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The study

We undertook a postal survey of consultant old age psychiatrists practising in the former South-East Thames NHS Region and also collected data on rates of detention from Mental Health Act managers in the same region. Census data on admissions of patients over the age of 65 years as well as patients detained at any one time were collected.

Findings

Twenty-six (72%) replies out of 36 questionnaires sent out were received from consultants. Responses to questions are shown in Table 1. Administrator's responses were available from seven hospitals and covered a total of 410 beds available for the assessment of the elderly. Figure 1 shows the percentage of all admissions under section on a month by month basis as well as cumulative data on the number of patients remaining detained. It should be noted that these changes appear to reflect alterations in the practice of some, but not all consultants.

Discussion

Over half of the consultants felt that their practice had changed as a result of the Bournewood judgement, but only a minority felt that the judgement still affected their practice. The majority of consultants agreed with Lord Steyn that the absence of safeguards for this group was not satisfactory. The data collected via Mental Health Act administrators show that the rate of detention was slow to increase following the COA judgement and this fits with the need to plan implementation of the COA judgement and the working groups which were established to do this at local level. By the time of the Lords ruling, the rise in detentions showed no sign of plateauing and it seems likely that detentions would have risen further had the judgement not been overturned.

Following the House of Lords judgement the detention rate appears to have returned to the pattern that pertained prior to the COA judgement. This suggests that the impact of the Bournewood case is now minimal and that the predicted permanent change in psychiatric care of the mentally incapacitated (Eastman, 1998) has not occurred. Even though around half the responding consultants felt that the judgement had had an impact upon their practice, there is no evidence of a continuing impact from the Bournewood judgement on clinical practice.

Although the Mental Health Act may not provide an ideal framework for the safeguarding of the mentally incapacitated, the effective absence of safeguards must, however, remain as concerning now as it was, last year, to Lord Steyn. At the present time in the UK, legislation is being considered that will change the management of the mentally incapacitated. A proposed revision of the Mental Health Act is considering the use of capacity as the key basis for detention, and the Government's proposals on mental incapacity have suggested the establishment of formal proxies for decision-making (Lord Chancellors Department, 1997).

Over two-thirds of responding consultants agree that the lack of safeguards is a problem. There is a risk, however, that if new processes were cumbersome, they might effectively obstruct the delivery of health care to the incapacitated. In our view the challenge now is to establish those safeguards in a way that is both effective as well as an efficient use of resources.

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Pressure on adult acute psychiatric beds

Results of a national questionnaire survey

AIMS AND METHOD

To quantify perceived problems with psychiatric bed availability nationally using a questionnaire survey of all 210 UK mental health trusts.

RESULTS

One hundred and seventy-three (82%) trusts replied. Thirty (17%) are often over-occupied, 21 (15%) often have problems with bed availability. Ten (7%) often use extra-contractual referrals (ECRs). Frequent over-occupancy is associated with deprivation. Frequent use of ECRs is associated with relatively few beds.

CLINICAL IMPLICATIONS

Problems with bed availability are found nationwide, but outside southern England are relatively infrequent. Such problems are less pronounced than in Greater London.

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Numerous reports have highlighted the pressures on acute adult psychiatric beds, both in London (Powell *et al*, 1995; Johnson *et al*, 1997) and nationally (Shepherd *et al*, 1997). These have demonstrated associations between occupancy, deprivation and number of beds. In contrast, there has been no comprehensive national survey to determine the frequency and geographical spread, rather than the severity and causes, of such problems outside London.

Methods and analysis

Between November 1996 and May 1997, the chief executive of every NHS trust providing in-patient adult psychiatric services in the UK was sent an open-ended questionnaire requesting information on:

(a) the size of their catchment area population;
(b) the number of acute adult psychiatric beds (excluding specialist beds, for example those for eating disorders, puerperal disorders and intensive care);
(c) the frequency of problems with bed availability and over-occupancy;
(d) how often the trust used extra-contractual referrals (ECRs).

Trusts within Greater London were excluded. Non-responders were followed up with two repeat mailings and telephone calls.

Responses were assessed and graded into three groups (rarely, sometimes and often) independently by D. H. and R. S. (see table footnote). The responses were rated as follows: rarely includes never, rarely, and very rarely; sometimes includes occasionally and sometimes; often includes often, frequently and continuously.

Trusts were grouped by country, region and health authority within which they were located, by Office for National Statistics area classification and by level of deprivation (Jarman UPA–8 score <1, 1–25, >25) for the host health authority, and by the number of beds per thousand population (<0.22, 0.22–0.42, >0.42). χ^2-tests of significance were calculated to assess differences between groups of trusts and are presented as odds ratios with 95% confidence intervals.

Findings

One hundred and seventy-three (82%) of the 210 acute adult mental health trusts outside Greater London replied (64% Northern Ireland, 80% Scotland, 81% Wales, 84% England). Fifty-three (31%) trusts were rarely or never over-occupied, while 30 (17%) often had such problems. The findings for bed availability are similar. Eleven trusts frequently use ECRs, all except one were in England (see Table 1).

No Scottish trust reported using ECRs, and problems were relatively infrequent in Wales and Northern Ireland. Over-occupancy occurs more often in English trusts (19% *v.* 11%) as does the use of ECRs (43% *v.* 23%) but the differences are only significant for Scottish trusts.

