Committee is chaired by Sir David Plastow of Vickers plc and has made a good start by publishing this booklet. As might be expected from such a document, the writing is upbeat and optimistic with deserved congratulations for much past research funded by the Foundation. One of the most important decisions made by the Foundation after a meeting in 1979 to discuss priorities in mental health research was to move its emphasis from basic science to clinical research and to give more of its funds for training fellowships in clinical psychiatry. This decision was far-sighted and there are many academic figures in psychiatry who have cause to thank the Foundation for its support at a crucial stage in their careers.

Despite this, there are some parts of the booklet that make depressing reading. Only 3% of the total medical research budget is spent on psychiatric disorders and only 0.3% on mental handicap. It is estimated that the total charitable expenditure on mental health research is currently around £6m and this would fall to a miserly £2m were it not for the generous support of the Wellcome Trust, which has always regarded the field of mental health as a major funding area. Psychiatric research accounts for only about 6% of all expenditure on medical research in the United Kingdom, an absurdly low figure. It has sometimes been said, patronisingly, that the reasons for this low figure is that the quality of research is so low that few projects deserve funding. If this was ever true it is certainly not so now and two out of three applications approved in 1988 could not be funded by the Foundation.

The sad fact is that clinical psychiatric research is largely ignored by the Government and public alike. The Appeals Committee of the Foundation appreciate that public funding is likely to remain low and wishes to improve the public perception of mental disorders as a priority area for concern. This is admirable, but I cannot see a cartoon of a crying child above a caption "Help Psychiatric Research Get Better" having the impact of the recent campaign for Great Ormond Street.

Nevertheless, it would be wrong to be too gloomy. If the appeal is as successful as the Foundation hopes, the major target areas for research identified in a recent survey – psychiatric genetics, non-pharmacological treatment of common disorders, evaluation of community psychiatry, family therapy, personality disorders and service provision for the elderly – should all receive valuable funding. The Foundation and its Appeals Committee represent the one man and his dog who are off to mow a very large meadow. It is to be hoped that many more men will join them before the job is finished.

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Not on Your Own: The MIND Guide to Mental Health

By Sally Burningham. London: Penguin Books. 1989. Pp 208. £3.99.

Over the past 20 years an increasing number of books and booklets have been published about specific emotional and psychiatric problems. However, little, if anything, has been published which covers the whole gamut of mental illness, its treatments and the services and people who provide these treatments. I can only think of two exceptions: one being a book by Bill Kenny and myself, rather preciously entitled *Insight*, and Joy Melville's *First Aid in Mental Health*. The first I thought was quite a good book but, unfortunately, not many agreed and it soon ceased to appear in the shops except those few shops which specialised in remaindered books and they, I suspect, were rather overstocked. Joy Melville's work was a lot better than ours but I think it had a misleading title which conjured up a picture of The Red Cross and St John's Ambulance dealing with emotional crises.

The subtitle of *Not on Your Own* tells you clearly what the book is about and the contents live up to this clarity. It is a relatively short work but contains quite an amazing amount of information. Like many things, it is divided into three parts. The first deals with psychiatric disorders, the second with professional help, which includes telling you what different professionals do, the various treatments available and hospital care. The third part covers self-help and information. Here, the impact of mental illness upon friends and relatives is considered, financial worries advised upon and information provided about the law and mental illness and it ends with a short glossary of terms users find confusing and a long list of resources, ranging from self-help groups to The Mental Health Act Commission.

As far as subject headings are concerned, my only mild criticism would be that there is not a bibliography of the books and booklets on specific facets of mental illness already mentioned.

This really is a very well-written, easy to understand and unbiased account of our present thinking on mental illness and its treatment. There are no attacks; only information, reassurance and hope. It is obviously not a comprehensive volume and, if it had been, would have defeated its own objectives. Victims of specific problems will obviously not find enough here and hence my regret that there was not a bibliography with clear guidance to individuals as to where to find more information about their problems. I imagine there will have to be a second, third and possibly fourth edition. If this is the case I hope my humble suggestion about a bibliography will be considered.

