

## Crisis resolution and home treatment teams and intensive home treatment teams are worthwhile – but not everywhere

On behalf of my co-authors, I thank the correspondents for their interest in our paper.<sup>1</sup>

The Edinburgh Crisis Centre is undoubtedly an important resource for the city, but it is not a crisis house in the Camden mould. They have a maximum of four beds, with a maximum duration of stay of 7 days. They do not take referrals from the National Health Service (NHS), and do not share information with the NHS. During a 12-month period, they had only 12 residential clients, who were also working with our intensive home treatment team (IHTT). So to conclude that the Crisis Centre is the reason for a reduction in hospital admissions is simply not accurate, although IHTT values the presence of the Centre.

Dr Bhattacharya will have noted that we demonstrated a 17% reduction in admissions requiring detention during our study (see previous letter by Bhattacharya & McQueen). This is in contrast to Forbes *et al* and Tyrer *et al* (see Bhattacharya & McQueen for references). The Forbes study was based on a nurse-led service operating in a semi-rural environment, which already had a good-quality community mental health team and low base rate of detention. We have already mentioned the limitations of the Tyrer study.<sup>1</sup> An important point about not conflating crisis teams with home treatment teams is also made, and we believe it is home treatment that can obviate the need for admission.

Finally, Drs Casserly & Palin<sup>2</sup> quite rightly suggest that our findings or model cannot automatically be generalised to other areas – this may be particularly true in remote or rural areas like Grampian. However, the planned bed closures they allude to would not have occurred without adequate alternative community provision – this was explicit in the strategy. Of course, once beds are closed, raw admission numbers fall, but not necessarily re-admissions or detentions (as we found). Further, mean length of stay has also fallen, consistent with a supportive 'early discharge' role. Naturally, we see a lot of dual diagnosis, but record only primary diagnosis. Last, pollsters such as MORI state that any postal survey with a response rate >10% is valid, and 29% of over 700 cases is a reasonable return, with many patients stating that they preferred home to the local psychiatric hospital as their locus of care. It should also be noted that in over 2 years of IHTT working with individuals who are by definition high risk, only one suicide has (tragically) occurred.

So, even in these austere times service innovation can have positive outcomes, but it is important to critically appraise these innovations against existing practice.

- 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 Casserly SM, Palin A. CRHT services and in-patient bed closures: the whole story? (e-letter). *Psychiatrist* 2011; 19 April (<http://pb.rcpsych.org/cgi/eletters/35/3/106#10826>).

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## For whose benefit?

Papers highlighting the difficult issue of 'off-label prescribing' are always of interest.<sup>1</sup> However, in the context of financial restraints and increasing cutbacks, the assertion, taken from the Royal College of Psychiatrists' guidelines, that such a modus operandi of prescribing requires frequent monitoring may be unhelpful.<sup>2</sup>

Clearly, several combinations of treatments for depression and other conditions might be 'off-label', yet they continue to be used regularly. Further, they are documented in widely known prescribing protocols such as the Maudsley guidelines and CANMET–MD, some with an arguably more transparent basis than the National Institute for Health and Clinical Excellence process for formulating guidelines. It might be time for psychiatrists to start using clinically appropriate, positive-risk 'off-label' prescribing that, as long as an evidence base has been followed, allows for the time interval between reviews to be increased. We should prescribe what makes a difference for the patient; not what contains the prescriber's anxiety.

- 1 Uzozechina CE, Hilvering P, Rogers C, O'Brien S, Pullela A, Yousafzai M, et al. Off-label prescribing in people with recurrent depressive disorder attending a community mental health service. *Psychiatrist* 2011; **35**: 84–9.
- 2 Holloway F. 'Gentlemen, we have no money therefore we must think' – mental health services in hard times. *Psychiatrist* 2011; **35**: 81–3.

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## Emotional intelligence in psychiatrists and surgeons: issue of gender bias?

Stanton *et al*<sup>1</sup> present an interesting paper looking at the comparative analysis of emotional intelligence between psychiatrists and surgeons, but what I really want to know is whether there was any evidence of a difference in constituents (subscales) of emotional intelligence between genders? The reason I am raising this question is because there are gender differences found for the main factors that comprise emotional intelligence.<sup>2</sup> More specifically, women are more aware of their emotions, show more empathy, relate better interpersonally, and act in a more socially responsible manner than men. On the other hand, men appear to have better self-regard, are more independent, solve problems better, are more flexible, and cope better with stress.<sup>3</sup>

This is of great relevance seeing that there was a clear evidence of imbalance of gender distribution in Stanton *et al*'s study: there were more female psychiatrists (39%) as compared with female surgeons (17%). This raises the possibility of a bias in relation to differences detected among psychiatrists and surgeons in the component factors that make up the total emotional intelligence. It is possible that a proportion of these differences detected among the two groups could be accounted for by gender imbalance. Future studies are needed to address this issue.

