

article the data-set they looked at applies only to one CRHT. The second CRHT was not in existence in the two time periods when the data were collected.

There are inaccuracies in the reporting; in the results section the authors report duration of bed use and refer to Table 2 which is occupied bed days. The duration of bed use and number of bed days are two different measures. Also, numbers do not add up in Table 2, however they do add up in Table 1.

In summary, the study reports no statistically significant difference in number of admissions or number of bed days following introduction of a CRHT when compared with an area without the team. However, raw figures demonstrate a decrease in informal admissions and bed days, and an increase in formal admissions in the area where there is a crisis team.

The authors make assumptions that the increase in compulsory admissions following the introduction of a CRHT was because some patients who would otherwise have been admitted to the hospital and then detained under Section 5(2) of the Mental Health Act were taken on by the CRHT and then getting admitted through mental health assessments and on a section. This assumption is not supported by the data-set or anecdotal evidence.

The study also found that there is an increase in suicide in the catchment area where there is a CRHT. However, none of these suicides happened when the patients were under the CRHT. As it stands, it is difficult to explain that the increase in suicide is somehow connected to the introduction of the CRHT.

It is safe to assume that in Cardiff as the experience of the team grows and the teams get more embedded they will have a significant effect on both number of admissions and bed usage as demonstrated by the National Audit Office report.²

1 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.

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

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Authors' reply Dr Mahadun & Sadiq are right on both counts. The title 'A controlled comparison of the introduction of a crisis resolution and home treatment team' should be the proper title of the article. The top two lines of data in Table 2 are also incorrect, and should read as shown here.

These data illustrate an effect of the crisis resolution team (CRT) overall in reducing bed days. We agree that the interpretation of the data cannot provide a causal pathway between the experience of seeing a CRT and then having a higher risk of being admitted compulsorily, as we were not following the experience of individual patients through the care system. However, it is a reasonable hypothesis to posit that the increase in compulsory admissions following the introduction of the CRT was a direct consequence of the change in service provision across the trust. The same conclusion might be made about the change in suicide rates, but of course we stress that this was not a significant difference. The conclusion we are

Table Number of bed days occupied in two 9-month study periods before and after the introduction of a crisis resolution (CRT) team

Patient status	Team	CRT service (number per 1000 population)	Control service (number per 1000 population)
Total	Pre-CRT	6133 (74.2)	15 525 (72.4)
	Post-CRT	5542 (67.1)	15 352 (71.6)

putting forward, and this was not one we were expecting when we started the study, is that the service configuration that follows the introduction of a CRT is one that tends to limit admissions and may possibly be directly associated with more compulsory admissions and more suicides. This is an important hypothesis to test, but we agree it cannot be confirmed from our data.

Drs Ogunremi & Talat argue from the position of enthusiasts for the CRT policy and we do not disagree with their opinion that it is a 'viable and acceptable approach to treating people with severe mental illness'. But all policies have to be tested and evaluated, and clearly all your correspondents would agree that if a CRT, for whatever reasons, makes decisions that lead to greater compulsion and more suicides in either the shorter or longer term, their implementation should be questioned. In this context it could also be argued that a reduction in bed usage is probably a poor outcome measure; quality of life, patient satisfaction and clinical improvement over a reasonable period (e.g. probably about a year to cover all aspects of an illness episode) are much preferred.

Declaration of interest

J.M. is currently a consultant in one of the Cardiff crisis resolution teams.

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Improving physical health monitoring in psychiatry – change we need?

Gonzalez *et al*¹ highlight the very important issue of routine blood testing of patients on antipsychotics, which currently is under-monitored in a psychiatric setting, particularly so in out-patients. However, the audit was conducted between 2004 and 2005, and it might not represent the current practice in UK. But physical health monitoring of patients with mental health problems still remains unsatisfactory. Some studies in 1986 and 2004 reported recording of physical examination carried out on admission by psychiatric trainees to be 'uniformly poor' to 'variable'.² The age-adjusted annual death rates from all causes among individuals with a psychiatric diagnosis is two to four times higher than in the general population.³ This makes it even more pertinent for us to take extra measures in order to provide the best care for our patients.

In 2009, we completed an audit with colleagues at North Derbyshire Mental Health Services NHS Trust. The results illustrated that physical examination on admission to an in-patient unit increased from 67 to 83% by the end of the audit cycle. The reasons for not examining patients varied from 'transferred from medical ward' to 'team to review tomorrow'. We encouraged the consultant-led teams to take more responsibility in ensuring that a complete physical examination (including investigations such as baseline bloods and electrocardiograms) is done for every patient admitted to the unit, and also recommended quick and easy access to physical health equipment, especially out of hours.

