precipitate rupture.[2] Regular radiological confirmation of successful transit through the bowel is essential. Endoscopic removal should not be attempted as the risk of inadvertently puncturing a package is high.[11] If there are signs of developing toxicity or the packets fail to progress through the gut satisfactorily then they must be removed surgically.

Acute cocaine overdose may occur at any stage if a package bursts. Standard resuscitation procedures should be applied. Intravenous lignocaine (50-100 mg as a bolus) may be used for ventricular arrhythmias. Refractory arrhythmias or seizures contraindicate further lignocaine, and propranolol (0·5-1 mg intravenously, to a maximum of 5 mg) can be used.[12] This may, however, worsen hypertension by increasing the peripheral vascular resistance. Labetalol is theoretically better, but experience with this drug in this condition is limited. Hypertension may be controlled by a nitroprusside infusion, which has the additional advantage of aiding heat loss by peripheral vasodilatation.

Seizures may be treated with intravenous benzodiazepines —for example, diazepam 2·5-5 mg—or short acting barbiturates—for example, sodium pentothal 25-50 mg—and very large amounts of anticonvulsants may be required.[13] Standard evaporative cooling methods are often insufficient to control hyperthermia, and cooling blankets, cooled intravenous fluids, and ice water gastric lavage have been used.[14] In our experience dantrolene sodium (1 mg/kg intravenously over 10-15 minutes, repeated every 15 minutes, up to a maximum of 10 mg/kg/24 hours) is successful in lowering the temperature, though others report less success.[15] Fever, muscle rigidity, and seizures may produce rhabdomyolysis and subsequent renal failure.[16] Intravenous "renal dose" dopamine and mannitol should be given to patients with proved myoglobinuria: cocaine is best excreted in acid urine, so alkalinisation of the urine to reduce precipitation of myoglobin is not desirable. Sedation, paralysis, and ventilation may be the only way to control fever and muscle rigidity and achieve haemodynamic stability until the acute crisis is over.

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Closing mental hospitals

Simple information about hospital closures is not available

Less than six weeks before the start of sweeping reforms to community care in Britain the government's policy on mental health care is getting an increasingly bad press. Public outcry followed the revelation that Ben Silcock, who was mauled after climbing into the lions' compound at London Zoo, was severely mentally ill and was not getting adequate treatment. In response the health secretary, Virginia Bottomley, promised that she would consider new legislation on compulsory supervision and treatment of mentally ill people in the community.[1]

Earlier this month the campaigning charity Sane (Schizophrenia—A National Emergency) reported the story of a mentally ill woman known to be at risk of suicide who attempted suicide while living rough.[2] Saneline, the charity's telephone helpline set up in 1992 to offer support and advice to people with mental illness and their carers, received 50 000 calls in its first year. More than half of the callers, says Sane, were seriously mentally ill and desperate for help.

Now another mental health charity, the National Schizophrenia Fellowship, has collected data that further call into doubt current mental health policy. On p 475 the results of the fellowship's survey of mental hospital closures in England show that 45 hospitals are due to close by the year 2000. Yet last July the Department of Health was aware of only 29 such closures, and last month the parliamentary secretary for health, Tim Yeo, could not say how many were planning to close because no data are held centrally. How can the government monitor the programme, and even speed it up, if it does not know the simple facts about the number of hospitals affected?

Devolution of responsibility from central government to regional and district health authorities may be a good thing, but when this includes the collection and use of important NHS data it hampers monitoring of national programmes like that for modernising mental health care. And data on mental hospital closures are important.

We need to know what is happening to mental hospitals because they still contain most of the country's long stay (continuing care) beds. Most commentators on mental health care agree that some people with severe mental illnesses (mostly those with chronic schizophrenia) need the safe, full time specialist care that is offered in the long stay wards of the old asylums. Asylum, of course, means a place of sanctuary.

Even the most ardent critics of the closure programme agree that modern, small, and homely residential "sanctuary" units are preferable to drafty wards in crumbling old hospitals where staff morale is often low. But they argue that until enough new units have been funded, provided, and shown to be working the traditional hospitals are better than nothing. And the old hospital sites might be the best places to build the new units because the local population is usually tolerant, and

both managerial and clinical staff have long experience of providing services for chronically mentally ill people.

