need or demand for the facility from the patients and their carers who are not in crisis. Continuing care beds provide a final home for very disabled patients and ideally should not be serving the acute needs of the elderly demented patients in the district. The realities of a very under-resourced service are very different. The striking finding was that if one has no continuing care beds to offer in the foreseeable future people stop asking for them. The placement of the 34 patients is summarised in the table below.

Placement	*Number of patients*
Home	10
Part III OPH	6
Other wards	7
Other hospitals	1
Left district	2
Deceased	8
Total	34

Three of the patients in Part III Homes were coping very badly and the other three were being cared for only because of the devotion of the care staff. One case illustrates the problems all too clearly. This lady had been on the waiting list since October 1986, when it was said by the visiting consultant psychiatrist that the home could not be expected to cope with her incontinence and wandering. The head of the home said that further help had not been requested because she felt there was no prospect of a hospital bed for this lady. This was in spite of her occasional aggressive outbursts to other frail residents.

Of the patients on other wards, two were in acute geriatric beds and two had been very kindly accepted by the geriatricians for long-term care. Although both these patients were profoundly demented they had been on our waiting list for so long, (one since December 1984 and one since August 1985) that they had been overtaken by physical frailty.

Five of the deaths had occurred on the waiting lists while the patients were on a medical ward. One of the two patients on the acute psychiatric ward had a presenile dementia and the other was on our own functional acute ward. The ten patients who were being cared for at home were all supported by a devoted family member. These carers felt strongly that they could not allow their demented relatives to enter long-stay care. They were all, except one who is too frail to attend, supported by the Psychogeriatric Day Hospital in the district. This facility can only be offered even in the most severe cases two days a week because of the limited number of places available.

While I would agree with Dr Blessed that hospital care may not be ideal, it does fulfil some of this need. There is no reason why hospital could not be made more comfortable and attractive for patients and their relatives. It may indeed have some advantages, particularly as these most severely ill patients have access to 24 hour medical cover and are often nursed by dedicated staff. Unfortunately, I fear the stigma attached to long-stay hospital wards will follow the patients into the nursing homes. Relatives will again be reluctant to place their demented family member in such a setting.

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Psychiatry of mental handicap in Ontario

DEAR SIRS

I wish to comment on the article by Dr Evans 'Visits to Centres of Excellence in Mental Handicap' (*Bulletin*, May 1988, **12,** 191–193).

Dr Evans commented on the scarcity and lack of understanding of the role of psychiatrists in Ontario in relationship to the mentally handicappd. I wish to point out that three medical schools out of five in Ontario (Queens, University of Toronto and the University of Western Ontario) have chairs of mental 'retardation' within the respective departments of psychiatry. Out of 1000 psychiatrists in Ontario, approximately 20 (within institutions and in the community) have expressed special interest in working with both mentally handicapped children and adults.

I agree with Dr Evans that with the current impetus for deinstitutionalisation of emotionally and behaviourally disturbed mentally handicapped individuals there is an even greater need for psychiatric manpower in Ontario and throughout the world. There is considerable encouragement through the University, the Canadian Academy of Child Psychiatry and the Royal College to develop greater expertise in developmental neuro-psychiatry.

Ontario psychiatrists have, however, distinguished themselves in the American Association on Mental Retardation and the International Society for the Scientific Study of Mental Handicap. It is also unfortunate that in Dr Evans' search for centres of excellence she was not directed to the Children's Psychiatric Research Institute in London, Ontario. This institute achieved the highest honour of the *American* Psychiatric Association, the Gold Award, for its achievements in developing comprehensive programs in service delivery, teaching and research in the field of mental handicap.

In terms of Dr Evans' observations about the use of physical restraint in Ontario, I would direct her to

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the articles by Oliver *et al* and Altmeyer *et al.*[1,2] In the former, it is pointed out that physical restraint and psychotropic medication are freely used with self-injuring mentally handicapped persons in an English jurisdiction. In the latter, a Texas, USA study, physical restraints, psychotropic medication *and* behaviour modification techniques are used. It is hypothesised by Oliver that there is a shortage of local clinical psychologists in England capable of mounting individualised behavioural interventions. (Let him who is without sin cast the first stone!).

On her next visit to Ontario and Canada, I will be delighted to assist her in arranging a more rewarding itinerary, as well as initiating a dialogue about the psychiatry of mental handicap in both our countries.

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Assessment of drunk patients

DEAR SIRS

Dr Kevin Healy's thoughtful contribution in the March issue of the *Bulletin*, and Dr Julius Merry's challenging one in the July issue, address an important issue for all doctors and nurses who see intoxicated patients. The patients have a series of wants. They also have needs which risk being unmet. These may be difficult to discern in the intoxicated state. To see such patients is to assess them. The assessment can be difficult, and sometimes dangerous. The intoxicated state can co-exist with any organic disease or injury and/or any psychiatric condition, and the assessor may be held responsible in a Court of Law for the assessment and the actions that were taken following it.

The intoxicated patient's wants are not necessarily needs. He/she may want to abuse verbally, attack physically, or smash the place up. Medication or bed and board may be demanded. Staff have rights, too, as well as a responsibility for both the assessment and for using whatever resource has been entrusted to them, as well as they can.

The staff on the Emergency Clinic of the Maudsley Hospital, confronted with intoxicated patients, do what no doubt is done almost everywhere else. They make their assessment, aware of their responsibility, looking for co-existing organic or psychiatric conditions which would warrant intervention in their own right, irrespective of the intoxication.

The problem is considerable. Of the more than 5,000 patients who come to the Emergency Clinic in a year, some 15% have alcohol-related problems. Not all of those will appear in an intoxicated state. What the staff often find themselves doing, conscious of their moral and legal responsibilities, is to persuade patients to come back to the Clinic when they are sober, and can give a better account of their difficulties, so the best package of treatment can be put together for them – out-patient detoxification, referral to a specialist unit, perhaps for in-patient care, counselling, marital or group therapy, or referral to AA, Accept, the Alcohol Recovery Project, or elsewhere.

To admit every intoxicated patient who demanded a bed would have the Maudsley Hospital deal with little other than alcohol problems. A courteous message to come back when sober, together with an appointment card for what will be a less arduous and dangerous assessment, is a method the Emergency Clinic staff have evolved to deal with this difficult and sizeable problem. We are studying the proportion of those given appointments who subsequently keep them and, of those, the proportion who have successful out-patient detoxification and/or are taken on by specialist services, to see if it is likely that "an important therapeutic opportunity" is being missed.

It is hard to know what conclusion to draw from Dr Julius Merry's acid test, "Hands up, please, those psychiatrists in private practice who would turn away a drunk alcoholic and ask him/her to return when sober rather than admitting them directly into a private psychiatric hospital?" Here, a person who can pay to have his wants met encounters a psychiatrist with a financial interest in meeting them. If a little of the violence, which Emergency Clinic staff encounter with some intoxicated patients, were to slip into the transaction between private patient and private psychiatrist, or with the nurses in the private psychiatric hospital, as society becomes more violent, perhaps a few more hands might creep up?

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Extension of licensing laws: a paradoxical move

DEAR SIRS

What do we think about the extension of licensing laws in this country? Do we all think this will lead to increase in alcoholism and alcohol-related problems?

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