the domiciliary clinic was a failed patient contact when attending the home.

Of course, the elderly and general adult populations are not necessarily comparable. One of us (DL) subsequently piloted a similar domiciliary clinic for the 16-64 years age group specifically because the non-attendance rate for new referrals to the hospital clinic over the previous six months was 53%. For the following six months, new out-patient referrals who would have been seen in the hospital clinic were visited at home. The non-attendance rate fell to 15%.

It appears that visiting patients at home is another effective method of reducing non-attendance and has the advantage that the psychiatrist can directly observe the patient's home circumstances. From an efficiency point of view the limiting factor is time spent travelling to patients' homes and efficiency savings may not be realised where distances are large. The services described are inner city and adjacent districts of Liverpool that may be similar to the Sheffield service described by Rustus, who notes that the average distance between patients' home and hospital was only 3.7 miles. The average distance travelled in the elderly domiciliary clinic was 12.6 miles per clinic seeing an average 2.7 patients per clinic.

Experience indicates that patients like the domiciliary arrangements. Jones et al (1987) found that 72% of new general adult psychiatric referrals stated a preference for home visiting and only 12% for out-patients or general practice clinic. Eighty per cent felt assessors had gained a better idea of their difficulties because they were seen at home.


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Progress in defeating depression

Sir: I note that one of the tasks of the Defeat Depression campaign as described by Priest et al (Psychiatric Bulletin, August 1995, 19, 491-495) is public education, and that 90% of their sample “thought that depressed patients should be offered counselling.” It is not clear from the discussion that follows whether they regard this as evidence of ignorance or as a valid request for services for depressed people.

R. G. Priest
Chairman, Defeat Depression Campaign

Sexism or pragmatism?

Sir: We read with interest the article by Hall and Deahl on the inadequacies of history taking by trainee psychiatrists in casualty (Psychiatric Bulletin, September 1995, 19, 538-540). While we agree that efforts are merited to increase alcohol and substance abuse histories in all groups, we disagree that this discrepancy is likely to represent ageist or sexist attitudes. The OPCS survey (Goddard, 1991) of drinking habits in the late 1980s (quoted in part in Hall & Deahl's article), found that 23% of men and 5% of women exceeded sensible drinking levels (21 units for men and 14 units for women). Excess drinking showed a decline with increasing age in both sexes. Based on these figures, if a full alcohol history had been taken in all cases at least a further 5.3% of men and 3.4% of women would have been identified as exceeding sensible drinking levels. The recording of disorders more likely

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