author upon request). An audit sampling two months' violent incidents demonstrated that the standardised NHS incident reporting form (IR1) relies on staff entering vital details of the episode as free text. This led to the identification of perpetrators of violent incidents for only 39 of 199 reports. Thirty-seven sets of case notes were recovered. Most of the perpetrators (27/37) had a history of violence documented in the case notes. The majority of perpetrators (20/37) were of informal status. A minority (11/37) of incidents were judged to be precipitated by psychosis or cognitive impairment.

This audit suggests that the College's Guidelines for restraint, seclusion and medication, apply only to a minority of patients who perpetrate violence against co-patients and staff in psychiatric settings. Application of the College's Guidelines may, therefore, have limited value in reducing the frequency of violent episodes. I suggest that, as violent conduct on the part of an informal patient could be viewed as withdrawal of consent to admission, the Mental Health Act may act as a useful template for decision-making following a violent incident. The College's Guidelines would then apply to those patients detained under the Mental Health Act. Where are the guidelines on how to manage the others?

Reference

ROYAL COLLEGE OF PSYCHIATRISTS (1998) *Management of Imminent Violence. Clinical Practice Guidelines to Support Mental Health Services.* Occasional Paper OP41. London: Gaskell.

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Psychotherapy provision within the NHS

Sir: The Bulletin recently published two articles pertinent to psychotherapy provision within the NHS (*Psychiatric Bulletin*, July 1999, **23**, 390–393 and 445–447). Both clearly highlight the important and vital role for consultant psychotherapists within the provision of NHS mental health services and the difficulties in persuading purchasers to fund such posts.

We wish to draw attention to a potential situation which may, in the long-term, make matters more complicated.

There has been an expansion in the numbers of consultant psychiatrists and currently there are many unfilled posts in England and Wales (perhaps in excess of 400). By contrast psychotherapy has had zero growth in numbers and there are no unfilled posts. Perhaps as a result of these facts there is concern among some specialist and senior registrars in psychotherapy that there may not be a consultant post for them when they have finished their training.

Many specialist and senior registrars undertake dual training in order to gain the Certificate of Completion of Specialist Training (CCST) in both general psychiatry and psychotherapy. Given the shortage of general psychiatrists, purchasers may find the creation of split posts preferable to the creation or pure psychotherapy posts. With the current demands on general psychiatrists those appointed to dual posts are likely to find themselves pressured into spending increasing amounts of time responding to acute problems to the detriment of their ability to practice psychotherapy in an effective manner. In addition employing psychotherapists with single CCSTs in psychotherapy may become regarded by trusts as a less attractive option. Consequently these individuals may have more difficulty in finding a consultant post.

If these changes do come to pass, the future of psychotherapy as a stand alone speciality within the NHS would be severely undermined to the serious detriment of both training and service provision.

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GPs views on discharge summaries and new patient assessment letters

Sir: The article by Dunn & Burton (*Psychiatric Bulletin*, June 1999, **23**, 355–357) highlighted the views of general practitioners (GPs) on discharge letters. I recently surveyed GPs in central Manchester on the same issue as part of an audit project. Specifically, I was attempting to investigate GPs views regarding discharge letters and new assessment letters.

I constructed a questionnaire for GPs which broke our existing letters down into 15 sections and asked them to rate on a five-point scale how useful they found that particular piece of information, ranging from one (essential) to five (irrelevant). The questionnaire also enquired about GPs opinions on letter length, whether they had time to read them and the speed with which they received the letters. Forty-eight of 77 GPs (62%) returned the questionnaire. GPs expressed broadly similar preferences over

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which items they valued most in letters. In order of relevance to the GPs the top most important letter items (mean rating score in parentheses) were diagnosis (1.00), presenting complaint (1.13), treatment recommendations (1.13), follow-up arrangements (1.18), mental state examination (1.45) and medication prescribed (1.63). It was interesting to note that overall no item was rated as irrelevant. Twenty-one of 45 (47%) GPs believed the letters were too long, 23 (51%) that they were adequate and only one (2%) that they were too short. Forty out of 47 (85%) said they did have time to read the letters, the other seven (15%) did not. Most, 41 of 45 (91%), received their letters quickly whereas four (9%) claimed they did not. Eight GPs additionally advised that diagnosis, treatment recommendations and follow-up arrangements should be listed at the top of all letters.

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Minimum wage legislation

Sir: I wish to draw the attention of College members to the implications of minimum wage legislation for sheltered employment projects. The Department of Trade and Industry advice is that such projects should now be paying workers the minimum wage. The effect of interpreting the act in this way is that as many as 10 000 disabled people face the risk of losing their employment as many sheltered projects will be unable to fund wages at this level. Even if the projects were able to increase wage levels there would be no net gain to many who would find their benefits reduced accordingly.

It would seem that legislation aimed at promoting social inclusion is in reality having the effect of excluding some of the most vulnerable members of society from their current employment.

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