Collacott & Cooper would care to contribute to these.

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The inappropriate question syndrome

DEAR SIRS

Drs Madeley, Mumford & Biggins have, I hope, amused the readership with their witty letter (*Psychiatric Bulletin*, October 1990, **14**, 629). There is a simple behavioural management technique for the inappropriate questioner which they do not mention; however, it requires an enormous amount of cheek. The presenter should say in a confident and self-assured manner, "with regard to this point, we should always remember the proverb which states that the greatest fool may ask more than the wisest man may answer". Such a consequence should fail to reinforce inappropriate questioning behaviour, possibly in the short and long term, a stunned silence being the most likely outcome. Clearly this drastic technique must only be used for the most extreme exponents of the inappropriate question syndrome.

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DEAR SIRS

Drs Madeley, Mumford & Biggins' description of 'the inappropriate question syndrome' (*Psychiatric Bulletin*, October 1990, **14**, 629) is well received. We recommend the following preventive strategy. At the end of a presentation, the chairperson invites each member of the audience to turn to his/her neighbour and voice any thoughts about the paper for five minutes. During that time, anyone with a burning question may approach the speaker at the front of the hall and the next presenter can be making necessary preparations.

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Psychiatric liaison service

DEAR SIRS

Having just completed a nine-month post as psychiatric liaison registrar at Westminster Hospital, I read with interest the article by Gourdie & Schneiden (*Psychiatric Bulletin*, September 1990, **14**, 548–549) which recounted their experience in a similar post at another London teaching hospital, University College. It appears that the main difficulties they encountered in their work were lack of time for adequate follow-up of deliberate self-harm patients and little opportunity to build up a fully involved psychiatric liaison service on the general wards. Both these problems stem from the disproportionate amount of time taken up by psychiatric assessment of deliberate self-harm patients in the Accident and Emergency Department and on the wards.

Every trainee in psychiatry gets a great deal of experience in emergency assessment of patients and assessment of suicide risk during their on call duty at night and weekends. A training post in liaison psychiatry should concentrate on experience which cannot be gained elsewhere. Reducing the amount of time spent on the assessment of deliberate self-harm patients would allow the trainee to benefit from a broader experience of liaison psychiatry, such as that described by Foster, 1989. In addition the general medical and surgical wards could expect an improved liaison service. But how can this be achieved without resorting to the duty psychiatrist?

Research which found that non-psychiatrists were able to make safe and reliable assessments of attempted suicide patients (e.g. Newson-Smith & Hirsch, 1979; Catalan *et al*, 1980) resulted in a change of policy as recommended by the Department of Health and Social Security (1984). The new guidelines acknowledge that adequately trained personnel (e.g. general physicians, social workers and psychiatric nurses) can undertake the psycho-social management of deliberate self harm patients. Consequently an increasing number of hospitals are changing their approach to the care of these patients.

At Westminster Hospital a system of joint management has been developed. All deliberate self-harm in-patients and some of those presenting in the Accident and Emergency Department are seen by one of the three social workers attached to the Carlyle Unit (deliberate self-harm unit). As most of our patients present with social problems or interpersonal conflicts (which often require follow-up counselling and advice) this initial contact with the social worker is both therapeutic and cost effective in terms of time and resources. The liaison registrar is available for consultation and is normally asked to further assess approximately half of all the patients seen. Those requiring psychiatric follow-up are referred to the appropriate services by the trainee. The social workers and liaison registrar meet with the consultant (liaison psychiatry) once a week to discuss cases seen and further management plans.

This system is efficient in that it makes the best use of available resources with minimum duplication of work; it also allows the trainee more time to pursue areas of interest within the specialty of liaison psychiatry. However in a large general hospital the registrar may find that he/she has to spread himself