



the columns

correspondence

In-patient care – staff training

Lelliott *et al* highlight some real and urgent problems in acute mental health services (*Psychiatric Bulletin*, October 2006, **30**, 361–363). As the Psychology Lead on adult acute in-patient services in Lambeth I have a long experience of working on acute in-patient wards and agree with all the problems described: focus has been on community services; the environment is often not therapeutic; there is always a staffing crisis and the bed management system governing the functioning of the services is there to meet the needs of the service rather than the needs of the service users.

As Lelliott *et al* point out there is no shortage of guidelines, but they are not always easily implemented. In-patient care is overshadowed by the focus on community care, which, although important, cannot remove the need for a safe and therapeutic environment for those who require hospitalisation. To improve the quality of care and the therapeutic environment on the wards we need to focus on the ward itself. Some fundamental changes are needed to support frontline staff. This is where I see a role for my profession – psychology.

Apart from organisational and systemic needs, there is also the issue of staff training. The accreditation of acute in-patient mental health services as described by Lelliott *et al* would be an important development. For this to work, frontline staff would need to perceive any training as something which supports and helps them in their work, rather than yet another bureaucratic demand. In South London and Maudsley NHS Foundation Trust we have developed a 1-day training course on implementing the recommendations of the Department of Health guidelines on adult acute mental health care provision (Department of Health, 2002). One of the objectives was to train staff in skills conducive to developing a therapeutic environment on acute wards. The courses were well attended and well received, suggesting that frontline staff might welcome such initiatives. Details of the course are available from the author.

DEPARTMENT OF HEALTH (2002) *Mental Health Policy Implementation Guide: Adult Acute Inpatient Care Provision*. Department of Health.

Katja Hajek Psychology Lead on Adult Acute In-patient Care in Lambeth, Oak House, Lambeth Hospital, 108 Landor Road, London SW9 9NT

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'Do not resuscitate' decisions – need for objective measures

Chakraborty & Creaney (*Psychiatric Bulletin*, October 2006, **30**, 376–378) described the understanding of 'do not resuscitate' (DNR) orders among staff in continuing care psychiatric wards. Many nursing staff and many psychiatric trainees connect DNR orders not only with cardiopulmonary resuscitation (CPR) but also with the intensity of medical intervention for physical illness. Deterioration of physical health is more common than cardiac arrest on old age continuing care psychiatric wards and requires a decision on whether or not to transfer to a medical facility. In the absence of clear guidelines, the role of DNR orders is debatable.

The argument for a DNR order is clear. In advanced dementia complicated by physical debilitation, CPR is unlikely to be successful. If successful, residual brain damage worsens the prognosis, contributing to an even poorer quality of life. Such information is understood by relatives. However, reasons given for not transferring to a medical ward appear vague and at worst inhumane to relatives. A common explanation from a medical registrar on duty is that further intervention is unlikely to improve quality of life. This is viewed by many relatives as evidence of ageism in an era of scarce resources. Indeed, transferring such patients may improve their quality of life by relieving pain and discomfort caused by reversible conditions such as pneumonia, septicaemia and bowel obstruction.

Perhaps the answer lies with clear and transparent guidelines supported by objective means of measuring quality of life. Old age psychiatrists need training in palliative care so that they can justify their

treatment choices in those with terminal illness.

David Cornelius Staff Grade in Old Age Psychiatry, Whitchurch Hospital, Park Road, Cardiff CF14 7XB, email: davycorn@yahoo.com

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We recently conducted an audit of the documentation of cardiopulmonary resuscitation (CPR) status in patients on a 20-bed dementia assessment ward (all with a diagnosis of dementia and lacking mental capacity to discuss resuscitation) and found that only a quarter had their CPR status documented. Following discussions with staff to draw their attention to trust policy on CPR, re-audit showed only modest improvement: CPR status was documented in half of the patients' notes. An educational programme was arranged to address the potential barriers to optimal CPR documentation. Subsequent audit showed documentation of CPR status in three-quarters of patients.

Poor quality of life and futility of CPR are often cited as the reasons behind the decision not to resuscitate. Despite the advanced age and diagnosis of dementia in our patients, judgements on patients' quality of life can be complex and emotive, and the critical factor seemed to be a lack of readiness among staff to initiate discussion of issues surrounding death.

We agree that relatives should be involved in discussions on resuscitation. However, this has to be done with sensitivity so that a decision not to resuscitate does not add to the relatives' sense of guilt. Often this can be achieved by presenting such decisions as a considered opinion of the team before seeking the relatives' view.

Zoë Hawkins Senior House Officer in Psychiatry, ***Ajay Upadhyaya** Consultant Psychiatrist, Herts and Essex Hospital, Cavell Drive, Bishop's Stortford, Herts CM23 5JH, email: frances.stride@hpt.nhs.uk

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Standard template for letters to general practitioners

Dinniss *et al* (*Psychiatric Bulletin*, September 2006, **30**, 334–336)



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demonstrated the impact of a standardised admission form on admission booking by psychiatric trainees. A similar audit was completed in our local trust (Bransholme) and showed considerable improvement in practice after the introduction of a standard template for writing letters from the out-patient clinic to the general practitioner.

The template combined recommendations from various sources, including Pullen & Yellowlees (1985) and College guidelines for new patient assessment (Royal College of Psychiatrists, 2001). The template stressed the inclusion of the diagnosis in each letter along with the ICD-10 code. The main focus of the template was encouraging trainees to use the bio-psychosocial approach while explaining the management plan in the letter.

