especially important in areas (such as surgery or prevention of suicide) in which randomised studies may be difficult or ethically unjustifiable. Because it limits itself to randomised studies the collaboration cannot promise answers to the most pressing clinical and policy questions but only to those accessible through randomised trials. Nor can it claim to have reviewed all of the evidence.

A second criticism of the collaboration is its lack of external peer review. In its defence supporters argue that conventional peer review is slow and flawed and that the reviews will undergo constant peer review through the comments of users, which can be incorporated in subsequent updates. But this does not obviate the need shared by all enterprises to have their processes and products exposed to detailed external scrutiny.

A final criticism is that too little emphasis has so far been placed on actively disseminating the results of reviews. A recent survey showed that few obstetricians in England were aware of the Cochrane database on effective interventions in pregnancy and childbirth and that fewer still were using it.[3] Researchers in the collaboration recognise that it is not enough just to give people the information, but they plead that their first priority must be to obtain and review the data. One of the review groups will examine strategies for effective implementation.

From last week's meeting it is clear that there is no lack of enthusiasts willing to volunteer for the unglamorous but essential task of searching journals (though the collaboration is keen to recruit more) or for the career long commitment of preparing and updating reviews. Even so the collaboration estimates that it will take a decade to systematically review a substantial part of the literature. What is lacking outside Britain is funding. In providing £0·5m a year the NHS acknowledges the importance of the collaboration's work as one means of achieving more effective health care. The European Union and other governments have contributed an additional £0·5m. This includes $0·5m from the National Institutes of Health for the Baltimore Cochrane Centre, where international efforts to create a registry of trials are concentrated. This money, welcome though it is, compares poorly with the $155m annual funding for the Agency for Health Care Policy and Research in Washington, which produces clinical practice guidelines at an average cost of $1m each.

Funding this important initiative is a challenge to which national governments must rise. To convince them of this the Cochrane Collaboration must meet challenges of its own. It must continue to explain its aims and limitations so as to avoid unrealistic expectations. It must insist on structured external scrutiny of its methods and results. And it must ensure that the same commitment and energy go into disseminating the results of its analyses as go into the collection and review of data.

FIONA GODLEE
Harkness fellow

Harvard Medical School,
Boston, MA 02215,
United States

1 Streptomycin treatment of pulmonary tuberculosis: a Medical Research Council investigation. *BMJ* 1948;ii:769-82.
2 Dickersin K, Min Y-I, Meinhart CL. Factors influencing publication of research results: follow up of applications submitted to two institutional review boards. *JAMA* 1992;267:374- 8.
3 Paterson-Brown S, Wyatt JC, Fisk NM. Are clinicians interested in up to date reviews of effective care? *BMJ* 1993;307:1464.

How many psychiatric beds?

The debate shouldn't be swayed by moral and political considerations

Forty years ago Houston wrote: "By incarceration we were aggravating the natural process of the disease. At last a new era is dawning and the doors of despair are being unlocked."[1] Since 1954 the number of psychiatric beds in Britain has fallen by almost two thirds to 50 278.[2] The key issue about this trend is, how far is far enough? Do we now need more or fewer psychiatric beds? To debate this thoroughly the emphasis should be on the whole mental health service system rather than on numbers of beds alone. Four issues need to be directly addressed: the mental health services required in each local area, the needs for secure provision and the links between forensic and community services, integrated methods of efficient management of psychiatric beds, and interagency working arrangements.

Not only beds are needed. As the Health of the Nation's key area handbook on mental illness indicates, a consensus now exists about the range and scale of services required in each local area.[3-5] The inquiry by the House of Commons Health Select Committee into services for seriously mentally ill people recently advised that local psychiatric facilities should include "24 hour staffed community houses, day staffed residential care, day centres and day hospital places, and the provision of community-based multi-disciplinary teams."[6] These teams can offer crisis intervention, home treatment, rehabilitation, continuity of care, and close liaison with primary care. The research evidence is clear: where these services exist and function well they reduce the use of acute inpatient beds by between 20% and 40%.[7 8]

Doctors working in the community are obliged to provide care to anyone living in their catchment area, regardless of whether they have the necessary resources to operate safely, let alone effectively. While minimum safe staffing levels operate for inpatient units, the same has not been achieved for community services. Evidence exists that to provide care to people who are most severely disabled by psychosis, who live with chaotic lifestyles, and who reject the current care systems, one key worker per 10-15 patients is required. With time, the establishment of trust, and a treatment regimen that is agreed and adhered to, the ratio can extend to one key worker per 40 cases.[9] Yet surveys of key workers around the country show that many community nurses carry caseloads of 50-70 patients.

The Clunis report highlighted the inadequacy of medium secure places for mentally disordered offenders and others who present a risk to the public; over 400 more places are planned.[10-12] At the same time, little evidence from research or examples of good clinical practice exists about how best to link forensic with general adult services —for example, through use of forensic community outreach teams, court diversion schemes, bail hostels, or medium stay hostels staffed 24 hours a day. Indeed, in many areas an "inverse pyramid" exists, with more high than medium secure beds available, so that graduated rehabilitation for such difficult patients is impossible. The

increasing practice of placing patients on remand or from court diversion schemes in general adult or medium secure units further intensifies demand for these beds. There is therefore no scientific basis to judge at this stage whether secure hospital beds or staffed community places should receive priority for investment to reduce rates of relapse, readmission, and reoffending.[11]

Hospital inpatient beds are the most expensive component of any mental health service, accounting for nearly three quarters of total costs.[13] Efficient management of beds is central to the debate on how many psychiatric beds need to be commissioned. Evidence is accumulating of inefficiency—with huge variations in spending on local mental health services (up to 40-fold differences in the costs of inpatient days[6]), which are not related to local service needs, along with unacceptably high rates of bed occupancy in some metropolitan areas.[14] Managing beds sparingly depends on the following factors: home assessment when possible, senior clinical gatekeepers for admissions, clear statements of the purpose of each admission, frequent inpatient review meetings with the authority to discharge patients, immediate transfer to housing services when the patient is homeless, and mental health teams with control over admission to and discharge from their own beds.[15,16] The prevention of further admissions, when this is clinically appropriate, is best effected by a policy of prioritising the most seriously mentally ill patients. Such patients will usually include those who have had multiple admissions in the past, those who have often been detained under the Mental Health Act, and those who have failed to adhere to treatment.

