

Correspondence

Disservice to the most needy!

I would be extremely concerned that patients with the major mental illnesses under Bohmer's standard care model would be classed as needing 'standard care' and would be handled by non-medical professionals.¹ To me, this is callous care and not standard care. It is a theoretically smart sounding concept, but, at a clinical level, most good clinicians would appreciate that just knowing the protocol and guidelines without knowledge of various other possibilities in the vast array of medical complexities is a dangerous practice. There is a clear difference between how a doctor diagnoses and attributes complaints to a cause compared with other professionals and these concepts are now being created only to undermine the role of a doctor in psychiatry.

What is further concerning is that the history and the future of research are never considered in these theoretical concepts. Research for these standard-care patients has come mostly from doctors who have closely worked with these patients day in and day out learning the subtleties of their presentations.

If research is to continue, doctors will have to work closely with these standard-care patients! This is a seriously concerning model to me.

- 1 Abed RT. Custom and standard care: implications for the future role of doctors in mental health. *Psychiatrist* 2010; **34**: 505–6.

Millia Begum is consultant psychiatrist, NHS Lanarkshire, Hairmyres Hospital, East Kilbride, email: millia.begum@nhs.net

doi: 10.1192/pb.35.3.117

Why not patient feedback on psychiatric services?

We read with interest the article by Hansen *et al*,¹ which brings the important issue of patient satisfaction back on the agenda. We would, however, encourage our colleagues to go further and collect patient satisfaction data for psychiatric services routinely. This is especially important considering the current time of austerity and the fact that, when compared with other high-income countries, the UK scores badly on patient-centred care.²

Most trusts in the current market-driven National Health Service are using Health of the Nation Outcome Scales (HoNOS) as an outcome measure to assess the quality of service provided. Although we do not dispute the importance of getting validated data on improved patient outcome, this is a clinician-rated tool and as such it has the inherent issues of bias.

Most large organisations get feedback from customers, and the success of companies such as TripAdvisor and Amazon is based on the fact that customers regularly give feedback on their websites. Should we not be doing the same regarding the service we are providing? How else would we know what the patients expect from our service?

When considering service provision in times of fiscal austerity, we need to consider all our stakeholders, of which

patients are the most important. When justifying our services to commissioners, we should also include the views of patients. We would go even further and suggest that patients could also inform us of how services could be cut in these difficult financial times.

- 1 Hansen LK, Vincent S, Harris S, David E, Surafudheen S, Kingdon D. A patient satisfaction rating scale for psychiatric service users. *Psychiatrist* 2010; **34**: 485–8.

- 2 The Commonwealth Fund. *Commission on a High Performance Health System*. The Commonwealth Fund, 2007.

Asif M. Bachlani is specialty registrar year 6 in general adult psychiatry, Department of Psychological Medicine, Princess Anne Hospital, Southampton, Hampshire Partnership NHS Foundation Trust, email: asifbachlani@doctors.org.uk, **Jessica Gibson** is research psychiatrist, MIAMI-UK, and honorary consultant psychiatrist, Oxfordshire and Buckinghamshire Mental Health Partnership NHS Foundation Trust, Oxford.

doi: 10.1192/pb.35.3.117a

Home treatment teams and compulsory admissions – more information needed

Forbes *et al*¹ found that the absolute number of compulsory admissions increased after the introduction of an intensive home treatment team and a reduction in hospital beds. Tyrer *et al*² also described an increase in compulsory admissions after the introduction of home treatment teams. These findings raise concerns about the current policy of gatekeeping home treatment teams.

Looking at our own data, in the London borough of Wandsworth there were 151 compulsory admissions in the second quarter of 2008–2009, 119 compulsory admissions in the third quarter and 144 in the fourth quarter. In March 2009, there was a reduction of 6 in-patient beds, and in the first quarter of 2009–2010 there were 181 compulsorily admitted patients, which dropped to 151 in the second quarter and dropped again to 126 in the third quarter. The closure of 6 beds might well explain the increase in compulsory admissions in the first quarter of 2009–2010, but after 3 months the number of compulsory admissions dropped to the previous level.

A temporary increase in compulsory admissions after a reduction in hospital beds and the introduction of a home treatment team should be avoided if possible, but the consequences for service planning are far less severe than with a more permanent increase in involuntary admissions. Maybe with a larger reduction of in-patient beds the number of compulsory admissions would return to previous levels after a longer time period had passed.

- 1 Forbes NF, Cash HT, Lawrie SM. Intensive home treatment, admission rates and use of mental health legislation. *Psychiatrist* 2010; **34**: 522–4.

- 2 Tyrer P, Gordon F, Nourmand S, Lawrence M, Curran C, Southgate D, et al. Controlled comparison of two crisis resolution and home treatment teams. *Psychiatrist* 2010; **34**: 50–4.

Dieneke Hubbeling is consultant psychiatrist, South West London and St George's NHS Mental Health Trust, London, email: d.hubbeling@nhs.net; **Keelyjo Hindhaugh** is a teaching fellow at St George's Medical School, and

Tom Lelmezh is head of the Mental Health Act Office, both at South West London and St George's Mental Health NHS Trust.

doi: 10.1192/pb.35.3.117b

Proposed College working party on psychiatry and religion

The establishing of a Royal College of Psychiatrists' working party to consider the boundaries of psychiatry and religion, as suggested by Poole & Higgs,¹ is indeed a pragmatic, constructive and, in our view, long overdue proposal.

