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.

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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.

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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 in 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.

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**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 & Higgo, 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. 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.

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, multifield 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, then surely the College can usefully now give a lead in Europe where these matters are particularly pressing.

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**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, Higgo 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.

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**Not all ‘crisis teams’ are the same**

I am concerned by the claims made in the paper by Forbes et al. 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, re provision 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. First, the Middiethian 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.

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**Simulated patients — stimulated patients?**

Mitchison & Khanna 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. 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.
Having read Michison & Khanna’s letter, I wonder whether the answer to the question lies in the emotionally distressed state the actor puts him or herself into while acting the role, and the perception of the candidate not responding to this sufficiently; whereas the examiner, who is not emotionally aroused, is less likely to down-score the candidate.

It is a pity that Mitchison & Khanna’s findings were not published in a full-length article because I would like to know more.

1 Mitchison S, Khanna P. Role players’ experience of psychiatric examinations. Psychiatrist 2010; 34: 542–3.

2 Whelan P, Church L, Kadry K. Using standardized patientss marks in scoring postgraduate psychiatry OSCEs. Acad Psychiatry 2009; 33: 319–22.

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Are reminders effective in reducing non-attendance?

Rajasuriya et al highlight an important issue of non-attendance among out-patients and look at how to deal with this effectively. Their results show a reduction in non-attendance rates after using reminders in the form of letters and telephone calls. Their study identified several risk factors for non-attendance such as affordability or patient’s level of education. However, they have overlooked many others.

The one important factor Rajasuriya et al failed to mention is the possibility of patients being admitted to hospital, whether for physical or mental health concerns. This could have led them to miss their out-patient appointments.

One significant issue raised in their study is in relation to healthcare services in Sri Lanka. These are not based on geographically designated catchment areas, therefore individuals can access the clinic of their choice in any part of the country. This means that some of the non-attendees in one service might have attended another service. Unless we have more information in relation to this, it would be difficult to make judgement about risk factors (male gender, substance use, bipolar disorder, schizophrenia, etc.) of non-attendance with any certainty (increased or decreased risk) and the real impact of reminders. It is quite possible that people might have shopped around for doctors and were planning to attend their next appointment anyway (with or without reminders).

In order to evaluate the effectiveness of reminders in reducing non-attendance, the design of the study should have been that of an intervention study, i.e. randomising non-attendees to an intervention (reminders) and control (no reminders) group. This is the only way of dealing with so many characteristics or risk factors mentioned in the study. This is important because all baseline characteristics that affect attendance and differ between treatment groups could potentially confound the relationship between reminders and non-attendance. Also, randomisation takes care of unknown confounding factors that are not identifiable, and these factors are distributed equally among treatment groups. Thus, randomisation can provide a degree of assurance about the comparability of the study groups that is simply not possible in any observational study design.

1 Rajasuriya M, de Silva V, Hanwella R. Effectiveness of reminders in reducing non-attendance among out-patients. Psychiatrist 2010; 34: 515–8.

2 Hennekens CH, Burning JE. Epidemiology in Medicine. Little, Brown & Co, 1987.

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