columns

demonstrated the impact of a standardised admission form on admission booking by psychiatric trainees. A similar audit was completed in our local trust (Bransholme) and showed considerable improvement in practice after the introduction of a standard template for writing letters from the out-patient clinic to the general practitioner.

The template combined recommendations from various sources, including Pullen & Yellowlees (1985) and College guidelines for new patient assessment (Royal College of Psychiatrists, 2001). The template stressed the inclusion of the diagnosis in each letter along with the ICD–10 code. The main focus of the template was encouraging trainees to use the bio-psychosocial approach while explaining the management plan in the letter.

Prior to the introduction of the standard template, trainees missed out important information such as diagnosis with the ICD–10 code and prognosis from the letter. Most trainees left out documentation of explanation of the condition to the patient, the item identified as important by general practitioners in the survey of Pullen & Yellowlees (1985)

The results of the completed audit cycle confirmed the effectiveness of the standard template. We also received positive feedback from general practitioners, many of whom thought that the standardised letters conveyed much more information. The standard template not only resulted in improved communication with the general practitioner but also helped trainees to prepare for the Membership examinations.

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Home treatment in early psychosis

As the practitioners in both home treatment and early intervention in psychosis we read the article of Gould *et al* (*Psychiatric Bulletin*, July 2006, **30**, 243–246) with interest. The conclusion that there is only a 'modest' role for home treatment in early psychosis is striking. To test the robustness of this finding we recently conducted a small local survey.

Using routinely collected computer data we followed all new patients with psychosis for 3 months over a 15-month period to August 2006. We recorded 29 new patients, representing an annual incidence of new cases of psychosis of approximately 46 per 100 000. Twelve patients (41%) were initially managed in the community; the other 17 (59%), were hospitalised. Only 3 patients (10%) were managed initially with home treatment. However, 11 (38%) were discharged from hospital to home treatment for facilitated early discharge. During this period, no patients were admitted to hospital from home treatment or any other community service, including early intervention in psychosis.

Our small survey appears to confirm the main findings of Gould *et al*, that over half of all patients with first-episode psychosis are initially managed in hospital when home treatment is available. As Gould *et al* point out this indicates the need for hospital-based early intervention. However, we also found a strong role for facilitated early discharge with home treatment. It is likely that such discharges not only shorten the duration of hospitalisation but also enhance care during a high-risk transitional period.

In summary, we found signs of a substantive but complex role for home treatment during the early phase of psychosis, one that may be enhanced rather than eclipsed by a service for early intervention. We also found some encouraging initial indications of the wider impact of early intervention and a need for early intervention teams to work within hospitals and alongside home treatment teams. Services should be configured and integrated to reflect this need.

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Implementation of care programme approach in learning disability

It is appalling that services have not all implemented the care programme approach (CPA) for people with learning disabilities and mental health problems (Roy, 2000). This is despite clear guidance regarding this patient group (Department of Health, 1999). Indeed, one meaningful way of promoting empowerment would be to ensure that such people receive the same recognised standard of mental healthcare as everyone else. The CPA audit in people with learning disabilities reported by Ali *et al* (*Psychiatric Bulletin*, November 2006, **30**, 415–418) is thus welcome. It raises two issues of care coordination.

First, there has also been resistance to CPA implementation by learning disabilities' psychologists here in South London. However, all professionals need to follow this modern, holistic, systematic, multidisciplinary way of organising mental healthcare. Services for people with learning disabilities are relatively well resourced with psychology staff compared with most generic mental health services. In addition, the lead intervention is frequently the introduction and ongoing review of behavioural management guidelines. Thus psychologists and/or behavioural therapists are often the best placed to become CPA care coordinators for some people with learning disabilities.

Second, Ali *et al* describe using care coordinators who are not employed by mental health trusts. However, it will always be difficult to monitor CPA properly through the governance systems of primary care trusts or social services departments or non-statutory organisations when none of these has a mental health focus or priority. The CPA is a major reason why mental health services for people with learning disabilities should always be sited within mental health trusts (O'Hara, 2001).

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