

problems and were involved in additional therapeutic activities. These findings suggest that either a significant proportion of those who were being treated and were identified as an anxiety disorder patient by the survey were not in fact considered to be so by their therapist, and were being treated primarily for something else, or that treatments intended for individuals with anxiety disorder were less focused and specific as research findings suggest they should be (Barlow & Lehman, 1996).

As far as anxiety management groups were concerned, these accommodated only a small proportion of the total number of identified anxiety disorder patients and may have been an inefficient use of therapists' time. When assessment time, administration and the fact that groups involved two practitioners working together were taken into account, they actually used some eight hours of practitioner time per patient, time that might have been better used in more individualised sessions.

These conclusions should not be read as criticism of the particular service we have investigated. Although other similar investigations are needed to confirm it, our view is that this was a representative service and comparable provisions elsewhere are unlikely to be significantly different. Instead they point to the continuing shortcomings of our approach to a common, frequently trivialised though often very disabling set of conditions for which effective treatments exist but are only sparsely available.

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Old age psychiatrists' views on continuing in-patient care

John Wattis, Andrew Macdonald and Paul Newton

Aims and methods The aim of this study was to elicit views from UK consultants in old age psychiatry concerning changes that were taking place in long-term care for older people with mental illness (especially dementia) and their views on a draft consensus statement produced by the Faculty for Psychiatry of Old Age on behalf of the College. A postal questionnaire was circulated as part of a wider survey of 472 consultants and a single postal reminder was sent to non-responders.

Results Two hundred and forty-two (51%) consultants responded. Nearly nine out of 10 respondents were in

favour of continuing NHS consultant-supervised long-stay beds and three-quarters of them preferred a return to national numerical guidelines for bed numbers, though at a level approximately half of previous guidelines and provision. This was accompanied by a view that such beds should no longer be 'for life' with over three-quarters of respondents supporting discharge if, for example, behaviour problems resolved. If Government policy continued to support 'eligibility criteria' rather than guidelines, 60% were in favour of national rather than local criteria. There was very strong support for the draft consensus statement (now

published in modified form as College Policy) and the 'eligibility criteria' it contained. Agreed criteria for waiting times in acute beds for continuing NHS, nursing home or residential care were not widely used.

Clinical implications Consultants want to continue to be responsible for some longer-term care and efforts should be made to develop the role of NHS longer-term care within the 'spectrum of services' provided for older people with psychiatric disorder, perhaps by acting as local 'centres of excellence' in dementia care as well as by providing services for patients with the more difficult behavioural problems. The more widespread use of 'agreed waiting times' for patients in acute beds requiring longer-term care should be explored.

National Health Service (NHS) provision for the continuing care of people with severe dementia has reduced over the past 10 years and there has been a shift in emphasis from national guidelines of provision to locally determined 'eligibility' criteria for such provision. These changes have been carried through often in the face of opposition from consultants working in the field and have sometimes resulted in serious ill treatment of patients (Health Service Commissioner, 1996). After a consensus meeting, the Section for the Psychiatry of Old Age of the Royal College of Psychiatrists produced its own draft statement on continuing care provision for people with severe dementia (Wattis & Fairbairn, 1996) which, after redrafting, has been accepted as a policy statement of the College (Royal College of Psychiatrists, 1997).

A series of surveys have been carried out into the provision of psychiatric service for old people in the UK (Wattis *et al.*, 1981; Wattis & Arie, 1984; Wattis, 1988) and a survey was planned for 1996. As part of this survey, consultant psychiatrists were asked their views on this draft statement and about other issues around continuing care.

The study

The Royal College of Psychiatrists' Section for the Psychiatry of Old Age maintains an annually updated list of consultants in the field. This was used as the basis for mailing, in the summer of 1996, standard questionnaires that were loosely based on those used in the 1985 survey but designed to be machine read using the 'Formic' system. The new format of the questionnaire was piloted and modified to improve useability before the main survey. The results of the main body of the survey will be reported elsewhere but at the end of the survey form there was a new series of questions covering issues of continuing care referred to above. Unlike the previous major survey, funding was not available for secretarial support to pursue non-responders by repeated

reminder letters and telephone. After two to three months, non-responders were sent a further questionnaire with a reminder letter and a closing date.

Findings

Four hundred and seventy consultants were surveyed and 242 responses were received, 42 in the second wave. This represents a response rate of 51%. Owing to an administrative error a few consultants in the second wave did not receive initially the draft consensus statement. Where this was drawn to our attention the error was rectified. The findings are presented in the form of responses to specific questions, directly derived from sections in the draft statement (Wattis & Fairbairn, 1996).

Do you believe that the NHS should continue to provide consultant supervised NHS continuing care beds?

There were 238 valid responses to this question: 206 (86%) were in favour, 21 (9%) against and 11 (5%) undecided.

Do you think there should be national numerical guidelines?

Of those who answered 'yes' to the first question, 203 responded to this: 155 (76%) were in favour of national guidelines, and 28 (14%) against with 20 (10%) undecided. Those who responded positively were asked to answer the next question.

How many beds per thousand over 65 should be provided?

Responses mistakenly given by those who had answered 'no' to the question above were filtered out before data were analysed. The format of this question forced choice in steps of 0.5 beds per thousand elderly population from 0.5 to 3.0, with a separate tick box for those who favoured more than three beds per thousand elderly. One hundred and thirty-one respondents answered this question and results are given in Table 1. Two-thirds favoured between one and two beds while nearly 14% opted for the previous guideline maximum of three beds per thousand elderly. The mean number of beds favoured was 1.7 beds per thousand people over the age of 65 years.

Do you believe that patients should be admitted to such beds for life, or should they be discharged if, for example, behaviour problems resolve?