While I appreciate the emphasis of the Royal College of Psychiatrists on increasing the awareness of physical illnesses in our client group and the importance of their detection, I believe actions speak louder than words. Our under-performance in this area is due to problems at multiple levels. Training in psychiatry has become completely detached from medicine. We need to increase psychiatric trainees' exposure to medicine by incorporating physical examination in the MRCPsych curriculum nationally and possibly offering a compulsory rotation in medicine during core training. We also need to change the ethos within psychiatric teams (in-patient and community based) by encouraging psychiatric nurses to also improve their medical skills.

It can be quite tricky in out-patients to address physical health problems while also managing mental health issues. Like other services, why can't we have a dedicated nurse at the out-patient clinic who records blood pressure, measures height, weight, hip and waist circumference, and does all the routine blood tests for every patient, before they go in to see the doctor?

- 1 Gonzalez C, Ahammed N, Fisher R. Improving physical health monitoring for out-patients on antipsychotic medication. *Psychiatr Bull* 2010; **34**: 91–4.
- 2 Garden, G. Physical examination in psychiatric practice. *Adv Psychiatr Treat* 2005; **11**: 142–9.
- 3 Harris EC, Barraclough B. Excess mortality of mental disorder. *Br J Psychiatry* 1998; **173**: 11–53.

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Attitudes to ECT – a nebulous concept with important implications

Kinnair *et al*¹ raise some important points regarding training and teaching students on electroconvulsive therapy (ECT). Some of the questions used, particularly in assessing students' attitudes to ECT, have been used in similar studies^{2,3} and would therefore carry some face validity. Clearly, it is important to consider the sequence of teaching events in any instructional design of a teaching block; however, I would disagree with some of the authors' conclusions. With such a descriptive study design, the use of binary variables (yes/no answers) and the absence of *P*-values, one cannot infer any significant differences between Groups A, B, C and D with regard to changes in knowledge of ECT. The relatively smaller sample sizes of these groups compared with the baseline

sample would make a Type I error more likely, that is any differences seen could be due to chance.

Intuitively, one would expect either Group B or C to do better with their follow-up knowledge questions, simply based on constructivist theory (i.e. building on previously attained knowledge). In Group B, a certain amount of knowledge will be acquired from simply watching an ECT procedure. The authors did not state how soon after the lecture and/or witnessed ECT event, students were asked to complete the questionnaire. One cannot therefore assume a limited benefit (in terms of knowledge obtained) from watching ECT before receiving a lecture, as this could equally be due to having the lecture closer to the questionnaire.

I find the absence of any tables to explain the results of their attitudes questions somewhat disappointing. Previous research in this area has shown that medical students' attitudes to ECT can be improved by receiving a didactic lecture on ECT,⁴ as well as observing an ECT application (either live or a pre-recorded video),⁵ so it is not surprising that Group B showed improved attitudes on two of the questions compared with Group D. It would have been interesting to know how many of those students who had seen either *One Flew over the Cuckoo's Nest* or *Beautiful Mind* belonged to Groups A or D, which could explain the different response with regard to question 10 – 'I would agree to have ECT if I was depressed'.

Better knowledge of ECT, particularly self-perceived knowledge, does not necessarily imply better attitudes to ECT.⁶ If we want to attract more students to our profession, further research in this area is essential to help unveil some of the secrets behind students' negative perceptions, attitudes and prejudices with regard to ECT.

- 1 Kinnair D, Dawson S, Perera R. Electroconvulsive therapy: medical students' attitudes and knowledge. *Psychiatrist* 2010; **34**: 54–7.
- 2 Clothier JL, Freeman T, Snow L. Medical student attitudes and knowledge about ECT. *J ECT* 2001; **17**: 99–101.
- 3 Abbas M, Mashrai N, Mohanna M. Knowledge of and attitudes toward electroconvulsive therapy of medical students in the United Kingdom, Egypt, and Iraq: a transcultural perspective. *J ECT* 2007; **23**: 260–4.
- 4 Papakosta VM, Zervas IM, Pehlivanidis A, Papadimitriou GN, Papakostas YG. A survey of the attitudes of Greek medical students toward electroconvulsive therapy. *J ECT* 2005; **21**: 162–4.
- 5 Warnell RL, Duk AD, Christison GW, Haviland MG. Teaching electroconvulsive therapy to medical students: effects of instructional method on knowledge and attitudes. *Acad Psychiatry* 2005; **29**: 433–6.
- 6 Gazdag G, Kocsis-Ficzere N, Tolna J. Hungarian medical students' knowledge about and attitudes toward electroconvulsive therapy. *J ECT* 2005; **21**: 96–9.

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Concerns over professional boundaries remain unresolved

The Executive Committee of the Spirituality and Psychiatry Special Interest Group (SPSIG) of the Royal College of Psychiatrists has made a rather late response¹ to Harold Koenig's editorial² published in this journal in 2008. We were co-signatories to a letter³ that was highly critical of some of