It was in 1991 that our Patron, the Prince of Wales, first reminded the College that therapy involved body, mind and spirit.² In that same year, the current President Dinesh Bhugra organised a meeting at the Institute of Psychiatry at which Bill Fulford cogently urged delegates to explore the limits of tolerance at the boundaries of psychiatric practice and religious belief.³

Can the President please, in his last year of office, establish a working party which would consider these matters, consult widely and make recommendations relevant to the core clinical, research and educational objectives of the College? Such a working party will require the arms-length approach of transcultural psychiatry as well as a broad, multi-faith perspective and astute leadership, fully sensitive to the concerns of religious and secular psychiatrists as well as service users and other health professionals.

If the World Psychiatric Association can be approaching an international consensus on this subject,⁴ then surely the College can usefully now give a lead in Europe where these matters are particularly pressing.

Declaration of interest

J.C. is a Christian from the Methodist tradition. A.J.G. was recently ordained Deacon in the Church of England.

- 1 Poole R, Higgs R. Psychiatry, religion and spirituality: a way forward. *Psychiatrist* 2010; **34**: 452–3.
- 2 HRH The Prince of Wales. Lecture by HRH The Prince of Wales, as Patron, to the Royal College of Psychiatrists, Brighton, Friday 5 July 1991. *Br J Psychiatry* 1991; **159**: 763–8.
- 3 Fulford KWM. Religion and psychiatry: extending the limits of tolerance. In *Psychiatry and Religion: Context, Consensus and Controversies* (ed D Bhugra): 5–23. Routledge, 1996.
- 4 Verhagen P, van Praag HM, Lopez-Ibor JJ, Cox JL, Moussaoui D (eds). *Religion and Psychiatry: Beyond Boundaries*. Wiley Blackwell, 2010.

John Cox is professor emeritus, Honorary Fellow and Past President, Royal College of Psychiatrists, and Co-Chair, Centre for Faith Science and Values in Healthcare, University of Gloucestershire, email: john1.cox@virgin.net.

Alison J. Gray is liaison psychiatrist, Birmingham and Solihull Mental Health NHS Foundation Trust, WholeCare Research Fellow and Research Associate, University of Birmingham School of Psychology.

doi: 10.1192/pb.35.3.118

Not all 'crisis teams' are the same

I am concerned by the claims made in the paper by Forbes *et al.*¹ It purports to add to the literature relating to the introduction of a crisis resolution and home treatment team (CRHTT), by demonstrating little impact on bed use and increased compulsory admissions. This is misleading as the

study actually shows the effect that a new CRHTT, which does not adhere to the consensus model, may have as part of a complex, changed system.

The paper describes admission and compulsory admission rates before and after a service redesign (which includes the inception of a CRHTT), but reports these as if the set up of the CRHTT was the only important change. In reality, the changes included a reduction in in-patient beds, reprovision of beds several miles away, and presumably uncertainty and anxiety in staff during the change period.

I am not surprised by the lack of impact on bed use and the increase in compulsory admissions. The CRHTT did not include key elements associated with reduced admissions as determined by evidence and the National Audit Office.^{2–4} First, the Midlothian team had no designated consultant or social worker (although there was 'ready access' to the latter). Second, the CRHTT did not do its own face-to-face gatekeeping in all cases, and the proportion of admissions subject to gatekeeping by the CRHTT is not supplied. Third, the team did not operate a 24-hour service.

It is vital to communicate accurately with commissioners and others about the economic value, safety and effectiveness of psychiatric services. Not all teams providing frequent visits outside of hospital are a CRHTT, but the distinction is not likely to be widely understood. The development of accreditation criteria for CRHTTs is now urgent.

- 1 Forbes NF, Cash HT, Lawrie SM. Intensive home treatment, admission rates and use of mental health legislation. *Psychiatrist* 2010; **34**: 522–4.
- 2 Joy CB, Adams CE, Rice K. Crisis intervention for people with severe mental illnesses. *Cochrane Dat Syst Rev* 2006; **4**: CD001087.
- 3 Glover G, Arts G, Babu KS. Crisis resolution/home treatment teams and psychiatric admission rates in England. *Br J Psychiatry* 2006; **189**: 441–5.
- 4 National Audit Office. *Helping People through Mental Health Crisis: The Role of Crisis Resolution and Home Treatment Services*. TSO (The Stationery Office), 2007.

Nicky Goater is consultant psychiatrist, West London Mental Health NHS Trust, London, email: nicky.goater@wlmht.nhs.uk

doi: 10.1192/pb.35.3.118a

Simulated patients – stimulated patients?

Mitchison & Khanna¹ contribute an interesting letter to *The Psychiatrist* about the experience of role-playing actors, or simulated patients, who have become ubiquitous in OSCE-based examinations (such as the CASC) in medicine and psychiatry. Using qualitative methods, they briefly describe aspects of the simulated patients' experience, but focus on one: the emotional stress the actors can experience after role-playing psychiatric patients repeatedly over the course of an examination.

The role of simulated patients in psychiatric OSCEs is a lightly researched topic. We conducted a study in 2009 looking at the role in examinations of the same population that Mitchison & Khanna describe, i.e. UK MRCPsych trainees.² One finding was that simulated patients and examiners scored 'empathy' and 'communication' differently (unlike the real examination, we asked the actors to mark the candidates). In a *post-hoc* unpublished exploration of why this might be (by using a questionnaire with both groups), we were unable to find the answer to this question.