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trends. Furthermore, such information would help contribute to relevant research in mental health service provision to Black and minority ethnic groups in the UK.

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Educational factors associated with e-learning

In her excellent editorial, Elizabeth E. Hare discusses e-learning for psychiatrists.¹ We wish to highlight another e-learning resource for psychiatrists, of which the readership may not be aware.

Mayes *et al* suggest that 'there are really no models of e-learning *per se* – only e-enhancements of models of learning'.² So as with all learning, e-learning needs to be based on good pedagogical principles, with good instructional design as a foundation.

Further, Hattie conducted a meta-analysis where he examined the relative effectiveness of various educational factors on student achievement.³ The top seven in terms of effect size were: reinforcement (1.13), student's prior cognitive ability (1.00), instructional quality (1.04), direct instruction (0.82), remediation/feedback (0.65), student's disposition to learn (0.61) and class environment (0.56).

It is possible to see how e-learning may enhance 'reinforcement' and 'student's disposition to learn'. Video e-learning represents another form of e-learning, which also addresses the 'direct instruction' and 'class environment' interventions – it may be easier to learn from a 'live' teacher talking with credibility and passion directly to the student in a classroom, rather than reading the same words from written text. By way of example, the *Video Journal of Psychiatry* is a sponsored online service providing

classroom-like lectures on MRCPsych curricula and continuing professional development topics to Irish psychiatrists (www.vjpsych.ie).

Cook *et al* have shown that internet-based learning is beneficial to students and is probably as effective as the traditional instructional methods.⁴ What is needed now is more research, comparing the efficacy of the various internet-based interventions.

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General practitioners and early intervention in psychosis

Delay in the initiation of treatment in individuals with first-episode psychosis has been associated with poorer long-term outcomes.¹ El-Adl *et al* report on general practitioner (GP) experiences of patients with a first psychotic episode.² However, I have a number of concerns about the reported results.

The low reported incidence of new cases per year within the authors' locality ($n = 100$) was demonstrated by the majority (68%) of GPs seeing only one or two such individuals per year. I find it difficult to see, given these low cell counts, how GPs could answer questions about initiating treatment (10%, 25%, 50% and 75% of the time) and thus conclude that GPs are unlikely to start treatment before referring to secondary care services.

The information requested from the GPs regarding engagement of patients with first-episode psychosis and causes of delayed referral are based on these low patient numbers and would be subject to recall bias on behalf of the GP. Getting the patients' views on barriers to mental

health services would certainly have helped triangulate the data.

I was also concerned that the data published were 5 years old and as such the current generalisability of these results could be questioned.

With the National Institute for Health and Clinical Excellence schizophrenia guidelines recently updated³ and early intervention/crisis resolution teams the norm rather than exception, El-Adl *et al* echo the view that active engagement with our primary care colleagues is paramount in ensuring these patients receive both a responsive and effective service.

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General practitioners and early intervention in psychosis: reply

We wish to express our thanks to Dr Bowers for the interest in our article.¹ Dr Bowers feels that the majority of GPs reporting seeing only one or two patients with first-episode psychosis a year is a low figure. However, this agreed with Shiers & Lister's findings.²

Dr Bowers expressed reservations about the GPs' ability to answer questions about their prescribing trends to patients with first-episode psychosis. I may disagree with this view as the low number of patients does not exclude or make it difficult for GPs to comment on engagement or otherwise. It is our view that clinicians, including GPs, may be more able to remember cases that are not very frequently seen than common ones.

Dr Bowers' suggestion that getting the patients' views on barriers to mental health services would certainly have helped to triangulate the data – this puts forward the idea for another study. The scope of this study was about GPs' experience and not patients' or carers' experience.