100,000 population). However hospital-hostels cannot 'house' all the disturbed chronic mentally ill. Failure occurs because of violent behaviour, fire-setting and self-discharge. At Coney Hill, 16 residual patients were deemed too disturbed to be placed in a hospital-hostel on the census date. The reasons were: chronic psychotic symptoms unresponsive to medication; excessive deviant behaviour; and secondary drug abuse. Women were in-patients for shorter lengths of time than men for which there is no easy explanation.

The Kidderminster District General Hospital survey (Cumella *et al*, 1988) of accumulation of long stay patients under 65 years over a six year period showed a turnover. No more than eight long stay patients were resident at any one time per 100,000 population. This figure included presenile dementias.

The present study indicates the use of 3–4 beds per 100,000 population for the long term mentally ill excluding presenile dementias. However, the long term wards have 4–5 beds per 100,000 population as there are extra beds for temporary readmission of ex-long stay rehabilitation patients and the hospital-hostel resident who has misbehaved. It is the policy to admit for three nights to give the resident and staff time to 'recover'.

The use of long-term beds vary with the psychiatric morbidity of the catchment area. If it is assumed low social deprivation as measured by the Jarman Scale of underprivileged areas (Jarman, 1983) means low psychiatric morbidity then Cheltenham, Gloucester and Kidderminster require fewer beds than most districts.

Local facilities were appreciated by relatives and friends, over half of the residual patients being visited at least monthly. There was only one man at St Andrews so a further locked supra-district facility is not viable.

Future service implications

Coney Hill is closing so armed with the census data two new wards of 12 and eight beds, i.e. four beds per 100,000 population, have been planned for residual patients adjacent to the new admission wards to be built on central sites in Gloucester and Cheltenham. A communicating corridor will be necessary because seclusion facilities will be in the admission units. The wards will be one storey high and have a large courtyard and fence. There will be a high nursing staff/resident ratio. The Gloucester ward for 12 residents will have 18 nursing staff and a nurse manager to ensure optimum rehabilitation, self-sufficiency and that the ward is rarely locked. Each resident will have a single room. A suite on the ground floor will have special aids for a physically disabled person. As the clientele steal food and have poor hygiene, the refrigerator and freezer need to be locked and main meals provided by the hospital kitchen.

References

Anstee, B. H. (1985) An alternative form of community care for the mentally ill. *Health Trends*, **17**, 39–40.

Cumella, S. J., Lawrence, R. & Robertson, J. A. (1988) A study of the accumulation of long stay patients in a general hospital psychiatric department. *Health Trends*, **20**, 48–51.

Jarman, B. (1983) Identification of underprivileged areas. *British Medical Journal*, **286**, 1705–1709.

Psychiatric Bulletin (1991), **15**, 667–669

Liaison psychiatry and Gulf casualties

The disaster that did not happen

David G. Stevens, Senior Registrar, Princess Alexandra Hospital, Royal Air Force Wroughton, Swindon, Wilts SN4 0QJ

This article describes the response of some RAF and RN mental health personnel and civilian mental health teams to the challenge of dealing with the psychological needs of wounded Servicemen. The preparation for war casualties could be seen as a useful exercise for future conflicts.

https://doi.org/10.1192/pb.15.11.667 Published online by Cambridge University Press

The military hospitals in the United Kingdom might have been overwhelmed by the number of expected casualties so the regional health authorities were asked to allocate beds for physical casualties in NHS hospitals as stated in Gulf Contingency Planning: NHS Medical Guide (DoH Public Health Medicine Liaison Division, 1990). No specific recommendations were made about the psychological needs of the casualties, their relatives or hospital staff, although a useful advice paper was distributed with the March edition of the *British Journal of Psychiatry* (Brandon, 1991).

The lifetime prevalence of post-traumatic stress disorder in wounded Servicemen may be as much as 40%, which is higher than for those who are not wounded (Pitman *et al*, 1989). It is widely accepted that early intervention reduces the associated morbidity of PTSD.

Identifying priorities

Some NHS hospitals sought advice from the start either by requesting lectures on post-traumatic stress or to meet to discuss strategy. They wanted to know what kinds of psychological reactions the wounded might suffer, how many would be affected and what specific treatment could be offered. Issues concerning military procedure, administration, rehabilitation and referral were also raised.

All staff, but particularly nurses, wondered what their response would be to the presence of large numbers of badly mutilated soldiers in their hospital. Many wanted a system of staff support geared specifically to their needs with other personnel allocated to help relatives.

