look forward to the involvement of Doctors Hall, Swann and other old age psychiatrists!

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Comparative costs of adult acute psychiatric services

DEAR SIRS

Peck and Cockburn on Cost Comparison (*Psychiatric Bulletin*, – February 1993, **17**, 79–81) cannot be taken seriously. The authors admit to having conducted a methodologically weak study of DGH based adult psychiatric service with various community services which only looked at cost with scant regard to the quality of care.

It was indeed a very small sample. A great pity that only four out of 13 supposedly innovative community services gave good enough financial information for comparison. They admit that the costs are imprecise. At any rate, only two out of these four (Community Services 2 and 4) seemed to provide at first glance a comparable range of treatments to the hospital model. The quality of service is not at all known, nor is there any mention of the opinions of the patients, carers and GPs as to how useful these services are.

While it is easy to agree that the capital costs of a bed based service are indeed going to be higher, even from the authors' own figures (Table IV), it is impossible to agree that the revenue costs are significantly greater in the hospital service and that hospitals have any greater appetite for revenue consumption.

The revenue costs given are mistakenly reported to be highest in the hospital based service. The authors' own table provides very clear evidence that even with the highest bed usage, the hospital based service costs per 10,000 population at £170,000, are in the middle of the costs range of the four community comparisons which work out between £130,000 and £1,000,000 (see Table). The comparable services cost £130,000 and £1,000,000, the latter showing about six times higher revenue costs than the hospital model.

It does seem that the authors perhaps in their own preference towards community "models" of service failed to notice correctly what their own figures are clearly telling them. One hopes that they will quickly rectify their conclusion lest the anti-hospital enthusiasts and uncritical observers get unduly excited, and the health managers raise their hopes at these flawed conclusions. We all need much more comprehensive costs and quality analysis in papers to generate an informed debate.

TABLE

Comparative revenue costs per 10,000 population

Community service 2*	130,000
Community service 4	150,000
DGH based service*	170,000
Community service 1	270,000
Community service 3*	1,000,000

(*Comparable provisions to DGH)

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Reply

DEAR SIRS

(***Editor's Note***: We regret that the final figure in Column 3 of Table IV should have read 100,000 and not 1,000,000.)

I am grateful for the opportunity to reply to Dr Bhatnagar's letter. The major thrust of his argument is undermined by the correction noted above. I will deal briefly with his other points.

We endeavoured to ensure that the services being compared were attempting to deal with the same range of needs. We were deliberately modest in our claims for the paper and made no attempt to do a cost – benefit analysis; however Dean & Gadd have reported on the apparent satisfaction of users and carers with Community service 2 replicating the findings of both Stein & Hoult in this respect. Furthermore, Community service 4 was the end result of a very thorough process of consultation with users and carers as well as the traditional stakeholders, such as psychiatrists. Unfortunately limitations on space precluded us exploring these issues in more depth.

Dr Bhatnagar accuses the authors of a preference for community models – in my case any such preference is the result of over six years of listening to users discussing their needs and preferred solutions. Within such models the challenge is to construct an effective balance between community and hospital.

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Training in liaison psychiatry

DEAR SIRS

The recommendations of the Liaison Psychiatry Group Executive Committee (1993) on this subject were interesting. In Melbourne there is a well established tradition of consultation liaison psychiatry

at several major teaching hospitals. The Austin Hospital, which is part of the University of Melbourne, has for the past ten years had psychiatric registrars undertaking consultation liaison experience and they have all clearly met the criteria your committee has suggested.

A part-time Director of Consultation Liaison Psychiatry has been responsible for coordinating the service in conjunction with a number of consultation liaison psychiatrists who together with a registrar have dedicated units to look after. In this way the non-psychiatric medical staff know who they are to contact for help with patients.

The Victoria State Psychiatric Services also have two third year registrars who rotate through this service for six monthly periods as part of their five year training programme. The hospital has its own registrars who are attached on an annual basis and may be involved with consultation liaison work for three years, rotating into different areas as needs are met.

Commencing this year we have a full time Fellow in Consultation Liaison Psychiatry who has completed the (Royal Australian and New Zealand College of Psychiatrists) exams.

Austin Hospital is famous for its large spinal injuries unit which has been well described elsewhere (Judd *et al*, 1989). In addition, for the past five years we have been the liver transplant centre for Victoria which has involved a considerable amount of consultation liaison work. This hospital has also a very large neurological and neurosurgical unit and is a centre for the Australian temporal lobectomy programme for patients with intractable epilepsy and the usual large general medical and general surgical units. The registrars are also rostered to the Crisis Service where they take part in the assessment of people with deliberate self harm.

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Discharge delays

DEAR SIRS

We read with interest Eapen & Fagin's correspondence on discharge delays (*Psychiatric Bulletin*, February 1993, **17**, 121). We carried out a similar study. To identify those patients on acute wards with an admission duration longer than three months, establish the proportion in need of alternative facilities, the nature of these facilities, and to identify the lack of access to alternative facilities, we sent a questionnaire to the consultants in charge of the two admission wards and two early rehabilitation wards of Napsbury Hospital and Barnet Psychiatric Unit. Items in the questionnaire included the placement of first choice, whether alternative placement was agreed, and if so, why patients were not transferred. The project was repeated on three occasions: August 1991, January 1992 and June 1992.

In August 1991, 44 patients remained in hospital for longer than three months and were currently on acute and early rehabilitation wards; 17 (39%) were reported to be inappropriately placed. In January 1992 and June 1992, 21 (51%) out of 41, and 16 (34%) out of 46 patients spending longer in hospital than three months were placed inappropriately. During this period the number of overall admissions did not change. Although in June 1992 the total number of inappropriate patients remaining for long periods on the wards had decreased, the fall in number was too small to be thought significant from a clinical and managerial viewpoint. The main reasons for patients being inappropriately placed were unavailability of long-term places in Napsbury Hospital; delays in transfer to resettlement team/hostel placements; and delays in housing and funding by local authorities. The results indicated that action was necessary. Places needed to be made available for long-term patients in independent accommodation in the grounds of Napsbury Hospital, although this did not open until February 1992. This made no difference to patients remaining too long on the wards audited, as the total number of beds continued to decline because of financial pressures. It was considered appropriate to change an all-female ward into a mixed ward, thereby providing places for men with chronic mental illness who were otherwise occupying beds on acute and early rehabilitation wards. Financial pressures have not yet permitted this to happen.

Liaison with social services took place to ensure that patients discharged into the community received appropriate funding in respect of housing and resettlement in supervised accommodation. A recommendation was made that the applied ban on health authority top-up funding for placement of the mentally ill in community facilities should be lifted. As expected, financial limitations and lack of provisions in the community are the reasons for delays in discharge of most patients remaining longer than three months in hospital. These factors are crucial for the successful implementation of community care. All aspects of the Community Care Act should have been implemented by 1 April 1993 when local government was given control of its financial aspects.