

the distant past and who are only now seeking permission to talk about it. There is also an increasing number of adults who present with a history of recent abuse or, more worrying, who present with symptoms indicative of current abuse. In those who are non-verbal or who have limited communicative skills, management decisions often have to be made on these symptoms alone without knowing who the perpetrator is. To complicate matters, many 'problem behaviours' are often, rightly or wrongly, accepted as an intrinsic part of mental handicap, e.g. enuresis, rocking, compulsive public masturbation (Brown & Craft, 1989).

At present it is difficult to know how to begin to manage such a case. There is, understandably, hesitation at calling for police involvement, but in my experience of two cases, one recent and one on-going, the police have been extremely helpful (O'Hara, 1989). How we protect an adult with mental handicap after abuse is suspected is an enormous problem, and I would very much support Dr Cooke's suggestion of an amendment to the 1983 Mental Health Act to enable guardianship to be used for such purposes.

On a slightly different point, it appears that the practice of 'sexual abuse' is the norm in large institutions for the mentally handicapped. By that, I mean that staff have often turned a blind eye to the sexual encounters of mentally handicapped residents of all abilities. To some extent, although many will have an intelligence quotient below 50 (and therefore considered incapable of giving consent), most are able to express an acceptance or rejection of sexual advances in their own limited way. This practice has not caused much of a problem until now. With the more able residents being discharged into small community homes, and a core of more dependent residents being left within the hospital, we are now in a position where ex-residents are visiting, explicitly to have sex with those remaining, outside of an actual relationship. Quite clearly our residents are being taken advantage of, and while there is often no resistance on their part, possibly because they are used to being treated in this way and enjoy the experience, not knowing any other form of affection or appreciation, professionals working in this field will need to be aware of this problem and the dilemma it poses. There should be a locally agreed policy for dealing with this problem, as well as abuse in general.

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References

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COOKE, L. B. (1990) Abuse of mentally handicapped adults. *Psychiatric Bulletin*, 14, 608-609.

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DEAR SIRS

We were interested to read the paper by Dr Leila B. Cooke (*Psychiatric Bulletin*, October 1990, 14, 608-609) concerning the possible high rate of abuse of mentally handicapped adults. Should this be proven, the abuse of mentally handicapped adults would be of serious concern to us all.

However, we feel that this situation is not currently proven. The methodology employed by Dr Cooke can be seriously faulted. She describes having circulated a questionnaire to 38 "representative" consultants in the psychiatry of mental handicap, of whom 63% returned the questionnaire. It is likely that the consultants to whom she sent the questionnaire represent a considerably biased sample. Additionally, she stated that she had received ten unsolicited questionnaires and she included these in her sample of respondents. It would seem inconceivable that such unsolicited questionnaires were unbiased.

The estimates of prevalence of abuse (and there must be uncertainty of its precise definition) range from between 0.2%-20%. An estimate with a range of a factor of 100-fold can be little more than impressionistic.

We believe that a proper study of the evidence for and true prevalence of abuse of the mentally handicapped is urgently called for. However, we do not believe that this study with its serious methodological faults should enter the canon of mental handicap psychiatry.

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DEAR SIRS

I am pleased to have the opportunity to respond to the criticisms of my paper cited in the letter from Drs Collacott & Cooper. I would refute the suggestion that the consultants contacted were likely to be a biased sample. As stated in the paper, these consultants had been elected by their peers throughout the United Kingdom to represent them at College or regional level. In addition, they all have large clinical practices and their experience of abuse is likely to be the same as that of any other consultant working in the field of psychiatry of mental handicap.

Estimates of prevalence can only be based on information currently available. I would point out that this was a preliminary survey only, intended to highlight the problem, and not a controlled trial. I agree that further studies are urgently needed in order to elucidate this serious matter - perhaps Drs

Collacott & Cooper would care to contribute to these.

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The inappropriate question syndrome

DEAR SIRS

Drs Madeley, Mumford & Biggins have, I hope, amused the readership with their witty letter (*Psychiatric Bulletin*, October 1990, 14, 629). There is a simple behavioural management technique for the inappropriate questioner which they do not mention; however, it requires an enormous amount of cheek. The presenter should say in a confident and self-assured manner, "with regard to this point, we should always remember the proverb which states that the greatest fool may ask more than the wisest man may answer". Such a consequence should fail to reinforce inappropriate questioning behaviour, possibly in the short and long term, a stunned silence being the most likely outcome. Clearly this drastic technique must only be used for the most extreme exponents of the inappropriate question syndrome.

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DEAR SIRS

Drs Madeley, Mumford & Biggins' description of 'the inappropriate question syndrome' (*Psychiatric Bulletin*, October 1990, 14, 629) is well received. We recommend the following preventive strategy. At the end of a presentation, the chairperson invites each member of the audience to turn to his/her neighbour and voice any thoughts about the paper for five minutes. During that time, anyone with a burning question may approach the speaker at the front of the hall and the next presenter can be making necessary preparations.

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Psychiatric liaison service

DEAR SIRS

Having just completed a nine-month post as psychiatric liaison registrar at Westminster Hospital, I read with interest the article by Gourdie & Schneiden (*Psychiatric Bulletin*, September 1990, 14, 548-549) which recounted their experience in a similar post at another London teaching hospital, University

College. It appears that the main difficulties they encountered in their work were lack of time for adequate follow-up of deliberate self-harm patients and little opportunity to build up a fully involved psychiatric liaison service on the general wards. Both these problems stem from the disproportionate amount of time taken up by psychiatric assessment of deliberate self-harm patients in the Accident and Emergency Department and on the wards.

Every trainee in psychiatry gets a great deal of experience in emergency assessment of patients and assessment of suicide risk during their on call duty at night and weekends. A training post in liaison psychiatry should concentrate on experience which cannot be gained elsewhere. Reducing the amount of time spent on the assessment of deliberate self-harm patients would allow the trainee to benefit from a broader experience of liaison psychiatry, such as that described by Foster, 1989. In addition the general medical and surgical wards could expect an improved liaison service. But how can this be achieved without resorting to the duty psychiatrist?

Research which found that non-psychiatrists were able to make safe and reliable assessments of attempted suicide patients (e.g. Newson-Smith & Hirsch, 1979; Catalan *et al*, 1980) resulted in a change of policy as recommended by the Department of Health and Social Security (1984). The new guidelines acknowledge that adequately trained personnel (e.g. general physicians, social workers and psychiatric nurses) can undertake the psycho-social management of deliberate self harm patients. Consequently an increasing number of hospitals are changing their approach to the care of these patients.

At Westminster Hospital a system of joint management has been developed. All deliberate self-harm in-patients and some of those presenting in the Accident and Emergency Department are seen by one of the three social workers attached to the Carlyle Unit (deliberate self-harm unit). As most of our patients present with social problems or interpersonal conflicts (which often require follow-up counselling and advice) this initial contact with the social worker is both therapeutic and cost effective in terms of time and resources. The liaison registrar is available for consultation and is normally asked to further assess approximately half of all the patients seen. Those requiring psychiatric follow-up are referred to the appropriate services by the trainee. The social workers and liaison registrar meet with the consultant (liaison psychiatry) once a week to discuss cases seen and further management plans.

This system is efficient in that it makes the best use of available resources with minimum duplication of work; it also allows the trainee more time to pursue areas of interest within the specialty of liaison psychiatry. However in a large general hospital the registrar may find that he/she has to spread himself