Correspondence

To convey or not to convey?

The process of conveyance with the Deprivation of Liberty Safeguards (DoLS) is an important issue.[1] Conveyance can involve restraint, which does not usually amount to a deprivation of liberty and is covered by the Mental Capacity Act 2005, Sections 5 and 6. Paragraphs 2.14 and 2.15 of the *Deprivation of Liberty Safeguards Code of Practice*[2] attempt to deal with this issue, although it is worth examining recent case law for an answer.

In *DCC v KH* (2009)[3] it was suggested that a standard authorisation would be sufficient to return an individual to the care home or hospital (from a place of residence), where the deprivation of liberty has been authorised, without any additional authority.[4] This judgment suggests that permission from the court is not required when returning somebody to where there is a standard authorisation for them to be deprived of their liberty. The DoLS Code of Practice states: 'In almost all cases, it is likely that a person can be lawfully taken to a hospital or a care home under the wider provisions of the Act, as long as it is considered that being in the hospital or care home will be in their best interests' (par. 2.14).

Notably, paragraph 2.15 of the Code describes 'exceptional circumstances' when conveyance could amount to a deprivation of liberty and an order from the Court of Protection (to provide a residence order) would be necessary. With the majority of complaints regarding the Court of Protection originating from the length of the process and delays,[5] effective planning for conveyance is advisable.

1 Shah A, Heginbotham C. Newly introduced deprivation of liberty safeguards: anomalies and concerns. *Psychiatrist* 2010; **34**: 243–5.

2 *DCC v KH* (2009) COP 11729380.

3 Ministry of Justice. *The Mental Capacity Act 2005: Deprivation of Liberty Safeguards. Code of Practice to Supplement the Main Mental Capacity Act 2005 Code of Practice*. TSO (The Stationery Office), 2008.

4 Department of Health. *Briefings on Legal Cases*. Department of Health, 2010 (http://www.dh.gov.uk/en/Healthcare/Mentalhealth/DH_111770).

5 Judiciary of England and Wales. *Court of Protection: 2009 Report*. Judiciary of England and Wales, 2010.

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Smoking and people with mental illness

People with mental health problems smoke significantly more, have increased levels of nicotine dependency and are therefore at even greater risk of smoking-related harm than the general population.[1,2]

We surveyed the smoking habits of in-patients on four adult open wards in Durham and compared them with those of the general UK population. The national statistics were obtained from Action on Smoking and Health Fact Sheets[3] and from the Office for National Statistics.[4]

The overall smoking prevalence for the in-patients was three times the national average (65% *v.* 21%). Addiction to nicotine can be measured by noting how long after waking a person smokes their first cigarette: 35% of in-patients and 16% of the general population had their cigarette in the first 5 minutes. Furthermore, 57% of the general population and 70% of in-patients said they would find it hard to go for a whole day without smoking. Worryingly, 78% of the in-patients said that they smoked more when they are admitted; the reasons given included boredom and a belief that smoking reduces side-effects of medication and causes weight loss. More than half of the patients (60%) expressed a desire to cut down smoking. It can be concluded that in-patients smoke more and are more addicted than the general population.

Following this survey, we have recommended that the in-patients should be offered advice on smoking cessation at the time of the admission and discharge. Treatment should also be offered routinely, particularly as a review of smoking cessation treatments for people with mental illness concluded that pharmacological aids that are given to the general population can be equally effective in helping people with mental illness to stop smoking.[5] However, care must be taken to avoid adverse medication interactions and to monitor antipsychotic medication in particular as cigarette consumption declines.

Boredom as an excuse for smoking should be challenged with structured occupational therapy programme. We also feel that patients should be encouraged to manage their weight by exercising and could be helped with advice from a dietician.

We would like to know if other readers have had similar experiences regarding smoking on in-patient wards, especially as there are plans to percolate the smoking ban down to lower levels of security. We are aware that some of the healthcare wings in prison are also now smoke free.

1 Cormac I, Creasey S, McNeill A, Ferriter M, Huckstep B, D'Silva K. Impact of a total smoking ban in a high secure hospital. *Psychiatrist* 2010; **34**: 413–7.

2 Faculty of Public Health. *Mental Health and Smoking: A Position Statement*. Faculty of Public Health, 2008.

3 Action on Smoking and Health Fact Sheets. *Smoking Statistics: Who Smokes and How Much*. ASH, 2010 (www.ash.org.uk/files/documents/ASH_106.pdf).

4 Robinson S, Bugler C. *General Lifestyle Survey 2008: Smoking and Drinking among Adults, 2008*. Office for National Statistics, 2010.

5 Campion J, Checinski K, Nurse J. Review of smoking cessation treatments for people with mental illness. *Adv Psychiatr Treat* 2008; **14**: 208–16.

