where one can no longer assume oneself to be safe with a patient.

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See Report of the CTC Working Party on training of junior psychiatrists with respect to violent incidents. (*Psychiatric Bulletin*, April 1991, **15**, 243–246).

Support groups for women psychiatrists

DEAR SIRS

The paper 'A support group for women psychiatrists' (*Psychiatric Bulletin*, September 1990, **14**, 531–533) was published at a time when a number of trainees on the Plymouth rotation were discussing the need for, and the setting up of, a support group for junior staff in psychiatry.

We convened an initial meeting in October 1990 and following considerable discussion decided to run a group for women only and to include our female clinical assistant colleagues and women working in psychiatry as part of a GP training scheme. We agreed at this time that the group should be open to new female staff in these grades if and when they joined the department.

We started with a group of seven women and decided to meet at three weekly intervals. We meet in the evening and are at present running without external consultation. Of the initial seven group members, four have been regular attenders.

I read Dr Griffin's letter (*Psychiatric Bulletin*, March 1991, **15**, 171–172) with considerable interest as our group is undergoing its first transition following a change of junior staff in February. We have said goodbye to two members and have invited three new members to join. Although we are still a relatively new group this change will undoubtedly alter the group process and it is therefore a time of uncertainty. However, we are confident in our decision to run an open group and Dr Griffin's letter highlights some of our concerns about a closed group.

The ease with which new members are able to join an existing group remains to be seen but I feel the onus is on the remaining members of the 'original' group to be flexible in accommodating changing needs and perhaps alternative ways of group functioning.

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A register for Munchausen's cases?

DEAR SIRS

I read with interest the letter on a register for Munchhausen's cases from Dr Davey (*Psychiatric Bulletin*, March 1991, **15**, 167). Although a register may be beneficial, there may be a tendency towards anger and resentment on the part of the staff on finding out that the patient had given them inaccurate information (Shah, 1990). This may lead to hastily developed management decisions and possible discharge. The purpose of the register should be to identify this group of patients who are much in need of help and be used to plan their long term care. This point needs emphasis, otherwise there is a risk of its misuse. Other advantages of a case register have been described elsewhere (Jones & Horrocks, 1987; Shah, 1990).

Where the register should be held is open to debate. Both the Royal College of Psychiatrists (Markantonakis & Lee, 1988) and the Department of Health (Jones, 1988) have been suggested. Clear guidelines as to who should feed information and have reciprocal access to the register should also exist.

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Future of psychotherapy services

DEAR SIRS

I read the article on the future of psychotherapy services (*Psychiatric Bulletin*, March 1991, **15**, 174–179) with great interest and some sorrow.

In the district where I work it has taken us a number of years to get staffing levels for general psychiatry up to the College recommendations. We have now just about achieved this and we felt that a consultant psychotherapist would be a valuable addition to the service. I have now discussed this with the managers, who told me that psychotherapy is provided by clinical psychologists, that the general practitioners like this service and that patients would rather be seen by a psychologist than a psychiatrist because it is less stigmatising. Finally it was pointed out to me that post for post psychologists are cheaper than psychiatrists.

The managers went on to tell me that now there are purchasers and providers it would be up to us to

persuade potential purchasers that a psychotherapist was a worthwhile investment.

I wonder if people in other districts have had similar experiences.

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Rehabilitation and community care in psychiatry

DEAR SIRS

General management, in all its aspects, is relevant to all branches of psychiatry. Apart, therefore, from being puzzled as to why the letter from Drs M. P. Sargeant and R. Ball (*Psychiatric Bulletin*, March 1991, **15**, 173) should have appeared under the above title, I would very much support the view that there is a need for information on general management as applied to psychiatry. I suspect this need might be greater among established consultants as one would hope that these topics are now being incorporated into the training programme for those aspiring to consultant status.

It has been for some time my contention that the College might be well placed to take the initiative in organising training sessions for psychiatrists on general management which, in practice, might be incorporated either into Divisional Meetings or into the Quarterly or Annual Meetings.

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Of pegs and piles and poppycock

DEAR SIRS

Thank you for letting me see Dr Edward's letter (*Psychiatric Bulletin*, June 1991, **15**, 368); there will, no doubt, be others in similar mode.

I wrote in support of colleagues who, like Dr Azuonye, have learnt, either by their own experience or from others that carpets have attractions that can sour. Dr Edwards is not in need of support for he aligns himself with those whose naive but insistent enthusiasm for these coverings causes a heavy heart for Dr Azuonye, myself and others.

Time will tell for Dr Edwards – he is likely to be around to learn – the enthusiastic managers will have rotated away long since. It is kind of Dr Edwards to invite me to his unit, an invitation I would like to take up during the second half of 1993. He will find me wearing no peg, no blinkers, neither am I deaf and I retain both a sense of taste and an appetite for this work that has proved enduring. Among my purpose is to enable others to do the same!

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Which section of the Mental Health Act – 2 or 3?

DEAR SIRS

Had the framers of the Mental Health Act 1983 realised the continuous nature of the assessment process, the wording of Sections 2 and 3 would have been very different.

Section 2 would have provided to *'Assessment, or assessment followed by treatment, for a period of up to 28 days'*, and Section 3 would have been for *'Assessment, or assessment followed by treatment for a period greater than 28 days'*.

This is the most meaningful way in which to use these two Sections of the Mental Health Act. Each time I admit a patient, on whom a diagnosis had been made, the admission is under Section 2. This applies also to those previously admitted under Section 3.

If the patient gets better during the initial 28-day period, I discharge him from detention or let the detention lapse. If, as we enter the fourth week of admission under Section 2, it is evident that the criteria for compulsory powers still apply, I recommend detention under Section 3.

The nationwide acceptance of this approach would make life considerably easier for consultant psychiatrists and approved social workers.

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'An Angel at My Table'

DEAR SIRS

I read with interest Dr Bhugra's review of the film 'An Angel at My Table' (*Psychiatric Bulletin*, March 1991, **15**, 190).

As one can understand, the film has received much acclaim in New Zealand, particularly for its vivid portrayal of the course of depressive illness in a young girl, her hospitalisation and her treatment.

Janet Frame's literary prowess is obviously apparent in her trilogy. The clarity she achieves in her various descriptions of events is superb. From a psychiatrist's point of view what better proof do we need that ECT has no lasting effects on memory!

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