The co-ordinating team and its functions

A small co-ordinating team was formed in each hospital; it included senior members of the hospital administration, nursing staff and the local mental health team. It was required at an early stage to liaise closely with the military administrators (MAOCH team) in the hospital and form the team responsible for casualty debriefing, staff and relative support. All these teams needed to be small, well informed and in close touch with the co-ordinating team.

There was an overwhelming response from professional and voluntary groups and the general public. The co-ordinating team collated these offers of help which, at times, required tactful handling. A list was compiled of people with various skills but there was a clear need for some means of screening, assessing and training these volunteers.

Psychological care of the wounded

In our opinion, casualties should be kept together unless medically inapproporiate to do so. Separating them from other Servicemen would have a detrimental effect on their morale and subsequent recovery. Issues of security and the handling of relatives would be made easier if they were nursed together.

Most hospitals agreed that a small number of suitably trained psychiatric nurses should have been allocated to the wards so that they could be seen as part of the 'medical team'. This would enhance their credibility with both the ward staff and the patients allowing early assessments to be made. The use of questionnaires was not thought to be appropriate at this stage and formal debriefing of all casualties impractical in view of the numbers anticipated.

A leaflet, entitled *Coping with Combat Stress* was made available to all wards. Its purpose was to explain the nature of post-traumatic stress and its possible sequelae. There was a similar leaflet produced specifically for relatives.

Psychiatric casualties

Many questions were raised concerning the management of casualties requiring psychiatric admission. It was agreed between the Services and the Department of Health that all casualties with a persisting psychiatric disorder would be transferred to the care of the Services as soon as their physical condition allowed. All psychiatric casualties would be cared for by the Services from the outset. Psychotic reactions which could not be managed within the Services would have been uncommon. Some cases of post-traumatic stress were managed at the Army and RAF in-patients units and a new rehabilitation facility for others was planned sited away from a hospital environment.

Care of the relatives

It was anticipated that relatives would be arriving at an early stage of the casualties' admissions. Accommodation, travel expenses and other financial assistance would have been handled by the Military Administrators (MAOCH team). An allowance was provided for the purchase of new civilian clothes for the casualties.

Many relatives would have required counselling and support. Key personnel, usually from the Hospital Social Work Department, were allocated this responsibility. A close liaison with the MAOCH team to answer specific Service administrative matters would have been essential.

Staff support

Many hospitals already had a confidential counselling service for staff often employing a single

https://doi.org/10.1192/pb.15.11.667 Published online by Cambridge University Press

counsellor for a General District Hospital. Nurses in particular felt that more comprehensive staff support would be required. However, the needs of other staff needed recognition.

Most nurses felt that experienced colleagues who were not working with the casualties would be best suited as debriefers. Problems arising from these debriefing sessions could have been discussed at regular meetings with a selected member of the mental health team.

Some junior staff felt that they might be inhibited if debriefed by senior colleagues. However, experience elsewhere suggests that debriefing on a team basis, rather than professional grouping is acceptable and effective, and that provision should be made to provide debriefing for those individuals and groups who are initially resistant (Dyregrov, 1989).

Conclusions

As few casualties were admitted to civilian hospitals, these plans were never put to the test. However, it is important to learn from this episode and integrate the lessons with other workers' experiences.

The response by professional groups and others to the probability of military casualties was overwhelming. A co-ordinating team to organise the available resources and make appropriate plans was invaluable. The collection and dissemination of accurate information, allocation of personnel, advice from outside experts and negotiation with medical and nursing staff is best done by this team. However, local circumstances such as staffing levels, pressure of routine work, staff opinion and levels of expertise may dictate how resources are used.

The degree and nature of staff support should be fully discussed and agreed at each hospital. Relatives would have special needs which may include psychological support, advice about accommodation, financial help and accurate information about the casualty's condition.

All this support should be given with an understanding of Service culture, language and traditions.

Acknowledgements

I am grateful for the advice given to me by Professor S. Brandon and Dr J. W. Rollins during the preparation of this article.

References

Brandon, S. (1991) Advice to psychiatrists concerning casualties repatriated to NHS hospitals from the Gulf. *British Journal of Psychiatry*, **158**, Advice Enclosure.

DoH Public Health Medicine Liaison Division (1990) *Gulf Contingency Planning: NHS Medical Guide*. London: Department of Health.

Dyregrov, A. (1989) Caring for helpers in disaster situations: psychological debriefing. *Disaster Management*, **2**, 25–30.

Pitman, R., Altman, B. & Macklin, B. (1989) Prevalence of post-traumatic stress disorder in wounded Vietnam veterans. *American Journal of Psychiatry*, **146**, 667–669.

A full list of references and the leaflets mentioned in the article are available from the author on request.

https://doi.org/10.1192/pb.15.11.667 Published online by Cambridge University Press