the columns

correspondence

Crisis intervention in the UK

Sir: Protheroe and Carroll (*Psychiatric Bulletin*, November 2001, **25**, 416–417) are clearly enthusiasts for crisis services. They relate that they are struck by the lack of awareness of and hostility towards the development of crisis services. Could it be that it is not lack of awareness of such services, but an awareness of the lack of up-to-date evidence for or against such services? The evidence base from randomised controlled trials for crisis intervention services is weak. Most of it is around 20 years old and only one study is derived from the UK. The older research studied hybrids of crisis intervention and assertive community treatment, rather than pure crisis intervention. Even the most up-to-date research of a service that approximates to crisis intervention, a study of the Daily Living Programme (Muijen *et al*, 1992), did not compare home treatment with the cornerstone of modern day community care – the community mental health team, using the framework of the Care Programme Approach. What is more, the terminology of crisis intervention, or home treatment as it is otherwise known, is inadequate and confusing and prevents adequate conclusions being formed.

Protheroe and Carroll complain that UK-based psychiatrists are hostile towards the development of crisis services. If indeed this is the case, such hostility is not reflected in the sentiments of health authority chairs and trust chief executive officers who responded to a recent questionnaire study: all health authorities and 97% of trust chief executive officers were in favour of the principle of providing home treatment (Owen *et al*, 2000). It would be interesting to know just how prevalent such hostility actually is among UK-based psychiatrists.

The authors note that the public continues to fear care in the community despite the evidence that de-institutionalisation has not increased the low risk of homicide by those with mental illness. This is a specious argument. Homicide is an uncommon event, violence on the other hand is not and its consequences can be very serious. Between 10% and 40% of patients commit assault before admission to hospital and 28% of discharged patients have been found to have committed at least one violent act within a year of discharge (Monahan, 1997; Steadman *et al*, 1998). As with intensive case management (Walsh *et al*, 2001), crisis intervention has not so far been demonstrated to reduce the frequency of violent episodes committed by patients. This is neither argument for nor against crisis intervention, but simply a statement that we just don't know what the impact of crisis intervention is on violence.

Finally, with regard to issues relating to the detainment of patients under the Mental Health Act, the authors' views may be too radical for liberal-minded UK psychiatrists. Our current system of detention of patients may be considered too slow and unwieldy by the authors, but the alternative proposal of a single individual (a crisis assessment and treatment team worker) alone being able to swiftly effect the deprivation of an individual's liberty is surely much more open to abuse than the English and Welsh system: surely our more elaborate processes of application are meant to serve as a safeguard for patients.

MONAHAN, J. (1997) Clinical and actuarial predictions of violence. In *Modern Scientific Evidence: The Law and Science of Expert Testimony* (eds D. Faigman, D. Kaye, M. Saks, *et al*), pp. 300–318. St Paul, MD: West Publishing Company.

MUIJEN, M., MARKS, J., CONNOLY, I., *et al* (1992) Home-based care and standard hospital care for patients with severe mental illness: a randomised controlled trial. *BMJ*, **304**, 749–754.

OWEN, A. J., SASHIHADRAN, S. P. & EDWARD, I. J. (2000) Availability and acceptability of home treatment for acute psychiatric disorders. A national survey of mental health trusts and health authority purchasers. *Psychiatric Bulletin*, **24**, 169–171.

STEADMAN, H., MULVEY, E. P., MONAHAN, J., *et al* (1998) Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighbourhood. *Archives of General Psychiatry*, **55**, 1–9.

WALSH, E., GILVARRY, C., SAMELE, C., *et al* (2001) Reducing violence in severe mental illness: randomised controlled trial of intensive case management compared with standard care. *BMJ*, **323**, 1093–1096.

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National Confidential Inquiry

Sir: Following the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (Appleby *et al*, 1999) we compared our services to the recommendations made for follow up of high-risk patients discharged from in-patient care.

Of 158 admissions to our service between 1 August 1999 and 31 January 2000, 40 were identified as high risk because they required one to one continuous nursing supervision. Eleven were offered follow up within 48 hours, 25 between 48 hours and 4 weeks and one after 4 weeks after discharge. Three had no follow up arranged. Twenty-three patients had trial leave before discharge.

Care Programme Approach was completed in 38 cases and six patients had the risk assessment form completed at discharge. Thirty-seven patients had discharge summaries – one recorded the nature of risk and two the need for special observation during admission. Thirty-eight patients were discharged with medication supply of less than 14 days and one with 19 days (missing data=1).

Following discharge, seven patients were involved in nine adverse incidents (seven overdoses, one suicide and one violence to property). Three of these adverse incidents occurred within 1 week of patient discharge and two of these patients had follow-up appointments within 48 hours, including the patient who committed suicide.

Seventy-three per cent did not meet the recommended guidelines for follow-up; 95% met the guidelines for 2-weeks supply of medication. There was a lack of documentation in discharge summaries of the nature of risk. Risk assessment forms were not completed on discharge in 85% of cases.

We have concerns that the recommendations are not being adhered to locally and suspect our service is similar to others nationally. To implement the recommendations considerable changes need to be made to existing practice.

