



Finally, Dr Bowers expressed his concern about the length of time elapsed between conducting our study and the results being published. We appreciate the importance of avoiding such delay but would point out the following: (1) clinicians with numerous clinical duties need to plan the study, make the time for data analysis, writing and submitting papers, responding to reviewers, and wait after putting the paper in the queue of the articles accepted for publication until it is published; (2) the real question should be whether or not this delay has any impact on applicability of the study results. We feel that where the early intervention service model has already been adopted it is not too late for it to be reviewed and further developed. If, on the other hand, some areas have not yet developed their early intervention model, it is not at all late.

- 1 EL-Adl M, Burke J, Little K. Frist-episode psychosis: primary care experience and implications for service development. *Psychiatr Bull* 2009; **33**: 165–8.
- 2 Shiers D, Lester H. Early intervention for first-episode psychosis needs greater involvement of primary care professionals for its success. *BMJ* 2004; **328**: 1451–2.

**\*Mamdouh El-Adl** Consultant Psychiatrist, Northamptonshire Healthcare NHS Trust, Campbell House, Campbell Square, Northampton NN1 3EB, email: mamdouhkandil@doctors.org.uk, **John Burke** Consultant Psychiatrist, Northamptonshire Healthcare NHS Trust, **Karen Little** Clinical Governance and Professional Development Manager, Preston Primary Care Trust

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## Doctors in the house. Home visits for older people: a practical model outside Yorkshire

There is a curious sentence in Negi *et al*'s paper about psychiatric out-patient clinics for older adults.<sup>1</sup> When they refer to Benbow's paper about community clinics,<sup>2</sup> they state that 'this model has not been adopted either in rural or urban catchment areas'. No evidence is quoted for this sweeping statement.

Admittedly, in our fast moving National Health Service it is difficult to keep track of changes. In 1997 we investigated the work of old age psychiatrists.<sup>3</sup> Every day of the week community clinics were reported by 20% or more of respondents (the corresponding figures for hospital out-patient clinics ranged between 17 and 28%). Additional community activity was undertaken as domiciliary visits and new home visits. Domiciliary visits are well-defined: they incur additional payment and occur at the request of the general

practitioner, normally in his or her company, to advise on diagnosis or treatment, where the patient cannot attend hospital on medical grounds. Home visits can involve follow-up or new assessments and are undertaken without additional remuneration as part of the doctor's working day.

We later reported a more in-depth analysis which found that community activity was greater among consultants working with colleagues in comparison with those who worked alone.<sup>4</sup>

Since then, Richardson & Orrell have reported that home assessments are popular with patients, carers and professionals, going on to argue that they also provide more information.<sup>5</sup> The College Faculty of Old Age Psychiatry seems to think community clinics are normal practice.<sup>6</sup>

In all the services we have worked in, home visits carried out during community clinics have been the norm – but then neither of us has worked in Yorkshire. Visits are efficient and cost-effective, with non-attendance rates consistently lower than 10% in our services, as well as providing the continuity of follow-up desired by patients, carers and colleagues in primary care and social services, and in line with the *National Dementia Strategy*.<sup>7</sup> It is important that Negi *et al* set the record straight: in many good services for older people home visits are the reality.

- 1 Negi R, Seymour J, Flemons C, Impey M, Thomas N, Witrylak R. Psychiatric out-patient clinics for older adults: highly regarded by users and carers, but irreplaceable? *Psychiatr Bull* 2009; **33**: 127–9.
- 2 Benbow SM. The community clinic – its advantages and disadvantages. *Int J Geriatr Psychiatry* 1990; **5**: 119–21.
- 3 Jolley DJ, Benbow SM. The everyday work of geriatric psychiatrists. *Int J Geriatr Psychiatry* 1997; **12**: 109–13.
- 4 Benbow SM, Jolley DJ. Gender, isolation, work patterns and stress amongst old age psychiatrists. *Int J Geriatr Psychiatry* 1999; **14**: 719–25.
- 5 Richardson B, Orrell M. Home assessments in old age psychiatry. *Advan Psychiatr Treat* 2002; **8**: 59–65.
- 6 Faculty of Old Age Psychiatry. *Raising the Standard. Specialist Services for Older People with Mental Illness*. Royal College of Psychiatrists, 2006 (<http://www.rcpsych.ac.uk/PDF/RaisingtheStandardOAPwebsite.pdf>).
- 7 Department of Health. *Living Well with Dementia: A National Dementia Strategy*. Department of Health, 2009.

