I said no such thing and obviously Dr Peel has misunderstood what I said and her reply has been on the wrong premises. I said 'No' to Dr Spencer's question as to whether there is a need to create a *new post* of Community Clinical Medical Officer for mentally handicapped adults. I work very closely with Clinical Medical Officers and I rate their input in mental handicap very highly. These Medical Officers are also involved in the care of people who are not mentally handicapped and I repeat I was objecting to the proposal of creating a new post of Community Clinical Medical Officer just for the mentally handicapped. I would reiterate: "The integration of mentally handicapped people is difficult enough; there is no need to make it more difficult by creating a new category of medical posts and depriving them of normal services which are available to other groups of the population."

I can put her mind at rest by saying I do include Community Clinical Medical Officers in 'normal services'. However, I think the caption of my letter perhaps contributed to the misunderstanding, albeit it was inherited from Dr Spencer's letter. Ideally, it should have read – 'Is there a role for Community Clinical Medical Officers just for the mentally handicapped?'

I would like to think I practise community care for people with mental handicap with the help of a number of different disciplines, including Community Clinical Medical Officers.

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Consultant psychiatrists in mental handicap

DEAR SIRS

I read with interest Dr Sarna's comments (*Bulletin*, September 1988, **12**, 383) about consultant posts in psychiatry of mental handicap. I think the first prize in England and Wales for being able to provide psychiatric services with the least consultant input for this special sub-group of its 'clients' should go to Portsmouth and South East Hampshire Health District, where there is only one part-time consultant (eight sessions) in post for a population of 535,000.

I must congratulate Wessex Region for its cost-effective exercise and in particular the present post-holder in Portsmouth who has been able to offer his expertise and cope with the demands this entails. As for the patients' psychiatric needs, several new breeds of therapists with fancy titles have emerged. To top it all, Portsmouth District Mental Handicap Services are also devoid of psychologists. From my brief experience in the District, I do not think that our patients are significantly worse than their counterparts in other Districts with extensive 'psychology' input and one may question the need and usefulness of such professionals.

In my opinion, the consultant psychiatrist also has a role in providing support, counselling and supervision to primary care staff in mental handicap services, as they are the ones most exposed to the demanding task of looking after mentally handicapped persons. I have deliberately omitted the effects of such drastic reductions in senior medical staffing on the morale and well being, both physical and psychological, of the primary care staff. Then who really does care about the needs of the staff in a stressful situation?

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Psychiatric casualty clinic: planning and training implications

DEAR SIRS

The benefits of psychiatric intervention after suicidal attempts have been reported in several clinical studies (Greer & Bagley, 1971; Hawton, 1987). At the beginning of 1986 I started a psychiatric assessment clinic in a busy Accident and Emergency Department (A & E) in Arrowe Park Hospital on the Wirral. The idea behind setting up this clinic was to re-assess suicidal patients and support them while they were waiting for their out-patient appointment, to support psychiatric trainees in dealing with difficult cases and to form a part of the senior registrar training in liaison psychiatry. The clinic is held in an observation ward attached to A & E. It is run by a senior registrar in psychiatry twice a week. The referrals were accepted only from duty psychiatrists who had seen the patient within 24–48 hours. The length of the follow-up varied between three and ten weekly sessions. The average length of the interview was 20 minutes.

I expected some teething problems since it was the first time such a clinic was held in A & E. Most of the staff there questioned its role and the wisdom of holding it in their ward. To start with I was not provided with any room to see the patients. I therefore used any room available, even if that meant using a very small, noisy room where the noises from the surgical saw cutting through plaster of Paris dominated the doctor–patient interaction.

There was 'acting out' from the nurses to show their resentment. They kept interrupting the interviews by coming in and out pretending to pick different items from the room. They adopted an "it has nothing to do with us" attitude. This meant that they

would not make patients' notes ready, they would not call the patients or show them the way to the clinic and they would not make any appointments. When all these manoeuvres failed the attendance register 'disappeared' after three months of running the clinic. Needless to say, this attitude had a negative effect on the patients who felt despised for taking an overdose. Another difficulty I faced was inappropriate referrals by the psychiatric trainees. The clinic was overwhelmed by referrals of drinking problems, marital difficulties and social and housing problems. This problem was solved by allocating two induction sessions for the newcomers to psychiatry to explain the function of the clinic.

Role of the clinic

It helps patients to avoid the social stigma of being labelled as a psychiatric case. It reduces the workload on the psychiatric out-patients and shortens the waiting lists. It reduces human suffering, both physically and psychologically, on a personal level and within the family. It shows A & E staff that this group of patients is 'treatable' and not merely a bunch of inadequate, immature and attention-seeking psychopaths.

I feel that it helps if the senior registrar has had training in various psychotherapeutic skills like counselling, problem solving techniques or crisis intervention. On the other hand, the clinic should not be used by the trainees as an expedient to avoid making an on the spot decision since many of them will be faced with this responsibility sooner or later.

The clinic has been providing a useful service for A & E patients for the last three years in spite of the usual disruption in the service due to shortage of medical staff.

I found that setting up and running this clinic has given me insight into the power struggle within the NHS hospitals and made me aware of such forces when planning any future service.

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Assessment of drunk patients

DEAR SIRS

Further to contributions in the *Bulletin* (March and November 1988) from Dr Healy and Dr Connolly, I wish to challenge certain widespread assumptions concerning the assessment of inebriated patients. Policy, either implicit or possibly enshrined in some document, is generally to exclude patients who attend for assessment whilst drunk. Often in condescending terms, they are asked to remove themselves (or be removed) and are invited in an equally condescending fashion to re-present when sober.

This clearly is both economic and safe since so many alcohol dependent patients cannot summon the courage to seek help during intervals of sobriety. Alcoholics Anonymous recognises this problem and welcomes the moderately inebriated so long as their behaviour is tolerable. Similarly, so long as I do not consider that the patient's behaviour is unreasonable, I find it often valuable to conduct the interview in the state in which the patient has been able to present him/herself. (I do not permit smoking.)

Contrary to accepted wisdom, caring interventions by the clinician are generally remembered by the mildly inebriated patient, and these greatly increase the likelihood of reattendance when sober. The disinhibition afforded by alcohol may render an otherwise prickly patient capable of providing an honest account of every aspect of his life, not least a more accurate drinking history.

I do take a certain risk, and sensible precautions are vital: I do not wish to be assaulted, my consulting room smashed up, or have my carpet vomited upon. However, *In vino veritas*, and surely *veritas* is the *sine qua non* of any assessment.

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Psychiatrists' use of investigations

DEAR SIRS

I read with interest Dr Anthony White's paper on psychiatrist's use of investigations (*Psychiatric Bulletin*, October 1988, **12**, 430–433). Dr White's comments on his findings fail to mention some rather obvious possible explanations for the results and make some assumptions that should be challenged. There appears to be an assumption that fewer investigations equate with better practice, and that the practices followed by consultants are inevitably better than those of their junior colleagues. I would like to challenge those assumptions by proposing that the reason the number of investigations thought appropriate for a particular case reaches a peak at registrar level, and thereafter declines to consultant level, is that registrars have their heads crammed full of facts and figures in preparation for their examinations, and that this mass of knowledge eventually decays to consultant level. It is with the decay of this knowledge that the unusual or rare case stands out more