- All letters must be typed with double spacing and signed by all authors.
- No letter should be more than 400 words.
- For letters on scientific subjects we normally reserve our correspondence columns for those relating to issues discussed recently (within six weeks) in the *BMJ*.
- We do not routinely acknowledge letters. Please send a stamped addressed envelope if you would like an acknowledgment.
- Because we receive many more letters than we can publish we may shorten those we do print, particularly when we receive several on the same subject.

After the asylums

SIR,—Dr Trish Groves's article aptly portrays the current confusion about so called community care for psychiatric patients.¹ Although the article deals largely with the problems of chronic schizophrenic patients, similar difficulties are affecting patients with severe dementia despite agreed estimates of need for long stay beds. There seems to be great difficulty in replacing facilities as large mental hospitals begin to close.

The service in Camberwell exemplifies some of the difficulties and frustrations that may be met when setting up alternative long stay facilities. Plans have existed for over 10 years for moving severely demented patients from Cane Hill Hospital in Surrey to purpose built and redesigned small homes within the catchment area. The first home, built with capital from the "Care in the Community" scheme and run by Age Concern, has now been functioning for about a year but serious administrative difficulties have hindered us in obtaining regional approval for the second home. The second home was to be funded by the South East Thames Regional Health Authority and run by a housing association. A project team was set up in October 1986, a suitable site was identified, and plans were produced by a commissioned architect.

Despite support from regional officers these plans have just been turned down for the third time by the regional health authority. Beds in Cane Hill Hospital have been run down and patients have had to be placed in private nursing homes, sometimes as far away as in Yorkshire. Approaches to the region have not been met by any satisfactory explanation. One can suspect only that the authority finds it more expedient and cheaper to delay funding the home in the hope that it will never be built and that patients will all be placed eventually in cheaper private facilities, often hundreds of miles away from the community which should be caring for them. The eminent architect who has taken a special interest in the scheme and has subjected his plans to numerous modifications wryly informs me that since he was first approached he has completed a 30 floor hotel which is open and is fully functional. Is this what community care means?

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¹ Groves T. What does community care mean now? *Br Med J* 1990;300:1060-2. (21 April.)

Day patient psychiatric treatment

SIR,—In their paper on psychiatric day patient care Dr F Creed and colleagues describe a day

hospital in a general teaching hospital which also has a psychiatric inpatient unit.¹ Thus a substantial degree of medical cover is probably available and severely disturbed patients can be managed.

In contrast current plans in West Glamorgan, stemming from the Welsh Office's mental illness strategy,² recommend relatively small day hospitals in the community, one of which will serve as the base for each catchment sector team. Medical cover will probably amount to only a limited number of sessions a week.

Clearly, it will not be possible in such settings to cope with acutely disturbed patients and the units are more likely to offer mainly support and psychotherapy. The site and degree of medical cover of such units thus have marked implications for the type of services which can be realistically provided.

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- 1 Creed F, Black D, Anthony P, Osborn M, Thomas P, Tomenson B. Randomised controlled trial of day patient versus inpatient psychiatric treatment. *Br Med J* 1990;300:1033-7. (21 April.)
- 2 Welsh Office. *Mental illness services: a strategy for Wales*. Cardiff: Welsh Office, 1989.

Sodium and potassium intake and blood pressure change in childhood

SIR,—The paper by Ms J M Geleijnse and colleagues¹ is in many ways similar to a previous article from the same unit.²

The range of ages in the more recent study was very wide, and it is not clear how the authors adjusted for this. We were surprised that, with an expected Gaussian distribution, they made an apparently arbitrary choice of upper and lower thirds of the distribution of sodium and potassium intake.

The main conclusion was that the slopes for mean systolic blood pressure over time were lower when potassium intake was higher (coefficient of linear regression -0.045 mm Hg/year; 95% confidence interval -0.069 to -0.020). When the ratio of urinary sodium to potassium was higher they found a rise in blood pressure (0.356 mm Hg/year; 0.069 to 0.642). This result is unlikely to be significant because the confidence interval stretches from almost zero to twice the slope.

We are concerned that these results, based on fractions of millimetres of mercury (45 thousandths in one case and a little over a third in the other), might be within the range of errors in the method of measurement. In both studies a random zero sphygmomanometer was used but the calibration of two such instruments might differ by up to

1 mm Hg while readings by different observers could vary by 2 mm Hg.³

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- 1 Geleijnse JM, Grobbee DE, Hofman A. Sodium and potassium intake and blood pressure change in childhood. *Br Med J* 1990;300:899-902. (7 April.)
- 2 Hofman A, Valkenburg HA. Determinants of change in blood pressure during childhood. *Int J Epidemiol* 1983;117:735-43.
- 3 Evans JG, Prior IA. Experience with the random zero sphygmomanometer. *British Journal of Preventive and Social Medicine* 1970;24:10-5.

AUTHORS' REPLY.—We thank Drs Sinclair and Preston for their interest in our study, although it is unfortunate that they do not appreciate our findings on excretion of electrolyte and change in blood pressure in childhood. It is precisely this aspect that makes the report quite different from the previous analysis, for which no data on sodium and potassium were available.

Age adjustment was carried out as usual by including age as a covariate in the multivariate analysis.¹ Moreover, data were analysed separately in two age strata. To examine the association between electrolyte excretion and blood pressure slope, data were analysed in two ways. Firstly, we used electrolyte excretion as a continuous independent variable in a model of multiple linear regression. Secondly, to show the impact of the association we compared slopes of blood pressure between two groups with a realistic difference in electrolyte excretion. Although centile cut off points are commonly used, our choice of thirds of the distribution was indeed arbitrary. Any other choice would have given results that were essentially similar, as shown by the regression analysis.

Drs Sinclair and Preston are not confident about the relevance and significance of the coefficients of linear regression. It is inappropriate to compare directly the magnitude of the coefficients of linear regression with the measurement error for blood pressure readings. One of the properties of this coefficient is that it has a unit. For potassium this unit is mm Hg/year/mmol. If the results are given in mm Hg/year/100 mmol the coefficient is -4.5 with a confidence interval of -6.9 to -2.0 . Would this be more convincing?

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¹ Kleinbaum DG, Kupper LL. *Applied regression analysis and other multivariable methods*. Boston: Duxbury Press, 1978.