Domiciliary visits

Sir: We write to highlight the importance of including a home visit in the assessment of a child or adolescent. Although it is commonplace to interview the whole of the family usually in the clinic, a home visit is not routinely carried out by all departments.

We report the case of a 12-year-old Caucasian girl referred to the department of Child and Adolescent Psychiatry by an Educational Social Worker who was concerned about the girl's poor school attendance. At her first appointment, the patient revealed that she was fearful of contamination by germs and had several rituals involving the preparation of food. She did not eat with the rest of her family, instead preparing pre-packed frozen meals using her own set of cooking utensils. She insisted on using her own soap and towel before and after meals. She was noted to be pre-pubescent and underweight.

An initial diagnosis of obsessive–compulsive disorder was made and behavioural therapy was recommended. However, subsequent poor attendance at out-patient appointments and complaints by neighbours to Social Services regarding the number of cats owned by the family prompted our home visit.

On visiting the home the reason for the cleaning rituals soon became clear. The family lived in a sparsely furnished flat which was in disrepair. There was no lock on the front door and the house was noted to smell of stale cat urine. The kitchen caused us the greatest concern since approximately 25 cats and their excrement covered all exposed worksurfaces. Our patient proceeded to demonstrate her cleaning rituals to us and it was immediately apparent that these were an understandable response to the insanitary environment she lived in. The case was referred as a matter of urgency to Social Services.

We recommend that the potential benefits of a domiciliary visit is considered on all new referrals since the information gained can be invaluable.

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Psychiatry in Tobago

Sir: I was interested to read the article about psychiatry in Tobago by Dr Cembrowicz (*Psychiatric Bulletin*, July 1995, **19**, 421–426). I have worked in the psychiatric team responsible for Tobago and offer a few comments.

There are factors additional to those mentioned which contribute to Dr Cembrowicz's finding of only 0.5% of patients at District Health Centres having 'psychological' problems. Few acutely ill psychiatric patients are seen there due, in part, to the adult clinics being held not on a daily basis but weekly or even less frequently in remote areas. Further, a well developed Community Psychiatric Nursing Service often refers patients directly to the psychiatric clinic. Few chronically ill patients are referred to the Health Centres, but instead are followed up in the Psychiatric Clinic, in recognition of the crowding at the Health Centres as well as the limited availability of psychotropic drugs at the pharmacies of the outlying Health Centres.

Dr Cembrowicz's estimate of 118 patients on depot neuroleptics is based on the assumption that each patient received 25 mg of fluphenazine decanoate (Modecate) or 50 mg of pipothiazine palmitrate (Piportil) monthly. In the psychiatric clinic there, and indeed the ones I have worked in within the UK, it is the exception rather than the rule for young adults to be maintained on this dosage. (The *British National Formulary*'s (1995) dose for Modecate is up to 100 mg every 14 days and Piportil up to 200 mg every 4 weeks). With patients possibly receiving up to eight times the assumed dose, I cannot agree with the author that the number treated with depots "may be reasonably accurate".

While very rough estimates of patient numbers are unavoidable using Dr Cembrowicz's methodology, I think it is wrong to use them to calculate rates per 100 000 for patients treated for psychosis and depression as these rates must lack validity. It is unfortunate that they are now liable to be quoted in the literature.

Reference

BRITISH MEDICAL ASSOCIATION AND THE PHARMACEUTICAL SOCIETY (1995) *British National Formulary*, **29**, 161–162.

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Sir: My estimates are based on the doses Clinic staff told me they used at the time. Tobagonian treatments will not necessarily correspond with the (maximum) *British National Formulary* dosages you describe. Perhaps my estimates will stimulate the production of more detailed statistics?

Great credit is due to local community psychiatric nurses who gave a sterling service at a time of great economic difficulty, often with little psychiatric support due to local transport difficulties.

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As a UK family doctor, I was particularly struck by how seldom Tobago's Health Centre patients 'medicalised' emotional distress, in contrast to my UK experience, where 'minor' psychological disorders are a significant part of every GP's daily work.

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Detention under Section 3 of the Mental Health Act and home security

Sir: When a patient is admitted to hospital under Section 3 of the Mental Health Act, the approved social worker is required to ensure that their residence is made secure. However, once this is done there is no requirement to continue to maintain security at the site. We have recently had experience of a patient whose entire belongings were stolen while receiving treatment as an in-patient. This was not only extremely distressing to the patient, but also delayed rehabilitation and discharge. Discussion with colleagues suggests that this is not an uncommon experience.

Patients detained under Section 3 usually have chronic psychotic illnesses and frequently live alone in housing that is less than ideal. They may be well-known in the neighbourhood and prolonged absence is clearly noted and acted on. As their detention is at the instigation of the psychiatric services, we feel that those services should carry some responsibility for maintaining the security of our patients' property. Especially as we usually justify compulsory detention as being in their interest.

We suggest that the team involved in the care instigate arrangements for regular (weekly) visits to the home to ensure it remains secure. Perhaps it would even be appropriate to make this aspect of patient care and support statutory. It is unfortunate that sometimes this aspect of a patient's social care is not considered, especially as it is obviously very important to them.

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Catchment areas

Sir: Kellett (*Psychiatric Bulletin*, June 1995, **19**, 240–342) and Thornicroft *et al* (*Psychiatric Bulletin*, June 1995, **19** 343–345) present arguments for and against the geographical catchment area. No system is perfect but having been a consultant operating within and without the catchment area I have to vote in favour. I think Kellett is wrong in saying there are no longer valid reasons for a catchment area, particularly when his own perceived benefits of the system seem to encompass many of the fundamentals of good psychiatric practice while his list of 'harms' contains little to do with patients.

At the request of our purchasers we have transferred from geographical catchment areas to consultants being linked to named general practitioners (GPs) who are grouped to produce 'neighbourhoods'. This was introduced as a purchasing strategy to allow groups of GPs (neighbourhoods) working in similar areas and experiencing similar problems to identify local service need in their dialogue with purchasers and providers. But these problems are very strongly geographically linked and this is demonstrated by our annual public health reports. The majority of GPs' patients reside in a local area but GPs are not geographically confined and can have patients widely dispersed. They tell me they have to keep patients living further away to maintain their list size and stay solvent. Our neighbourhood arrangement means the consultant seeing the patient is determined by the GP's name though the GP has a choice of two consultants. Consequently, consultant patients are now spread over a larger geographic area than before.

While working with geographical areas I was able to establish community out-patient clinics where patients are reviewed in their own home. This system will only work if the population served generates a manageable caseload but more importantly is sufficiently concentrated in a geographical area to minimise time lost travelling between houses. Now that I track GPs I have to travel further, the number of patients I can see in a session will inevitably drop and the cost of the clinic will rise. The clinics may become non-viable.

The community clinic is exceptionally popular with patients, does away with tedious ambulance arrangements, dramatically reduces non-attendance and meets the needs of elderly people with high levels of physical and mental disability in the inner city who cannot easily use traditional services. Would it be progress to abandon a development of this sort?

I still believe the geographical catchment area provides a good basis for the delivery of mental health services. It facilitates the identification of local needs, close liaison between disciplines and the development of service and expertise relevant to a locality. Kellett is quite wrong in suggesting the purpose of locality-based services is to take over complete care of the patient. On the contrary, detailed knowledge of the locality