

Holmes & Lindley have argued the need within the NHS to adapt psychoanalytic techniques and values in order to reach the people most in need of psychotherapy. Training at senior registrar level should encourage initiative in tackling this issue.

Finally, the duties of a consultant psychotherapist are more likely to be approached flexibly and humanely by someone with life experience and interest in things outside the psychotherapeutic sphere than by the highly trained practitioner who has not had time to read, listen to music, dig the garden or chat with friends.

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What would you have done?

DEAR SIRs

The letter from Drs Joyce & Palia (*Psychiatric Bulletin*, 1992, 16, 52) reminded me that some years ago an elderly patient continuously and agonisingly screeched, causing great distress in a 25-bedded ward. Her teeth were very carious and the gums infected. She was too demented to give real consent to treatment and her husband, likening dentists and surgeons to butchers, was opposed to treatment. I consulted a member of my medical defence society and he said that if a senior psychiatric consultant colleague, the dentist and I all signed to the effect that we considered dental treatment essential we could go ahead with it. We did so and the result was pleasing to all concerned, including the husband, who bore no resentment.

Joyce & Palia's patient, not knowing her age or the year, month, season, day or the name or the nature of the place she was in and not remembering having been told she had a stone in her bladder, seems incapable of giving consent to essential treatment and, although questions of consent have become more complicated in recent years, perhaps Joyce and Palia would consider following the same procedure as I did, presumably substituting the appropriate health authority solicitor for the medical defence society.

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The standard Eire and other deviations

DEAR SIRs

Professor Fahy (*Psychiatric Bulletin*, February 1992, 16, 113) is, of course, quite right: the English name of our homeland is Ireland. However, an ethnic error, if

deliberate, can sometimes help to prevent a postal one. Just as mail addressed to Basel, Switzerland, from the United States is not infrequently routed via Brazil or Sweden, whence it may arrive after some delay, mail for Ireland, even if posted in Boston, can take longer to arrive than expected. The "Defensive Strategy", discouraged by Professor Fahy, of insisting that Ireland is a Republic does not always help, for Iceland is a republic as well. But if at least the purveyors of junk mail originating in America were encouraged to locate Dublin (and even Galway) in Eire, their products would be unlikely to be forwarded at all from Zaire.

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Resettlement of long-stay patients in the community

DEAR SIRs

We would like to comment on Double & Wong's (*Psychiatric Bulletin*, 1991, 15, 735-736) follow-up study of patients resident in Middlewood Hospital on 12 January, 1982.

In general, their findings must give grounds for cautious optimism regarding the resettlement of long-stay patients in the community in Sheffield, although we doubt that there is reason for complacency. HRH Prince of Wales (1991) has succinctly outlined the large gaps that still exist in our knowledge regarding the impact of deinstitutionalisation.

The authors assert that they found no homelessness in their follow-up study of discharged long-stay patients: yet two patients were found to be resident in the Sheffield hostel for homeless men. It is possible that by using such a narrow definition of homelessness (i.e. rooflessness) the authors have underestimated the extent of the problem.

The authors state that studies on community care should distinguish between the needs of acute patients and those of the long stay. This is clearly true. A recent study (Meltzer *et al*, 1991) drew attention to the impoverished social circumstances of acute psychiatric patients discharged to the community and suggested that the priority given to the resettlement of long-stay patients into supported accommodation is depriving the former group of adequate community care. In support of this, George *et al* (1991) found high rates of recent psychiatric hospitalisation in a census of single homeless people in Sheffield.

We suggest that in their efforts to counter the "poorly reasoned polemic" of others, Double & Wong are tilting at windmills: it would be unfortunate if such controversies distracted attention away

from the real problems of unmet need and lack of community resources.

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DEAR SIRS

I wish to comment on the article by Drs Double & Wong about long-stay patients who were in-patients in 1982 (*Psychiatric Bulletin*, 1991, **15**, 735–736). They are to be congratulated on their persistence in finding all the patients on the register at that time. It is a pity that they were unable to assess the quality of life issue as this would have made the article far more meaningful.

The Psychogeriatric Service in Sheffield has to deal with patients in Part III homes and it has become obvious that the chronic psychotic mentally ill people are not in a suitable environment. Part III homes in Sheffield have become mini-nursing homes as between 60 and 80% of the residents have not got a degree of dementia. Over the past few years some of the chronic new long-stay and old long-stay have been admitted. At a recent meeting with principal social workers who deal with the elderly, the principals of homes and the home care organisers came to the conclusion that they were unable to cope with the chronic mentally ill.

It is therefore very worrying that increasing numbers are being sent to the part III homes, with a top-up from the hospital service. The patients are in homes where there are two care staff for 40 residents. There is no stimulation whatsoever and they become more disturbed. On my own list, I have approximately 20 chronic psychotic patients who, in my opinion, could, and should, be in hospital, but of course, there is nowhere for them to go.

An even greater worry and an absolute heart-break are those patients who are now in the private nursing homes for the mentally ill. Here there is no doubt that the standard of care is deplorable. The argument runs, however, that it is no longer our responsibility; if the registration officer does not think the standard is correct, he should close the

homes. However, the registration officer is unable to do so when there is nowhere for them to go. Over the past year, when there was some suggestion that perhaps one of the homes might be closed, we were asked, in the hospital service, if we could admit approximately 40 chronically ill people, but our wards had been closed.

Before the mental hospitals are closed, I think some measure of quality will have to be defined. We all know the adage that it is very easy to close a hospital, but it is what you put in its place that is the real test of successful policy.

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DEAR SIRS

I appreciate the interest shown in our study in Sheffield, particularly by someone who works here (Dr Conway) and someone who used to work here (Dr Geddes). Perhaps the essential message is that, contrary to popular impression, long-stay patients are not being discharged to live in large numbers "on the streets".

I agree that it would be valuable to have information about the quality of life of patients, although this was not the point of our study, and I would maintain, as we did in our article, that it is not an easy question to answer because of methodological problems. It may be of interest to compare the results of our study with that of Professor Eve Johnstone (1991) (now in Edinburgh, of course, where Drs Newton and Geddes are) which traced 93.6% of 532 patients with schizophrenia discharged from Harrow services over 10 years. Almost all of them had permanent homes, and only one was in prison. Not all patients fared badly, but unemployment, social difficulties and a restricted life-style were found to be common. Poor outcome is generally a defining characteristic of schizophrenia whether patients are in hospital or the community.

Dr Conway is rather sweeping in his condemnation of Part III homes. I do agree, though, with the implication of his argument that resettlement of long-stay patients should be for clinical reasons and not for the financial expediency that both health and local authorities gain because of the arrangements about "top-up". There is also a real problem about what registration authorities should do when homes do not meet adequate standards. It may be of benefit to inspect long-stay psychiatric wards by the same procedures.

I hope we did not seem complacent in our article. Sheffield Hostels (previously Sheffield hostel for homeless men) is a voluntary organisation, supporting several people in houses belonging to South Yorkshire Housing Association, some of which are