field, the approach of some responsible bodies towards the development of psychiatric services certainly appears to suggest 'an excessively economic motivation for the most recent period of the shift towards community services at the expense of the mental hospital'.

However, Peter Sedgwick's statement that 'no mental hospital has actually yet been closed down' is untrue. Holloway Sanatorium, Virginia Water, Surrey, was a hospital of 700+ beds with a national reputation for the care of the mentally ill. Sadly, the Sanatorium was closed in December, 1980.

Holloway Sanatorium took on a National Health Service catchment area in 1968 and continued to provide a busy service for most of North West Surrey right up until the day of closure.

Although several smaller psychiatric hospitals had closed before Holloway Sanatorium, we believe the Sanatorium was the first psychiatric hospital with a catchment area to close, and certainly the first to close while actually giving a service.

STEPHEN CRASKE

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Consultant psychiatrists in mental handicap

DEAR SIRS

Those of us who are working in Wales are well aware of the recommendations of the All Wales Working Party Report on the future development of the Mental Handicap Service in the Principality. Transfer of resources from the Health to Local Authorities may be a good thing for the majority of mentally handicapped people and their families, provided these resources are specifically used for their benefit. But a significant minority of the moderately and severely mentally handicapped, multiply handicapped, mildly handicapped with personality and behaviour problems, and those with emotional and psychiatric problems as well as families under stress and in crisis also need the therapeutic environment of a hospital or hospital unit.

This extremely important need of the service has not only been given no significant place in these recommendations, but, on the contrary, the closure and run down of mental handicap hospitals and no further development of new hospital units has been strongly recommended. One can see the reduction in the size of large institutions—which can only be good for patients and the staff, but it is hard to understand the logic of closure. I think we are all aware of the implication of such measures. The role of the consultant psychiatrist in mental handicap has always been precarious and seems to be more ambiguous and confused with the changing trends and policy in this field. This again has serious implications for the care of the mentally handicapped as well as for the future recruitment of able, enthusiastic young trainee doctors to this 'specialty'—already a difficult problem.

I would like to raise this very much neglected issue of Mental Handicap as a specialty of psychiatry and the role of consultant psychiatrists in this context, particularly in view of changing policies and trends as a result of the influence of powerful pressure groups like MIND and MENCAP in dictating these changes. I hope the views of my colleagues and the College will be expressed and discussed in the near future.

T. HARI SINGH

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Psychiatric Charge Nurses and their conditions of work

DEAR SIRS

Sadly, it is now rare for any Charge Nurse responsible for a ward within a psychiatric hospital to be always present at the most critical times during working hours, viz. during the mornings and afternoons of each weekday. These are the times when routine admissions, ward rounds, consultations with social workers or occupational therapists, removal of blood for tests, interviews with key relatives, preparation of patients for ECT, the administration of ECT itself, supervision of drug rounds, participation in group work and the like, take place.

Unfortunately, the present system of payment laid down by the Whitley Council encourages an emphasis on shift work. Consequently a Charge Nurse will often prefer to work in the evenings and at weekends where there is a choice.

This state of affairs inevitably means that there tends to be considerable lack of cohesion and co-ordination, with resultant misunderstandings, delays and also lowering of morale.

While there is nothing anyone working within a psychiatric hospital can do about this directly, it might well be that your readership can see ways out of this dilemma. After all, for many years now, there has been endless talk about ensuring that the standards of patient care do not drop.

K. M. G. KEDDIE

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The Mental Health (Amendment) Act—a personal view

DEAR SIRS

It seems that the Mental Health (Amendment) Act is destined to become law before very long. It has never ceased to amaze me how English psychiatrists, in particular the Royal College of Psychiatrists (who after all are to be operating the Act) seem to have accepted it with the minimum of fuss. The one successful feature of the yet untested Act is its general flavour of bias against psychiatrists.

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It seems to be assumed that any bias against psychiatrists is automatically a bias in favour of patients.

In the new Act patients detained under a 28-day Order are to be able to appeal to tribunals from day one of their detention. This implies that many are wrongly detained.

