Ladies among the guests

DEAR SIRS

À propos the interesting paper by Floate & Williams (*Psychiatric Bulletin*, January 1991, **15**, 28–30) describing the events leading to the admission in 1894 of the first woman member to the Medico-Psychological Association, readers may be further interested to know that it was not until 1920 that ladies, as guests, attended the Annual Dinner of the Association. The *Journal of Mental Science* (October 1920, **61**, 496–497), reporting the 79th Annual Meeting of the Medico-Psychological Association, held at Stafford County Asylum, Cheddleton, states, "The Annual Dinner of the Association was held at 8.00 pm on Wednesday July 28th, at the Palace Hotel, Buxton... Ladies were included among the guests and it is hoped that their presence may be an annual event in future".

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Functional beds in old age

DEAR SIRS

Parikh & Stern (*Psychiatric Bulletin*, November 1990, **14**, 657–660) prompt us to report the findings of an audit of admissions to our unit for functional illness in old age (over 65) that highlighted similar points of interest regarding the factors that influence the duration of psychiatric admission.

During the 12 months of 1989–90, 102 patients were discharged, with mean age 75 and female:male ratio of 1.9:1. The mean duration of stay was 41 days but 16 admissions exceeded 10 weeks, meaning 16% of admissions occupied 38% of the total bed time. Comparing patients staying more or less than 10 weeks showed the longer stay group to be more likely to suffer psychotic depression ($P<0.05$) and less likely to have a major depressive disorder without psychosis ($P<0.01$) – a finding consistent with that of Baldwin (1988). They were also more likely to include admissions from medical wards ($P<0.05$), less likely to be living with a spouse ($P<0.05$), more likely to have poor or no family support ($P<0.001$) and be discharged to residential care ($P<0.001$).

Of the 16 longer stay group, six spent 196 days waiting for residential care after their treatment was completed, i.e. 33 days per patient. The importance of reducing admission time of longer stay patients has been demonstrated (Hirsch, 1983) but the urgency to discharge patients admitted for longer than 10 weeks declines rapidly (Hirsch *et al*, 1979). It is easy to become complacent while looking for residential placements for patients who have already spent substantial time in treatment and make few demands on staff, yet this is clearly an area for saving bed time.

The audit data suggested other clinical areas for bed saving including intensive treatment and rehabilitation of physical and medical problems, use of newer psychotropic drugs with fewer adverse effects, and the earlier use of ECT for major depression.

Social variables like quality of community services, availability of residential care and family support need to be considered when determining requirements for functional beds in old age. The problem remains that of persuading managers that this type of data should be acknowledged and incorporated into decisions affecting service provision, and, though we commend audit as a mechanism to demonstrate areas for action, we are yet to be convinced that managers and administrators will respond to the information they are given.

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Community care of the elderly

DEAR SIRS

Care in the community should be the provision of facilities for people in that community. It should not be the provision of people for facilities! A large influx of residents for speculatively developed care-homes would have adverse effects on existing services in that locality and be contrary to the College's Report (*Psychiatric Bulletin*, August 1987, **11**, 278–282). The return of long-stay patients, or the migration of retired people to desirable areas, is reasonable. However, when wildly excessive care-home provision is developed in an area, residents have to be actively sought. The home's need, not the community's, may become paramount.

Current trends are worthy of note. Not only are some areas grossly over-provided (*Psychiatric Bulletin*, August 1990, **14**, 460–461) but homes tend to conglomerate – a high percentage of buildings in one road or estate may be care homes. Such localities have been called 'ghettos" by our College and by local councillors who nevertheless cannot refuse

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planning permission on grounds of over-provision. Individual homes are tending to become much larger, e.g. over 90 beds, and are increasingly passing from individual to corporate ownership. Financial return, rather than patients' need, could become a determining factor in a patients' management. Empty beds are financially undesirable. The admission of a patient to hospital or their transfer to a more suitable home could be disadvantageous to the current home when a high vacancy factor exists in the area.

When hundreds of dependent elderly are housed in adjacent buildings in areas chosen for available beds rather than personal associations, we are returning to the asylum village, not developing care in the community. We have institutionalised the community!

It has to be said that many of these new and large developments offer excellent care. Choice is desirable and competition should improve standards. Statutory services and the professions need to further clarify relationships with the independent sector as suggested in the College report mentioned above, to ensure the best service for elderly people is developed. NHS and Social Service provision in an area must be proportional to the numbers of dependent elderly not merely to the total elderly population.

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Better use of out-patient and in-patient data in psychiatry: a necessary step towards medical audit

DEAR SIRS

The continued failure to classify psychiatric beds into short, medium or long-stay makes audit and, therefore, effective planning impossible. Superficial scrutiny of one service in Scotland (West Lothian) shows, using nationally derived data, an average length of stay of 220 days which compares unfavourably with the Scottish average of 132 days.

More accurate information can be achieved when the beds are identified by classification. Hirsch (1988) showed for selected assessment units a mean length of stay of 38 days $+13$. Those for the index hospital were 34.9 days in 1987. If this information was gathered nationally along with standard measures, such as percentage bed occupancy and turnover interval, medical audit is possible.

An internal audit could consider length of stay in specific diagnostic categories and relate these to specific clinical teams. In Scotland nationally first admission rates, while higher than in England, have been fairly consistent for over a decade. There has been a two-fold increase in *readmission* rates. Where there are "blocked" beds are rehabilitation services utilised at the correct time? Are current rehabilitation units dealing with an appropriate clientele?

A similar exercise would help in determining services for the elderly. For Scotland the national returns for the category *geriatric assessment beds* were a mean length of stay of 39.9 days with a turnover interval of 4.1 days. For the *psychogeriatric* assessment unit in West Lothian the mean length of stay was 52.7 days with a turnover interval of 4.7 days which compares favourably with the national average for Geriatric Assessment Units. Yet again national data classify all beds for the elderly as one in psychiatric hospitals.

Finally, and of greater significance in determining community-based services, the production of age specific information about new out-patients and the location of a clinic is highly relevant. New contacts in West Lothian were 1.32 per 100 population (Scottish average 0.74). When these were further broken down by age 15–65 and 65+, new contacts for the index service were 1.30 and 2.34 respectively. McKechnie (1985) had already demonstrated that the rise in new psychiatric out-patients could be attributed to the development of out-patient facilities based in health centres.

Medical audit requires that the process should be relevant, objective, quantified, repeatable and able to effect appropriate change in the organisation of service and clinical practice Shaw & Costain (1989). Simple classification if adopted nationally would make medical and, eventually, clinical audit attainable. Without such simple steps attention cannot be paid to resource management, audit, and especially, quality assurance.

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Standards of care revisited – medical audit in practice

DEAR SIRS

The clinicians in the North Audit Group for Mental Handicap Psychiatry in the South West Region have

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