The argument for extension is that this will result in more availability of the services provided by pubs in this country, but do we no longer believe that availability leads to abuse? Do people not realise that we have severe problems in this country with alcoholism and alcohol-related crimes? We know that there has been an increase in alcohol abuse over the recent past and that this is seen more frequently now, both among women and in younger age groups, but, despite this, opening times are paradoxically being extended.

It seems clear that some of the patients who attended alcoholism addiction units could only stay out of a pub if they were either too intoxicated to walk or if the door was shut. Alcohol is easily obtainable from off-licences, but keeping pubs open longer will increase its availability and its related problems. Furthermore, I would like to point out that the message some advertisements on television are trying to put across about alcoholic drinks is false or incomplete. Alcoholic drinks are made out to be able to relieve instantly the boredom and tediousness of life – life is filmed in black and white and depicts miserable looking people either pushing heavy boulders up hills or looking as though they are about to fall to pieces in a cobwebbed library – and replace it with happy, healthy looking people sitting comfortably in a bright, warm atmosphere. Is this the truth? What about the misery and suffering of alcohol-related illness, accidents and crimes? Obviously a non-seller.

A. MARKANTONAKIS

The Ipswich Hospital
Ipswich, Suffolk

Part-time training in psychiatry

DEAR SIRS

I should like to respond to the letter from Dr Nancy Darroch-Voloshanovich (*Bulletin*, July 1988).

I am reluctant to offer reassurance to Dr Darroch-Voloshanovich and her colleagues about the difficulties experienced by doctors who wish to train in psychiatry on a part-time basis, as I am aware that these are still substantial.

However, I do think that there is cause for hope.

A Joint Working Party between the Profession and the Department of Health was set up in January 1984, and I have been a member of it, representing the Joint Consultants' Committee and the Central Manpower Committee throughout. Having been a part-time trainee myself as a senior registrar, I have taken advantage of this to represent the needs of part-time trainees in psychiatry, as well as the views of the College on this matter.

As a result of the recent publication of Dr Isobel Allen's book on *Doctors and their Careers*, increased publicity is to be given to the ways in which part-time training can be obtained, as it has become increasingly clear that there is ignorance about this, as well as unhelpful attitudes, in members of our profession who occupy positions where they are looked to for career advice.

There is an articulate body of opinion in the medical profession that part-time training should be facilitated, particularly as the proportion of female medical students has now exceeded 50% in some intakes.

More specifically, there are individuals who have detailed knowledge about how the difficulties in obtaining part-time training can be overcome, and I recommend that anyone who is interested in availing themselves of such an opportunity should approach one of us.

F. CALDICOTT

Uffculme Clinic
Queensbridge Road
Moseley, Birmingham B13 8QD

AIDS and the psychiatrist

DEAR SIRS

I am sure that Dr Katona is right when he suggests that psycho-geriatricians will be called upon to provide services for the more advanced cases of dementia due to the Human Immunodeficiency Virus (HIV) and that there is a need to be vigilant lest these services be provided at the expense of other patient groups (*Bulletin*, May 1988, **12**, 187–188). In fact, I suspect that pressure will be exerted on all those with access to medium and long-stay beds to accommodate these unfortunate individuals, as already occurs with cases of presenile dementia and severe, incapacitating brain damage.

HIV is a new phenomenon in the UK and the various psychosyndromes associated with infection require varying degrees of special provision. This novelty demands new money: Her Majesty's Government has released funding for research into HIV, for the training and establishment of highly specialised personnel to advise on HIV-related problems and, of course, to combat drug abuse. The case must be made for additional monies to be made available from outside the Health Service to pay for the psychiatric provision that the HIV epidemic demands.