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APPLEBY, L., SHAW, J. & AMOS, T. (1999) *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Safer Service.* London: Department of Health.

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Can deception be therapeutic?

Sir: We are gratified that the case we described (Sandford *et al*, *Psychiatric Bulletin*, June 2001, **25**, 206–280) stimulated such interest and controversy. However, much of Dr Adshead's commentary (*Psychiatric Bulletin*, October 2001, **25**, 374–375) related to the general issue of deceiving patients and failed to take into account the particular features of the case that made it exceptional.

First, the case was not 'ordinary' insofar as we were dealing with a person with a pervasive developmental disorder whose communication and cognitive difficulties lay at the heart of this dilemma. Adshead wonders if it had been possible to talk to the patient about moving over a long period. As we described, the many previous attempts to do this had caused extreme anxiety that had precipitated assaultative behaviour and led to the potential placements falling through. Adshead appears to assume that the communication issues for our patient were the same as for the non-autistic majority, unfortunately this is not supported by the research evidence.

Second, Adshead was incorrect to describe this as a forensic case; the patient was detained under a civil section and had been for many years inappropriately placed in a forensic facility, hence the impetus to move her into an autistic friendly environment.

Third, again as detailed in the case, her suspicions around the time issue are unfounded, planning around the move took many months of careful negotiation. Fourth, at no point was false information given to the patient (i.e. the patient was not told a lie), we rather withheld information. Last, the concept of human dignity is now widely used in a variety of complex bioethical debates from care of children with behavioural disorders through palliative care to the patenting of DNA and xenotransplantation.

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Psychiatrists, stigma and unlimited responsibility

Sir: Howlett (*Psychiatric Bulletin*, August 2000, **24**, 287–288) has an incontestable right to advance the concerns of those affected by homicides perpetrated by psychiatric patients, particularly if they are deemed to have occurred as a consequence of failed community care. Nevertheless he appears unable to give nuanced and contextually relevant arguments as evidenced by his most recent commentary (*Psychiatric Bulletin*, November 2001, **25**, 414–415). This, to my mind, illustrates the invidious position we straddle between the Government/pressure group instigated paternalism and the respect for autonomy so beloved of our patients. He appears to marshal point after point in pursuit of his central thesis that we as a group have not been called to account as frequently and severely as our perceived failings would suggest we deserve. And in the process convicts himself of an overarching stigmatising prejudice towards patients who kill and ourselves as their responsible medical officers. Casting them as if grotesques – medication- and supervision-free, roaming the streets looking for victims – and ourselves as overpaid incompetents. Surely the real issue is the rather low priority given to our patients by successive governments in the face of unemployment, poor housing, derisory benefit entitlement, badly resourced services and demoralised staff. All of the aforementioned occurring in a deeply fearful and prejudiced society, where the press continues to poison the atmosphere with sensational and jaundiced reportage. The gloves should come off and psychiatry needs to shout a lot louder, 'more resources and less of the stigma'. Something I am happy to say has started in earnest!

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the college

Honorary Fellowships

Nominations to the College's Honorary Fellowship will be discussed at the October meeting of the Court of Electors.

The regulations of the College state under Bye-Law Section VI that 'Subject to the Regulations the College may elect as an Honorary Fellow any person, whether or not he is a member of the medical profession, who either is eminent in psychiatry or in allied or connected sciences or disciplines or has rendered distinguished service to humanity in relation to the study, prevention or treatment of mental illness or to subjects allied thereto or connected herewith or has rendered notable service to the College or to the Association'.

Nomination forms are available from Mrs C. Cole, Department of Postgraduate Educational Services, to whom nominations for the Honorary Fellowship should be sent by 30 September 2002. Such nominations must contain recommendations by no less than six Members of the College, and include full supporting documentation.

A. M. Dean Head of Postgraduate Educational Services, Royal College of Psychiatrists

Hospital doctor awards – 2002

The College is keen to become more closely involved with the above prestigious awards event, which is held annually at the Grosvenor House Hotel, London. It is hoped that our active participation in these awards will not only improve the morale of psychiatric teams, but also draw attention to the excellent work being carried out in specialist units throughout the UK.

The overall aims of the *Hospital Doctor* Awards are to:

- highlight and reward excellent work being undertaken in the NHS
- identify teams that have devised creative solutions to improve patient care
- raise awareness in a therapy area
- share best practice in secondary care through coverage in *Hospital Doctor*.

The awards will be launched in April, and entrants have between 10 and 12 weeks to enter. If you are aware of good work being carried out in your area, and would like to make a nomination, please write directly to Kathy Lambart, Hospital Doctor Awards, Reed Healthcare, Quadrant House, The Quadrant, Sutton, Surrey SM2 5AS (tel: 020 8652 8614; fax: 020 8652 8780; e-mail: kathy.lambart@rbi.co.uk).

The Ferdinande Johanna Travelling Fellowship

Please note that this biennial Fellowship will next be awarded in 2004 and not 2002, as indicated in the current edition of the Prizes Booklet.

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