The debate on numbers of hospital beds should now be widened to included the contributions of agencies other than health providers, such as social services, housing, and voluntary agencies, which substantially reduce the need for inpatient care. In particular, long term NHS psychiatric beds are rapidly being replaced by places in smaller, voluntary or for profit residential care and nursing homes, which may be poorly regulated and not have 24 hour staffing.[2] In this mixed economy, effective collaboration among agencies assumes a new importance, both for service provision and for commissioning. Without such collaboration shortages and duplication of services are likely.

Without more information along the lines suggested above, the debate about how many psychiatric beds are needed will be guided more by moral and political than by clinical or research considerations. We shall lose sight of the fact that, when patients are asked for their views, they universally prefer community based services—where these are good.[16]

GRAHAM THORNICROFT
Senior lecturer

Psychiatric Research in Service Measurement,
Institute of Psychiatry,
London SE5 8AF

GERALDINE STRATHDEE
Consultant community psychiatrist

Maudsley Hospital
London SE5 8AZ

1 Houston F. A project for a mental-health village settlement. *Lancet* 1955;? vol:1133-4.
2 Davidge M, Elias S, Jayes B, Yates J. *Survey of English mental illness hospitals March 1993. Inter-authority consultancy and comparisons.* Birmingham: University of Birmingham, 1993.
3 Department of Health. *The health of the nation. Key area handbook. Mental illness.* London: DoH, 1993.
4 Strathdee G, Thornicroft G. Community sectors of needs-led mental health services. In: Thornicroft G, Brewin C, Wing J, eds. *Measuring mental health needs.* London: Gaskell, 1992:140-62.
5 Wing J. *Epidemiologically based needs assessment: mental illness.* London: NHS Management Executive, 1992.
6 House of Commons Health Select Committee. *Better off in the community? The care of people who are seriously mentally ill.* London: HMSO, 1994.
7 Tyrer P, Turner R, Johnson A. Integrated hospital and community psychiatric services and use of inpatient beds. *BMJ* 1989;**299**:298-300.
8 Tansella M. Community-based psychiatry: long-term pattern of care in South-Verona. *Psychol Med* 1991 (suppl 19):1-51.
9 Stein LI, Test MA. Alternative to mental hospital treatment. *Arch Gen Psychiatry* 1980;**37**:392-7.
10 North East Thames and South East Thames Regional Health Authorities. *Report into the inquiry into the care and treatment of Christopher Clunis.* London: HMSO, 1994.
11 Coid J. Failure of community care: psychiatry's dilemma. *BMJ* 1994;**308**:805-6.
12 Reed J. *Review of health and social services for mentally disordered offenders and other requiring similar services. Final summary report.* London: HMSO, 1992. (Cm 2088.)
13 Mental Health Foundation. *Mental illness: the fundamental facts.* London: MHF, 1993.
14 Department of Health, Mental Health Task Force. *Mental health in London. Priorities for action.* London: DoH, 1994.
15 Strathdee G, Thornicroft G, Watts A, Snailum A. *Factors influencing psychiatric bed management.* London: Psychiatric Research in Service Management, 1994.
16 Muijen M, Marks IM, Connolly J, Audini B. Home based care and standard hospital treatment for patients with severe mental illness: a randomised trial. *Br J Psychiatry* 1992;**160**:379-84.

The limits to health promotion

They lie in individuals' readiness to change

Everybody knows that prevention is better than cure, but the opposite, equally attractive, principle of paying tomorrow for what you can have today is an efficient way to use your resources: health economists call it "discounting."[1] Discounting is efficient because resources usually devalue over time, and numerous unexpected events are likely to overtake the person who delays gratification. To "eat, drink, and be merry for tomorrow we die" is a discounting approach to life. This is a challenge to the health promotion movement, particularly in relation to those in their teens and 20s, for whom tomorrow is a long way off. Health promotion has, of course, been achieved through traditional public health measures—for example, clean water and air and manipulation of the population[2,3]—but success in local communities and with individuals is more controversial when people's choices are an important factor. Indeed, the limits to health promotion lie in the paradox that "a measure which brings large benefits to the community offers little to the participating individual."[2]

Health is not a unidimensional concept, and many research workers have found that personal concepts of health vary according to context.[4-7] Energised, health seeking people or families[8] remain a minority in our society because most people regard health as a free asset to be used or enjoyed.[5-9] Health can certainly be viewed as a resource that will devalue through aging and accidents. Most people struggle to modify their homes, work, diet, or habits in the interests of greater security, comfort, social desirability, or health and safety, but any health gains achieved are often difficult to sustain against social circumstances.[10,11]

Twelve field projects, mainly from the less developed parts of the world, show how providing practical opportunities for healthy choices in a non-coercive way can be important. The Peckham Pioneer Health Centre in south London in the 1930s was a cross between a health centre, modern leisure centre, and city farm.[12] The Valley Trust sociomedical experiment in rural South Africa was launched in 1950 to promote healthy eating, gardens providing produce, environmental awareness, local sports facilities, outlets for home craft, clean water, and fish cul-