their health, and 85% with a non suicidal risk to themselves of others.

Our conclusions were, firstly, that a full-time nominated deputy of the RMO, who had to be a junior doctor, was an acceptable system which paradoxically prevented more senior practitioners having a role in S52. Secondly, there was a need for pilot audit studies such as these to identify valid audit parameters, and clarify the 'numbers' issue. Thirdly, despite the informal outcome it was reassuring to note that good grounds for detention were clear despite the informal outcome.

We are currently unsure as to the reasons why patients destined to become informal are on S52 longer than those further detained, but it appears likely that any attempt to reduce the average duration of S52 in this group will result in more people being detained for longer.

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Which psychotherapy?

DEAR SIRS

The paper 'The future of psychotherapy services' (*Psychiatric Bulletin*, March 1991, **15**, 174–179) carefully side-steps the question of which psychotherapy services should be developed for which type of patient. It blandly states that 'psychotherapy' is the main or adjunctive treatment for a long list of psychiatric disorders. For most of these the authors are presumably referring to behavioural-cognitive and similar problem-solving psychotherapies which have been effective in many controlled studies (apart from personality disorders, for which little has been of help). Fewer tham 2% of consultant psychotherapists are expert in such effective methods, 98% being trained in dynamic methods with far less controlled research to show their value. This imbalance is risible. The authors express a commendable desire for audit and the use of performance indicators, but these are no substitute for controlled trials.

The article suggests that consultant psychotherapists should be responsible for a full range of psychotherapy services, but they have rarely played such a role. Behavioural-cognitive methods have usually been developed by general adult psychiatrists, nurse therapists and psychologists rather than by consultant psychotherapists. The appointment of psychiatrists as consultant psychotherapists (behavioural) may be blocked on the grounds of too little dynamic training, though very few consultant psychotherapists have adequate behavioural cognitive experience.

Posts with a Special Interest or Special Responsibility in Psychotherapy are less suitable for dynamic therapists (due to their length of training) than for Specialists in Behavioural Cognitive Psychotherapy. Posts which train and meet service needs in behavioural cognitive psychotherapy can be well integrated with general adult psychiatry.

We welcome the President's initiative in setting up a group to examine the training and appointment of specialists in behavioural cognitive psychotherapy and the representation of such interests in the College.

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Revival of Psychotherapy Section, Irish Division

DEAR SIRS

I would like to report on the revival of the Psychotherapy Section of the Irish Division of the Royal College of Psychiatrists. A meeting was held in Ardee, County Cavan on 22 March 1991. Speakers were invited to outline the current psychotherapy training in Ireland.

Dr Michael Fitzgerald spoke on training South of the border. There are Master of Medical Science degree courses in Psychotherapy and Family Therapy in Dublin and, although in great demand generally, the interest from general psychiatrists has been poor. Support from child psychiatrists in child psychotherapy training has been more substantial. Representations have been made to College to put pressure on the scheme for General Adult Psychiatry, but this had not borne fruit. Dr Fitzgerald hoped that the revival of the Psychotherapy Section would provide a forum for concentrating on these issues, and making further representation to improve training.

Dr Alderdice spoke about current training North of the border. He was more optimistic about the interest of general psychiatrists and felt that the role of the Psychotherapy Section should be more one of providing a forum for academic presentations and co-ordination of different interests. Although there had not been a meeting of the section, the situation with regard to training had improved in recent years with the appointment of a consultant psychotherapist.

Debate on whether the needs and interests of the North and South differed to such a degree that there should be separate sections ensued. This has been an issue for the Royal College in Ireland because of the differences in hospital services and training schemes. There is a separate Northern Ireland Section of the

Royal College. However, it was decided that the Psychotherapy Section could best serve the interests on both sides of the border by alternating the venues North and South and by holding residential meetings to attract members from the more distant areas.

Dr Anne Jackson of St Brigid's Hospital, Ardee (in the South) was elected as Secretary and the writer (from the North) as Chairperson. It is hoped that this revival of the Psychotherapy Section in Ireland will initiate renewed interest and activity from the general psychiatrists.

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Alcohol history-taking

DEAR SIRS

We wish to report the inadequacy of recorded drinking histories in patients admitted to a psychiatric hospital. Cefn Coed Hospital in a general psychiatric hospital providing services to the county of West Glamorgan with a catchment population of 360,000. We performed a retrospective case-note study of 120 consecutive new admissions to the hospital.

In the study, the ICD-9 diagnoses were noted. Each set of notes was examined to test the adequacy of the drinking history recorded. They were then classified using the following system:

(a) no mention
(b) qualitative assessment, for example, "social drinker"
(c) quantitative assessment, for example, "10 pints of beer a week".

The drinking history may have been recorded more than once, for example, on admission by the duty doctor and again by the ward doctor during the patient's stay in hospital. It was noted whether the CAGE questionnaire (Mayfield *et al*, 1974) was recorded and if the drinking history was taken by a psychiatric trainee or a GP SHO in psychiatry.

There were 139 histories on 120 patients as some had more than one history recorded during admission. The case-notes were completed by 12 GP SHOs and five psychiatric trainees. Two consultant psychiatrists recorded a quantitative history in five patients with an alcohol related diagnosis. Excluding these five we were left with 134 histories.

A quantitative history was obtained in 57 (43%), qualitative history in 35 (26%) and no history in 42 (31%). There were no significant differences between the type of drinking history recorded and the age, marital status or religion of the patients. Eighty per cent of patients with a diagnosis of alcohol dependence or abuse had a quantitative history recorded compared to 43% of those with a non-alcohol related diagnosis. Fifty-four per cent of GP SHOs recorded a quantitative history compared to 25% of psychiatric trainees. Only once was the CAGE questionnaire recorded. This was in a 41-year-old man with a diagnosis of neurotic depression and it was recorded by a GP SHO.

The GP SHOs failed to record a drinking history in 25% of cases studied whereas the psychiatric trainees failed to record the drinking history in 45% of cases. This compares unfavourably with the psychiatric trainees in a London teaching hospital (Farrell & David, 1988) who failed to record drinking histories in 21% of cases. Seventy-eight per cent of histories taken by the Cefn Coed psychiatric trainees failed to contain a quantitative assessment compared to 47% of histories taken by GP SHOs. We suggest these findings indicate differing attitudes to alcohol dependence and abuse in our small sample of non-teaching hospital junior psychiatric doctors. This may reflect a more open and less judgmental approach by doctors who have opted for a career in general practice.

From our sample, 20% of admissions had a diagnosis of alcohol dependence or abuse. This group is well recognised as requiring a significant and important clinical commitment and as such, doctors should retain a high index of suspicion. Drinking histories should always be quantified. Routine use of the CAGE questionnaire as a simple screening procedure can act as an *aide-memoire* for more detailed history taking. We suggest that further research is required to assess the effect of junior doctors' attitudes to drinking on their alcohol history taking.

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Competition between pre-senior registrars

DEAR SIRS

I share Dr Double's concerns about the current position of pre-senior registrars (*Psychiatric Bulletin*, December 1990, **14**, 743). The present bottleneck between registrar and senior registrar grade means