Bed occupancy in psychiatric units in Greater London is 113%

EDITOR,—On 26 May this year we surveyed bed occupancy in the acute psychiatric units in inner and outer London. Using a telephone method described elsewhere,¹ we obtained information from all 117 wards within 50 NHS units covering 29 districts. The bed occupancy of all the Thames regional areas of Greater London exceeded 100% (table 1). Beds were available in only four districts. These figures are lower than those found in other studies² but exceed those found in our four year study (in 1990-3) by a startling margin (113%, compared with 101% for 1993).¹

Table 1—Bed occupancy in all acute psychiatric units in Greater London

	No of acute beds	Total No of patients	Occupancy (%)
Inner London	1315	1507	114.6
Outer London	1022	1137	111.3
All London	2337	2644	113.1

These occupancy levels are a considerable underestimate because of the many patients treated in the private sector, on whom we had no information. Such findings are not specific to London. In more than a dozen urban areas in the United Kingdom, bed occupancy reached 100% at times (unpublished findings). In many urban areas, spending on extracontractual referrals has been vast and unplanned. Thus services are becoming more expensive and less cost effective, with disinvestment in local services.

What does this mean for patients? People who are severely disturbed, aggressive, at risk of suicide, or need to be detained under the Mental Health Act may not be admitted or are often sent a considerable distance from their homes. Care is fragmented, with two or more geographically distant teams being responsible for a single episode of care. Plans for aftercare are designed by teams who may have little direct knowledge of the local conditions and services to which the patient will return. This is plainly inconsistent with the principles of community care.

The pressure of high occupancies may lead to demoralisation of patients and staff, with premature discharges and patients being placed inappropriately in isolating bed and breakfast or hostel accommodation with untrained or ill prepared staff. Under such circumstances, conditions are ripe for the occurrence of serious incidents. Management, paralysed by the enormity of its task, responds with serial restructuring of services, which further depresses the morale of staff.

As a short term measure, bed closures must stop. The opening of villas in hospital grounds would help to steady a service spinning out of control. The impact of alcohol, drugs, and so on on services and the requirement for beds demands exploration. A thorough review by a royal commission on community care and mental health services is now overdue.

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Effect of antihypertensive treatment on cognitive function of older patients

Effect is not proved

EDITOR,—On the basis of the results of two cognitive tests Martin J Prince and colleagues conclude that hypertensive drug regimens in elderly people impair cognition no more than does a placebo.¹ This may lead to the changes suggested by the key message "Concerns about damaging cognition should not deter doctors from treating hypertension in older patients." We have concerns about the study's design: the nature of the outcome measures used, the lack of any run in period before treatment to minimise practice effects, and the use of slopes as measures of individual learning rates.

Any battery of cognitive tests for elderly people should test four fundamental cognitive factors: perceptual speed, working memory capacity, access to long term memory, and

spatial orientation.² In this study the authors analysed the variance associated with the paired associate learning task and the Reitan trail making test. Both tasks have methodological constraints that make testing of cognitive factors imprecise. Paired associate learning tasks are poor predictors of learning in real life situations.³ Because they operate under severely controlled time conditions the outcome in Prince and colleagues' elderly population was an extremely restricted range (mean 17 (SD 1.7)). Consequently, estimates of the internal consistency of the paired associate learning tasks⁴ are close to zero.

The Reitan trail making test is assumed to assess attention, concentration, and psychomotor skills. In the authors' study the average time to complete it over five occasions fell, which suggests that the test scores were subject to practice or learning effects, or both, which are likely to mask treatment effects. A validated battery of cognitive tests exists with limitless numbers of parallel forms, which ameliorate practice effects and negate memory effects.^{2,5}

For any standardised slope (correlation coefficient) based on five individual measures the limits of the 95% confidence interval are 0.75 and -0.75. This means that the result of correlating five scores with five time intervals must show a value of 0.75 or -0.75 in order to be treated as a non-random value for a single hypertensive patient. The authors admit that many scores were identical from point to point in time. Whenever this is so the correlation (slope) will fall within random limits, making any possible treatment effect redundant.

While we agree that there are no significant differences among the means in the treatment and placebo groups, there may have been confounding factors in this study's design and execution. We therefore advocate the more conservative conclusion of "not proved."

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Authors' reply

EDITOR,—Strictly speaking, it is never possible to prove a null hypothesis. However, lack of support for rejecting a null hypothesis is an important finding in a study in which treatment has been randomly allocated to over 2500 subjects. This

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