Correspondence

Effects of ward closure on patients

DEAR SIRS

Recently a mixed, predominantly female, long-stay/rehabilitation ward with which I was involved was closed and the patients distributed into empty beds on other wards around the hospital—not an unusual occurrence in these days of 'Care in the Community', the decreasing in-patient population of psychiatric hospitals and part of the 'Management of Change'. This particular closure, however, was made more traumatic for the patients in that no warning or preparation was given prior to the week the moves were implemented. This was because neither the ward nursing staff nor the medical team involved with the ward were given advanced warning themselves. There was therefore no opportunity to discuss care and future plans with the staff who would now be looking after these patients. There was also a hiatus from the medico-legal point of view as to who was the consultant responsible for the patients during the time between their transfer and the eventual agreement of the consultants on whose wards they had been placed, with no prior consultation or agreement, to take over their care.

The patients, six men and 18 women, were distributed in groups of one to six, to nine different wards. On the day the closure was implemented both the sister and charge nurse were on days off. Staff and patients were crying together—hardly a therapeutic environment. In the six weeks since closure, the effects on the patients have been as follows:

One patient, already seriously ill before the move, died.

Another took his own discharge rather than change wards.

Ten patients accepted the change of environment with no obvious problems. One of these is said to be improved behaviourally in her new setting.

Five patients showed a deterioration in behaviour and condition which have settled with the appropriate treatment.

Three patients are still deteriorated to a level below their previous functioning. One of these, an elderly subnormal lady, had to be physically assisted from her original ward as her distress at the change was so intense.

A group of four men awaiting discharge to a MIND hostel in the community were transferred to a male ward together. Their psychiatric condition has not deteriorated, but staff have noted their cohesiveness as a unit, which had been noticed on arrival on the new ward, has markedly changed. Whether or not this will affect their behaviour in the community remains to be seen.

Three of the above patients were considered to have been wrongly placed so were moved again. One of these is now under review for a third move, owing to her psychiatric and behavioural deterioration.

To an outsider, one long-stay ward may seem very like another. However, to the patients concerned, a move is a major life event, in this instance made more distressing than necessary by the absence of preparation. The ward was their home, the staff and other patients their family. These aspects, as well as financial consideration, should be taken into account when a move is planned. Time taken to allow patients to get to know their future wards, by day visits over a period of time, would help to reduce the impact of the change in terms of morbidity and possibly mortality.

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Treatment of pre-senile dementia patients

DEAR SIRS

I was most interested to note the article in which the need for institutional care for those suffering from Huntington's Disease was discussed at some length. (*Bulletin*, June 1987, **11**, 187–188).

It may be of some interest to your readers to know that in the five and a half years since I was appointed to Salford Health Authority as a psychogeriatrician I have agreed to accept referrals of all those suffering from presumed pre-senile dementias of all types, originating from a catchment population of approximately 245,000.

As I am sure you will appreciate, this is a somewhat unusual stance for a psychogeriatrician to take and could not be contemplated if I was entirely reliant for facilities upon a District General Hospital base where I would necessarily have to concentrate on those presenting with dementias of later life, leaving the pre-senile group and those with organic brain syndromes of other types, arising before the senium, to the general psychiatrists.

Peculiar circumstances, however, have conspired to allow me to provide a service to this group based in a large mental hospital with a large number of residual long-stay beds, within which provision we have earmarked specific facilities for the long-term care of the pre-senile dement, regardless of diagnostic categorisation.

In addition, in the setting of our limited day care facilities for true elderly severely mentally impaired (ESMI) patients, we provide both day care and community relief admission to a small number of such patients, thereby facilitating their families' almost universal wish to continue to look after such patients up to and often including the time of death within the family home. I am sure you will appreciate these latter provisions thereby circumscribe the facilities that we can provide for the true ESMI patients.

