columns

specialties at the clinical interface of psychiatry. Only by identifying our clinical weaknesses and then actively seeking teachers to address our learning needs will we be able ultimately to provide the best clinical care.

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Admission is not a failure of community care

Dr Mackirdy gives an interesting account of the pressures leading to change within adult psychiatric services (*Psychiatric Bulletin*, August 2006, **30**, 283–285). As a member of a community mental health team I also have noted with concern what she describes as 'healthy competition between the sector teams to have the fewest in-patients', which may not be so healthy if it prevents a clinically indicated admission from taking place. I would also be unhappy with the view of in-patient admission as a 'failure of community care'. As Dr Mackirdy herself has observed, the provision of home treatment as an alternative to hospital admission has been one of the best developments of the past decade. Making an assumption that all admissions are failures of home treatment would suggest an impressive evidence base which is simply not yet available (Joy *et al*, 2005).

There will always be occasions when admission to a place of safety is required irrespective of the excellence of the available home treatment team (Department of Health, 2002). To view an appropriate clinical decision or indeed patient preference for admission as a failure of that service would remove any real sense of an alternative or choice for those availing of our services.

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JOY, C. B., ADAMS, C. E. & RICE, K. (2005) Crisis intervention for people with severe mental illness. *Cochrane Library*, issue 3. Chichester: Wiley InterScience.

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Decrease in health service use and cost following group treatment of patients with personality disorders

It is well known that patients with personality disorders are one of the groups with the highest use of mental health services and hence one of the most expensive to treat. In an out-patient group treatment centre for personality disorders at Royal Perth Hospital, Australia, we examined service use before and after treatment. This was a retrospective analysis of 153 patients (60% female, mean age 34 years). Treatment was for 6 months and patients attended two eclectic oriented psychotherapy groups each day for 5 days per week. Inclusion criteria were presence of one or more personality disorders. Exclusion criteria were psychosis and antisocial personality disorder.

Hospital database records were examined for the 12 months before and after treatment, and data for psychiatry in-patient bed-days, out-patient visits and presentations at the emergency department were retrieved. Costs included all aspects of service delivery; for example, staff wages and building costs.

Cost was reduced from Aus$1.3 million (Aus$8561 per patient) in the year before treatment to Aus$556 789 (Aus$3639 per patient) in the year after treatment. This was an offset of Aus$753 073 (Aus$4922 per patient). These changes were significant; for example, a 65% reduction in in-patient and bed-days, from 19 days in the year before treatment to 7 in the year after ($t(152)=2.52$, $P=0.01$).

Our results are similar to those of others (Dolan *et al*, 1996; Chiesa & Fonagy, 2002), and suggest that mental health services should fund group psychotherapy for personality disorders as this treatment may result in cost-offsets.

CHIESA, M. & FONAGY, P. (2002) From the therapeutic community to the community: a preliminary evaluation of a psychosocial outpatient service for severe personality disorders. *Therapeutic Communities*, **23**, 247–258.

DOLAN B. M., WARREN, F. M., MENZIES, D., *et al* (1996) Cost-offset following specialist treatment of severe personality disorders. *Psychiatric Bulletin*, **20**, 413–417.

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Smoking and substance misuse in pregnant women with mental illness

Shah & Howard (*Psychiatric Bulletin*, August 2006, **30**, 294–297) investigated smoking and substance misuse in pregnant women with mental illness. We are concerned about the interpretation of their data and the lack of adequate accounting for confounding factors.

Our recent review highlighted that the timing and level of alcohol consumption in pregnancy was important to outcome (Mukherjee *et al*, 2006) but this was not taken into account by Shah & Howard. It would have been better to divide the alcohol consumption group into no alcohol, previous alcohol and ongoing alcohol consumption in order to exclude it as a confounding effect. Since 61% of the population has been shown to drink during pregnancy, and there is a large underestimate of consumption, it is a risk factor that must be adequately excluded.

This publication potentially challenges data emerging from international literature. Here the small numbers in some of the subgroups, combined with the failure to control adequately for the important risk factor that is alcohol, means that an otherwise important piece of research will have to be interpreted with caution.

MUKHERJEE, R. A. S., TURK, J. & HOLLINS, S. (2006) Fetal alcohol spectrum disorder: an overview. *Journal of the Royal Society of Medicine*, **99**, 298–302.

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https://doi.org/10.1192/pb.30.12.470 Published online by Cambridge University Press