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.

KEVIN HEALY

Cassel Hospital
Richmond, Surrey

REFERENCE

[1] 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.

C. M. HAW

St Bernard's Hospital
Southall, Middlesex

C. P. LANCELEY

St Augustine's Hospital
Canterbury, Kent

S. J. VICKERS

Imperial College
London SW7

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.

U. J. DEY

Brockhall Hospital
Old Langho, Nr. Blackburn
Lancashire

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?

JONATHAN LOVETT

Countess of Chester Hospital
Chester

LISETTA LOVETT

Department of Psychiatry
University of Liverpool

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.

What we must avoid at all costs is public squabbling, between the specialties, for cash. It only makes 'good news'. On the other hand, a press statement signed by all the College Presidents, expressing concern about current levels of funding in the whole of the NHS, was released shortly after Mr Moore's statement in the House on 20 January to the Press Association. The press ignored it completely! A sign to return to the usual channels perhaps.

J. L. T. BIRLEY

One of our associations is missing!

DEAR SIRS

Permit me space in the *Bulletin* to write briefly about the African Psychiatric Association.

In May 1985 I applied to the then Chairman to join the Association, paying the enrolment/annual fee of £12 to him.

I later received an acknowledgement of the fee paid, with the promise of further correspondence about the Association's programme for the next year. The Chairman moved on to a new post, and that was the last I heard from the African Psychiatric Association.

I have met several other people who have enrolled in the said Association, but had no further correspondence apart from the acknowledgement of the fees paid. Unfortunately it is very difficult to write back to the Association, as the 'Headquarters' tends to move with the Chairman.

If it is possible for you to publish information about the African Psychiatric Association in the *Bulletin*, it would enable many people to locate its officials and find out what has become of the fees they paid, or what the Association's current programme of activities is. It might also enable the Association to realise that many of its members have no idea where it is currently based.

I. O. AZUONYE

Claybury Hospital
Woodford Green, Essex

Is there a role for community clinical medical officers in mental handicap?

DEAR SIRS

The Yorkshire Regional Association of Consultant Psychiatrists in Mental Handicap has discussed the question of the co-ordination in the community of the medical care of adults suffering from mental handicaps. One solution that has been debated is the creation of a community clinical medical officer appointment in mental handicap. Opinions on the subject differ among consultants and it would be useful to have a wider sounding of views on this topic.

The programme of discharging people from hospitals to the community has gained speed. While the 'medical model' of care has been condemned there has been a failure to acknowledge the medical input, psychiatric and general, which has been available in the mental handicap hospital where patients are cared for by nursing staff able to recognise the early indications of illness and to arrange investigation without delay. In most hospitals in-patients have had a complete physical examination each year. Regular dental and ophthalmic reviews and chiropody have been available. Wheelchairs and other aids have been readily available.

In the community former hospital in-patients are transferred to family doctor services to have their needs met in the same way as for normal people. Few general practitioners would claim to have experience or expertise in recognising and assessing the significance of the symptoms, signs, and changes in behaviour shown by mentally handicapped patients. A general practice with 3,000 patients could expect to have a dozen severely mentally handicapped people on its list.

The appointment of doctors to monitor and co-ordinate the medical and social care of mentally handicapped adults is one suggestion to meet this need. The appointments might be made within the Department of Community Medicine. These doctors would work closely with the Community Mental Handicap Teams and fulfil a similar role to that of the newly appointed community paediatricians. They would be able to visit mentally handicapped adults in day training centres and residential hostels and community houses.

In the community many mentally handicapped people and their families suffer because their needs are not appreciated or co-ordinated. This applies not only to those being discharged from hospitals under present policies, but also to mentally handicapped adults already living in the community. The introduction of a clinical medical officer service would be complementary to and not a replacement for the consultant psychiatrist in mental handicap. There is a serious gap becoming apparent in the community medical services for mental handicap. How it should be filled is unclear.

D. A. SPENCER

Meanwood Park Hospital Leeds
and *Yorkshire Regional*
Association of Consultant Psychiatrists
in Mental Handicap

Private clinic

DEAR SIRS

The June 1987 issue of the *Bulletin* carried a note about a clinic for treatment of male impotence. It failed to mention that it is a private facility and not quite unrestricted as one is led to believe. One of my patients was greatly disappointed and I felt in some way responsible for having referred him there without informing him fully.

I wonder if the editors were aware of this fact. If not, they have unwittingly allowed a private establishment to advertise its services through the *Bulletin*.

S. CHATTREE

Queen's Park Hospital
Blackburn

The editors regret that this point was not made explicit in the original notice.