**\*Susan Mary Benbow** Professor of Mental Health and Ageing, Centre for Ageing and Mental Health, Staffordshire University, Blackheath Lane, Stafford ST18 0AD, email: drsmbenbow@aol.com, **David Jolley** Consultant Psychiatrist, Pennine Care NHS Foundation Trust, and Honorary Reader, Manchester University Personal Social Services Research Unit

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## Therapists' competence – maintenance matters too

Davidson & Scott left us in no doubt that therapist competencies matter in the delivery of psychological therapies.<sup>1</sup> As a concept there has always been a degree of 'face validity' to this assertion, but it is the attention they devote to maintaining competence that is perhaps of most significance – and most concern – within psychiatry. In 2005, the *Psychiatric Bulletin* published the results of a survey of psychiatrists who had received training to diploma level at one of Scotland's recognised cognitive-behavioural therapy (CBT) courses.<sup>2</sup> The results clearly established that access to personal supervision and for some also opportunities in continuing professional development were poor. Nevertheless, there was optimism that with the advent of job planning, consultant psychiatrists could spell out and negotiate for the time needed to undertake this, so as to ensure that these specific skills are not wasted. Indeed, Whitfield concludes that 'planners should think carefully about how to harness and hold on to psychiatrists with these (CBT) skills if future diversity in psychological skills training is to be assured'.<sup>2</sup>

For CBT at least, the assessment of the competencies required to deliver effective therapy has been aided by the publication of a self-assessment tool by the British Association for Behavioural and Cognitive Psychotherapies ([www.babcp.com/members/-a-self-assessment-tool-of-cbt-competences-/](http://www.babcp.com/members/-a-self-assessment-tool-of-cbt-competences-/)), in response to the 2007 Department of Health publication,<sup>3</sup> and the Royal College of Psychiatrists has outlined the competencies required for training in psychotherapy in general. Not knowing why, how or what to do is no longer an issue.

Unfortunately, in 2009 consultants face increasing pressure from employers to replace supporting professional activity time with direct clinical care time, the assumption being that this will bring better value for money for the National Health Service. Jobs with as few as one supporting professional activity are being advertised which in our view is inadequate to allow consultant psychiatrists to be involved in teaching and training as well as maintaining their own continuing professional development. This would be regarded as completely unacceptable by others involved in delivering psychological therapies, for example clinical psychologists.

It seems highly likely that increased direct clinical care time by consultants will come at the expense of robust supervision arrangements for them and for the supervision that they can supply. This makes it likely that improved access to psychological therapies, at least as delivered by psychiatrists, will not bring



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with it the desired outcomes for patients. Davidson & Scott are right to be anxious about the quality of what is offered.<sup>1</sup>

- Davidson K, Scott J. Does therapists' competence matter in delivering psychological therapy? *Psychiatr Bull* 2009; **33**: 121–3.
- Whitfield G, Connolly M, Davidson A, Williams C. Use of cognitive-behavioural therapy skills among trained psychiatrists. *Psychiatr Bull* 2006; **30**: 58–60.
- Roth AD, Pilling S. *The Competences Required to Deliver Effective Cognitive and Behavioural Therapy for People with Depression and with Anxiety Disorders*. Department of Health, 2007.

**\*Moira Connolly** Consultant Psychiatrist and Clinical Director, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow G12 0XH, email: moira.connolly@ggc.scot.nhs.uk, **Tom Brown** Consultancy Liaison Psychiatrist, Western Infirmary, Glasgow

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## Quality of dementia referrals

I was interested to learn from the audit of dementia referrals to a later life psychiatry service that only 13.2% of referral letters contained Mini-Mental State Examination (MMSE) results.<sup>1</sup> Findings from a neurology-led dementia service were little better, with around 20% of referrals from primary care containing evidence of cognitive test results, most commonly the MMSE.<sup>2</sup> These results contrast with those from a postal survey which claimed 79% use of dementia screening tests in three English primary care trusts.<sup>3</sup> How can the discrepancy be accounted for?

