agreeing with the general thrust of the paper, I must challenge their statement that provision for all patients with special needs for continuing care and challenging behaviours could be provided away from mental hospital sites.

As a forensic psychiatrist, I see chronically psychotic patients who pose intractable management problems such as violence or inappropriate sexual behaviour. These are referred to the forensic service because they cannot be safely managed within an acute DGH unit or a continuing care hostel in the community. Unfortunately, the needs of these patients are not well met by regional secure units, with their emphasis on shorter term, medium security care. A recent survey of patients in Broadmoor Hospital from the South Western Region (Smith *et al*, in preparation) indicated that a significant number no longer required treatment in conditions of maximum security. However, in the absence of local facilities catering for chronically disturbed psychotic patients, they remained inappropriately in a special hospital.

There may only be very few patients requiring long-term medium security in each district. However, these patients' needs are considerable and should not be overlooked. If one accepts that there is a need for both a degree of security and a comprehensive range of back-up facilities to ensure a reasonable quality of life, it is unrealistic to assume that community units isolated from other services can provide these.

I find it hard to envisage anywhere but a hospital campus, albeit much reduced in size and redesigned, possibly organised on a sub-regional or regional basis, being able to provide the necessary care for this group of patients.

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DEAR SIRS

We too are concerned about the currently inadequate residential and rehabilitative provision for people with special psychiatric needs in both continuing care and challenging behaviour contexts. Action rather than rhetoric is required, and there remains great scope for the introduction and application of diverse and imaginative solutions to the many problems facing affected individuals, their carers, health authorities, social services departments, and policy makers. In the event, some authorities may well establish provision on mental hospital sites. In doing so they will have accepted the well known pitfalls of such a policy, in particular the professional isolation inherent in small remote sites, the danger of institutionalisation, and worse, the potential for even greater neglect of this group in a descending spiral of low morale, high staff turnover and inevitably declining standards of clinical care in the absence of quality control and peer review. Such is the stuff of Enquiries.

The central issue is that the work of caring for people with intractable severe mental illness appears to be an unattractive occupation, personally demanding, lacking in status, and unrewarding financially and as a career. The practical result is a major problem in recruiting professionals of all disciplines to provide the appropriate mix of skills and high quality treatment for this group.

It is imperative that steps are taken to seek to ensure the attraction, recruitment and training of professionals from all disciplines to work with people with severe and chronic mental illnesses as this is likely to determine the quality of services provided. Management systems must be appropriately supportive of such staff and staff–patient ratios ought to be weighted not only by physical dependency but also by psychological dependency. Career planning, regular staff appraisal, and financial incentives may be required to avoid rapid turnover of staff and 'burnout'. It should be a requirement of clinical training that some time be spent in the care of people with chronic mental illness. Efforts should also be made to encourage clinical research in the area of chronic mental illness as this serves to develop critical awareness of the related problems as well as serving as a stimulus to improve standards and encourage innovation.

The quality of the care provided to people with chronic mental illness is a crucial measure of the adequacy of mental health service provision. By this yardstick present provision is failing.

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Audit of admissions to a psychiatric intensive care unit

DEAR SIRS

We would like to describe our findings from two surveys of admissions into a psychiatric intensive care unit at the North Wales Hospital. Opened in

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July 1982, and initially a 24 bed mixed sex ward, admissions data for two six month periods were collected. For the first six months questionnaires were completed on all admissions into the unit, although some data had to be obtained retrospectively. The second period of study was in 1986 (July to December) and was retrospective.

Compared to other such units, it had a relatively higher admission rate, with a longer length of stay, and admissions were more directly from the community, with fewer forensic admissions. Examination of the changes during the unit's first four years showed that fewer patients were admitted and that it was used more selectively, with admission criteria more rigidly adhered to. The number of admissions fell from 292 during the first six month period to 116 in the second. There was a reduction in the number of informal admissions although these still accounted for about half the admissions. More patients were admitted directly from the community and discharged back there. Diagnostic categories admitted remained similar, although there were fewer with personality disorders, and an increase in schizophrenia. Length of stay on the unit increased. Our findings suggest that such units tend to be used more for young males, in the age group 20–40, with males outnumbering females by about two to one.

The unit was criticised by a Mental Health Act Commission visiting team. The admission of different types of patients onto the same unit was seen to be detrimental to patient care in having long and short-stay cases, forensic and acutely disturbed cases nursed together. This has been dealt with by separating the two elements into a small intensive care ward of six beds, and a ten bed mixed-sex ward for those with behaviour difficulties needing treatment over a longer period, including forensic cases. The number of consultants admitting cases was also criticised, and now the two new units have patients admitted under the care of one consultant for each unit.

As intensive care units have become an accepted part in managing the most acute physically ill patients, the model of the psychiatric intensive care unit has developed over the past two decades (Basson & Woodside, 1981 and Goldney *et al*, 1985). Psychiatric intensive care units may have advantages in dealing with severely disturbed cases which merit further research and investigation. The units allow more concentrated care than is available on ordinary admission wards, as well as easing the burden of nursing care there. They offer semi-secure facilities and high nurse:patient ratios and less tranquillisation with medication may be required. It is accepted that patients should be dealt with in the least restrictive way possible, but some need a high level of nursing care and may be disruptive on an ordinary admission ward. A level of expertise in managing such cases may be developed by the staff of such units which may be used in training staff elsewhere.

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ElCoT MF-1000 ECT units

DEAR SIRS

Our attention has been drawn to an inadvertent error in some of our advertising for the ElCot **MF-1000** ECT units: some of our advertisements state that this unit "... meets and exceeds ... (amongst others) ... RCP requirements ...", whereas this should have read "... **B.S. 5724-1** requirements ...". While ElCoT MF-1000 units indeed meet and exceed British Standards 5724 Part 1 specifications, the Royal College has of course never published any such standards or requirements.

We frankly do not know how this error crept into our advertisements, but we deeply regret it and have taken immediate steps to correct it and you will have noticed that the more recent advertisements all state 'B.S. requirements ...".

We would be most grateful for your cooperation in making your readers aware of this.

IVAN G. SCHICK

ElCoT Inc
14 East 60th Street
New York, NY 10022
USA

DEAR SIRS

We are grateful for this letter which clarifies the problem raised in our Report and enables us to withdraw our cautionary remarks.

The next edition of *Practical Guidelines for the Use of ECT* will be amended accordingly.

DR C. FREEMAN

Chairman
Research Committee