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Correspondence

Letters to the Editor should not exceed 500 words.

Overcrowding in Psychiatric Hospitals

SIR,—Recently there has been a focusing of public attention on the overcrowding present in psychiatric hospitals. It is my view that blame for these conditions must rest with the medical staff of the hospitals concerned. With energy and skill many patients in psychiatric hospitals can now be improved and the great majority discharged after only a few weeks' stay. A careful review of all patients in long-stay or medium-stay wards carried out at consultant level can result in many so-called "chronic" patients being treated and greatly improved, and even, in many cases, discharged from hospital. It is essential in psychiatric hospitals that every patient should be carefully reviewed by a consultant at frequent intervals, whether he or she be in a short-stay or a long-stay ward.

At Rubery Hill Hospital a "male division" of 375 beds was taken over in 1962. At this time all beds were full, and overcrowding was said to be present on the 12 wards which composed the division. A regimen of careful review and active treatment of every patient was instituted, and every long-stay or medium-stay patient was reviewed by the consultant at very frequent intervals. Within one year this unit was able to empty and convert a 25-bedded ward to a female admission ward. A year later a further 25-bedded ward was emptied and again made into another female admission ward. Unfortunately, this process was slowed owing to the forced acceptance of 40 long-stay patients from neighbouring hospitals to enable these psychiatric hospitals to set up child psychiatric units. However, these 40 patients could be accepted from these hospitals and accommodated in the empty beds that had been created. At the present time many beds have been taken down and much greater spacing of beds and the policy of curtaining the beds has been carried out on a number of wards. The unit, with only one consultant in charge, now admits 650 patients a year, which is two-thirds of all the admissions to the hospital. Very few of these admissions ever leave the short-stay admission wards.

The unit long ago abolished all waiting lists, and all patients are admitted at once. At the present time the unit has 70 unoccupied beds. Hence it can be shown that over a period of about six years approximately 160 long-stay patients have been freed. I am fully convinced that this can be done in every psychiatric hospital in the country, with the full use of modern treatments by energetic doctors. It has been said that there are no chronic patients in mental hospitals, only neglected ones. The blame for this neglect must rest with the medical profession and can be shifted on to no one else.—I am, etc.,

Rubery Hill Hospital, Birmingham. C. ENTWISTLE.

Anencephalus and Spina Bifida

SIR,—Your leading article "Anencephalus and Spina Bifida" (16 March, p. 660) does service in drawing attention to the importance and complexity of the factors, genetic or otherwise, which determine the incidence of these common malformations. It will be a loss to embryological thought if the wider epidemiological aspects, which after all can be collected and analysed from hospital records alone, obscure the important morphological problems raised by anencephaly, problems which can only be solved, or at all events brought into focus, by detailed examination of each anencephalic foetus. Among them are the causes of the erratic sex incidence, the reason for wide variations in the associated hydramnios, the dysgenesis of the adrenals, and often the perfect development of the foetal trunk despite the absence of any pituitary bodies.

Perhaps the main interest from an obstetrical standpoint is the marked tendency of anencephalic pregnancies to continue beyond term if there is no associated hydramnios present and the foetal trunk is well developed. This was pointed out over 50 years ago by both Ballantyne and Fothergill, and lends point to the view that in normal pregnancy the onset of labour is mediated by a normal foetal brain.—I am, etc.,

PERCY MALPAS.
Liverpool Maternity Hospital, Liverpool.

Vaccination Against Measles

SIR,—Dr. R. M. Forrester (23 March, p. 764) asks the important question whether future mothers will acquire sufficient antibody from measles vaccination to protect their infants during the first 9 months of life. This was one of the cautionary points which I also raised when reviewing the whole question of routine measles vaccination as a community health measure.[1]

If, in the event, babies do become more susceptible to measles in the first few months of life, this could be a serious matter. There are, however, two possible means of dealing with such a situation. A booster dose of measles vaccine might be given routinely during pregnancy. Alternatively, if it was found that babies lost their transmitted maternal antibody more quickly, it should be possible to give measles vaccine earlier than 10 months of age and still get a satisfactory immunity response.—I am, etc.,

Health Department, City of Oxford. JOHN F. WARIN.

REFERENCE
1 Warin, J. F., *Roy. Soc. Hlth J.*, 1967, 87, 261.

Intramuscular Injections

SIR,—I read with interest the article (23 March, p. 744), leading article (p. 721), and correspondence (30 March, p. 836) concerning intramuscular injections into the buttocks.

There are three accepted sites for intramuscular injections, the deltoids, the buttocks, and the lateral aspect of the thighs. The first two of these sites are not far removed from the circumflex and sciatic nerves respectively. Every year there are cases reported of mis-