

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).