be done

The clinical hazards experienced while working with clozapine, recounted by Adams & Essali (*Bulletin*

1991, 15, 336–338), may have partly reflected the constraints of the drug trial into which the patients discussed had been recruited. In this open study, administration of clozapine followed a fixed-dose schedule rather than clinical titration as is generally the rule with antipsychotic drugs. This may have led to the use of higher doses than would have been reached in routine clinical management and thus an increased risk of adverse side effects. Further, the sample of refractory schizophrenic patients featured in the study included a number for whom it proved impossible to withdraw their previous antipsychotic medication. In such cases, clozapine was tested as an adjunctive rather than single treatment, as Adams & Essali mention. Whether using clozapine in combination with other antipsychotic drugs compromises its therapeutic efficacy or increases the risk of side effects remains unclear.

The clinical problems described by Adams & Essali are undeniably part of the risk-benefit balance which needs to be considered by a clinician starting patients on clozapine. Further, the arrangements for haematological monitoring and prescription of the drug may be time-consuming. Nevertheless, it would be a shame if, for these reasons, clinicians shied away from the use of the drug in those for whom it might offer clear therapeutic benefit.

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Psychiatry of opera

DEAR SIRS

Dr Jones' six-part series on the psychiatry of opera is easy prey for hostile criticism. I had hoped that others would reply to it, but in their absence it is necessary to point out, in the interests of scholarship, some of the grave deficiencies of Dr Jones' writings. One critic expressed his view after the first instalment, but Dr Jones admonished him for being too impatient (*Psychiatric Bulletin*, 1990, 14, 563–564). It is appropriate now to comment on the entire series.

Dr Jones correctly noted that limitations of space could not do justice to his subject but he failed to use whatever space he had. First, he unnecessarily described the lives of the composers and offered us the plots of the operas. This kind of background information is readily found in most encyclopedias, opera programmes or Kobbé's *Complete Opera Book* (Harewood, 1976) which he should have cited. In 1991, the bicentenary of the death of Mozart, the casual reader has been engulfed with numerous versions of his biography without an additional contribution in the present opera series.