

## Correspondence

### College president elections – are members not bothered?

Only 26.5% of members participated in the voting process in the 2011 Royal College of Psychiatrists president elections, even though there were many options to get involved including online voting. Only 12.2% of members voted for the president (at first stage, 7.8%). And even though using the internet would appear to be an easier option, there were fewer votes cast using this method. When will the British psychiatrists wake up and start to take part in these elections?<sup>†</sup>

**Abdul K. Al-Sheikhli** is consultant psychiatrist, Crisis Resolution and Home Treatment Team, Woodlands Centre for Acute Care, St Leonards on Sea TN37 7RD, UK, email: aalsheikhli@aol.com

doi: 10.1192/pb.35.6.237

### The hubris syndrome: is it necessarily pathological?

The 'hubris syndrome' is of unquestionable interest but unfortunately the account given by Russell and Owen was lacking in sociopolitical and historical context.<sup>1,2</sup> In addition, it was unhelpful to confound this putative syndrome with the impairment of a politician's decision-making as a result of physical or mental illness. These two phenomena are unrelated and must therefore be kept separate.

By contrast, Freedman's comments<sup>3</sup> were more nuanced and took account of the complexity of this interesting phenomenon. Freedman pointed out the important distinction that must be made between leaders in democratic and non-democratic systems. Whereas egalitarian systems of leadership appear to have been prevalent among pre-Neolithic hunter-gatherers,<sup>4</sup> following the advent of agriculture more tyrannical forms of leadership become the norm. Certainly since the rise of the state some 5000 years ago the most common systems of governance have been autocratic or tyrannical.<sup>5</sup> The checks and balances that leaders in a democratic system (a very recent historical development) have to endure, although imperfect, severely limit their ability to indulge in the kind of hubris that their tyrannical counterparts can do. I suggest that the syndrome in its purest form should therefore be studied in autocrats and tyrants to correctly identify its full-blown manifestations. There is no shortage of candidates for such a study both historical and contemporary. It is of interest that the events taking place in many Arab countries at present involve the actual or attempted removal from power of a group of tyrannical leaders who represent extreme examples of the hubris syndrome. Any of these leaders would qualify as a case study of hubris syndrome.

It is debatable as to whether the syndrome is an illness or simply a human psychological phenomenon or response that results from the interaction of certain specific personality traits with the experience of power, authority and elevated status. It

<sup>†</sup>Professor Sue Bailey, the new College President, will take office on 30 June 2011.

may even be argued that this syndrome has been a necessary qualification for all tyrants throughout history and that it has only become dysfunctional and maladaptive in democratic systems.

- 1 Russell G. Psychiatry and politicians: the 'hubris syndrome'. *Psychiatrist* 2011; **35**: 140–5.
- 2 Lord Owen D. Psychiatry and politicians – afterword. Commentary on . . . Psychiatry and politicians. *Psychiatrist* 2011; **35**: 145–8.
- 3 Freedman L. Mental states and political decisions. Commentary on . . . Psychiatry and politicians. *Psychiatrist* 2011; **35**: 148–50.
- 4 Boehm C. Egalitarian behaviour and reverse dominance hierarchy. *Curr Anthropol* 1993; **14**: 227–54.
- 5 Abed RT. Tyranny and mental health. *Br Med Bull* 2005; **72**: 1–13.

**Riadh T. Abed**, psychiatrist and medical director, Rotherham Doncaster and South Humber NHS Foundation Trust, St Catherine's Hospital, Doncaster DN4 8QN, email: abedrt@btinternet.com

doi: 10.1192/pb.35.6.237a

### What about the Crisis Centre's contribution?

Barker *et al*<sup>1</sup> argue that the introduction of a 'high fidelity' model of a crisis resolution and home treatment team (CRHTT) in Edinburgh is responsible for a marked reduction in acute psychiatric admissions. The authors found a decrease of 24% in acute psychiatric admissions in the year after the introduction of two intensive home treatment teams in November 2008. They claim, 'there were no changes to mental health services' in Edinburgh at that time other than the introduction of the CRHTT and a coinciding reduction in acute general adult in-patient beds.

