nize that staff will need great support to maintain an input of work with these youngsters when the change that they see in them may only be slight. With youngsters with whom we have an on-going commitment it would appear essential that we are able to obtain accommodation outside a secure setting, e.g. group homes or perhaps hostels so that we can gradually re-introduce them back into the community.

I was pleased to note the comments the Working Party made about the importance of on-going evaluation of a Unit such as ours and the obligation we have to become involved in research and looking at the effectiveness of what I would like to stress is not just an in-patient Unit, but a Service.

SUSAN M. BAILEY

Prestwich Hospital
Prestwich, Manchester

Use of the Nursing Process in psychiatry

DEAR SIRS

The use of the Nursing Process in psychiatry continues to cause debate. May I be permitted to make the following observations.

Inherent in the New Syllabus of Training for psychiatric nurses is a requirement to change the framework within which psychiatric nursing is practised. It assumes that care is organized within a 'needs meeting and problem solving concept'. This approach defines nursing as a deliberate, planned and scientific activity, tailoring nursing care to the unique needs of each patient. In its purest form the requirement is that each patient is assessed as to their nursing needs, goals and objectives are set, and a care plan is formulated and implemented. Subsequently, the plan is evaluated in terms of effectiveness in achieving the stated goals, and modified or changed accordingly.

The use of the Nursing Process in such a pure form in psychiatric nursing is seen as problematic by many experts in the field. Schrock[1] pinpoints one of the main reasons for this: 'with the advent of a multidisciplinary approach to patient care, the planning of nursing care as such, may become counter effective, as a separate nursing care plan may simply be duplicating the effort, and may unintentionally exclude some nurses from the full multidisciplinary plan.'

It is advisable that psychiatric nurses gain the support of the multidisciplinary team in organizing individual care plans and consider the views of other disciplines involved.

Should this not occur, the early achievement of clearly defined objectives remains doubtful.

D. M. COX

Broadgate Hospital
Beverley, W. Yorks.

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Practice of psychiatry in the 1880s

DEAR SIRS

We read Dr Parry-Jones's article (*Bulletin*, November 1984, **8**, 208–209) on the practice of psychiatry in the 1880s with interest. We would like to add a few points about that period from our own published research here in Ireland.

The RMS of the Richmond Asylum (now St Brendan's Hospital) at the time, Dr Conolly Norman (1886–1908), together with his nursing staff, were very concerned with the strict economies imposed by the Asylum Governors. Infectious diseases were endemic within the institution. The patients' clothing, received from the hospital stores, was often eaten by rodents. However, the Governors were not too sympathetic.[1]

Between 1857–1885 the number of inmates rose from 600 to 1,100. The RMS became worried at the large numbers being admitted for legal reasons. An Act of 1867 allowed the courts to order committal in the case of insane persons who were apprehended whilst attempting to break the law. The Lord Lieutenant required to be satisfied by two doctors of the patient's recovery before the criminal lunatic could be discharged. Admissions, as a percentage of total admissions, coming under these regulations, rose from 66–88 per cent between 1868 and 1885. By 1898 this asylum had 2,375 inmates. The 1890s saw three major outbreaks in the Asylum of beri-beri.

Nurses had to be locked in with their charges. A special pass was required before they could leave the grounds. The arms of any inmate who broke glass were secured. Violence led to solitary confinement, and vile language led to 'degradation' to the 'Frantic Ward'. However, the education of doctors and nurses at the Richmond Asylum was acknowledged by Hack Tuke and others as being superb.

What diagnostic system was in use in Dublin's main asylum in the 1880s? We found the following categories in a consecutive series of 38 male admissions from 1 January 1888: alcohol-related—10 cases; 'hereditary'—12 cases; epilepsy—7 cases; 'self-abuse'—4 cases; 'trauma' and GPI—2 cases each; and 'old age'—1 case. There were sufficient data available on the first 50 male admissions of that year to make the following retrospective diagnoses: schizophrenia—42 per cent; organic brain syndrome, alcoholism and mental subnormality—14 per cent each; psychotic depression—10 per cent; GPI—4 per cent; and one case of (? abnormal) grief reaction. The three most common reasons for admission to the same hospital in 1980 were: schizophrenia—37 per cent; alcohol-related—21 per cent; and organic brain syndromes—17 per cent.[2]

BRIAN O'SHEA
JANE FALVEY

St Brendan's Hospital
Dublin 7

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