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Proposed College working party on psychiatry and religion

The establishing of a Royal College of Psychiatrists' working party to consider the boundaries of psychiatry and religion, as suggested by Poole & Higgs,¹ is indeed a pragmatic, constructive and, in our view, long overdue proposal.

It was in 1991 that our Patron, the Prince of Wales, first reminded the College that therapy involved body, mind and spirit.² In that same year, the current President Dinesh Bhugra organised a meeting at the Institute of Psychiatry at which Bill Fulford cogently urged delegates to explore the limits of tolerance at the boundaries of psychiatric practice and religious belief.³

Can the President please, in his last year of office, establish a working party which would consider these matters, consult widely and make recommendations relevant to the core clinical, research and educational objectives of the College? Such a working party will require the arms-length approach of transcultural psychiatry as well as a broad, multi-faith perspective and astute leadership, fully sensitive to the concerns of religious and secular psychiatrists as well as service users and other health professionals.

If the World Psychiatric Association can be approaching an international consensus on this subject,⁴ then surely the College can usefully now give a lead in Europe where these matters are particularly pressing.

Declaration of interest

J.C. is a Christian from the Methodist tradition. A.J.G. was recently ordained Deacon in the Church of England.

- 1 Poole R, Higgs R. Psychiatry, religion and spirituality: a way forward. *Psychiatrist* 2010; **34**: 452–3.
- 2 HRH The Prince of Wales. Lecture by HRH The Prince of Wales, as Patron, to the Royal College of Psychiatrists, Brighton, Friday 5 July 1991. *Br J Psychiatry* 1991; **159**: 763–8.
- 3 Fulford KWM. Religion and psychiatry: extending the limits of tolerance. In *Psychiatry and Religion: Context, Consensus and Controversies* (ed D Bhugra): 5–23. Routledge, 1996.
- 4 Verhagen P, van Praag HM, Lopez-Ibor JJ, Cox JL, Moussaoui D (eds). *Religion and Psychiatry: Beyond Boundaries*. Wiley Blackwell, 2010.

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Not all 'crisis teams' are the same

I am concerned by the claims made in the paper by Forbes *et al.*¹ It purports to add to the literature relating to the introduction of a crisis resolution and home treatment team (CRHTT), by demonstrating little impact on bed use and increased compulsory admissions. This is misleading as the

study actually shows the effect that a new CRHTT, which does not adhere to the consensus model, may have as part of a complex, changed system.

The paper describes admission and compulsory admission rates before and after a service redesign (which includes the inception of a CRHTT), but reports these as if the set up of the CRHTT was the only important change. In reality, the changes included a reduction in in-patient beds, reprovision of beds several miles away, and presumably uncertainty and anxiety in staff during the change period.

I am not surprised by the lack of impact on bed use and the increase in compulsory admissions. The CRHTT did not include key elements associated with reduced admissions as determined by evidence and the National Audit Office.^{2–4} First, the Midlothian team had no designated consultant or social worker (although there was 'ready access' to the latter). Second, the CRHTT did not do its own face-to-face gatekeeping in all cases, and the proportion of admissions subject to gatekeeping by the CRHTT is not supplied. Third, the team did not operate a 24-hour service.

It is vital to communicate accurately with commissioners and others about the economic value, safety and effectiveness of psychiatric services. Not all teams providing frequent visits outside of hospital are a CRHTT, but the distinction is not likely to be widely understood. The development of accreditation criteria for CRHTTs is now urgent.

- 1 Forbes NF, Cash HT, Lawrie SM. Intensive home treatment, admission rates and use of mental health legislation. *Psychiatrist* 2010; **34**: 522–4.
- 2 Joy CB, Adams CE, Rice K. Crisis intervention for people with severe mental illnesses. *Cochrane Dat Syst Rev* 2006; **4**: CD001087.
- 3 Glover G, Arts G, Babu KS. Crisis resolution/home treatment teams and psychiatric admission rates in England. *Br J Psychiatry* 2006; **189**: 441–5.
- 4 National Audit Office. *Helping People through Mental Health Crisis: The Role of Crisis Resolution and Home Treatment Services*. TSO (The Stationery Office), 2007.

