

When I was preparing myself for a working life devoted to the elderly mentally ill I visited and worked with a number of services both in psychogeriatric and geriatric medicine which were of good repute and very active. It was notable that the environment of wards was often spoiled and dominated by the smell of urine and/or faeces. Where this lingered it was always traceable to carpets, pseudo-carpets or (less often) inappropriate chairs.

I determined that there would be no carpets in units within my service. There was immense resistance to this suggestion from nursing officers, administrators and others who knew very well that the provision of carpets was a sign of a good and sound caring attitude to the elderly. They were not themselves going to work with them. Often they had never worked with them. But they knew that good souls provided carpets.

I have visited a number of units which claim to have succeeded with carpeting or similar coverings in geriatric/psychogeriatric wards. In all instances there were explanations for their 'success': a patient mix that included few severely demented, restriction of use of the carpeted areas to able and continent patients; recourse to rigid and restrictive use of incontinence devices. These are not for me—we must provide for the most severely disabled and behaviourally disordered. They must have freedom to use the territory to the full and not be restricted in movement, nor be required to wear catheters or other similar intrusive devices.

We have no carpets. There are none in staff rooms either—thus confirming equality for all and ridding anyone of the need to eject wandering patients for fear of an 'accident'. Our wards are recognised to be more pleasant than general psychiatry wards within the same units. Carpeted they are, and smell they do.

There are no carpets nor carpetlike materials that can cope with the heavy repeated wear expected in a day room for twenty mobile incontinent elderly adults without retaining a uriferous smell—it suits manufacturers to claim otherwise and we would all wish their claims were true. They are not.

Speedily available cleaning systems and domestic staff cannot always be to hand. For heaven's sake, the funding of my service requires that letters are two weeks or more on from dictation before they are typed for lack of secretarial time. Who would dare to suggest that there will be an inappropriately equipped and highly motivated domestic cleaner behind every pillar on Sunday afternoon, and Monday morning and Wednesday noon etc.!

Of course Greater Persons than we will tell us that carpets are good and reflect well on everyone. If they smell, then it is not their fault, nor the manufacturers faults. It is our fault—we who toil day by day. We have failed and so we and our patients and their relatives suffer.

Dr Azuonye is right. For a tough child you buy a Tonka toy. Psychogeriatric wards: use vinyl throughout.

Attention to the design and distribution of furnishings, wallcoverings and other equipment and, most of all, the behaviour and attitudes of staff are the main factors in ensuring homeliness.

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DEAR SIRS

I read the letters from the NHS Health & Scottish Hospital Advisory Services on 'Stinking Wards' (*Psychiatric Bulletin*, November 1990, 14, 67) supporting carpet-like fabrics for psychogeriatric wards instead of the lino advocated by Dr Azuonye (*Psychiatric Bulletin*, July 1990, 14, 431).

I feel the reason for "carpet-like" surfaces in hospitals is the claim by those individuals who check cost efficiency and budget control that these are "more efficient" as less staff are required to "clean" the area.

I cannot accept that the matrix of "carpet" damp from the cleaning and warm from the heating will not offer a culture medium for bacteria and possibly mould and spores which may affect the chests, skin and digestion of the ageing population.

In case this reason for *not* carpeting hospitals with their changing clientele is not accepted, the Environmental Protection Agency in the United States of America describes people at work in certain buildings who have sore throats, running noses, headaches and difficulty in concentrating as a result of the adhesives used to fix the pile and carpet to the floor. There are other factors in 'Tight Building Syndrome' but carpets are one.

I also feel that many wards benefit from modern synthetic surfaces that are softer underfoot, easy to clean properly and which have a wide choice of 'homely' colours. There is an escape of solvents for a while, although nothing is perfect for the variety of clients and patients.

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Liaison psychiatry in general practice

DEAR SIRS

I have read the paper by C. Darling & P. Tyrer (*Psychiatric Bulletin*, October 1990, 14, 592–594) with great interest. It highlights the value of liaison services provided through psychiatric clinics in primary care settings.