Some critics also argue that there is a direct link between hospital closures and widespread homelessness and vagrancy, but this argument is not borne out by research. The Team for the Assessment of Psychiatric Services has shown, for example, that long stay and "new long stay" patients (those who have been in hospital between one and five years) generally do well when they are discharged into the community.[3] But there is a world of difference between these patients, discharged carefully to a community hostel, and those sent out at short notice after a few months in an acute psychiatric ward. This second group never gets the chance of continuing care because there are too many admissions and too few long stay beds or suitable community residential places. Their plight is an indirect result of the closure programme.

Since 1991 health authorities are meant to have ensured that mentally ill people who need continuing care are monitored on formal care programmes. This approach includes ensuring that patients are not discharged from hospital until adequate community care is available. But use of care programmes is patchy, not least because acute wards are under too much pressure to allow bed blocking.[4]

With so many problems impinging on the plans to close Britain's mental hospitals and, whether justified or not, a public perception that closures cause tragic failures of care, it seems extraordinary that the Department of Health cannot say how many mental hospitals are due to close. Such ignorance hardly inspires confidence. Nor is it in keeping with the call in the *Health of the Nation* for better information and understanding about the burden of mental illness.[5]

The aims of the new mental health task force, set up in January to monitor the mental health service modernisation programme (p 475), seem sensible, but if central data on the programme had been collected all along the team would not now have to go to the districts for information. At the very least, Mrs Bottomley should ensure that such data are collected regularly until there is clear evidence from research that the alternative to mental hospital care is working.

TRISH GROVES

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Complaints by patients

A wide gap separates patients' and doctors' proposals for change

How complaints are dealt with strongly influences our assessment of a product or a service. A well handled complaint can enhance the supplier's reputation. The converse is equally true. Companies anxious to promote the quality of their products have found that advertising for complaints improves confidence. Doctors have been slow to appreciate that in a similar way their standing in the community could be raised if they encouraged complaints, investigated them rigorously, and made restitution when appropriate.

Medical complaints are increasing, but the response to them is still slow and convoluted—especially complaints against general practitioners. Complainants often end up disillusioned with the system of redress and angry with the whole medical profession; and the doctor against whom the complaint was made is often also traumatised by the experience. Patients who complain want information and explanation, and some also want compensation. A good system must be accessible, impartial, speedy, open, and effective.

Growing interest in the rights of consumers has spread to health care, and the dictates of the patient's charter have generated renewed interest in complaints systems in the NHS. Five papers are now in circulation, two from consumer groups,[1 2] one from managers,[3] and two from medical organisations.[4 5] All accept that the public is dissatisfied with the existing system, and all propose reforms. Some key elements are evident at this early stage.

The first perceived fault in the existing systems is the lack of common procedures for complaints against hospital staff and general practitioners, and for clinical and non-clinical problems. Three of the five papers recommend that all complaints should be dealt with in ways as similar as possible. Secondly, they recommend "inquisitorial" procedures, in which the complaint is investigated by designated people and the outcome is based on those facts which are established by the investigation. The ombudsman's office already conducts its inquiries in this way.

By contrast, most health service complaints at present are investigated by the "adversarial" system, which takes evidence from the two parties and comes to a decision—guilty or innocent. The paper from the Association of Community Health Councils and from Action for the Victims of Medical Accidents sees the investigation of complaints as just one important segment in the overall maintenance of standards. It recommends a complaints commission under the jurisdiction of an independent statutory health standards inspectorate. Such a body would have substantial lay membership.

The medical profession's proposals are much more cautious. The General Medical Council recognises the importance complainants place on rectification and that complaints systems should be able to rectify the circumstances that gave rise to the problem. Rectification is often more important than restitution. It recognises the need to take remedial action when poor general performance is alleged—but its inability to do so has, I believe, brought its regulatory function into disrepute.

The General Medical Services Committee and the General Medical Council seem unaware of the philosophical gulf that exists between the medical profession and user representatives. The papers from these two bodies are still talking about "self regulation." Non-medical advocates of reform have long since lost faith in that concept. They want an "independent" review by a body including a substantial proportion of non-medically qualified people.

The General Medical Council has tried to soothe doctors' fears of even limited lay participation by asserting that it would be restricted in clinical matters. Nevertheless, its paper agrees that "lay members are as able as doctors to recognise and respect the professional principles observed in safe-