Correspondence

Bombing mental hospitals

DEAR SIR

No one who saw the television coverage of the devastation of a mental hospital during the seige of Beirut two years ago could fail to have been moved. Now we have heard that a mental hospital was bombed during the invasion of Grenada. This time there were very few pictures as Governments have learned the value to themselves of controlling the media as they undertake their unsavoury deeds. A re-showing of the Beirut mental hospital scenes would, I suspect, illustrate the Grenadan disaster.

These are not the first, nor will they be the last, mental hospitals to be bombed unless something is done to prevent such repellent behaviour. Presumably a single nuclear strike would destroy several mental hospitals.

It is quite inadequate for individuals or Governments to protest their lack of intention and to offer their regrets for such clearly avoidable behaviour. I am left wondering how it is possible that those who bomb mental hospitals, or who threaten to use weapons which would undoubtedly destroy mental hospitals, can be classified as sane while the residents of mental hospitals are regarded as insane?

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Consent to treatment in the Mental Health Act

DEAR SIR

Dr Gosling's letter (*Bulletin*, December 1983, **7**, 226) raises an interesting question.

Under the 1959 Mental Health Act it was never legally clear if you could impose treatment on any detained patient. The Act was operated on the assumption (never tested in the courts) that patients detained for treatment for mental disorder under Section 26 could have, without their consent, in the words of Sir Keith Joseph (the Secretary of State for Health and Social Services in 1973), 'such recognized form of treatment considered necessary for such a disorder'. Informal patients and other detained patients could only have treatment without consent if they were 'incompetent' and in a life-threatening situation.

Under the new Act informal patients and patients detained for 72 hours are, save for some minor amendments, in the same position. Patients detained for 28 days or more can have 'medical treatments for mental disorder' imposed upon them without their consent in certain circumstances in accordance with the consent to treatment provisions of the Act. Therefore, the situation does not really change and the severely subnormal patient can only have treatment in the absence of consent if they are detained under the Act and then it has to be medical treatment for mental disorder.

The Act, quite rightly, does not 'rectify' the situation raised in Dr Gosling's letter because until the Act highlighted the whole question of consent to treatment nobody identified this as an acute problem. In practice, the type of treatments envisaged in Dr. Gosling's letter are frequently given to severely subnormal patients in the absence of proper consent and no legal consequences arise because there is nobody interested or capable of seeking a legal remedy. I agree with the implications of Dr Gosling's letter that this is not good enough for either patient or professional. With the growing number of elderly people in the population this will be an increasing problem.

The crucial question is who should be able to consent on behalf of a patient who is incapable of giving or withholding consent? I would argue that it is not sufficient to give this power to the patient's doctor and/or relatives. Such momentous decisions require an independent non-medical component.

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An alternative form of community care

DEAR SIR

In these days of financial cutbacks, lack of resources and unemployment, I wish to publicize a means of discharging patients into the community which is rarely mentioned, but which is cost effective. Even in the College's Report of the Working Party on Rehabilitation of the Social and Community Psychiatry Section, *Psychiatric Rehabilitation in the 1980s*, supervised lodgings are mentioned and then dismissed.

In a supported lodgings scheme there is security for the medical staff referring the case because the supported lodgings officer supports the landlady and landlord, and the social worker and community psychiatric nurse support the patient. Many of these ex-patients attend a day centre, which allows continuing, unobtrusive observation and care. The social worker of the team can refer patients easily if the supported lodgings officer is based in the social work department of the hospital. The lodgings can be tailored to the patients' needs, with guidelines and regulations set up by the Social Services Department.

There is no difficulty in obtaining lodgings, as long as the initial landladies and landlords are nurses. The scheme expands without much publicity. It is surprising how selective the supported lodgings officer can be and also how

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good the care is. The supported lodgings scheme produces two different forms of accommodation: (a) family care, and (b) hostel-like—both are greatly needed in many districts.

