Correspondence

Consultant psychiatrists' caseload

Sir: The analysis of the consultant psychiatrist's caseload by Fagin *et al* (*Psychiatric Bulletin*, September 1995, **19**, 532–535) is commendable and relevant to advances in the costing of care and future purchasing plans.

The article nevertheless included several common misconceptions concerning standard NHS consultant contracts which I wish to draw attention to.

While consultants have a professional contract which requires their continuing responsibility for the care of their patients, the available guidance defines this commitment as ten and not eleven sessions (3.5 hours each, adding up to 35 hours a week). There is no difference in the sessional commitments of whole-time and maximum part-time consultants, though the latter group is paid 1/11th less in return for unrestricted private earnings.

Consultants can and should include their travelling time between various locations of work in their calculation of their sessional commitments. Maximum part-time consultants should also be able to include an allowance for their home-base travel.

Consultant on-call duties are not additional to their sessional commitment but constitute part of it.

And finally, consultants with standard contracts may not be able to include their court or forensic work in the calculation of their NHS duties, especially when this work attracts a separate fee.

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Improper terminology

Sir: I was saddened to see the term 'dements' used as a title of a letter in your journal (*Psychiatric Bulletin*, November 1995, **19**, 704–705). This is certainly a dehumanising derogatory term. I doubt terms such as 'schizos' or 'psychos' would be acceptable for printing, so why 'dements'? We as a profession are striving to remove the stigmatisation of those with mental health problems, to see the whole person not just the illness. Such language in such a journal hampers our efforts. I hope it was an oversight.

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It was.
THE EDITOR

Mental Health Task Force Support Group

Sir: Drs Reid and Turner are obviously very adept at reading between the lines. Their interpretation of the work that John Wattis and I reported (*Psychiatric Bulletin*, April 1995, **19**, 250–251) is substantially correct. Both John Wattis and I had precisely the impression which Reid and Turner obtained from our report of the work which we had to carry out on behalf of the College in order to allow Council to remain informed of the work of the Mental Health Task Force. I shall be as interested as they will be if anyone can identify any "tangible benefits of the Mental Health Task Force".

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Social deprivation, ethnicity and violent incidents on acute psychiatric wards

Sir: We were interested to read the paper by Sheehan *et al* (*Psychiatric Bulletin*, October 1995, **19**, 597–599). We investigated a slightly different but similar relationship between the level of violence on acute psychiatric wards in two health districts, Nottingham and Lincoln, and were able to establish a relationship between the levels of violence in both districts with that of the general population (Walker & Caplan, 1993). A significant area of difference was that we found a higher incidence of violence in detained patients whereas the majority of Sheehan *et al*'s perpetrators were informal. However, given the broadly similar message which can be drawn from both papers it should be possible to estimate the expected level of

violence in acute psychiatric wards locally by combining Jarman scores and data from annually published figures in the Criminal Statistics of England and Wales. Annual average per cent bed occupancy and nursing staff levels might also have predictive value and an index of these four factors might inform the local need for provision of intensive care or high dependency psychiatric units.

WALKER, W. D. & CAPLAN, R. P. (1993) Assaultative behaviour in acute psychiatric wards and its relationship to violence in the community: a comparison of two health districts. *Medicine, Science and the Law*, **33**, 300–304.

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Home versus out-patient psychiatric assessment

Sir: In South Manchester 50% of all newly referred patients to the Department of Psychiatry fail to keep their out-patient appointments. This is wasteful of medical time, permits mental illness to go untreated, and deprives medical students of valuable experience.

In the second and fourth quarters of 1992 new patients were therefore seen in their homes. In the first and third quarters of 1992 they were assessed in the out-patient clinic. Three new patients were appointed per clinic. In home-based assessments, the consultant took the medical student to the patient's home and introduced the student to the patient. The consultant then went to see another patient and returned an hour later.

Forty-six out of 59 (78%) appointments at patients' homes and 30 out of 55 (55%) appointments at psychiatric out-patient clinics were kept, a significant difference (χ^2=6.01, P=0.014). Home visiting often revealed diverse life circumstances and enabled a friend or relative to act as an additional informant. This aided the assessment of premorbid personality and functioning as well as their social, family and supportive relationships which has special relevance with respect to the care programme approach.

Over 12 months, 14 medical students participated in home-based, and 13 in hospital-based psychiatric assessments. Home visiting did require the use of the consultant's car and driving between six and eight miles an afternoon, which incurred on average an additional 30 minutes per clinic.

In an urban area, therefore, home visiting can lead to more new patients being assessed, and greater efficiency. The rate of availability for assessment was not as high as that found by some community based mental health teams (Burns *et al*, 1993; Jackson *et al*, 1993). However, most patients preferred their initial assessment to be at home and medical students found such assessments more interesting. It is possible to teach medical students psychological medicine in domestic settings as well as exposing them to the concept of caring for people in the community.

BURNS, T., BEADSMOORE, A., BHAT, A. V., *et al* (1993) A controlled trial of home-based acute psychiatric services: I. Clinical and social outcome. *British Journal of Psychiatry*, **163**, 49–54.

JACKSON, G., GATER, R., GOLDBERG, D., *et al* (1993) A new community mental health team based in primary care. A description of the service and its effect on service use in the first year. *British Journal of Psychiatry*, **162**, 375–384.

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How caring is community care

Sir: With the current ethos of 'community care', more of our patients are being seen outside of the hospital and out-patient clinic. In old age psychiatry this can give a deeper understanding of the interaction between a patient with dementia and their environment. It allows us to assess the safety and cleanliness of the home, as well as the patient's orientation and function within it. It also fits the 'politically correct drive' that sometimes occurs with community care.

In Swindon we are fortunate to have a compact catchment area, most of our caseload are within 15 minutes drive from the base hospital. As a consequence 80% of my patients (new cases and follow-up) are seen in their residence.

However, in the last month, three families, on asking have stated their preference for hospital consultations. In two cases it was a break from the daily routine, and in the other the carer felt it would ensure the patient got out of bed early.

I sometimes wonder if our drive for community orientated care runs contrary to the patient's desire. Hence to use the jargon, I have developed a more 'service-user led model of care delivery'.

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Mad poets?

Sir: I feel moved to comment on Hugh Freeman's review of Alex Mezey's book *Muse in Torment* (*Psychiatric Bulletin*, September 1995, **19**, 588–589). In particular, the concluding comment on

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