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Environmental health or psychiatric rehabilitation

Dear Editor – While most of us would agree that bacteriological, chemical, accident prevention and suicide prevention strategies need to be worked into our mental health as well as general hospital facilities, it has become quite clear that some of these measures are not appropriate in a domestic setting. An important part of rehabilitating clients of the psychiatric services is their training in activities of daily living. However it appears that the institutional standards are being generically applied to all institutions, no matter how small, sometimes to the severe disadvantage of psychiatric rehabilitation to the extent that it endangers the function of our day centres. We have recently had visits from environmental health officers who suggest that our clients should not have access to cooking knives, that they are only allowed to drink tea in a designated dining area, and that they have to follow the same complicated mop and bucket protocol as any large institution. This means that clients in residences may be left waiting for dinner as some tables are in kitchen areas in smaller residences, their clients will never be judged to be able to assist or take over cleaning and maintenance of their own living areas or kitchens, and will be prevented from either being able to prepare food properly or to handle normal living situations. Ultimately the effect of current environmental health legislation is that, rather than learning to live in a home, clients are learning to live in an institution, and their ability to substantially participate in the running of a home is being militated against.

Where local environmental health officers insist on following the letter of the law it appears there is no way for clients to improve their functioning in day centres or psychiatric residences unless some kind of derogation is made, especially for smaller staffed residences and day centres with ADL training. Perhaps we need to be reminded that 50 years ago clients were regularly involved in all kinds of 'dangerous' work, such as farm work, laundries, kitchens, shoe repair and tailoring facilities.

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The Norman centenary

Dear Editor – The ministrations of Conolly Norman in the Richmond Asylum, Grangegorman, and the administrative load on medical superintendents in Irish asylums have recently been featured in the Journal.[1,2] Perhaps space can be found for a brief biographical note on Doctor Norman in this his centenary year. The fifth son of Rev. Hugh Norman, he was born on March 12, 1853 at Newtown Cunningham, county Donegal, and was educated at home before he commenced the study of medicine in 1870 at the Carmichael School, Richmond Hospital and Trinity College Dublin. He qualified in 1874, proceeded FRCSI in 1874 and FRCPI in 1878, and was conferred with an honorary MD in 1907.[3]

From the time he qualified at the age of 21 he devoted himself to the study of mental diseases and served at Monaghan, Castlebar, and Monaghan again before he was appointed to the Richmond Asylum in 1888. 'He found the premier asylum a gloomy prison … and he left it presenting the twofold aspect of a hospital and a hive of industry where the bodily strong found occupation and relief … he was no mere administrator but essentially a physician'. He was widely versed in the continental literature and served as joint editor of the Journal of Mental Science.[4]

He used adversity in the shape of an epidemic of dysentery and outbreaks of beri-beri to rail against overcrowding, and succeeded in persuading the authorities to build an auxiliary asylum at Portrane – even while he argued that overcrowding could be alleviated by allowing harmless lunatics to be cared for outside in the community. In his presidential address to the Royal Medical Psychological Association in the Royal College of Physicians in January 1894 he bewailed the institutionalisation of staff as a result of unremitting care and toil with trivialities.

Norman suffered from angina pectoris for the last twelve years of his life. He developed influenza with bronchitis in December 1907, and only resumed duties on the Monday before his sudden death after walking a couple of hundred yards from his home on Sunday February 23, 1908.

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Anti-psychotic poly-pharmacy and combined high-dose anti-psychotic prescribing in schizophrenia

Dear Editor – Irish research in the areas of anti-psychotic poly-pharmacy (concomitant use of two or more anti-psychotics) and combined high-dose anti-psychotic prescribing, in psychiatric inpatients, especially patients with schizophrenia, is important because of the evidence in the international literature about the dangers, prevalence, possible reasons for and legal significance of these sub-optimal prescribing practices.[1,2]

Our retrospective, non-randomised survey aimed to find the prevalence of: 1) anti-psychotic poly-pharmacy and 2) combined high-dose anti-psychotic prescribing, in patients with ICD-10 diagnosis of schizophrenia, in discharge prescriptions, in 50 consecutive discharges, from the 50 bedded acute adult psychiatric unit at Kerry General Hospital, in the year 2004.