In addition to the available space within the large hospital (before it is closed down) is our proximity to Dr David Neary's pre-senile dementia research unit at the Royal Infirmary, Manchester which provides us with a Regional diagnostic reference centre. Near the Royal

Infirmary is St Mary's Hospital, Manchester which contains the Department of Clinical Genetics (Professor Harris) which can also provide genetic counselling to our patients' families, as and when appropriate, leaving the community and day care for such patients to a District based but not, I hasten to add and emphasise, a DGH based service.

Over the last five and a half years, our experience has suggested that for a variety of reasons this group has peculiar psychological and nursing and social support requirements, many of which will be self-evident. However, we have had some surprises, most notably being the observation that the true Alzheimer type pre-senile dementia patients retain considerable insight into and affective responsiveness to their predicament and immediate environment, despite the fact that they often have considerable difficulty in communicating their awareness of their predicament and their feelings about it to outsiders, due to their profound language disorder. This last finding has encouraged us to try to place these patients in long-term care settings, especially those which are separate from our provision for our long-term ESMI patients.

With the steady closure of the large mental hospitals, however, and especially with the relocation of District based services, our ability to replicate this service within Salford, when the 'acute' services are relocated away from the large mental hospital, remains uncertain as currently there are no guidelines to suggest the exact level of provision required.

Since January 1982 within the catchment population noted above this team has had clinical contact with 43 persons suffering from Alzheimer type pre-senile dementia, 8 suffering from a presumed diagnosis of Pick's Disease and 6 persons suffering from Huntington's Disease. In addition, I have been asked to see a considerable number of patients with other organic brain syndromes arising before the senium, primarily associated with alcohol abuse, vascular brain disorder and post-traumatic and post anoxic brain damage.

The problems for inner city psychiatric services such as ours are particularly acute *vis-à-vis* the provision of services for the younger brain damaged and we are attempting, using the Salford Case Register, to estimate service requirements for this particular group.

It would seem, therefore, that the Public Policy Committee of the College require to address themselves to these issues more closely, as such patients will undoubtedly require a range of Local Authority and Health Authority provision, equivalent to that currently provided for the elderly demented, albeit on a very much smaller scale.

I would suggest that each District Health Authority requires to develop its own in-house services for these groups with additional provision for inner-city areas so that both patients and families can have ready access to locally provided resources.

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Psychiatric health care—private and NHS

DEAR SIRS

The gremlins removed a crucial line from my letter in response to Professor Brandon (*Bulletin*, June 1987). It serves me right for quoting SOGAT as an example of closed shops.

The filleted sentence was making the point that if private psychiatric hospitals can achieve desirable levels of service whilst producing the revenue to fuel further development and to satisfy shareholders or Boards of Governors, then surely the NHS could do at least as well, if properly managed.

I entirely support Professor Brandon's aspirations for high quality health care and his statements about the demoralisation and pseudo-democratisation of the NHS.

I do believe he is unduly pessimistic about the benefits of symbiosis between the NHS and the private sector, and prejudice and mistrust merely ensure that isolationism will prevail. The NHS may have had a virtual monopoly on psychiatric care, but none of us has a monopoly on wisdom.

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Responsibilities of consultants

DEAR SIRS

I welcome the College's endeavours to look at interdisciplinary relationships in the joint meeting with the British Psychological Society reported in the June 1987 *Bulletin* (**11**, 210–212). This report states that "the concept of 'ultimate responsibility' was shown to be a myth". The General Medical Council, however, in *Professional Conduct and Discipline: Fitness to Practise* (April 1987) states that "the doctor should retain ultimate responsibility for the management of his patients because only the doctor has received the necessary training to undertake this responsibility". The College guidelines (*Bulletin*, July 1984, **8**, 123–126) state that "the final decision rests with the consultant on matters where the consultant has the final responsibility". It then states that "with patients the medical role is the prime mover for the whole process of treatment and care".

This remains a hazy area which is becoming increasingly important with the setting up of community mental health teams. Surely dialogue is preferable to denial and I hope that the College will continue to face these issues so as to clarify the responsibilities of consultants.

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