Patients detained under twelve-month Orders will henceforth be only on six-month Orders and instead of the right of appeal there will be an automatic appeal. This implies that patients are being kept in hospital too long for very little reason.

A patient cannot be given psychosurgery, medication or ECT against his will unless an independent medical practitioner sanctions it or else it is a dire emergency. This implies that patients are being forced to have unnecessary treatments by psychiatrists when they neither require nor wish for them. Where is the evidence for these implied allegations of maltreatment, mistreatment or false imprisonment?

Could it be that the advisers on whom the Government based its findings had evidence that is not publicly known, or is it that these allegations are based on hearsay, isolated stories or, more likely, out-dated politically-motivated information?

It does not follow automatically that clamping down on psychiatrists benefits patients. This implies that psychiatrists are actively engaged in devising compulsory, damaging treatments for long periods of time without recourse to any release and without any attempt to discuss the implications with other professionals or relatives of the patient. If this is the view that psychiatry has projected to central Government, it is a wonder that any District can provide a viable psychiatric service without riots of large numbers of untreated or maltreated mental patients and relatives.

The truth is that Government has been hoodwinked by carefully prepared vociferous groups of politically motivated, so called do-gooders, who seek to undermine psychiatry at every level. In this respect psychiatrists are easy meat as they are by nature mild-mannered, long-suffering, downtrodden and guilt-ridden.

The only spark of hope most of us retain is that the new Act is totally unworkable and with psychiatry as understaffed as it is, the Act is a recipe for total bureaucratic chaos as doctors travel all over checking up on each other and eroding the patient-doctor relationship to a slim thread.

So much for progress.

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Psychology of nuclear disarmament

Dear Sirs

Simon Brooks has expressed alarm about the possibility that psychiatrists might be encouraged to 'treat' people's anxieties about nuclear war (*Bulletin*, February 1983, **7**, 31–2.) Since he shares my abhorrence about it, but is sceptical that it could happen, I would like to explain why I raised the question.

Firstly, other doctors have said to me that we should always reassure our patients. Major General Frank Richardson, an army doctor for 34 years and a medical adviser on civil defence, has written an article for *World Medicine*, quoted in the *Guardian*. He says: 'In a few decades we might not know there had been a bomb ... in the interest of morale, the attitude towards patients and their relatives should be optimistic. Between 200–300 rad—even 500 rad—the acute radiation syndrome, properly handled, will have a favourable outcome in the overwhelming majority of cases ... we must encourage a belief in recovery. Anyone's service to the community would be enhanced by avoidance of a doom-laden attitude.'

Information about the health risks posed by nuclear weapons is frightening and I have never discussed them with a patient during a clinical interview. I regard this in the same light as health education about any public policy decision, such as road safety. I feel it is essential that policies take into account their impact on health.

Secondly, I discovered that several colleagues who had informed themselves about health service plans for nuclear war had been required to sign the Official Secrets Act. The effect of this is to stifle open medical debate on the issue, which restricts our ability to make purely medical judgements about it. Much of the medical information about the survivors of Hiroshima is still held as a secret by the Pentagon. Unless it is available in the medical literature, how can we reassure our patients or otherwise?

Thirdly, the DHSS has issued the confidential instructions that Dr Brooks was so doubtful about. HDC (77)1 states: 'The general aim in a crisis would be to keep disruption of the social, economic and industrial life of the country to a minimum as long as possible. Any large scale reorganization of the Health Service, to put it on a war footing, should therefore be avoided.' 'Medical staff should not be wasted by allowing them to enter highly radioactive areas to assist casualties ... and no staff should leave shelter until authorized to do so by the District Controller.' 'General life saving operations in areas of fall-out might not be possible therefore until days or even weeks after a nuclear strike.' In short, we are asked to act normally until the last moment, but will be prevented from practising medicine on the sick and injured.

Fourthly, there has been pressure in America and West Germany for doctors to be involved in planning for war. The Pentagon tried to secure 50,000 beds to be held in reserve for casualties of a European nuclear war. The German government attempted to pass a bill compelling doctors to participate in war planning. The issue of compulsion apart, the important point about this is that the plans are not based on medical criteria, nor on the basis of information in the medical literature, and are totally unrealistic. But they

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