- 1 Stanton C, Sethi FN, Dale O, Phelan M, Laban JT, Eliahoo J. Comparison of emotional intelligence between psychiatrists and surgeons. *Psychiatrist* 2011; **35**: 124–9.

- 2 Sánchez-Núñez MT, Fernández-Berrocá P, Montañés J, Latorre JM. Does emotional intelligence depend on gender? The socialization of emotional competencies in men and women and its implications. *Electr J Res Educ Psychol* 2008; **15**: 455–74 (<http://www.investigacion-psicopedagogica.org/revista/new/english/ContadorArticulo.php?253>).
- 3 Mission: Possible. *Emotional Intelligence – Tactical Tips* ([http://www.missionpossibleinc.com/emotional\\_intelligence.htm](http://www.missionpossibleinc.com/emotional_intelligence.htm)).

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## Quixotic jousting over mental states

Neither Thomas Szasz<sup>1</sup> nor Edward Shorter<sup>2</sup> grasps the nettle of mental pain, which is at the heart of the psychiatric experience. As in any institution, consensus in medicine is a political process; Shorter represents the one we have now, which is that doctors treat lesions. (The neurologist Henry Miller declared over 40 years ago that ‘psychiatry is neurology without physical signs’.<sup>3</sup>) Szasz’s charge is that this stance deprives patients of a responsibility to make use of the help they seek. When asked to ‘to raze out the written troubles of [Lady Macbeth’s] brain’, Macbeth’s physician is right to imply that there is more to this than cerebral pathology. Many people suffer terribly; some – like Lady Macbeth – through their own deeds, others through events or diseases beyond their control. But what is Szasz’s ‘active patient’ to do with a doctor who only wants to look at his or her brain? Psychiatry is diminished to the extent that it cannot face the experience of patients and their desire to be understood, as well as treated.

- 1 Szasz T. The myth of mental illness: 50 years later. *Psychiatrist* 2011; **35**: 179–82.
- 2 Shorter E. Still tilting at windmills. Commentary on . . . The myth of mental illness. *Psychiatrist* 2011; **35**: 183–4.
- 3 Miller H. Psychiatry: medicine or magic? *Br J Hosp Med* 1970; **3**: 122–6.

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## Proportional or balanced decisions?

I was interested to read Curtis *et al*’s analysis of the proportionality principle and what it means in practice.<sup>1</sup>

I was intrigued as to the authors’ views on the role of balancing (in the legal sense) in reaching decisions day to day in relation to patient healthcare and the competing interests related to the use of the Mental Health Act. Certainly, proportionality has

been described by some as the dominant underlying theme of the European Convention on Human Rights, but others argue that the principle of balancing has had at least as prominent a role to play in UK courts. For example, there is significant variation across different jurisdictions in terms of the consistency with which the proportionality principle has been applied by the courts. Goold *et al*<sup>2</sup> report that in comparison with other countries, the UK has been more likely to adopt a balancing approach – described as ‘a broad brush, and sometimes opaque analysis aimed at resolution of the interests and rights involved’. This is in contrast to the multistage analysis that occurs when the proportionality principle is applied. Goold *et al* comment that in terms of the right of liberty, Germany is the jurisdiction which applies a strict necessity test against any deprivation of liberty, whereas UK courts have been inclined to balance rights and interests against each other. The authors liken the balancing principle to a utilitarian analysis of the rights and public interest goals in question.

Curtis *et al* quite rightly point out that multidisciplinary team decision-making often involves an analysis of the rights and interests of the patient and the public, and liken this to the legal principle of proportionality. I suspect in practice the decisions multidisciplinary teams make daily are more in keeping with the legal concept of balancing, and perhaps the authors refer here to proportionality in the common rather than legal sense of the word. My point here is that given the propensity of UK courts to opt for a balancing approach, it is perhaps a one-dimensional view to refer only to the principle of proportionality in relation to the Convention. Additionally, I am not convinced that there will be many clinicians who opt to make use of the four-pronged Huang test as opposed to a broad-sweep analysis when it comes to decisions in daily practice. This, of course, does not take away from the usefulness of highlighting the need for clinical decisions to be mindful of human rights, but I am not convinced that readers should feel obliged to use a multistage analysis test for clinical decisions for fear of contravening human rights legislation – as this would not appear to reflect the legal situation as it stands today.

- 1 Curtice M, Bashir F, Khurmi S, Crocombe J, Hawkins T, Exworthy T. The proportionality principle and what it means in practice. *Psychiatrist* 2011; **35**: 111–6.
- 2 Goold B, Lazarus L, Swiney G. *Public Protection, Proportionality and the Search for Balance*. Ministry of Justice Research Series 10/07 (September 2007).

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