from the study team, with particular attention being paid to addressing vulnerability factors determining relapse and presentations which were likely to lead to hospital readmission. This provisional finding implies that for this particular subgroup, targeted intensive case management which achieves improved costs and clinical outcomes might indeed benefit from or require small case-loads of around 1:10. This adds to the conclusion of Burns *et al* (2007) that as well as care structures such as case-load size, and the type and quality of care, it is also the targeted patient population that determines the impact of intensive case management.

Burns, T., Yiend, J., Doll, H., *et al* (2007) Using activity data to explore the influence of case-load size on care patterns. *British Journal of Psychiatry*, **190**, 217–222.

Harrison-Read, P., Lucas, B., Tyrer, P., *et al* (2002) Heavy users of acute psychiatric beds: randomized controlled trial of enhanced community management in an outer London borough. *Psychological Medicine*, **32**, 403–416.

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Authors' reply: Harrison-Read's observation of the impact of intensive case management on hospitalisation in highly selected heavy service users confirms a clinical observation with which we would generally agree. The UK700 trial (Burns *et al*, 1999) generated considerable controversy and consequently we were reluctant to perform *post hoc* analyses. Subsequent work has generally confirmed and, to some extent, explained the UK 700 findings (Burns *et al*, 2002). It is quite possible that a low case-load size has particular advantages for some groups with severe mental illness, and the UK700 study did find such benefit for those with mild or moderate intellectual disability (Hassiotis *et al*, 2001); groups with very heavy service use may contain more of such service users.

We did not, however, conclude in our current paper (Burns *et al*, 2007) that '. . . there is no overall clinical advantage associated with any particular case-load size within the approximate range 1:10 to 1:20' as Harrison-Read states. Our conclusions are more limited, namely that there is a change in practice across this range but we make no claims about its impact on outcome. Indeed, we make it clear that we cannot draw such conclusions because of the way in which our two proxy measures were constructed. If anything, our findings confirm the likely importance of case-load size by demonstrating that different levels are associated with change in practice. The importance of our findings are that they challenge a strongly held belief that there is a predetermined case-load level at which intensive case management 'switches' to assertive community treatment. This view was frequently advanced to discount the UK700 trial's results, claiming that the intensive case management case-load (1:15) was above this critical threshold.

We agree wholeheartedly with Harrison-Read that clarity and precision about case-load size, content of care and effective targeting of the patient population are all necessary for both good clinical care and for meaningful research. We hope that researchers will move on from trying to explain away differences in outcome studies to exploring differences to obtain a better understanding of which components are effective. Our original conclusion that 'how extra resource is used is more important than how it is organised' (Burns *et al*, 1999) remains valid.

Burns, T., Creed, F., Fahy, T., *et al* (1999) Intensive versus standard case management for severe psychotic illness: a randomised trial. *Lancet*, **353**, 2185–2189.

Burns, T., Catty, J., Watt, H., *et al* (2002) International differences in home treatment for mental health problems. Results of a systematic review. *British Journal of Psychiatry*, **181**, 375–382.

Hassiotis, A., Ukoumunne, O. C., Byford, S., *et al* (2001) Intellectual functioning and outcome of patients with severe psychotic illness randomised to intensive case management. Report from the UK700 trial. *British Journal of Psychiatry*, **178**, 166–171.

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One hundred years ago

On the Pathogenesis of some Impulsions (Journ. Abnorm. Psychol., April, 1906) Janet, P.

A large number of patients have impulses to perform certain useless, bizarre, and even dangerous acts, not generally, however, very important acts; when it is a question of dangerous acts the patient is apt to feel himself drawn towards them rather than actually impelled to accomplish them. The mechanism of the impulsion is not always the same. Sometimes it is analogous to that of suggestion; at other times the impulsion appears to develop subconsciously, entering the field of a retracted consciousness too late to be easily controlled. Beyond these and other causes there is, Janet believes, a mental disposition common among the obsessed and impulsive which plays an important part in many cases.

To illustrate the factor in question five cases are briefly narrated, all in young women. One is a case of periodical dipsomania, the attacks occurring at intervals of a few weeks or months and being followed by repentance and despair; another of the rarer impulsion to eat, the patient feeling a constant need of support; the third of dromomania, or the mania for walking, the patient not beginning to feel at her ease until she has walked over forty kilometres along a public highway, so that no sanatorium can be found sufficiently spacious for her; the fourth must tear out her hairs one by one and eat them, and has thus lost a luxuriant head of hair; the fifth is never happy unless she tortures and wounds and bruises herself. These impulsions, though apparently different, have common clinical characteristics. They are periodic and irresistible, while their

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