Correspondence

GPs' opinions of discharge summaries

Sir: This letter presents findings on general practitioners' (GPs) opinions about psychiatric discharge summaries.

One hundred and sixty-seven questionnaires were sent to all GPs in Coventry, the first part enquiring about the current, and the second part, about the desired format. After one reminder 131 completed forms were returned (78%).

Summaries sent to GPs were delayed one month (64%), most of which were too long (53%). Forty-seven GPs (36%) complained of their unstructured form and content, and the time spent reading them. The majority of GPs prefer a brief summary (63%), confined to one page (71%) and to reach them within a week of discharge (52%). The content should highlight diagnosis, medication on discharge and follow-up arrangements including the name of the key-worker. Some stressed the importance of telephone communication especially in cases of seriously disturbed patients while others suggested psychiatric trainees should spend three months of their training in general practice.

These findings confirm Kerr's opinion that "Abandoning lengthy discharge summaries would lead to reduced boredom on the part of general practitioners and increased clarity of thought among trainee psychiatrists" (Kerr, 1990). It also emphasises the need for effective liaison between the psychiatric services and the primary care providers.

KERR, M. S. (1990) *British Medical Journal*, **300**, 260–261

E. A. ARSANY, *St Mary Mental Health Resource Centre, 12 St Mary's Road, Leamington Spa, Warks CV31 1JN*

Danger of assault at tribunal hearings

Sir: In my capacity as responsible medical officer I have recently been the subject of a physical assault by a psychotic patient at her tribunal hearing. The patient concerned was placed next to me and in such a position that I could not escape or obtain any rapid assistance from other mental health professionals present. Thankfully I was able to restrain the patient before she was able to do me any significant harm.

Tribunal or Managers hearings can act as significant stressors for patients and patients may act unpredictably. I wonder whether sufficient attention is given by all concerned as to the potential danger for those present. I would be interested to know whether Members of the College have had any similar experiences. An exchange of thoughts as to the optimal arrangments of such hearings might lead to improvements in safety.

JO BOWEN, *South Kensington & Chelsea Mental Health Centre, London SW10 9NG*

Appropriate placement of dements – lamenting lost opportunity

Sir: The need for NHS continuing care beds is acknowledged. (Jolley, 1994). When Hollymoor Hospital closed, to serve the east sector of Birmingham (elderly population of 31 000) we recommended 42 acute admission beds (functional and organic) and 60 continuing care beds. Managers conceded 32 assessment and 24 continuing care beds. They also agreed to invite Coventry Churches Housing Association (CCHA) to provide 36 specialist psychiatric nursing home beds for *exclusive* use of this population. The CCHA had already established an expertise in this field. As inducement to CCHA, land belonging to the area health authority was given on a 99-year lease for a peppercorn rent, and money given for pump priming. Besides for every bed, a sum of £70.00 inflation-proofed was to be given by the area health authority. (The major funding would no doubt come from the patients' estate or Social Security Department). In return the CCHA would take patients only from the old age psychiatry consultants of the east sector of Birmingham.

The facility opened in March 1993. The consultants had hoped that after assessment dements requiring institutional care would be recommended placement in one of five categories of institutions in order of increasing levels of skill input. In ordinary old people's homes (OPH) the skills are restricted to trained

care assistants only, going onto specialist OPH and further up the ladder a medical nursing home and higher still, a specialist nursing home of the kind described above and ultimately psychiatric hopsital continuing care wards.

The following month the National Health Service and Community Care Act 1990 came into force and funding arrangements were transferred from the Department of Social Security to the local Social Services Department. The Manager of Social Services took the view that it was the exclusive responsibility of his department to decide where patients should be placed. He feared if it were left to other professionals, budgetary constraints might be exceeded. Consequently we lost the exclusive admission rights to the CCHA nursing home. Demented patients assessed elsewhere were placed in this CCHA nursing home. In our judgement all placements were not matched by the need for psychiatric nursing expertise.

Patients going through the admission/assessment facility considered suitable for the CCHA facility are having to wait unduly long and are sometimes placed elsewhere. We lost a valuable opportunity to maintain working relationships between the two sectors of continuing care facility, one NHS managed and another charity nursing home managed.

JOLLEY, D. (1994) Services for Patients with Dementia. Editorial. *Psychiatric Bulletin*, **18**, 389.

D. GASPAR, *Northern Birmingham Mental Health Trust (East Sector), Little Bromwich Centre for Elderly Mental Health, Birmingham B10 9JH*

A hidden cost of community care

Sir: Before my mental hospital closed, I covered approximately 600 miles per month in my car. Since its closure and the dispersal of patients into small local units, my mileage now has jumped to 1200 and, given the geography of my catchment area, this amounts to approximately three sessions per week purely behind the wheel of my car. The workload, of course, does not decrease and, indeed, is increasing with supervision registers and the like. Community care for me, therefore, has resulted in more work having to be fitted into substantially less time which, of itself, is highly stressful.

In my old mental hospital I could go from ward to ward on foot and as it was relatively large I got a reasonable amount of exercise; not so now, my car is the only reasonable means of transport to get me between the various dispersed units and the increase in mileage I cover is matched with a decrease in the amount of exercise I take.

Put these two factors together and community care for me and a great many of my colleagues, means a substantially increased risk of coronary heart disease and stroke. Is this *really* an acceptable price to pay for political correctness?

D. R. DAVIES, *Avalon Somerset NHS Trust, Rydon House, Cheddon Road, Taunton TA2 7AZ*

Sick doctors

Sir: We were glad to see that the issue of sick doctors is being addressed in the mental health field (*Psychiatric Bulletin*, April 1995, **19**, 267).

This reminded us of one of the unstuffy gifts available from the College, and worn by some of its younger members, namely the 'Shrink Proof' T-shirt.

We wonder whether this slogan gives the wrong message that psychiatrists are immune to mental health problems. What is required is an awareness that everyone may need help, and that psychiatrists are trained to prevent it.

In view of this, perhaps an updated slogan for the next batch of T-shirts should be 'Shrink-wrapped'!

E. J. WALTER, *Downend Clinic, Bristol BS16 5TW* and N. D. MORGAN, *Barrow Hospital, Bristol BS19 3SG*

Early retirement on mental health grounds

Sir: I have been asked to prepare several reports on people in which early retirement on mental health grounds is being sought by the individual or his/her employer. Although such reports are requested after a prolonged episode of ill-health the individual concerned appears not to have been offered specialist psychiatric treatment. The most striking example was a man who had been psychotically depressed and on the verge of suicide.

Have other colleagues noticed the tendency?

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