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