supporting services in the community were discussed, e.g. social service provisions (day centres, hostels, special services for the elderly, accommodation at all levels of dependence) or alcohol treatment agencies. In three quarters of the interviews relatives asked how they could help the patient or manage the problem. This led to discussions on interpersonal relationships, behaviour, preventative measures, etc. The relatives' own needs and emotions were prominent—guilt or anger when demented patients were admitted or discharged, or when the supply of alcohol to housebound patients was discussed. Other matters frequently raised were arranging and evaluating ECT and interpreting medical or surgical investigations and treatments. Legal matters discussed included injunctions, access and custody of children, court of protection and many aspects of the Mental Health Act.

Similar information was obtained from non-relatives, e.g. friends, neighbours and staff of old folks homes. These interviews are not included nor are the many other interviews with relatives held by other members of the team. Relatives seem to want guidance on management, information about ancillary services, but not diagnoses. Relatives have usually spent more time observing the patient than the doctor has, know what is 'normal' for the patient and may pick up early or subtle changes for the worse or better, before they are apparent to the doctor. These views must be listened to. The doctor should always ensure he is treating the appropriate person!

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ECT on OPD basis

DEAR SIRS

I was pleased to read Dr Anvil V. Shah's letter (*Bulletin*—September, 1986, **10**, 248) in which he discusses modified ECT given on an out-patient basis. His reason for doing it is the same as mine since 1945 when I was working at the Psychiatric Department of the Pazmany Peter University in Budapest. My feeling was that I had no right to admit patients, only because they were depressed, to a psychiatric ward and exclude them from their family support and home environment. I remember my first OPD treatment in 1945 of a 35 year-old female patient whose husband did not return from concentration camp. I thought she had been punished enough not to be locked up among more severe cases. Her sister came along with her for each treatment and looked after her until she recovered.

I also administered Pentothal for anaesthesia, as prior to 1942 the ECT was carried out without anaesthetics.

Since 1966 I have given modified ECT whenever I could count on the family's support. In 1974 I have established a day clinic, where cases of endogenous depression, schizophrenia, patients are receiving treatment, in florid cases two to three times a week, then in chronic cases as follow-up, once a week, then in two weeks.

Because the interior of the clinic looks like a pleasant art gallery and has little resemblance to the old fashioned surgeries or hospitals, patients are coming back of their own volition when they have recurrent symptoms.

May I also emphasise that one has to be sure of the right indications and be careful of complications; I am always on the premises and also this way no stigma attaches to the patients. They stay with the family and go back to work as soon as they recover from the acute state. And last, but not least, there is a cost saving for the government because no hospital bed is required for 24 hours, which is the most expensive part of most of the medical services.

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Hospital beds for psychiatric patients

DEAR SIRS

I am sure that Professor Priest's letter 'Hospital Beds for Psychiatric Patients' (*Bulletin*, November 1986, **10**, 322–323) was a well intentioned attempt to assist psychiatric planners to obtain more resources. However I was dismayed that he should attempt to provide figures for bed norms without relating them to other parts of the service. There are alternatives for the treatment of even seriously ill psychiatric patients. The need for in-patient beds will vary with the availability of these alternatives as well as with local psychiatric morbidity. By continuing to concentrate on bed norms in isolation Professor Priest encourages the tradition of a 'bed led' service. He then goes one step further and suggests that 30% of these beds should be empty! I do not think this approach is much help in the planning of a comprehensive service. It inevitably leads to the relative impoverishment of community resources which might offer more appropriate responses to the needs of patients.

D. MCGOVERN

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DEAR SIRS

Dr McGovern points out that there are alternatives to a hospital bed for the treatment of even seriously ill psychiatric patients. I accept that in theory, and in places, this is so, and most of us are following with interest experiments that offer a radical alternative to the traditional pattern of care.

However that was not the issue that my letter entitled 'Hospital Beds for Psychiatric Patients' was intended to deal with. The problem faced by many of our members, in trying to plan for mental health services, is that in their conversations with administrators the general rules are not clear. My letter was intended to throw some light on that. Because my letter was welcomed by the Regional Advisers—to whom it was sent in the first place—it was suggested that it might have a wider reading.