



Anomaly in the transitional arrangements for the Mental Health Act 2007

The new Mental Health Act 2007 (Department of Health, 2008) takes New Ways of Working (Royal College of Psychiatrists & National Institute for Mental Health in England, 2005) to a new level. For the first time in history, nurses, psychologists, social workers and occupational therapists may take on the role of responsible clinician (previously responsible medical officer), but will first have to undertake initial training and demonstrate the competencies laid out to be an approved clinician.

Transitional arrangements are in place for current responsible medical officers to become approved clinicians on 3 November 2008, when the provisions of the Act come into force, as long as they have carried out the functions as responsible medical officer in the past 12 months. Therefore, not all Section 12-approved doctors will be automatically approved as approved clinicians and therefore cannot act as responsible clinicians. This leaves trainees applying for their first consultant post and newly appointed consultants who have not acted as responsible medical officers in the past 12 months in a place of uncertainty. Provisions have not been made for these doctors who may be taking over the care of service users who may require a responsible clinician after the 3 November 2008. New appointments could be jeopardised if trusts realise potential candidates will not be able to take over as responsible clinicians after 3 November.

It is unclear whether Section 12-approved doctors first have to undertake the training and demonstrate the competencies as for other professionals seeking approval as approved clinician. It is unclear how long this process would take. Interim responsible clinician arrangements have not been outlined for these doctors and it appears that trainees aspiring to become responsible clinicians have been forgotten. Clarity is urgently required.

ROYAL COLLEGE OF PSYCHIATRISTS & NATIONAL INSTITUTE FOR MENTAL HEALTH IN ENGLAND (2005) *New Ways of Working for Psychiatrists*. Department of Health.

DEPARTMENT OF HEALTH (2008) *Mental Health Act 2007: Consultation on Secondary Legislation*. Department of Health.

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Integrity

Bhugra (2008) says that if our trainees see us as tired, fed up and demoralised they are likely to question not only our commitment but also their own professional attributes. But there are other possibilities. Feeling tired, fed up and demoralised should lead to reflection on what internal and external factors are driving this. Our trainees should see the real world as it is and what they are signing themselves up for. It is not in their interests to see a rose-tinted picture. Questioning is good, but both they and we must ask the right questions. I see this as an issue of integrity and being honest with trainees and ourselves.

Walking in to work every day with masked depression is not healthy.

BHUGRA, D. (2008) Renewing psychiatry's contract with society. *Psychiatric Bulletin*, **32**, 281–283.

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An alternative to conventional care for young people with anorexia nervosa

A community intensive therapy team (CITT) for young people with complex mental health problems was developed in South Wales in 1998 (Darwish *et al*, 2006). We report here a small study of 30 service users (27 female, 3 male) with anorexia nervosa, referred to CITT over a 4-year period.

Mean age at referral was 14.56 years (14.4 for females, 15.67 for males; range 12–17 years); body mass index (BMI) at referral ranged from 13.1 to 18.0 (mean=15.52). A mean discharge BMI of 19.3 was recorded following an average period of treatment of 16.7 months for females and 10 months for males. The duration of out-patient care provided by CITT ranged from 5 months to 3.5 years for 16 patients, with the remaining 14 patients receiving ongoing intervention. During the 4-year study period no service users were admitted to hospital.

DARWISH, A., SALMON, G., AHUJA, A., *et al* (2006) The community intensive therapy team: development and philosophy of a new service. *Clinical Child Psychology and Psychiatry*, **11**, 591–605.

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Limitations of observational studies with known confounders

The recent article by Dibben *et al* (2008) provides positive evidence that crisis resolution and home treatment teams for older people reduce admission rates to hospital by 31%. Their findings are based upon a 6-month observational study conducted before and after the introduction of the new service. We believe the results are unreliable and should be treated with caution.

The analysis of baseline characteristics shows no significant difference between the patient groups; however, it is misleading as external factors are likely to confound the results in this case.

The authors confirm that during the study period a dementia care ward was closed, as were two day-hospitals. These changes are likely to represent known confounding variables. Closure of the dementia ward will invariably lead to reduced admission rates as a direct result of reduced capacity to admit service users. The day hospital closure may also serve to raise the clinical threshold required for admission given the reduction in day attendance capacity.

No data is provided regarding in-patient bed capacity and how this was reduced following bed closures, thus readers are unable to estimate the magnitude of the potential impact upon results. In addition, no data is provided for the potential known confounding variable of out-of-area admissions, which can occur when a hospital reaches full occupancy.

Clearly, the gold standard for study design would have been a randomised controlled trial. This is often not possible given feasibility implications. Ideally, the authors should have used a control group of service users who were not treated by the new service. This should then have been followed by appropriate use of multivariate regression analysis to account for the effects of the known confounding variables. The authors rely on past randomised research to support their findings (Johnson *et al*, 2005; Joy *et al*, 2006). The participants of the cited studies were not solely older adults and the results are therefore not directly generalisable to their sample. We accept their research is novel and designed with service limitations in mind, but we believe they offer only a basic understanding of their subject.



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DIBBEN, C., SAEED, H., STAGIAS, K., *et al* (2008) Crisis resolution and home treatment teams for older people with mental illness. *Psychiatric Bulletin*, **32**, 268–270.

JOHNSON, S., NOLAN, F., PILLING, S., *et al* (2005) Randomised controlled trial of acute mental health care by a crisis resolution team: the north Islington crisis study. *BMJ*, **331**, 599.

JOY, C. B., ADAMS, C. E. & RICE, K. (2006) Crisis intervention for people with severe mental illnesses. *Cochrane Database of Systematic Reviews*, **18**, CD001087.

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Pragmatic comparison of outcome measures before and after the introduction of a crisis and home treatment service for older people

We found admission rate decreased after introduction of the crisis resolution and home treatment team (CRHTT; Dibben

et al, 2008) but believe this was not due to bed cuts. Reducing the number of beds will reduce total number of admissions but not necessarily admission rate (total number of admissions over number of crisis events). We tested (Chi-squared) differences in this proportion and not total number of admissions *per se*.

Beds for older people were cut from 42 to 24. We did not examine bed occupancy but during the study period no patients were admitted out of area. Even if occupancy rate remained the same after the introduction of the CRHTT, one could argue that the CRHTTs were effective because they were operating on a total reduced in-patient capacity.

Our study is one of the first in examining the impact of CRHTTs for older adults. We mentioned that our findings are consistent with results from studies of CRHTTs in working age adults, but we do not claim that the work in general adult psychiatry is generalisable to our sample.

A research question may be answered in many ways using different epidemiological designs. We are aware a double-blind randomised control trial is the gold standard for measuring effectiveness of an intervention, but we used a pragmatic design with a 6-month period before introduction of the CRHTT as control. We defined case appropriately, compared

groups at baseline, examined several outcome measures and used appropriate statistical methods, which make our findings valid and reliable.

The introduction of the CRHTT for older people, it should be noted, took place in the context of a service with well-established community mental health teams. A recent report from another old age psychiatry service supports the encouraging conclusions of our study (Warner & Lowery, 2008).

DIBBEN, C., SAEED, H., STAGIAS, K., *et al* (2008) Crisis resolution and home treatment teams for older people with mental illness. *Psychiatric Bulletin*, **32**, 268–270.

WARNER, J. & LOWERY, K. (2008) A successful older adult home treatment team. Report in Old Age Psychiatrist. *Newsletter of the Faculty of the Psychiatry of Old Age*, Spring, 10–11.

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