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Simulated patients – stimulated patients?

Mitchison & Khanna¹ contribute an interesting letter to *The Psychiatrist* about the experience of role-playing actors, or simulated patients, who have become ubiquitous in OSCE-based examinations (such as the CASC) in medicine and psychiatry. Using qualitative methods, they briefly describe aspects of the simulated patients' experience, but focus on one: the emotional stress the actors can experience after role-playing psychiatric patients repeatedly over the course of an examination.

The role of simulated patients in psychiatric OSCEs is a lightly researched topic. We conducted a study in 2009 looking at the role in examinations of the same population that Mitchison & Khanna describe, i.e. UK MRCPsych trainees.² One finding was that simulated patients and examiners scored 'empathy' and 'communication' differently (unlike the real examination, we asked the actors to mark the candidates). In a *post-hoc* unpublished exploration of why this might be (by using a questionnaire with both groups), we were unable to find the answer to this question.

Having read Michison & Khanna's letter, I wonder whether the answer to the question lies in the emotionally distressed state the actor puts him or herself into while acting the role, and the perception of the candidate not responding to this sufficiently; whereas the examiner, who is not emotionally aroused, is less likely to down-score the candidate.

It is a pity that Mitchison & Khanna's findings were not published in a full-length article because I would like to know more.

- 1 Mitchison S, Khanna P. Role players' experience of psychiatric examinations. *Psychiatrist* 2010; **34**: 542–3.
- 2 Whelan P, Church L, Kadry K. Using standardized patients marks in scoring postgraduate psychiatry OSCEs. *Acad Psychiatry* 2009; **33**: 319–22.

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Are reminders effective in reducing non-attendance?

Rajasuriya *et al*¹ highlight an important issue of non-attendance among out-patients and look at how to deal with this effectively. Their results show a reduction in non-attendance rates after using reminders in the form of letters and telephone calls. Their study identified several risk factors for non-attendance such as affordability or patient's level of education. However, they have overlooked many others.

The one important factor Rajasuriya *et al* failed to mention is the possibility of patients being admitted to hospital, whether for physical or mental health concerns. This could have led them to miss their out-patient appointments.

One significant issue raised in their study is in relation to healthcare services in Sri Lanka. These are not based on geographically designated catchment areas, therefore individuals can access the clinic of their choice in any part of

the country. This means that some of the non-attendees in one service might have attended another service. Unless we have more information in relation to this, it would be difficult to make judgement about risk factors (male gender, substance use, bipolar disorder, schizophrenia, etc.) of non-attendance with any certainty (increased or decreased risk) and the real impact of reminders. It is quite possible that people might have shopped around for doctors and were planning to attend their next appointment anyway (with or without reminders).

In order to evaluate the effectiveness of reminders in reducing non-attendance, the design of the study should have been that of an intervention study, i.e. randomising non-attendees to an intervention (reminders) and control (no reminders) group. This is the only way of dealing with so many characteristics or risk factors mentioned in the study. This is important because all baseline characteristics that affect attendance and differ between treatment groups could potentially confound the relationship between reminders and non-attendance. Also, randomisation takes care of unknown confounding factors that are not identifiable, and these factors are distributed equally among treatment groups. Thus, randomisation can provide a degree of assurance about the comparability of the study groups that is simply not possible in any observational study design.² I give credit to the authors for acknowledging the need of randomisation in the limitations of their study. I still feel, however, that it is difficult to draw any meaningful inferences from this study due to the drawbacks associated with the study design.

- 1 Rajasuriya M, de Silva V, Hanwella R. Effectiveness of reminders in reducing non-attendance among out-patients. *Psychiatrist* 2010; **34**: 515–8.
- 2 Hennekens CH, Burning JE. *Epidemiology in Medicine*. Little, Brown & Co, 1987.

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