and they breed defensive practices in responses to
too much (adverse) publicity.

Looking at the language he uses to express
crises, however, one detects an under-
ly anxiety about the place of the bereaved 'secondary' victim in this process and, perhaps, a
reluctance to acknowledge their right to express
their anger and pain in public. Hence Jayne Zito,
a campaigner and professional in her own right,
as well as a victim, is described as ‘distracted’;
Muljen’s proposed new system for inquiries
would inevitably lead, he says, to “various
parties screaming ‘Cover-up’”, and too many
people describing themselves as experts are not
only “quite prepared to rub salt into the wound in
return for a media slot” but seem also to be
responsible, somehow, for the current “spiral of
irrational, hysterical and sometimes terrifying.
The second is that given the state of the Law of Negligence, it seems as if these
secondary victims are not currently owed a duty of
homicide. Although he does not explicitly
address the legal issue, Dr Grounds’ powerful
response to Dr Muljen (Psychiatric Bulletin, 21,
March 1997, 134–135), makes it clear that
independent inquiries are the essential, indeed
the only, forms of redress and understanding
available to bereaved families. To bureaucratise
the process in the way proposed would, I suggest,
add further insult to injury.

MICHAEL HOWLETT, Director, The Zito Trust

London bed fever

Sir: A recent survey of London’s acute mental
health service revealed a bed occupancy of 113%
for Greater London (Hollander et al, 1996). At the
same time in Brent (which is an inner-urban
London borough of 240,000 people with a Jar-
pin rate of 28, served by 94 acute
admission beds (105% occupancy)) the local
Health Commissioning Agency were supporting
around 30 extra contractual referral (ECR) beds
at a minimum cost of approximately £100,000
per month. The authors were concerned that
such high occupancy figures might be disguising
a problem of high ECR usage that was not
peculiar to Brent. With this in mind we
attempted to ascertain acute ECR usage across
the capital.

To start with we identified local ECR usage and
expenditure. Unfortunately, our figures did not
tally with our local purchaser’s receipts, though
there was a rough approximation. We then
attempted the same exercise on a broader scale.

It transpired that other trusts within Greater
London either did not know how many ECRs they
had or had no idea what they were costing. It is of
course possible that commercial interests resulting
from internal market forces prevented them
from sharing this information.

We then attempted to ascertain the problem
from the purchasers’ perspective. Initially we
approached the Health Authorities directly. They
did not know what they were spending on ECRs
(or would not tell us). Our own Health Authority
tried to assist by approaching the other purchas-
ing agencies on our behalf. They still could not
tell us. Lastly, we asked North Thames Regional
Office: we were informed that such information is
no longer monitored by the NHS Executive.

Taking Britain’s conurbations as a whole, it is
likely that there is a flow of tens of millions of
pounds each year from deprived urban areas to
suburban and rural areas and to the private
sector. This uncontrollable switch of resources
compromises the community care approach of
acute mental health services and brings into
question the policy of planning for geographical
equality in mental health care.

This unplanned disinvestment in local services
has profound consequences. Commissioning
agencies have to cut budgets beyond those for
merely mental health services. Such short term
exigencies result in forgone opportunities:
the loss of resources and the diversion of managerial
attention lead to delays in service improvements.
Further hidden costs include those of transfer-
ing patients and monitoring their contracts, the
problems of poorly planned follow-up and the
likelihood of readmission rates.

Clinicians are being asked to share clinical
information about their patients across geogra-
phical boundaries and between various agencies.
There are good grounds for this, such as
comprehensive planning of patient care and
integrated and efficient working practices. In
contrast it seems that the notion of planning
service needs at the population level is of little
interest to those who commission services.

occupancy in psychiatric units in Greater London is
113%. British Medical Journal, 313, 166.

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London bed fever
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