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More can be done to improve readability of patient letters

The quality of communication with our patients is of paramount importance and it is crucial to promoting successful therapeutic engagement.

We recently completed a study, similar to that by Bhandari,[1] exploring the readability of assessment letters being produced by an adult community mental health team (CMHT) in south-west England. We looked at all new assessment letters produced over a 3-month period. As the CMHT assessment is usually the first point of contact with services, we felt that the readability of assessment letters was particularly important with regard to engagement and promoting a shared understanding of a person's difficulties.

We used readability software available as a standard with Microsoft Word 2007 to establish the Flesch Reading Ease.[2] This is a validated tool widely used to assess readability, based on the syllabic and sentence structure of the text. Reading ease on this scale ranges from 0 to 100, with specific intervals categorised from 'very easy' (90–100) to 'very difficult' (0–29).

Like Bandari, we found that no letters were 'easy' or 'very easy' to read. However, we found that letters were significantly more readable ($P = 0.004$) if they were addressed to the patient with the general practitioner copied in, rather than *vice versa*. We speculate that this is because when dictating a letter to the patient, the patient and their understanding is borne in mind to a greater extent than when addressing a colleague.

In addition, the readability of letters varied by professional group. Whereas there was no significant difference in readability between junior doctors', occupational therapists' and social workers' letters, community mental health nurses and consultants produced significantly less readable letters ($P = 0.001$ and $P = 0.000$ respectively). The fact that no letters reached the standard of 'easy' or 'very easy' may reflect the difficulty of using simple terms to describe psychopathology. However, some authors produced much more readable letters than others, which suggests that improvement is possible.

We found it interesting that junior doctors wrote more readable letters than their consultant colleagues. We speculated that corresponding directly with patients is a skill with which consultants may lack historical experience as they have spent more of their careers corresponding principally with fellow health professionals. As a result they may be less familiar with methods to make letters more readable to the general public.

We concluded that assessment letters produced by community mental health workers do not score well for readability. We feel is of the utmost importance that the reading ability of our patients is borne in mind when writing such letters. Simple changes such as addressing the patient directly may help improve readability.

1 Bhandari N. Readability – writing letters to patients in plain English. *Psychiatrist* 2010; **34**: 454.

2 Flesch R. *The Art of Readable Writing*. Harper & Row, 1973.

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Risk to staff in a crisis resolution team

Crisis resolution and home treatment (CRHT) teams are now well established. There is significant evidence that they reduce bed use, are cost-effective and patients prefer them to admission.[1]

A CRHT team is dependent on the expertise and imagination of its staff to help understand and resolve a crisis. However, the risk to staff of working intensively with people who would otherwise be in hospital is not well documented. The evaluations of CRHTs have not considered the staff or the impact of frequent visits from different staff on people at high risk of acting violently.[1,2] Risk management is a continuous task in a CRHT team. There is some concern that risks to patients may increase with the introduction of a CRHT team, although this is far from established.[3]

We conducted an anonymous survey of the Hammersmith and Fulham Crisis Resolution Team in London. We asked whether they had felt physically vulnerable during community visits and encouraged them to describe any relevant incidents. Respondents included doctors, nurses, occupational therapists, support workers and bank staff. Duration of work with the team ranged from a few weeks to over 6 years. All had at least two jobs in psychiatric services before joining the crisis team and most had several years of previous mental health experience, in CRHT teams and on wards.

More than half of the respondents (13 of 20) had felt physically vulnerable while on a home visit. Their experiences ranged from feeling concerned about personal safety when with patients who were aroused or were experiencing psychosis, to being chased out of an abode when violence was threatened. No one had been physically harmed. The remaining seven people had all worked with the team for less than a year. Everyone working in the team for longer than a year reported feeling physically vulnerable during at least one visit.

We found that exposure to risk from patients was ubiquitous among all established CRHT staff in our study. It is particularly important to document risk to staff to avoid minimisation. As health services reduce costs, crisis teams will be asked to increase the threshold and reduce the duration of in-patient care further. Crisis resolution home treatment teams receive several hundred referrals a year. The short response times, high expectations and anxiety of referrers, as well as pressure to act and prevent admission all potentially reduce thinking about risk.

1 Joy CB, Adams CE, Rice K. Crisis intervention for people with severe mental illnesses. *Cochr Dat Syst Rev* 2007; issue 4. CD001087.

2 National Audit Office. *Helping People through Mental Health Crisis: The Role of Crisis Resolution and Home Treatment Services*. TSO (The Stationery Office), 2007.

3 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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Polypharmacy: should we or shouldn't we?

Much has been written recently in *The Psychiatrist* about how psychiatrists should manage antipsychotic polypharmacy. Taylor[1] could hardly be more emphatic: 'evidence supporting antipsychotic polypharmacy has, if anything, diminished and