Trusts which often use ECRs were significantly more likely to have fewer than 0.22 beds per thousand population than others (odds ratio 5.8; 95% CI 1.3–35.0). Those in England are significantly more likely to be

Table 1. Results of survey

	Country/Region	Frequency of problem			Total	OR (95% CI)[1]
		Never, rarely	Sometimes	Often		
Beds over-occupied	England	38 (27.6%)	74 (53.6%)	26 (18.8%)	138 (100%)	1.0
	Wales	4 (44.4%)	4 (44.4%)	1 (11.1%)	9 (100%)	0.48 (0.12–1.86)
	Scotland	10 (58.8%)	5 (29.4%)	2 (11.7%)	17 (100%)	0.27 (0.09–0.75)*
	Northern Ireland	1 (11.1%)	7 (77.7%)	1 (11.1%)	9 (100%)	3.04 (0.37–25.13)
	Total	53 (30.6%)	90 (52%)	30 (17.4%)	173 (100%)	–
Beds not available	England	41 (29.8%)	76 (55%)	21 (15.2%)	138 (100%)	1.0
	Wales	4 (44.4%)	4 (44.4%)	1 (11.1%)	9 (100%)	0.53 (0.14–2.07)
	Scotland	10 (58.8%)	5 (29.4%)	2 (11.7%)	17 (100%)	0.30 (0.1–0.83)*
	Northern Ireland	1 (11.1%)	7 (77.7%)	1 (11.1%)	9 (100%)	3.38 (0.41–27.9)
	Total	56 (32.3%)	92 (53.2%)	25 (14.5%)	173 (100%)	–
Extra-contractual referrals	England	79 (57.2%)	49 (35.5%)	10 (7.2%)	138 (100%)	1.0
	Wales	5 (55.6%)	4 (44.4%)	0	9 (100%)	1.07 (0.28–4.16)
	Scotland	17 (100%)	0	0	17 (100%)	0.0
	Northern Ireland	5 (55.5%)	3 (33.3%)	1 (11.1%)	9 (100%)	1.07 (0.28–4.16)
	Total	106 (61.3%)	56 (32.4%)	11 (6.3%)	173 (100%)	–
Extra-contractual referrals used: English regions	Southern four[2]	27 (44.3%)	26 (42.6%)	8 (13.1%)	61 (100%)	1.0
	Northern four[2]	52 (67.5%)	23 (29.9%)	2 (2.6%)	77 (100%)	0.4 (0.2–0.8)*
	England total	79 (57.2%)	49 (35.5%)	10 (7.2%)	138 (100%)	–

1. Odds ratio for trusts reporting problems ever (sometimes plus often) (*v.* never/rarely).

2. Southern four regions: Anglia & Oxford, North Thames, South Thames, South & West. Northern four regions: Northern & Yorkshire, North-Western, Trent and West Midlands.

* $P<0.05$. Rarely includes never, rarely and very rarely; Sometimes includes occasionally and sometimes; Often includes often, frequently and continuously.

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located in one of the four southern regions (ever use ECRs: odds ratio 2.62; 95% CI 1.24–5.57; often use ECRs: odds ratio 5.66; 1.06–56.14). There is no similar association for bed availability or over-occupancy.

Trusts reporting frequent problems with over-occupancy were significantly more likely to be situated in health authorities with Jarman scores above 25 (odds ratio 8.1; 1.7–41.8). There is no relationship between ECR use and deprivation, nor between any of the measures and area classification.

Five of the seven trusts reporting both frequent use of ECRs and frequent problems with bed availability were in one of the four most southerly English regions and none were outside England.

There is a significant correlation between bed density and the deprivation score (r=0.337, P=0.001).

Discussion

This survey was undertaken to quantify problems with bed availability nationally and to compare those previously reported for London. Hirsch *et al* (1998) have defined ideal bed occupancy as 85%, allowing a margin for the unexpected. However, Lelliott *et al* (further details available from author upon request) reported levels up to 130%; so this study started from the premise that, in practice, bed occupancy up to 100% did not constitute over-occupancy.

The methods used differ from previous studies in particular by using open-ended questions. However, despite the possibility of response bias (which could be expected to exaggerate the extent of problems) this simple approach was adopted to obtain a rapid overview of the situation and is justified by the high response rate.

We did not observe associations between bed occupancy or use of ECRs and the type of area served by the trust. This may be because the Office for National Statistics classifications used relate to the host health authority, which is not necessarily the same as the catchment area served by the trust. However, as reported previously (Jarman *et al*, 1992; Powell *et al*, 1995; Shepherd *et al*, 1997), we noted relationships with deprivation and bed density. We therefore believe the findings are valid.

English trusts (particularly in southern regions) experience greater pressure on beds and consequently use ECRs more often than elsewhere. However, compared with reported mean four-year bed occupancy figures for London trusts of 98% (Powell *et al*, 1995), and subsequent increases (Hollander *et al*, 1996), problems appear considerably less severe nationally than in the capital.

Nonetheless, we did observe frequent problems with bed availability in individual cities and trusts, suggesting the need for more detailed study using, for example, bed census models. In addition, certain rural areas face surprisingly frequent pressures on beds. The question raised is whether the development of community-based crisis teams, day hospital places and assertive outreach teams, as proposed by the government, will reduce these pressures. Certainly, these preliminary findings would not support further bed reductions in the absence of a greatly improved community infrastructure.

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