services are 'multidisciplinary', but what has caused special problems for child psychiatrists is that they are frequently part of 'multi-agency' teams in which the primary responsibility for the service is unclear.

In the coming months, with the abolition of the ILEA drawing near, child psychiatrists in London child guidance units previously administered by ILEA's 'Medical Department', would do well to clarify their position with their employing health authorities. Will the 'day-to-day' running of the clinics be the responsibility of the health authority or the local authority's education or social services department? How will the statistical returns be made? How will the priorities for work be established? What authority will have ownership of the notes?

For some clinics, there will be strong arguments for total integration with the local district child psychiatry service; for others a clearer consultative or collaborative model may emerge. What should be recognised is that with this re-organisation there arises an opportunity for providing a better service, but also a risk of loss of resources. 'Community care' is easily marginalised.

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Will you become a PENpal?

DEAR SIRS

Later in the year I am hoping to launch a Quarterly Video News Service for Psychiatrists provisionally entitled *Psychiatry – Education and News*.

Most medical specialities have some form of video news service, usually supported by advertising. These programmes appear to be highly regarded and valued, particularly by those in training. In this respect, there is no reason to suppose that psychiatrists are any different. It has to be recognised that the amount of potential advertising support is likely to be less than for programmes aimed at GPs for example. This is because there are fewer psychiatrists and they spend less on drugs and equipment. In spite of the potential financial constraints it is possible to make a useful educational production, although in the long run it may prove necessary to charge a small amount.

The possible format I have in mind might be 20 to 30 minutes of regular items, each lasting five to seven minutes, followed by an illustrated lecture lasting say 40 minutes. Some of the short items might include the following: (i) What's new since you left medical school; (ii) short clips from teaching tapes and comments from a reviewer; (iii) short report from quarterly conference; (iv) what I do in my job: pitched at SHOs and registrars describing work in various sub-specialties; (v) teaching tape – consensus views on the management of various conditions; (vi) 'letters page': taking sent-in video clips and letters; (vii) interviews with established leaders within psychiatry and interviews of public figures.

Several possibilities exist for distribution: (i) via cassette on a request only basis; (ii) sent unsolicited; (iii) satellite transmission. In the long run this last option may prove satisfactory but there are a number of important logistic and technical problems which will have to be resolved first.

I am writing at this stage because I would like to assess potential interest in the venture and to see whether there are people willing to co-operate. I do not think it will be a money-spinner but with support and goodwill it could become an important contribution to education.

In the first instance I would be grateful if people could write to me at the Department of Psychiatry, St George's Hospital, Blackshaw Road, Tooting, London, SW17 ORE.

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'Let the Old Man Drink'

DEAR SIRS

Drs Al-Bachari and Acharyya (*Psychiatric Bulletin*, March 1989, **13**, 149) ask for readers' comments on 'Let the Old Man Drink'. The first point is that there are many old women who drink to excess! Edwards *et al* (1973) report a male: female ratio of 1:1.3, a ratio I confirmed (Malcolm, 1984). It must be remembered that females predominate in the elderly population and society may cover up old ladies' bad habits even more than old men's. Perhaps one day the elderly ratio will approach the 1:1, as in younger groups

Alcohol problems in the elderly are common, 6% was quoted by Mishara & Kastenbaum (1980) although they admitted denial was relevant. I reported 10% in a study of 223 new patients seen at home between 1978 and 1981 (Malcolm, 1984). Only half these cases were previously known to the family doctor. Figures over 10% are widely accepted now. While many elderly suffer physical, mental, social and financial harm from alcohol, very many others benefit from its judicious and social use. It is our responsibility to be sure into which group our patient falls. The idea of 'it's too late to help, let him have it' is discredited in a charming handbook by Kinney & Leaton (1978). The concept of recent or remote onset drinking is a helpful one (Rosin & Glatt, 1971). Recent onset suggest a treatable cause for the problem, e.g. a response to bereavement, isolation, pain etc. The remote onset implies that a long-term drinker has achieved old age, he must aim for sobriety. It is essential to consider the source of alcohol in the elderly. Housebound or frail elderly may have more than one supplier, relatives who give in to

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