would foresee little difficulty in fulfilling our criteria for approval.

In conclusion I welcome continuing constructive debate on these matters.

SANDRA GRANT

Chairman
Psychotherapy Specialists' Advisory Committee
Lansdowne Clinic
Gartnavel Royal Hospital
Glasgow G12 0AA

Research in psychiatry

DEAR SIRS

Professor Crisp (*Psychiatric Bulletin*, March 1990, **14**, 163–168) is hopeful that his statement on 'The case for teaching and research experience and education within basic specialised training (registrar grade) in psychiatry' will be of interest. It may produce some controversy within the College. He makes a good case for research and teaching but I think it would be undesirable if all psychiatrists were expected to do research. In support of his case he notes that doctor means 'teacher'. By contrast, I would argue that research is not essential to the psychiatrist's job of treating psychological disorders.

I think the misunderstanding may have arisen because of the notion that research has advanced psychiatry. Is it true? Is psychiatry a science? What is a social science? These are questions that need research but are far too philosophical for most current psychiatric research.

Of course, research can be of value to psychiatry. Such education and training should be available in all training schemes. My case is that trainees should be allowed to choose whether they want to do research, and not be expected to do so as part of a career in psychiatry.

D. B. DOUBLE

University Department of Psychiatry
Northern General Hospital
Sheffield S5 7AU

Models of care for AIDS dementia

DEAR SIRS

Although it was flattering to see our Bow Group Memorandum being given such an extensive review by Professor Chris Thompson (*Psychiatric Bulletin*, February 1990, **14**, 126), I was somewhat disconcerted at the way his critique involved such a dismissive approach and rubbishing tone on my efforts to raise the public debate on an issue which seems to have obtained little currency or discussion elsewhere; namely the need to provide long-term institutional care for AIDS dementia patients at the end of this decade. I am quite robust enough to fully accept that some of my figures may be incorrect as they are based on averaging or interpolating some of the ranges of AIDS prevalence figures published in the Cox report, and furthermore my paper predates both the recent more optimistic predictions emanating from the Department of Health as well as the Dutch trial alluded to which suggests that Zidovudine will considerably alleviate the neuropsychiatric morbidity of AIDS, although this study makes no allowance for the possible emergence of Zidovudine-resistant HIV strains. As to the 4th International Conference on AIDS figures which were quoted, I drew upon two selected abstracts. The first is Abstract No 8565 done in Stockholm by Alexis, B. and Wetherberg, L. *et al* who examined 50 HIV infected patients with MRI and neuropsychological tests and found about 75% of the HIV infected homosexual men had frontal, parietal or occipital cortical atrophy with 70% having impairment of fine motor function with neuropsychological testing. The next Abstract is 8566 by Boccellani, A., Dilley, J. W. *et al* of San Francisco General Hospital on 46 hospitalised subjects with the first episode of *P. carinii* (i.e. the onset of AIDS). They found impairment in 78% on 6 of 10 neuropsychological tests. "These results support previous findings of a large incidence of cognitive pathology in patients with AIDS".

However I would like to take issue with a number of inaccuracies and points raised. I still maintain that AIDS patients if psychiatrically disturbed would be best kept in separate facilities even if physically ill, as in my experience general physicians are seldom happy to manage confused or disturbed patients as they find them too disruptive and are unfamiliar or unwilling to employ the Mental Health Act if this is required. The alternative, I suggest would not be an "ill-equipped mental hospital", as I clearly point out in our paper that any possible AIDS dementia unit would require very special joint care approaches between psychiatrists, infectious disease physicians, and genito-urinary physicians, and thus would require all the requisite funding and modifications to ensure adequate and modern medical care.

I also take particular issue with the very insensitive and critical attitude of Professor Thompson to our long-stay hospitals. I have spent a considerable amount of time as a junior psychiatrist at a long-stay mental asylum and was not aware of working in "an unmanageable sprawling complex in which individuality of all but the most disturbed was submerged among the faceless masses of the mentally ill". Frankly, this frontal attack on our long-stay hospitals does a disservice to their dedicated staff and patients whose morale is already at a nadir faced with the prospects of imminent closure and an uncertain future with social services managed community care.