HIV encephalopathy is but one means by which young adults may be struck down and rendered brain-impaired to a degree that precludes independent life. I believe there is a clinical and administrative case to be made for grouping this 'forgotten cohort' so that humane and need-oriented services can be planned and provided. To this end I would suggest that the College should establish a working party to examine the needs of the young brain-damaged. The overburdened mental handicap

services are unable to deal with this group and, traditionally, services have been provided either by units for the chronically mentally ill, or by psychogeriatricians. I agree with Dr Katona that the latter is inappropriate, and would also suggest that the care and rehabilitation of chronic schizophrenic patients does not sit easily with the care of the group I have outlined. It may well be that a unitary service for such patients is not appropriate: I have recently voiced my concern over the risks posed by behaviourally disturbed HIV patients[1] and such factors would need consideration. Nonetheless, I believe that the HIV epidemic affords a golden opportunity for the College to review services for the brain-damaged, and make its recommendations known.

Fenton[2] points out that "... by the mid-1990s psychiatry will have become a 'front-line' speciality in the management of AIDS victims.": perhaps the profession can still bring some good out of ill and, after the example of our military colleagues, apply the experience of tragedy to the advantage of our broader patient group.

D. R. DAVIES

Moorhaven Hospital
Ivybridge, S. Devon

References

[1]DAVIES, D. R. (1988) Behaviourally disturbed HIV patients. *British Journal of Psychiatry*, **152,** 577–578.
[2]FENTON, T. W. (1987) AIDS-related psychiatric disorder. *British Journal of Psychiatry*, **151,** 579–588.

A Working Party of the Public Policy Committee recommended in 1983 that there should be better provision for patients with acquired brain damage, with comprehensive facilities on a Regional or sub-Regional basis. As a number of medical specialities as well as non-medical professionals are concerned with this group of patients, it was suggested that the DHSS might convene a Working Party to survey the whole field and make appropriate proposals for this priority group of patients. Countrywide enquiries by the College have shown that many health authorities recognise the problem and are preparing plans. Action is needed – and the Public Policy Committee is at present drawing up recommendations on the role of psychiatrists in this area. The HIV epidemic makes the need for action an even higher priority.

A. R. M. FREEMAN
Secretary, Public Policy Committee

Modern psychiatric services

DEAR SIRS

'Conflicts and Context in Managing the Closure of a Large Psychiatric Hospital' (*Bulletin*, August 1988, **12,** 310–319) was stimulating reading. Indeed, it points to a number of issues which are affecting some of us. I was sad to see that a number of basic issues were not included.

(a) Although the managers and clinicians work together, their roles are very different and hence the potential for conflict. Both sides will have to extend goodwill and willingness to work together for a successful provision of the services.

(b) Clinicians, being the persons at the centre of the service and having to deal with people in the clinical context, are naturally worried about changes in the model of the service that they have provided so far with varying degrees of success – it is human nature, and should not be viewed as a shortcoming.

(c) Continued clinical responsibility for clinicians is the rule, but current day short-term contracts managers, especially middle managers in the Health Service, are likely to move on, thereby leaving the implications and repercussions of the changes to the service to the clinicians.

(d) Lack of direct patient contact for managers is a shortcoming. This is especially true of post-Griffiths managers who may not have had any previous experience in dealing with a service that is entirely for people who are seriously disadvantaged, either in an acute or continuing sense. What should be a consultant psychiatrist's response to a manager whose sole concept of long-stay chronic schizophrenic in-patients is: "They lack moral fibre, don't they?"

I was pleased to see in the same issue of the *Bulletin* questions raised by Thomas Freeman commenting that "only the future will decide whether they (modern day psychiatric practices) will be for good or ill". I provide a service where this cautionary note is an inherent part.

R. K. BARUAH

Queen's Medical Centre
University Hospital, Nottingham

Open door movement – request for information

DEAR SIRS

I am researching the open door movement in mental hospitals in Great Britain – especially the period of the 1950s. The literature is scarce. Some major Reports, deservedly famous, have helped, and the trials and tribulations of about five hospitals are well-known. I require information about changes in restrictions on patients for *any* hospital from the early 1950s to the present day, confidentiality assured (if required).

W. F. CLARKE (Tutor)

Sussex Downs School of Nursing
Psychiatric Training Department
Hellingly Hospital, Hailsham
East Sussex BN27 4ER