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.

BENJAMIN GOLDBERG

Mental Retardation
Developmental Disabilities Program
The University of Western Ontario
London, Canada

References

[1]OLIVER, G., MURPHY, G. H. & CORBETT, J. A. (1987) Self-injurious behaviour in people with mental handicap: a total population study. *Journal of Mental Deficiency Research*, **31**, 147–162.

[2]ALTMEYER, B. K., LOCKE, B. J., GUFFEN, J. C., RICKETTS, R. W. *et al.* (1987) Treatment strategies for self-injurious behaviours via large service-delivery network. *American Journal of Mental Deficiency*, **91**, 333–340.

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?

J. CONNOLLY

Emergency Clinic
Maudsley Hospital, London SE5

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?

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