Furthermore I would suggest that to label our Victorian asyla as "workhouses' is far more ludicrous and inaccurate than our intention to address a public health issue which even stripped of the "debris" has to my knowledge no moral overtones whatsoever, and if Professor Thompson re-reads my paper he would see that we are well aware that modern and well financed facilities must be provided for all long-stay patients irrespective of aetiology.

Professor Thompson can indeed take comfort that my proposals have little chance of finding favour as in fact the Secretary of State for Health, Kenneth Clarke, delivered a written reply to a Parliamentary Question to Chris Butler, MP who raised the issue of my memorandum during a debate in the House of Commons on the passage of the NHS and Community Care Bill. In essence the Department of Health having respectfully considered the issue I attempted to address (in spite of any inaccuracies or mistakes we may have made!) has decided that the way ahead for both the functionally psychiatrically ill as well as the AIDS dementia population lies in providing community care facilities and therefore the closure programme of the long-stay hospitals is to continue unabated.

Although I take full cognisance of other models of care for AIDS dementia which are equally correct if properly implemented and funded, I would maintain the validity and usefulness of debating the need for a traditional institutional role model, given that until recently the AIDS prevalence figures were far more alarming than the more recent downwardly revised predictions and given the propensity for all governments to restrict NHS financing wherever possible. It may be interesting for Professor Thompson to note that not all authorities are quite as belittling on this issue.

Professor Raphael, from Queensland, Australia, has raised the issue of making psychiatric institutional care provisions for AIDS dementia. I will quote from the 3rd National Conference on AIDS from Hobart, Tasmania, Australia. In session 9 he quotes the frequency of occurrence of the AIDS dementia complex as ranging from 35% to 87% in AIDS patients as evidenced by the 'Report of the Consultation on the Neuropsychiatric Aspects of HIV Infection', Geneva, March 1988, WHO, which also states "The extent to which AIDS dementia patients can be cared for at home is debatable and it may be necessary to plan for long-term in-patient care". Professor Raphael goes on to say "In-patient services for those with delirium and dementia are also required with the utilisation of special units also a possibility. Other psychiatric morbidity such as major psychoses may require in-patient care. Physical facilities to deal with these, as well as well-trained staff and the development of special skill all need to be taken into account as service implications. Staff concerns about the nature of disturbed behaviour in HIV infected patients such as poor impulse control, sexual acting out or biting, all perhaps with risk of spreading infection to other patients or staff, need to be provided for. Special sensitivity is also required from the staff in view of the degree to which insight is preserved. At the present stage major implications rest with education in both the nature and diagnosis of such conditions and their management. And, depending on the extent of the epidemic, special facilities may need to be developed".

It would be interesting to know if any other of the *Bulletin* readers have any further views or information to shed on this major public health issue.

CHARLES TANNOCK

Charing Cross Hospital
Fulham Palace Road
London W6 8RF

Audit of admissions for alcohol detoxification

DEAR SIRS

We were interested to see that the College now expects trainees for the MRCPsych to have experience of medical audit (*Psychiatric Bulletin*, February 1990, **14**, 116). We report a prospective audit of in-patient detoxification in West Berkshire Health District, where 200 deaths and 6000 GP consultations in a population of 454,000 were attributable to alcohol misuse in 1987. The district has a community team and an out-patient clinic for people with alcohol problems. Patients who need admission for detoxification go to acute wards in a general psychiatric hospital, where we conducted the study.

We included all patients who had primary diagnoses of alcohol dependence syndrome and were admitted directly from the community for planned detoxification between May 1988 and January 1989. On admission a 14-point questionnaire was used to record social and drinking histories and to confirm the diagnosis of alcohol dependence syndrome. Presence of withdrawal symptoms was checked with a self-assessment questionnaire, based on the Selected Severity Assessment Scale (SSA) (Gross *et al*, 1973), but modified to include questions on disturbance of mood and craving for alcohol.

Just before discharge, even if unplanned, we interviewed patients again and recorded whether they had completed treatment, whether they thought that follow-up arrangements had been made, and what they intended to do about drinking, accommodation, and employment on leaving hospital. Follow-up plans mentioned by ward doctors in their discharge letters to general practitioners, and actual follow-up within six months as entered in hospital and clinic