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