a clinical viewpoint, it appears that relapse prevention strategies need to be pursued actively for the first few months following the completion of treatment.

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Blood Alcohol Survey in Patients with Self-Poisoning

SIR: One hundred and fifty-eight consecutive admissions for self-poisoning were studied for alcohol use in an Accident and Emergency Department. Forty-one per cent of the case population had blood alcohol present and 29 per cent had levels exceeding 17.4 mmol/l (80 mgm/100 ml) These findings are similar to those from a study by Holt *et al* (1980) of casualty attenders at a teaching district general hospital. Our results also showed that blood alcohol levels were higher in older patients (40+) ($r = 0.25$, $P < 0.01$) for both sexes. The association of sex with a weekday/weekend variable was significant ($\chi^2 = 5.72$, $df = 1$, $P < 0.05$): higher blood alcohol levels were associated with female self-poisoners on weekdays and with male self-poisoners at weekends. Blood alcohol levels of women arriving during "risk" times (2200–0659 hours) were significantly higher than those of women arriving at the other times ($t = 3.45$, $df = 92$, $P < 0.001$). These variations between the sexes deserve further study.

The intoxicated patient presents a diagnostic challenge to the casualty officer since the contribution of alcohol to the clinical state may make the assessment critical, especially in self-poisoning cases. This also becomes important in the early evaluation and management of psychological distress. Although the association of alcohol intoxication and suicidal risk has been well documented (e.g., Barraclough *et al*, 1974), the extent of this association becomes ambiguous if information on the level of intoxication is obtained through self-report.

Our results alert us to the need for providing better psychiatric back-up services in the assessment and management of these patients. We may have to place greater emphasis on the subject of alcohol abuse and comprehensive assessment of self-poisoning cases in the training of junior physicians. Brief alcoholism questionnaires (Wanberg *et al*, 1979) may be used in selected cases where there is a suspicion of dependency. Immediate counselling or therapy, especially for self-poisoners with higher levels of neurotic symptomatology, should be arranged to tackle the alcohol abuse problem (Newsom-Smith & Hirsch, 1979). There is a strong case for integrating alcoholism treatment services with accident and emergency department services

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Schizophrenia and the Media

SIR: I write, as a retired psychiatrist, to suggest that psychiatrists could use and add to the present publicity on schizophrenia.

"The most disabling illness known to mankind" is how *The Times* referred to schizophrenia after months of informed articles and correspondence. "The most heart-rending assignment I have ever had. I could not believe that people in Britain lived like that today" said the producer of the recent Central Television programmes. "Top level neglect is a thriving concern" and "community care may be on the tip of every fashionable tongue, but prison care is a likelier fate" according to a *BMJ* review. Daily papers and popular journals carried tragic case-histories. Dr Thomas Bewley, our President, had a supporting letter in *The Times*, and he and Professor Wing and other distinguished psychiatrists were at

the crowded and eager seminar in Oxford organised by the National Schizophrenia Fellowship on March 17th.

Ignorance and prejudice about the disease are prevalent even among the educated. During the last week a woman has told me of her struggle to get her apparently schizophrenic son seen. The third GP advised her to throw the young man out, the fourth prescribed tranquillizers for her, but would not see the son. A general practitioner has told me that, in a lifetime's practice she had only seen one case of schizophrenia. Oxford academics have told me that they were not interested in schizophrenia as they did not have it in their colleges!

The National Schizophrenia Fellowship is an association of relatives and professionals to further the needs of sufferers and their families. We are concerned about the discharge of patients from mental hospitals to an uncaring community and the difficulty in getting admission for those in need of nursing and asylum. Ten times the present number of community psychiatric nurses need to be trained, social work training re-designed and satisfying occupation provided for the half million unemployable patients. Legislation is needed for treatment in the community of people who have lost insight in an acute episode. Psychiatric care for the mentally ill offender should be up to NHS standards.

As a result of close contact with sufferers, the NSF is convinced of the "medical model" for schizophrenia, and in the absence of a known cure acknowledges the need for drugs. We reject the view that schizophrenia is caused by faulty upbringing, psychiatric labelling or Western culture. Our organisation has extensive and specialised knowledge of schizophrenia which could and should be used in cooperation with the NHS for the benefit of sufferers and their families.

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CORRECTION

(*Journal*, March 1986, **148**, 334). The second paragraph of the letter from Dr Sireling and Professor Paykel should read: "They suggest that the exclusion of patients who had seen a psychiatrist or received antidepressants in the past three months would have "creamed off" many severely depressed patients. We believe that antidepressants make patients less, not more severely depressed, and that the approximately 10% of depressed patients whom general practitioners refer to psychiatrists cannot be legitimately regarded as 'general practice depressives'."