Correspondence

CRHT services and in-patient bed closures: the whole story?

Barker *et al*'s examination of the introduction of a crisis resolution and home treatment (CRHT) service to Edinburgh[1] was of great interest to us in the North-East of Scotland. However, we have significant concerns as to the widespread reproducibility of their findings. The authors conclude that this service reduced admissions by 24%, but we believe that they paid scant attention to the planned, concurrent closure of 30% of adult beds. They made little attempt to account for this and consequent effects on admission rates and bed pressure, leading us to question the suggestion that CRHT may catalyse more efficient use of in-patient beds.

Owing to the paucity of demographic data, we found it difficult to assess the applicability of the results. The study population described had a high proportion of people with major mental illnesses, with a striking lack of dual diagnoses and adjustment disorders. We can only hypothesise on the effect of other nearby emergency psychiatric services on the CRHT case-load, and were surprised that the provision of overnight stay, from March 2009, at the Edinburgh Crisis Centre was not considered a confounding variable.[2]

We would question the outcome of high user satisfaction, given the 29% response rate to the questionnaire, with possible selection bias. We would also have been interested to hear how patients rated the CRHT in comparison to hospital admission, and how allied services, within Edinburgh and beyond, including adjacent health board areas, rate their satisfaction with this novel team.

We struggle with comparisons made to admission rates in Scottish health board areas without CRHTs – for example, the reported 9% reduction in Grampian admissions. Grampian is a diverse area of 3400 square miles, with a mixed rural and urban population, yet comparisons have been offered to the 100 square mile City of Edinburgh, which is but one part of the Lothian Health Service.

Using Information Services Divisions (ISD) Scotland data for general psychiatry adult admissions in 2009–2010, adjusted for the 2008 NHS Scotland Resource Allocation Committee (NRAC) population formula, we calculate an admission rate of 3.39 per 1000 adult population for Grampian, compared with 3.77 for Lothian, with a reported mean stay for Grampian of 35.1 days per episode, compared with 40.4 days for Lothian (further details available from the authors).

In addition, the 2009–2010 Mental Welfare Commission report confirms a lower rate of immediate detention in Grampian, with emergency detention rates of 15 per 100 000 in Grampian against 31 per 100 000 in Lothian, and short-term detention rates of 70 per 100 000 in Aberdeen city compared with 78 per 100 000 in Edinburgh.[3]

In our opinion, despite the conclusions of the Barker *et al* paper (including comparisons with other health board areas), we remain concerned that similar services, with the obvious attraction to managers of potential bed closures, will be prematurely implemented across Scotland, and we question whether a CRHT service would provide any additional benefits to the population of Grampian, where continuity of care based on primary care and local authority aligned services remains the cornerstone of practice.

Declaration of interest

A.P. and S.M.C are employees of NHS Grampian.

1 Barker V, Taylor M, Kader I, Stewart K, Le Fevre P. Impact of crisis resolution and home treatment services on user experience and admission to psychiatric hospital. *Psychiatrist* 2011; **35**: 106–10.

2 Nicholson JJ. Crisis Centre's contribution? (eLetter) *Psychiatrist* online 5 April 2011 (http://pb.rcpsych.org/content/35/3/106.full/reply#pbrcpsych_el_10797).

3 Mental Welfare Commission for Scotland. *Our Overview of Mental Welfare in Scotland 2009–10*. MWC Scotland, 2010 (http://reports.mwcscot.org.uk/annual_monitoring/overview2009-2010/annualreport2009-2010.aspx).

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Case-based discussion – focus on feedback, not tick boxes

As a trainee who has gone through Modernising Medical Careers (MMC) and completed numerous workplace-based assessments (WPBAs), including case-based discussions (CbDs), I read with interest the paper by Mynors-Wallis *et al*[1] on CbD as a tool for revalidation. Their conclusions were that consultants were positive about CbD but research on trainees showed resentment and mistrust. I suspect that the trainees' views mentioned by the authors are not representative of current opinion, as the study does not acknowledge when the research was done, which was just after the MMC and 6 months after WPBAs were rolled out. This was the time of a seismic change in delivery of training, with both trainees and supervisors adjusting to the new landscape.

I carried out research focusing on the educational value of WPBAs 2 years after their introduction, using a questionnaire and trainee interviews (the results are unpublished, details available on request). The questionnaire was completed by 48% of trainees (41/86 specialist registrars years 1–5) and 41% of educational supervisors (35/86). This showed that 73% of trainees and 79% of supervisors felt that WPBAs had an educational value which was heavily dependent on feedback. Similarly, in the results obtained by Babu *et al*,[2] CbD was ranked the most useful by trainees, with no difference between higher and lower trainees. Trainees valued the discussion around the case, particularly on diagnosis and management, and supervisors felt that this gave better sense of trainees' independent functioning. Both supervisors and trainees identified the importance of assessor training, and noted the tension between the formative and summative