Of 91 patients, 66 (73%) sat opposite the psychiatrist and 25 (27%) to the side. There was no statistical difference between first and other attenders. Thus the majority of patients sat opposite the psychiatrist across a desk. Although the study measured seating behaviour rather than patient preference, individual patients later suggested they preferred to have a desk between them and the doctor as this made them feel more comfortable.

In view of these findings we question the "received wisdom" that patients should not be interviewed across a desk.

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References

MARTIN, P. *et al* (1985) *Towards Better Practice*. Churchill Livingstone. Pp 189–190.

MYERSCOUGH, P. R. (1989) *Talking with Patients. A Basic Clinical Skill*. Oxford University Press. Pp 14–15.

Advocacy services

DEAR SIRS

The introduction of an advocacy service in our local long-stay hospital is causing what can at best be described as teething problems. At worst it is taking psychiatric rehabilitation back half a century.

We had naively assumed that the advocacy service would confine themselves to representing the patients' views about alternative placements to hospital. However, it seems that advocates see their role as much wider. After meeting with the advocate our patients are refusing to cooperate with even the most basic of daily living activities. They now spend their days lying on their beds or sitting in easy chairs saying they do not have to do anything "because the advocacy person told them they didn't". We are having to stand by helpless while these patients lose their hard-won basic daily living skills and choose instead to pursue the non-deliberate self-harm which being in hospital is intended to prevent. Everything learnt from the decades of post-war research on institutionalisation seems wasted.

The greatest concern arises with the small minority of patients who are detained long-term under a renewed Section 3 of the Mental Health Act, 1983. As Responsible Medical Officer, I feel I have a burden of responsibility to ensure these patients receive the treatment necessary for their health. My treatment is vetted regularly by the Mental Health Act Commission and by Mental Health Review Tribunals. Yet a lay person with neither training nor vetting has equal and opposite power to sabotage my recommended treatment. Further, this person has no responsibility for the outcome.

I wonder if others are having similar experiences and whether they have any helpful suggestions?

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Length of stay: a more meaningful approach?

DEAR SIRS

A problem of current bed usage statistics is that large psychiatric hospitals provide a number of distinct types of service: admission, respite, rehabilitation and long-stay. Each of these occupies beds for different lengths of time. Glover *et al* (1990) showed that analysis of percentiles of length of stay after admission can be used to separate out the acute component of care. However, the method remains retrospective. We report here the results obtained using a new method to analyse the in-patient population of a large psychiatric hospital. The method was developed to model the patient flow in the St George's Department of Geriatric Medicine in conjunction with academic mathematicians. It produces a mathematical model of the current in-patient population and hence provides up to the minute information which relates to the current bedstate and can be used to make predictions about the future.

The duration of stay since admission is analysed using the BOMPS (Bed Occupancy Management and Planning System) software package. The date of admission, date of birth and ward of residence of all in-patients is obtained from a midnight bed return provided in ASCII code by the Patient Administration Office. The software determines the best fit, demonstrates the relation between curve and data and calculates the overall length of stay and the two compartmental statistics. The results can then be produced graphically and numerically.

Analysis of the pattern of bed occupancy in one psychiatric hospital indicates that the method can be used to separate out distinct components of a hospital's work, i.e. to produce statistics relating to the average length of stay of two groups of patients, a short-stay and a long-stay group. Analysis of 469 in-patients in Goodmayes Hospital showed two groups of patients, one representing the adult unit, the other the elderly unit. The acute adult unit had 67

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