

and the norms from *The Rising Tide*<sup>2</sup> recommend, for a comprehensive service, i.e. functional and organic, 35 (6) assessment beds, 100 (26) rehabilitation and continuing care beds, and 150 (20 to come) day hospital places. (The figures in the brackets are the existing provisions.) There are no immediate plans to increase the number of beds in the next 10 years. It is clearly apparent that these present provisions fall far short of anybody's recommendation.

As a result of the shortage of statutory beds, the bulk of the elderly are looked after by the private sector. Whereas 900 elderly are looked after in private beds (probably half of these are mentally ill), only 38 beds are designated by statutory authorities (Health Authority 26, Social Services Department 12).

There is no formal screening by Medical and Social Service Departments before they are admitted to private beds and so elderly people with less severe mental illness are looked after by expensive methods when they are entitled to Supplementary Benefit. Of course, treatable illnesses might never be brought to light.

Having created this private sector bonanza, the Government are now changing the rules of the game. Firstly, it is suggested that the funding for the Supplementary Benefit should come from the local authorities. Secondly, it is trying to invalidate from the entitlement of Supplementary Benefit the homes run with either NHS Management or NHS Staff secondment. This might close the door for the private sector beds altogether.

Without beds and provision, how can a small team of workers cope with a swelling tide of elderly, other than drowning in frustration and disillusionment? Perhaps that was what was meant by the HAS when they named their Report *The Rising Tide* (Keep Away!).

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#### REFERENCES

- <sup>1</sup>ROYAL COLLEGE OF PSYCHIATRISTS (1981) Interim guidelines for regional advisers on consultant posts in psychiatry of old age. *Bulletin of the Royal College of Psychiatrists*, 5, 110–111.
- <sup>2</sup>HEALTH ADVISORY SERVICE (1982) *The Rising Tide* (Developing Services for Mental Illness in Old Age). Sutton: NHS Health Advisory Service.

### *Medical insurance fees*

DEAR SIRS

It would be of interest to know if the members of the Royal College of Psychiatrists share the official view of the College in relationship to the present situation.

On querying as to the College's attitude, the Executive and Finance Committee reported back that the increase in Defence Fees was an issue that concerned "terms and conditions of service" and therefore was not within the remit of the College.

I am sure that financially hard pressed junior psychiatrists would not share this view. It is of interest in a recent article in the *British Medical Journal*<sup>1</sup> that a random analysis of 100 medico legal cases in the West Midlands did not contain one psychiatric case. Clearly, psychiatrists are being overcharged. It could be strongly argued that the College should be actively involved in supporting a differential for psychiatrists and also putting pressure on the Health Service to pay the insurance cover for psychiatrists in the Health Service.

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#### REFERENCE

- <sup>1</sup>HAWKINS, C. & PATERSON, I. (1987) Medicolegal audit in the West Midlands region: analysis of 100 cases (1987) *British Medical Journal*, 295, 1533–1536.

### *Assessment of drunk patients*

DEAR SIRS

The article 'Patients at a Psychiatric Walk-in Clinic—Who, How, Why, and When' by Haw, Lanceley & Vickers (*Bulletin*, October 1987, 11, 329–332) stimulated my interest. It provided a useful overview of the operation of the Maudsley Emergency Clinic and reminded me of my experience of working in a similar setting, the Assessment Centre of a large urban psychiatric hospital in Dublin.<sup>1</sup> I was struck by the statement that "it is the clinic's policy not to interview drunk patients and so no details, other than their name and arrival time, were recorded". Alas, by this policy I fear a possible important therapeutic intervention is lost.

In Dublin the problems caused by 'drunk and drinking patients' attending the Assessment Centre were considerable and a major hassle for harassed registrars covering the centre at night-time. Policy at the centre, which had eight beds for lodging or 'guesting' patients overnight as indicated, was to refer all such patients to a nearby Alcoholism Treatment Unit for assessment at the next available clinic time. In the absence of guidelines individual doctors were left to decide their own approaches to the management of drunken patients presenting at night-time. A small research project helped clarify one approach.