However, Barker *et al* omitted to include other changes that may have influenced acute psychiatric admissions. The Edinburgh Crisis Centre operated as an interim service between 2006 and 2009.<sup>2</sup> In March 2009 the service became fully operational, with overnight facilities and four beds. The Crisis Centre is a unique user-led service in Scotland jointly funded by NHS Lothian and City of Edinburgh Council. The Centre is based on a crisis house model with a voluntary sector provider and provides a round-the-clock, non-medical crisis service to residents of the City of Edinburgh. The staff team has a manager, assistant manager and 5.5 full-time equivalent project workers, some with social worker and nursing qualifications. The team also has 5.5 full-time equivalent crisis workers. The service only accepts self-referrals via its free-phone number.

Since opening in 2006, the Crisis service has systematically collected service usage data; between November 2008 and November 2009, 1241 service users self-referred. The introduction of four beds to the Crisis Centre in March 2009 gave users a further community-based option to hospital admission; 6% of those who self-referred used the beds for periods varying from one night up to seven nights. Some of these individuals also received treatment from the intensive home treatment teams in Edinburgh while using the Crisis Centre overnight. I suggest that this unique model of mental health service provision in Edinburgh of a Crisis Centre

with a small number of beds as well as the introduction of CRHTT has supported the decrease in admissions to hospital.

- 1 Barker V, Taylor M, Kader I, Stewart K, Le Fevre P. Impact of crisis resolution and home treatment services on user experience and admission to psychiatric hospital. *Psychiatrist* 2011; **35**: 106–10.
- 2 Atkinson A. *Edinburgh Development of a Mental Health Crisis Centre*. Scottish Development Centre for Mental Health, 2004 (<http://www.edinburghcrisiscentre.org.uk/wordpress/index.php/downloads/>).

**Jacqueline J. Nicholson**, manager, Edinburgh Crisis Centre, email: [jacque@edinburghcrisiscentre.org.uk](mailto:jacque@edinburghcrisiscentre.org.uk)

doi: 10.1192/pb.35.6.237b

### Overstated 'clinical implications'

The study by Okorie *et al*<sup>1</sup> of an accident and emergency (A&E) unit in Galway, Ireland, was of some interest given our experiences in an A&E in Middlesbrough.<sup>2</sup> Interestingly, the authors did not mention the proportion of mental health service users presenting with self-harm, a well-known cause of frequent attendance in our neck of the woods.

Whether the authors include presence of self-harm as evidence of mental disorder is another matter. It is an interesting debate, one which needs to happen with regard to accepting the role of services in managing emotional distress and at what threshold it should be labelled as mental disorder, an issue which was highlighted before.<sup>3</sup> Nevertheless, we know that self-harm and attempted suicide are represented at a higher rate in individuals with personality disorder, schizophrenia, bipolar disorder and alcohol/substance misuse. Yet Okorie *et al* have decided to disregard that particular and significant piece of the puzzle in those presenting to A&E seeking psychiatric assessment and care.

I am not sure how services are structured in Ireland. To appreciate the possible impact of a crisis team on local A&E services, it would have been useful to first describe how psychiatric assessments are currently made available to the attendees, including screening those not known to have previous involvement with mental health services. However, whether 'community-oriented teams' such as a home treatment team would lead to cost reduction (by reducing A&E attendances as the implication seems to be) might be stretching existing evidence and is evidently unsupported by this survey. This effort should also have accounted for a wide variety of variables which have an impact on individuals seeking psychiatric care and assessment in A&E and hence at least a replication should have been attempted before the study was submitted for publication.