Most psychiatric units and departments now have information booklets for their patients. It would be

nice if a copy of *Not on Your Own* could be distributed to every new patient and their relatives and friends. This is most unlikely to be taken up by our present management but the thought should be there and it could, at least, become part of every unit's patients' library.

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We are Just in Time – AIDS, Brain Damage and Psychiatric Hospital Closures: A Policy Rethink
By Charles Tannock and Caroline Collier. London: Bow Group. Pp. 10. £5.00. 1989.

This ten-page political pamphlet could be damaging if it were not so silly. The thesis of the two authors is that AIDS is a big epidemic which causes a lot of dementia. The people with dementia will therefore require psychiatric care. The best place to provide this psychiatric care is in mental hospitals, of which, therefore, they "recommend that as a measure of strategic and contingency reserve between two and eight long stay hospitals be mothballed for this purpose".

There may be many good reasons for not closing all mental hospitals and quite a lot of bad ones as well. This one is probably the least relevant to the argument. There are many errors and distortions of facts in the background to the argument.

Some examples of the errors in interpreting the literature include the percentages of patients who suffer from various kinds of nervous system damage during the course of their illness. For example, it is stated that, at the Fourth International Conference on AIDS, some studies showed 70 to 78% of AIDS sufferers developing some form of brain damage. Because this paper does not present references (it is a political pamphlet rather than a scientific article) it is impossible to tell which papers they are referring to. However I have the Stockholm book of abstracts before me and attended that conference and do not recall such figures being quoted. An oft quoted figure is that 80% of AIDS sufferers will develop some kind of neuro-psychiatric 'disorder' during the course of their illness but this will include illnesses such as depression, transient confusional episodes and anxiety states as well as disorders of the peripheral nervous system certainly not relevant to the argument of the authors.

Another example is the statement that the demented AIDS patients would be best kept in separate facilities from general medical wards even though they may be seriously physically ill. This is a highly questionable statement, especially if the alternative is to be an ill-equipped mental hospital.

The authors make a major clinical error. They assume a significant longevity for AIDS-dementia patients. However, it is very clearly the case that the dementia of AIDS is a late phenomenon in the course of the illness and indicates a bad prognosis. Work showing technical cognitive impairments on a few tests in asymptomatic patients has not been replicated and even if true, indicates a very minor abnormality which cannot be called dementia. The authors have their facts wrong. I imagine that at this point in the argument the authors would bring in the effects of therapy. I think they would say that the development of anti-HIV drugs such as Zidovudine will exacerbate the problem by prolonging life expectancy without preventing brain damage. However, the latest information on this question suggests the opposite, i.e. patients with early dementia whose immune systems respond to Zidovudine also get an improvement in cognitive functions.

How would the argument look if they had all their facts right? Here we must remember that mental hospitals were designed not to treat the physically ill, indeed most of them were hardly designed at all. They grew pell-mell from their planned, relatively small, sizes to unmanageable sprawling complexes in which individuality of all but the most disturbed was submerged among the faceless masses of the mentally ill. Can it be that two doctors, one a general practitioner the other a psychiatrist, can advocate keeping available Victorian facilities in order to treat this most highly complex and demanding clinical condition of our times? The argument is so ludicrous that one is left, after clearing away its debris, with the strong impression that their argument is a moral rather than a practical one. Surely if it is really true that we were to be faced with large numbers of young, possibly cognitively impaired, sick patients in the next decade or two we should, in the wealthy society which the Conservative Government have helped to create, be able to afford both financially and morally to provide proper modern facilities for our patients – not workhouses.

I take comfort in the fact that this 'memorandum' has little chance of finding favour. You cannot, after all, mothball a Victorian asylum without spending a lot of money on it or it would simply fall down.

Although I disagree entirely with Dr Tannock and Dr Collier's ideas, they are at least aware that AIDS is a problem which will have to be faced by psychiatrists as well as other specialties. They just seem to have got stuck in a time warp and need to be encouraged to think about other models of care, not only for patients with AIDS dementia who are likely to be short-lived, but also for brain-injured and mentally handicapped people whose disabilities they incorrectly assume are mimicked by AIDS dementia.

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https://doi.org/10.1192/pb.14.2.125 Published online by Cambridge University Press