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.

D. Chakraborti

Windsor Unit
King's Lynn, Norfolk

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?

A. Kumar

Coldeast Hospital
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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

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