no such 'specialist' and in these hospitals it might be difficult to arrange proper teaching experience. For the majority of trainees the opportunity for clinical experience in liaison work is likely to be rather haphazard and competing with other clinical duties. Further, in 92 per cent of schemes self-poisoning referrals were seen either occasionally or often and so it is possible that junior staff are expected to cover this aspect of general hospital psychiatry (perhaps because senior staff are less willing to do it) and have less opportunity for other referral work. Specific links with medical teams, which would provide such opportunity for this form of referral was only available to a minority.

To improve the clinical experience and teaching of liaison psychiatry means identifying at least one consultant prepared to see part of his responsibility in this area and therefore able to properly supervise the junior staff on such referrals. It may not be possible to designate specific training posts in liaison psychiatry in most rotational training programmes, but some posts should be able to accommodate one or two days each week to liaison work. Such sessions should not get swallowed up as a convenient way of dealing with the self-poisoning cases.

There are many potential advantages to having effective liaison psychiatry services in the general hospital for patients, psychiatrists and general medical staff. To make these services effective postgraduates must be given the correct teaching, experience and support to develop the proper skills.

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A suggested forum for newly-appointed consultants in child psychiatry

DEAR SIRS

There are five components to the job of consultant: clinical, teaching, research, administrative and political. The first three are usually better taught and assimilated during our senior registrar training than are the last two, which really only begin to make sense when we take up our first post as consultant. Yet particularly in child psychiatry there are many hazards and difficulties. It seems to me that there might be some sense in newly-appointed consultant child psychiatrists meeting together regularly in their first year with senior colleagues to discuss these problems.

Child psychiatrists have more difficulties because they are very often the only member of their discipline in a District or Hospital and because they work more intimately with non-medical disciplines. I am willing to convene a monthly forum if there is enough interest. Perhaps newly-appointed consultants in child psychiatry could write to me if they are interested.

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Linked or joint consultant posts in the psychiatry of mental handicap

DEAR SIRS

In a letter to the *Bulletin* last year (May 1984, **8**, 96), I asked readers for information about possible changing trends in appointing psychiatrists to joint/linked appointments in two different branches of psychiatry.

Nine consultants replied with information about eight specific posts. One of these was a special interest post with two sessions in mental handicap and nine in general psychiatry; three were formal joint appointments, one with seven sessions in mental handicap and four in mental illness and the other two equally divided. Four were informal joint appointments in which the majority of the work load was in the psychiatry of mental handicap and a significant minority in child psychiatry.

In addition, five senior registrars wrote or telephoned to express an interest in joint appointments or special interest posts after reading my letter.

I asked readers about the success or otherwise of such an appointment and the response was largely favourable. The only criticisms were expressed in terms of recommendations to prospective applicants; that job descriptions should be studied with care to see if the stated allocation of duties is realistically divided and will not be weighted retrospectively in one direction. The comment was made that advertisements do not always reveal that a special interest in mental handicap is required.

A view repeated by several of the correspondents was that joint appointments are a success where they are welcomed by the local general psychiatric fraternity. It was commented that joint posts are likely to be more interesting and stimulating and should attract more able applicants, with the added bonus of the support of colleagues from general psychiatry. It was also suggested that joint appointments would enable better treatment facilities for those people with mental handicap and mental illness. In addition a consultant in a linked post is in an advantageous position to have an overview of all community facilities. This overview would be made easier where linked posts enabled the catchment area of any one consultant to be reduced. The same respondent suggested that a good balance in any one district could be achieved by appointing one consultant with a mental illness background and one with a child psychiatry background, both with linked posts in the psychiatry of mental handicap. Another obvious advantage of linked posts is the increase in the number of consultants available for on-call rotas and for cover of both sick leave and holidays.

The fact that joint posts were initiated in Scotland by the 1971 Batchelor Report was referred to frequently. Such posts are commonplace in Scotland, and in the Republic of Ireland there is current interest in establishing formal joint appointments.

Another respondent argued in favour of a restructuring of specialties in psychiatry into three broad areas: general (functional) psychiatry; organic psychiatry (including