

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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- <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