Two hundred and thirty-three respondents answered this question: 52 (22%) believed NHS long-stay beds should be 'for life' and 181 (78%) that patients should be discharged if problems resolved.

In the absence of Department of Health (numerical) guidelines, should eligibility criteria for long-stay care be determined locally or nationally?

Table 1. Preferred numbers of NHS long-stay psychiatric beds per thousand people over 65 years

NHS long-stay beds/thousand > 65 years	0.5	1.0	1.5	2.0	2.5	3.0	> 3.0
Number of respondents	10	34	18	36	13	18	2

There were 234 valid replies to this question, 140 (60%) in favour of national criteria and 94 (40%) in favour of local criteria.

Do you have locally agreed eligibility criteria?

One hundred and sixty-eight of 234 (74%) responding to this question had locally agreed criteria.

Do you have locally agreed criteria about how long someone should wait for a long-stay bed or nursing place once the need has been agreed?

A possible way of reducing blocking of acute beds by those waiting for long-stay care was suggested at the consensus meeting. This was to have locally agreed criteria about how long someone should wait once the need for long-stay placement had been agreed. Only 17/235 (7%) respondents to this question claimed to have such criteria. Only four of them gave criteria for NHS long-stay waiting time; one at 14 days, two at 21 days and one at 90 days. Thirteen gave waiting criteria for nursing home placement with a mean of 27 days (range 1–60) and residential home placement with a mean of 25 days (range 1–60).

Do you broadly agree with the College consensus statement?

Two hundred and nine respondents answered this question, 196 (94%) affirmatively.

Do you consider the 'eligibility criteria' in paragraph 10 of the statement to be applicable to your local situation?

Two hundred and three responded to this, 192 (95%) affirmatively

Do you agree that decisions about admission to and discharge from NHS beds should ultimately rest with the consultant (in consultation with others)?

Of the 234 who answered, 227 (97%) agreed. The remainder disagreed.

Comment

The 51% response rate was disappointing, though still relatively good for a postal survey. The response rate is lower than previous similar surveys but we did not have additional resources to pursue non-responders. Replies were received from all parts of the UK and there was no reason to suspect any systematic bias in response. In

particular, the fact that this series of questions was at the end of a fairly long questionnaire makes it unlikely that non-respondents were reacting to this particular section of the questionnaire since 238/242 responding to the full survey responded to at least one question in this section.

There was overwhelming support for the need for some consultant managed long-stay beds in old age psychiatry. Three-quarters of respondents supported national numerical guidelines. This may have been due to a feeling that, without such guidance, it was likely that many purchasers would make little or no provision, a concern taken into account by the Department of Health in its monitoring exercise. The number of beds favoured (1.7/1000 over 65 years) was, however, less than half the national average provision of 10 years ago and below previous national guidelines. However, it was above the existing rate of 1.1/1000 over 65 reported elsewhere in the survey. The explanation for this was probably contained in the strong majority view that NHS long-stay beds should no longer be 'for life' but that patients should be discharged if problems resolved. This probably represented an adaptive response to the reduction in NHS provision and the parallel growth in means-tested private sector care.

In the absence of national numerical bed number guidelines, about three-fifths of respondents believed that eligibility criteria should be set nationally. The vast majority supported the College draft consensus statement and the criteria contained within it (now approved, after some redrafting, as College policy) suggesting that, for older adults with severe mental illness including dementia, these criteria could be used as a basis for national standards of provision.

Nearly three-quarters were aware of local eligibility criteria. However, such criteria should have been available for all areas by spring of the year of the study and there was strong central guidance from the Department of Health that clinicians should have been involved in their formulation. This suggests that in up to a quarter of health authorities either no criteria had been set or the local clinicians had not adequately been involved in their formulation.

Very few respondents had agreed criteria about how long patients should wait in acute beds once a decision had been made in favour of long-stay placement and criteria were generally rather generous, at around a month. This method of controlling the use of acute psychiatric beds by

older adults waiting for long-term placement should be explored further, as it is capable of being audited, though it is recognised that the present financial arrangements for nursing home and residential home care militate against rapid transfer despite an apparent excess of supply in these facilities in some areas.

Finally, perhaps not surprisingly, consultants were overwhelmingly in favour of retaining decision-making power over admission to and discharge from NHS beds.

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Death certification in a psychiatric hospital

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Aims and method A retrospective review of death certificates issued at a large psychiatric hospital in North Cheshire during the 1980s and 1990s.

Results Dementia, which was the recorded clinical diagnosis in 78% of all deceased, was reported in 31% of death certificates, while other psychiatric disorders (22% of all deceased) appeared in only 2% of certificates. Autopsy appears to have very little or no value in improving the quality of death certificates in psychiatry.

Clinical implications The onus is on the clinicians to produce adequate death certificates. Recording chronic conditions present at death, such as dementia and other psychiatric disorders, in addition to those directly causing or contributing to death would improve the epidemiological value of death certificates.

Death certificates, despite their inadequacies, remain one of the most commonly used sources

of data for the estimation of the prevalence of most diseases. However, morbidity and mortality statistics that arise from death certificates are seriously flawed, mainly because of the omission of important materials (O'Sullivan, 1996). Certain diseases are grossly underestimated on the death certificates such as dementia (Burns *et al*, 1990; Macera *et al*, 1992). Possible sources of error in the use of statistics based on death certificates may arise from inadequate information provided on the certificate, errors in the pre-mortem diagnosis or non-documentation of the confirmed diagnosis on the death certificate (Macera *et al*, 1992). Deciding what should or should not be included on death certificates may be difficult and become a matter of opinion and not fact, which it purports to be. What needs to be recorded is not just the 'diseases or conditions directly leading to death', but 'with what diseases or conditions' did death occur (Ashworth, 1991). These conditions may not be directly related to