It would seem unlikely that general practitioners (GPs) would not report MMSE results in a referral letter to a dementia service if the test had been undertaken. More likely, the MMSE is too time consuming in primary care and/or too difficult to interpret. If so, then the use of other, briefer, screening instruments with unambiguous cut-offs, such as Mini-Cog or GP-Cog,<sup>3</sup> must be vigorously encouraged in primary care. No example of their use was encountered in the Fisher & Larner study.<sup>2</sup>

This could form one aspect of the 'raising awareness' strand in the implementation of the *National Dementia Strategy*.<sup>4</sup>

- Hussey D, Foy K, Meehan K. Quality of dementia referrals to later life psychiatry service. *Psychiatr Bull* 2009; **33**: 154–5.

- Fisher C, Larner AJ. Frequency and diagnostic utility of cognitive test instrument use by GPs prior to memory clinic referral. *Fam Pract* 2007; **24**: 495–7.
- Milne A, Culverwell A, Guss R, Tuppen J, Whelton R. Screening for dementia in primary care: a review of the use, efficacy and quality of measures. *Int Psychogeriatr* 2009; **20**: 911–26.
- Department of Health. *Living Well with Dementia: A National Dementia Strategy*. Department of Health, 2009.

**Andrew J. Larner** Consultant Neurologist, Cognitive Function Clinic, Walton Centre for Neurology and Neurosurgery, Lower Lane, Fazakerley, Liverpool L9 7LJ, email: a.larner@thewaltoncentre.nhs.uk

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## Web information about electroconvulsive therapy

Joshi is understandably concerned about the bias to much of the information about electroconvulsive therapy (ECT) that can be found on the internet.<sup>1</sup> However, he and his patients do not need to look even as far as www.patient.co.uk to find reliable information for services users, carers and families, as the College has a range of such materials available on its website (www.rcpsych.ac.uk/mentalhealthinformation.aspx). It has gained a reputation for reliable content written in a style that is accessible to most readers. We have won several commendations at the British Medical Association awards over the past few years and receive consistently complementary feedback from our web readers.

Our ECT page is rather longer than most of our leaflets and perhaps not quite as readable because of the complexity of the issues involved. However, I think it holds up well against most such web-published information on the subject. Although we do not yet have a printed version, a copy can be printed off the internet. Many of our leaflets are available in paper form and I would commend the readers to have a look at these. They are free to individuals who request them and available to purchase in bulk through the Leaflets Department at the College.

- Joshi N. Internet electroconvulsive therapy (letter). *Psychiatr Bull* 2009; **33**: 155.

**Philip W. Timms** Consultant Psychiatrist, Chair of the Royal College of Psychiatrists Public Education Committee, START team, South London and Maudsley NHS Foundation Trust, 88 Camberwell Road, London SE11 0EG, email: philip.timms@slam.nhs.uk

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## What's right for older people

Hilton's article is a clear and challenging description of the current state of play.<sup>1</sup> I understand her declaration of interest – 'I work in a trust where I perceive older adults' services to be less well-funded relative to services for younger adults' – has been deemed controversial by some. How can this be? She is simply stating her perception of things and that perception is congruent with the truth of the matter in every mental health trust in the country, and in every setting in which older people receive sponsored care.<sup>2</sup>

Things were much worse before we created specialist services, when older patients were housed in 50-bed wards and received no therapeutic input.<sup>2</sup> It was deemed they did not need therapy because they would not benefit from it. Yet older people and those of us who have worked with them have never shouted loudly for equality, preferring to make modest best-use of the resources made available to us.

I was astonished, when working for a while in a learning disability setting, to find that individuals with dependency and behavioural profiles quite commonly seen in old age services were regularly being supported with care-packages costing several times the top rate payable for older people with dementia.

Perhaps now is the time to ask for more.

Sadly, the Healthcare Commission's review ducks the issue, preferring to cite commendable examples of good practice and pursuing the line that age-related services should be abandoned.<sup>1</sup> That should bury the problem and make it less visible – just as it was when we came in.<sup>2</sup>

- Hilton C. Psychological therapies, older people and human rights. *Psychiatr Bull* 2009; **33**: 184–6.
- Healthcare Commission. *Equality in Later Life: A National Study of Older People's Mental Health Services*. Commission for Healthcare Audit and Inspection, 2009.
- Robb B. *Sans Everything: A Case to Answer*. Nelson, 1967.

**David Jolley** Honorary Reader, Consultant Psychiatrist, Personal Social Services Research Unit, Manchester University, Dover Street Building, Dover Street, Manchester M13 9PL, email: David.Jolley@manchester.ac.uk

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