I would like to share my own experience of working with the general practitioners (GPs) and other

members of the primary health care team at a community health centre (CHC) in Melbourne, Victoria, Australia.

Deer Park CHC, Melbourne, serves 18,000 people (with predominance of nuclear families, working-class families and a migrant population). The clinical staff of the centre comprises medical (eight full-time salaried GPs), nursing (two community nurses, two clinic nurses and one nursing aide) and paramedical (one clinical psychologist, one welfare officer, one craft supervisor and one physiotherapist). People of all ages and of both sexes attend the centre (3,000 contacts per month).

The psychiatric clinic was initiated by a senior psychiatrist from Footscray Psychiatric Hospital (the regional psychiatric hospital about 11 km from the centre). Initially, one session per week was provided but later changed to one session per fortnight. The main objectives of the clinic were:

- (a) (i) to see the patients referred by the GPs or the clinical psychologist; feedback was provided through the written reports and face-to-face discussions
 - (ii) to follow-up the patients discharged from Footscray suffering from major psychiatric disorders who lived in the catchment area of the centre.
- The new and difficult patients were initially followed-up by the consultant psychiatrist alone or jointly with the other team members, but every attempt was made to refer the patient back to the GP with backup support.
- (b) to be available for consultation with members of the primary health care team.
 - (c) Other services provided were:
 - (i) Review meetings once in 4 to 6 weeks to meet the GPs and other members of the primary care team to review cases and discuss difficult management problems.
 - (ii) Availability of the consultant psychiatrist at the 'base' hospital to discuss management problems on the phone and/or provide early/immediate assessment/intervention to prevent admission at times.

Thus, GPs and other team members of the primary health care team at the centre were managing not only their usual cases with minor psychiatric disorders but also patients with major psychiatric disorders. The community nurses maintained close contact with the patients and their families through regular home visits or contacts at the centre providing support and also monitoring patients' medication.

The evaluation of the liaison service using a simple questionnaire revealed:

- (a) Advantages to the primary care giver: better understanding of the psychiatric disorders,

especially psychotic disorders; better understanding of treatment procedures, especially psychotropics; improved confidence and ability to cope with patients particularly psychotics; better relationship with the patient; backup support from psychiatrist.

- (b) Advantages to the patient: more comfortable about the environment of the centre; close proximity to home and reduction in travelling; better co-ordination of care; less stigma.
- (c) Advantages to the family: convenience because of close proximity; easy availability of the psychiatrist; improved relationship by better communication.

In conclusion, combination of different psychiatric 'liaison-attachment' schemes (Mitchell, 1989) employed at a primary health care setting appeared to be quite effective and useful placing a lot of emphasis on face-to-face contacts and discussions between the psychiatrist and primary health caregivers.

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Reference

- MITCHELL, A. (1989) Participating in primary care: Differing style of psychiatric liaison. *Psychiatric Bulletin*, 13, 135-137.

Family psychiatry and family therapy

DEAR SIRS

In Hugh Freeman's 'conversation with John Howells' (*Psychiatric Bulletin*, September 1990, 14, 513-521), comment was made on the differences between family psychiatry and family therapy.

I don't know where he got his ideas on family therapy from, but they are certainly not what any family therapists nowadays would say about themselves. In fact, all the things that John Howells was saying about family psychiatry are precisely things that family therapists would claim. The only difference may be that family therapy works with all kinds of family, not just those with a "sick" member.

Family therapy views a family as a "system", or in John Howells' words, "a total situation" to which the family therapist also hopes to be able to bring about harmony, and a return to normality for the whole group. Perhaps more than in family psychiatry, family therapists might look at the function of the "sick" label or role and expect to replace this in due course with other ways of understanding the group.

If family therapy and family psychiatry are so similar, perhaps we should join forces rather than