Over a 10 week period specific information on every patient presenting to the centre with problems directly related to alcohol abuse was collected. Of 118 such patients, 85% were males with a mean age of 38.2 years (s.d. 10.7) and 15% were females with a mean age of 42.7 years (s.d. 10.9). Approximately one third were single, one third married, and the remainder separated; 62% were unemployed and 24% were of no fixed abode; 65% had one or more previous psychiatric admission; 59% reported drinking within the previous six hours and 52% were drunk on presentation, with a further 19% judged to be 'smelling

strongly of drink'. In contrast to the Maudsley Emergency Clinic, 21% presented during the day, 63% during the evening (5 p.m.–12 midnight), and only 16% overnight (12 midnight–10 a.m.).

The point I want to highlight is that of the 57 patients who were lodged or 'guested' overnight in the centre, 73% attended the next available clinic at the Alcohol Treatment Unit in contrast to only 46% of the 61 patients not lodged. There was no evidence that the junior doctors chose for lodging only those patients likely to attend. The most likely explanation is that lodging favourably influenced attendance. Why this was so may have many reasons ranging from proximity and practical ease of access, to the response of disturbed dependent persons to a 'holding environment'.

Recently the pessimism and gloom about the prognosis for those who abuse alcohol or become dependent on it at stages during their lives is lessening. It would be a pity if a response or lack of response to such persons inhibited a process that may lead to beneficial life changes. Whether this is so at the Maudsley Emergency Clinic, a setting which many would hope to emulate, is a question worth considering.

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#### REFERENCE

- <sup>1</sup>MCGENNIS, A. J., O'CALLAGHAN, J., TEDDERS, J. G. *et al* (1980) Screening psychiatric admissions: 6-months' experience in the assessment centre of a large urban psychiatric hospital. *Journal of the Irish Medical Association*, 73, 351–356.

*Dr Haw and colleagues reply*

DEAR SIRS

We feel the Maudsley Emergency Clinic's policy of turning drunk patients away and asking them to return for assessment when sober is both humane and sensible. If every client who presented drunk and claimed drinking problems was admitted the clinic's resources would be overwhelmed. Asking people to return when sober is a small test of motivation and selects those clients amongst this difficult group who show some inclination to stop drinking.

The project described by Dr Healy in his letter is an interesting pilot study but the assertion, "There was no evidence that the junior doctors chose for lodging only those patients likely to attend", needs to be validated by a randomised study. Thus at present we see no justification for a change to existing policy.

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## *The College and NHS cuts*

DEAR SIRS

Presently, we are seeing a general turmoil in the National Health Service due to the Government's policy of cutting services and closing long-stay hospitals. From the psychiatric point of view, the main impact has been on psychogeriatric and mental handicap hospitals. The most worrying aspect is the closure of hospital wards before the opening of comparative treatment facilities in the community which has resulted in suffering for patients and their families.

Recently, three Royal College Presidents gave their views on the Government's National Health Service policies. Perhaps it would be helpful if a fourth member, the President of the Royal College of Psychiatrists, joined the team of protesters. It would also be more relevant as psychiatry as a whole is taking the brunt of the changes which alter its long-standing functions and practices.

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DEAR SIRS

We have been interested to observe the public comments of the Presidents of the Royal Colleges of Surgeons, Physicians and Obstetricians and Gynaecologists on the parlous state of the National Health Service. We have been surprised by the absence of any such activity from the officials of our College. Is this a tactical manoeuvre suggested by our recently appointed public relation consultants?

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*The President writes:*

Public activity is, to some extent, a matter of timing. The letter from the three Presidents was closely followed by the delivery of a petition to Downing Street, by a delegation in which I took part. This activity may have contributed to the release of a small amount of extra money.

The longer term requires less public, but equally forcible, activity. We have pointed out, with good evidence, to the DHSS that funding has been diverted from mental health services to the acute sector. This may be more publicly discussed in due course, but the point has been made. All this relates first, to the possible extra funding for the NHS in 1988–1989 from the budget and secondly, to the longer term plans for the NHS. The government has been repeatedly advised that people with persistent disabilities and recurrent illness fare very badly from private insurance schemes. Our present concern is with the (unpublished) Griffiths report. Some of its recommendations sound very worrying.