Finally, Okorie *et al*'s conclusions, as stated in the clinical implications in the abstract, are quite surprising, despite the mentioned limitations. Their wording, in my opinion, is unfortunate and overestimates evidence, and is completely out of synch with the survey.

#### Declaration of interest

M.K. is Consultant Lead for an England-based crisis resolution and home treatment team.

- 1 Okorie EF, McDonald C, Dineen B. Patients repeatedly attending accident and emergency departments seeking psychiatric care. *Psychiatrist* 2011; **35**: 60–2.
- 2 Kripalani M, Nag S, Nag S, Gash A. Integrated care pathway for self-harm: our way forward. *Emerg Med J* 2010; **27**: 544–6.
- 3 Patil P, Rasquinha N, Badanapuram R, Kripalani M, Gash A. Moving towards the problem and away from diagnostic classifications (eLetter).

*Br J Psychiatry* 2010; 26 Feb (<http://bjp.rcpsych.org/cgi/eletters/196/1/26#28599>).

**Mukesh Kripalani**, consultant psychiatrist, crisis team, Tees, Esk and Wear Valleys NHS Foundation Trust, email: [drmukesh@doctors.org.uk](mailto:drmukesh@doctors.org.uk)

doi: 10.1192/pb.35.6.238

### Matched or overmatched?

We read with interest the paper by Okorie *et al*,<sup>1</sup> which studied the characteristics of patients who present frequently to emergency services. Knowing the local profile of emergency presentation is critical to targeting improvements in service provision, and we were glad to see the authors tackle this matter. We do raise two issues with the study, one methodological and one regarding applicability of the conclusions.

First, age and gender were matched as part of the study between the two groups. These are important measures of demographics that may predict frequent attendance, as has been concluded in the previous studies referenced.<sup>2,3</sup> We presume the authors were aiming to reduce confounding by these variables using a case–control design. Matching is used 'to ensure that controls and cases are similar in variables which may be related to the variable we are studying but are not of interest in themselves'.<sup>4</sup> We think age and gender are of interest, and wonder whether controlling for these factors makes it less easy to decide the target group for community-oriented strategies. The previous studies were in different health systems, and it may be an unwarranted assumption that there will be similar gender and age relationships in an Irish population. It is unsurprising that the mean age and gender of the two groups are equal, as this was matched for at the start of the study. This led to an incorrect conclusion being made in the first paragraph of the Discussion – 'frequent attenders . . . had equal gender distribution as compared with single attenders'. From the data, it appears that one can only draw the conclusion that gender distribution was equal within the frequent attender group.

Second, it would be useful to know what other services are available in Galway. If no early intervention in psychosis team was present, then perhaps this is why people with schizophrenia present more often at the accident and emergency department according to this study data. Without this information, it would be difficult to apply the conclusions to other localities. We would like to know about the structure and nature of community teams in the area and the provision of substance misuse services.

- 1 Okorie EF, McDonald C, Dineen B. Patients repeatedly attending accident and emergency departments seeking psychiatric care. *Psychiatrist* 2011; **35**: 60–2.
- 2 Arfken C, Zeman L, Yeager L, White A, Mischel E, Amirsadri A. Case control study of frequent visitors to an urban psychiatric service. *Psychiatr Serv* 2004; **55**: 295–301.
- 3 Sullivan PF, Bulik CM, Forman SD, Mezzich JE. Characteristics of repeat users of a psychiatric emergency service. *Hosp Community Psychiatry* 1993; **44**: 376–80.
- 4 Bland JM, Altman DG. Statistics notes: matching. *BMJ* 1994; **309**: 1128.

**Jennifer R. M. Martin** is core trainee (CT2) in adult psychiatry, Tees, Esk and Wear Valleys NHS Foundation Trust, Hartlepool, email: [jennymartin@nhs.net](mailto:jennymartin@nhs.net), **Joe Reilly** is Professor of Mental Health, Durham University, Stockton on Tees.

doi: 10.1192/pb.35.6.238a