Prior to the introduction of the standard template, trainees missed out important information such as diagnosis with the ICD-10 code and prognosis from the letter. Most trainees left out documentation of explanation of the condition to the patient, the item identified as important by general practitioners in the survey of Pullen & Yellowlees (1985)

The results of the completed audit cycle confirmed the effectiveness of the standard template. We also received positive feedback from general practitioners, many of whom thought that the standardised letters conveyed much more information. The standard template not only resulted in improved communication with the general practitioner but also helped trainees to prepare for the Membership examinations.

PULLEN, I. M. & YELLOWLEES, A. J. (1985) Is communication improving between general practitioners and psychiatrists? *BMJ*, **290**, 31–33.

ROYAL COLLEGE OF PSYCHIATRISTS (2001) *Curriculum for Basic Specialist Training and the MRCPsych Examination*. Royal College of Psychiatrists. <http://www.rcpsych.ac.uk/files/pdfversion/cr95.pdf>

Vijayendra Waykar Senior House Officer, Humber Mental Health Teaching NHS Trust, Victoria Dock, Hull HU9 1PQ, email: vijayendra_waykar@rediffmail.com

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Home treatment in early psychosis

As the practitioners in both home treatment and early intervention in psychosis we read the article of Gould *et al* (*Psychiatric Bulletin*, July 2006, **30**, 243–246) with interest. The conclusion that there is only a 'modest' role for home

treatment in early psychosis is striking. To test the robustness of this finding we recently conducted a small local survey.

Using routinely collected computer data we followed all new patients with psychosis for 3 months over a 15-month period to August 2006. We recorded 29 new patients, representing an annual incidence of new cases of psychosis of approximately 46 per 100 000. Twelve patients (41%) were initially managed in the community; the other 17 (59%), were hospitalised. Only 3 patients (10%) were managed initially with home treatment. However, 11 (38%) were discharged from hospital to home treatment for facilitated early discharge. During this period, no patients were admitted to hospital from home treatment or any other community service, including early intervention in psychosis.

Our small survey appears to confirm the main findings of Gould *et al*, that over half of all patients with first-episode psychosis are initially managed in hospital when home treatment is available. As Gould *et al* point out this indicates the need for hospital-based early intervention. However, we also found a strong role for facilitated early discharge with home treatment. It is likely that such discharges not only shorten the duration of hospitalisation but also enhance care during a high-risk transitional period.

In summary, we found signs of a substantive but complex role for home treatment during the early phase of psychosis, one that may be enhanced rather than eclipsed by a service for early intervention. We also found some encouraging initial indications of the wider impact of early intervention and a need for early intervention teams to work within hospitals and alongside home treatment teams. Services should be configured and integrated to reflect this need.

***John Lowe** Consultant Psychiatrist, Home Treatment Team, St Charles Hospital, London W10 6DZ, email: jlowe@nhs.net, **Kate Beary** Senior House Officer, Home Treatment Team, **Raj Tanna** Consultant Psychiatrist, Early Intervention in Psychosis Team, **Gary Wannan** Consultant Psychiatrist, Early Intervention in Psychosis Team and Child and Adolescent Mental Health Service, Central and North West London Mental Health Trust

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Implementation of care programme approach in learning disability

It is appalling that services have not all implemented the care programme

approach (CPA) for people with learning disabilities and mental health problems (Roy, 2000). This is despite clear guidance regarding this patient group (Department of Health, 1999). Indeed, one meaningful way of promoting empowerment would be to ensure that such people receive the same recognised standard of mental healthcare as everyone else. The CPA audit in people with learning disabilities reported by Ali *et al* (*Psychiatric Bulletin*, November 2006, **30**, 415–418) is thus welcome. It raises two issues of care coordination.

First, there has also been resistance to CPA implementation by learning disabilities' psychologists here in South London. However, all professionals need to follow this modern, holistic, systematic, multi-disciplinary way of organising mental healthcare. Services for people with learning disabilities are relatively well resourced with psychology staff compared with most generic mental health services. In addition, the lead intervention is frequently the introduction and ongoing review of behavioural management guidelines. Thus psychologists and/or behavioural therapists are often the best placed to become CPA care coordinators for some people with learning disabilities.

Second, Ali *et al* describe using care coordinators who are not employed by mental health trusts. However, it will always be difficult to monitor CPA properly through the governance systems of primary care trusts or social services departments or non-statutory organisations when none of these has a mental health focus or priority. The CPA is a major reason why mental health services for people with learning disabilities should always be sited within mental health trusts (O'Hara, 2001).

DEPARTMENT OF HEALTH (1999) *Effective Care Co-ordination in Mental Health Services. Modernising the Care Programme Approach*. Department of Health.

O'HARA, J. (2000) Learning disabilities services: primary care or mental health trust? *Psychiatric Bulletin*, **24**, 368–369.

ROY, A. (2000) The Care Programme Approach in learning disability psychiatry. *Advances in Psychiatric Treatment*, **6**, 380–387.

Colin Hemmings Consultant Psychiatrist in Learning Disabilities, South London and Maudsley NHS Trust, Guy's Hospital, 47 Weston Street, London SE1 3RR, email: Colin.Hemmings@slam.nhs.uk

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