psychogeriatric assessment units, we find that in Cornwall (1) 9 per cent of discharges were to a psychiatric hospital and 33·5 per cent to geriatric and general wards (*total to 'hospital' 42·5 per cent*) and in Nottingham (2) 7·5 per cent of discharges went to a psychiatric hospital and 21·5 per cent to other wards (total to 'hospital' 29 per cent). In the former unit the agreed policy was to admit a higher percentage of patients with dementia than in the latter, thus explaining the discharge differences between the units. The Gloucestershire discharge figures, which are so much at variance with others published, also suggest a high degree of admission selectivity, which in our view make the conclusions misleading. The total picture of admission policies and description of the relevant services in Gloucestershire are unfortunately not included in this paper, and we question most seriously the suggestion that the number of beds for severely demented patients recommended by the DHSS may be excessive. At least we do not believe that evidence to support this conclusion has been presented. We hope that the DHSS planners will also consider the paper by Drs Early and Nicholas in the same journal which comes to very different conclusions and makes recommendations which we would (strongly) support.

E. V. B. Morton
T. S. Wilson
I. E. I. Williams
J. F. Donovan

Cornwall Geriatric Unit,
Barncoose Hospital,
Redruth

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Dear Sir,

Drs Baker and Byrne offer us 'Another Style of Psychogeriatric Service'.

They present the account of a mere six months, presumably not long after the service had been established, and yet claim to have demonstrated the permissibility of far-reaching generalized conclusions.

Psychogeriatric services are intimately linked with and dependent on the success and level of provision of geriatric services and Local Authority residential care. Perhaps Drs Baker and Byrne ought also to pay tribute to the humble and unacknowledged geriatric physicians, matrons and care attendants of Gloucestershire when they claim such success in the care of elderly people with organic psychiatric disorder.

The burden of proof is on Dr Baker to refute Professor Adams' statement: 'The geriatric physician with a high turnover and no long-stay problem is (equally) suspect as a gerontological spiv. Somebody, somehwere, must carry the can for him' (Adams, 1974).

Many a new service, run with enthusiasm and hard work, makes a startling impact and is reported on before the chickens come home to roost. We should view Dr Baker's activities with interest but await a more extensive and comprehensive report and react with caution and perhaps alarm to the dangerous and unsubstantiated claims made in this paper. Claims such as these may hinder the provision of resources in under-endowed areas of the country, especially in these times of financial stringency.

Let us hope that the elderly, their hard-pressed families and all of us who are concerned with the care of the elderly are not made to suffer on the basis of Drs Baker's and Byrne's inadequate analysis.

Klaus Bergmann

Newcastle General Hospital,
Westgate Road,
Newcastle upon Tyne NE4 6BE

Reference

Adams, G. F. (1974) Eld Health. *British Medical Journal, iii*, 789–91.

Dear Sir,

As the three Consultant Physicians in Geriatric Medicine working in the same clinical area as Drs A. A. Baker and R. J. F. Byrne, we would like to comment on 'Another Style of Psychogeriatric Service'.

We have personal experience of the benefit that has been derived from improved community services and increased day hospital provision, but we are seriously concerned with other aspects of the policy. We note in particular the statement that it is felt the 'number of beds for this type of patient recommended by DHSS may be excessive', and that a further bed reduction seems likely as only 5 per cent of admissions appear to become long-stay. This figure is in considerable contrast to that found by other workers (1, 2) and we feel our experience may help to explain the difference.

We have found that since the introduction of this service an increasing number of mentally-disabled