A supported lodgings scheme can release patients for other needs, or to overcome crowding in the wards. A consultant with special responsibility for rehabilitation is particularly helped by such a scheme and it should be an essential part of a rehabilitation department in any traditional psychiatric hospital or district general hospital.

In Gloucestershire the Department of Health and Social Security pay £50–£65 per week to the landladies and landlords. All patients are in receipt of invalidity benefit or non-contributory invalidity benefit, so variable amounts are payable and every case is assessed by this section of the Department of Health and Social Security. This amount does not fully cover the cost of the supported lodgings, so the remainder of the lodgings fee, plus the patient's money, comes from supplementary benefit, if the patient's personal savings are below £3,000.

The supported lodgings officer's post is funded by the Gloucestershire Association for Mental Health and the Gloucestershire Social Services Department and is at present part-time, but is to become full-time soon.

During the first 15 months of the Gloucestershire scheme, 75 patients were discharged. A similar scheme started in Salisbury in January 1974 discharged within three years 90 patients, and at six years, 125. With experience of supported lodgings schemes for nearly 10 years now, I am sure a supervised lodgings scheme allows many patients to be discharged from hospital who could not cope in group homes or bed-sits. The 'new long-stay' can often be discharged by this means as well as the 'old long-stay'. It is also helpful with some 'short-stay' patients. The mentally handicapped are well known to be helped by such a scheme.

A well organized and supervised supported lodgings scheme is invaluable—why is it not used more often?

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Single-handed consultant practice in psychiatry

DEAR SIR

In the practice of psychiatry, especially mental handicap and the psychiatry of old age, there are many consultant psychiatrists who work single-handed. That is, they work in Health Districts and hospitals where there is no colleague with whom they can share duties, responsibilities and problems.

Occasionally single-handed posts are the first in a developing service. Sometimes the case load of a sub-specialty may warrant only one consultant. Often, for example in mental handicap, the consultant psychiatrist works single-handed because posts are vacant as a result of consultants retiring and the Health Authorities failing to fill the posts.

Single-handed practice has many disadvantages. Such a consultant is on call almost the whole time and even if the demands and calls out of working hours are infrequent, he must remain accessible which places restriction on his social and professional life. If he has responsibility for large numbers of in-patients he is more restricted in this respect than a colleague in a sub-specialty with few in-patients. He will also be more likely to be working without the help of registrars or senior registrars. Because of difficulty obtaining locum cover and persuading other psychiatrists to provide cover, he is unable to arrange annual and study leave as easily as consultants working with colleagues. He is also less able to have time off to attend meetings which involve travel. There are also the risks of isolation and over-commitment with the possible impairment of mental and physical health with consequent risks to patients and the service.

Often where a single-handed consultant is operating a service apparently satisfactorily there is no incentive for Health Authorities to fill vacant posts which would provide him with a colleague. The Authority can procrastinate, save on salaries and contend that the service can manage with fewer consultants anyway.

What are the possible medico-legal implications for a single-handed consultant if something goes wrong? Where he is covering a service which should have two or three consultants to provide it, he is trying to do the impossible and to blame him for this would seem unreasonable. Perhaps a consultant in such a position should inform the employing authority of the limitations the inadequacy of staff must impose.

Single-handed consultant practice appears to have no advantages and can be unfair to doctor and patient. In long periods during which consultant posts are unfilled it should not be beyond the capacity of Regional Health Authorities to arrange, at a supra-district level, for single-handed consultants to be 'paired' with others in the same specialty. The single-handed consultant receives sympathy but little practical help. He becomes a willing slave to try to offer a service which he appreciates cannot be as good as in a fully staffed organization. From all points of view single-handed consultant psychiatric practice deserves scrutiny by professional bodies.

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Psychopaths in Special Hospitals

DEAR SIR

May I compliment Dr Mawson on his well argued article, 'Psychopaths in Special Hospitals' (*Bulletin*, October 1983, **7**, 178–81).

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