Acute psychiatric wards

Sir: Muijen (*Psychiatric Bulletin*, May 1999, **23**, 257–259) calls for psychiatrists to address the deficiencies of acute psychiatric wards. He does not specify how they should do this.

Beds have closed despite increasing demand, particularly for admissions of young men (Lelliott, 1996). Also, the increasing cost per bed means that little money has been released. Those closing beds believed, incorrectly, that better community care, through the use of case management, would reduce demand. The new vogue, 'assertive outreach', is advocated as fervently as was case management, and often by the same people. The leap of faith is that the efficacy of assertive outreach, in reducing bed use, will translate from research to the real world.

Community services have been the focus of commissioning and planning; the neglect of psychiatric wards has been a consequence. Pay and conditions mean that ambitious nurses opt for work in the community; other care staff have been relocated from district general hospital to dispersed community settings and in-patients now have little access to day hospital facilities. How do you reverse these trends and re-engage these staff with in-patients, let alone find the additional staff needed for the small specialist units, which Muijen suggests should replace existing 20-bed wards?

Muijen rightly calls for a systemic approach. However, in services with few beds, continuity of care between community and hospital is only achieved by giving several consultants admitting rights to the same ward. This hinders the development of the close knit teams needed to provide good quality care to in-patients.

Reference

LELLIOTT, P. (1996) Meeting the accommodation needs of the most severely mentally ill people. *Journal of Interprofessional Care*, **10**, 241–247.

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Electroconvulsive therapy ending where it began

Sir: By a directive of the Minister of Health, Rosy Bindi, in Rome where 62 years ago, Cerletti and Bini introduced it into psychiatry, electroconvulsive therapy (ECT) has been almost abolished in Italy.

It is an irony that this is Rosy Bindi's second foray into ECT. The first, in December 1996, resulted in her decreeing, in face of anti-ECT agitation, that it was an essential therapeutic procedure, and that to dispense with it would magnify the risks of deterioration or death in certain conditions. The response to this was redoubled pressure by libertarian and not so libertarian psychiatrists and by lay groups, some with broader anti-psychiatry agendas than ECT.

Some years ago, when I attended a professional conference on ECT in Rome, with invited speakers from abroad, and with a contribution by Professor Lamberto Longhi on witnessing the first ever ECTs, I had to make my way to it through a street demonstration with banners denouncing the participants.

The commission reconstituted to advise the Minister a second time stated that the practice of electroshock was out of line with recent tendencies and distinguished by improper use and abuse. Moreover, it added that, despite the great volume of research in recent decades, its mode of action had not been clarified in any precise way – as if that justified discontinuing its use.

ECT is a minority interest among psychiatrists in Italy and Professor Andreoli, who heads the Verona-Soave Department of Psychiatry, welcomed the Minister's pronouncement. He declared that ECT belongs to the archaeology of science and should be acknowledged for what it meant in the 1940s. He went on to say that, in face of all that science has discovered from 1940 until today, it was crazy to regard electroshock as an effective therapy, and that while he admits to hospital 340 patients annually, he has only once in the past two years resorted to using it.

On the other hand, Professor Casano in Pisa, well known for his single-minded advocacy of physical treatments in psychiatry, lamented that the Minister's circular would set off a witch hunt in deference to inflammatory ideologists.

Henceforth, ECT is only permissible in cases of psychotic depression with psychomotor retardation, unresponsive to drug therapy, and in cases of malignant catatonia – provided the patient gives informed consent. It is not explained how informed consent can be obtained from persons in the grip of such extreme conditions.

Furthermore ECT is no longer permitted in private clinics while, in public hospitals, the presence of the patient's psychiatrist is obligatory with that of an anaesthetist. The Italian regional authorities are now working out more rules of their own.

Curiously enough, this and other political intrusions into everyday clinical practice stir no protest nor even any ripples in the medical profession in Italy. But perhaps it is not so curious because, after all, is that so peculiar nowadays to Italy?

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