Reply

DEAR SIRS

Dr Medley's point seems very reasonable. Dr Hotopf is right to point out that offensive comments appear not only in case-notes, but in scientific papers, a matter beyond the scope of our study, but which responsible editors should probably take more seriously. Although we did not ask medical patients to rate labels such as "a diabetic", we suspect that Dr Hotopf may be right in thinking that they too might find these offensive.

Drs Howard & Lovestone seem to have misunderstood when they assert that "contrary to the conclusions of this study most psychiatrists do not write offensive comments in case-notes." What we concluded was that most of the psychiatric case-notes we examined contained offensive comments and not that most psychiatrists write offensive comments in case-notes. Although we did not attempt to find out how many offensive comments individual psychiatrists or physicians made, our impression was, not surprisingly, that some made considerably more than others and many none at all.

Howard & Lovestone speak of the "silliness" of what the authors deemed to be offensive. The point is not so much whether comments which the authors rated as extremely offensive are "silly" or not, but that patients themselves rated the comments as extremely offensive. Howard & Lovestone's secretary thought the comments merely 'offensive": perhaps she is so used to typing rude comments (viz: "downright silliness") that she no longer raised an eyebrow.

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Patient dispersal

DEAR SIRS

The recent survey by Benbow & Jolley (*Psychiatric Bulletin*, 1992, **16**, 533–535) and response by Murphy & McDonald (*Psychiatric Bulletin*, 1992, **16**, 801–802) suggest that, contrary to the usual course, Britain is following in American footsteps in development of what Ralph Footring (*Psychiatric Bulletin*, 1992, **16**, 795–796) would have us call "patient dispersal."

As a result of the patient dispersal movement in the United States there was discharge of the mentally ill from state hospitals to nursing homes. The population of the former changed from 1,500,000 to 500,000 and of the latter from 500,000 to 1,500,000. A lot of studies were done (Birkett, 1991) and these mostly concluded that the mentally ill did badly in nursing homes. This led to the passage of a rider to the Omnibus Budget Reconciliation Act of 1987. The legislation, commonly called OBRA'87, was designed, according to its originator, Senator Waxman to "stop dumping the mentally ill into nursing homes". It also imposed onerous restrictions on the prescribing of psychotrophic drugs in nursing homes.

The terminology adopted by the South London Family Housing Association for their homes containing 12 seriously disabled people, with consultant input, is intriguing. The question must now arise of how many patients, and how much consultant input, a domus must have before it is called, if you will forgive the expression, an asylum.

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Reference

BIRKETT, D. P. (1991) *Psychiatry in the Nursing Home*. New York: Haworth Press.

Response of management and patients to loss of unit

DEAR SIRS

I was impressed with Alison Wood's perspective on her training placement as a senior registrar at an adolescent psychotherapy unit which was about to close (*Psychiatric Bulletin*, 1992, **16**, 547–548). Much that she describes resonates with my own experience as the consultant in charge of a day therapeutic community. More than with adolescents, who at least can be seen politically as holding potential for the future, the kind of patients we treat on a long-term basis can be seen as a drain on dwindling resources; not much of an asset in the brave new world of the market economy in the NHS.

My anxieties on this topic were recently brought into focus by a serious fire in the lovely Victorian house where the unit was based. The response of