Correspondence

Innovative and effective approaches to crisis services

As a patient, I was recently under the care of a London crisis intervention team. The compassion of the individual staff members was negated by systemic flaws in the way the service was delivered.

The experience was very unsettling. Different staff would arrive twice daily at my home because shift patterns would not allow the same workers to see me regularly. Consequently, a constructive, consistent relationship with members of the crisis team was not possible. A stream of strangers entered my small, cramped flat, and the crisis team actually became part of my mental trauma.

The problem with the crisis team as an institution is that it is about cost-cutting rather than caring. It felt like a mere sticking plaster on a huge mental wound.

While cost-cutting remains the ethos, patients are bound to suffer. The loss of in-patient beds is putting pressure on community services that they cannot sustain. Cost-cutting may masquerade as streamlined efficiency and effectiveness, but it is really a way to hobble and cripple psychiatric provision.

Good treatment cannot be delivered without flexibility and variety, both community-based and hospital-based. The crisis team concept is an ineffective half-way (and half-baked!) house between community and hospital.

Declaration of interest
The author is a psychiatric patient.

The name and address of the London trust and the name and address of the patient have been withheld for confidentiality reasons. To contact the author, please email pb@rcpsych.ac.uk

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British television viewers, cover your ears!

While watching a well-known, popular soap on the BBC recently, I was disgusted to hear one of the characters with recently diagnosed bipolar affective disorder being referred to by another character as a 'mentalist'.

Both entertainment and news media seem to model negative reactions to the mentally ill, including fear, rejection, derision and ridicule. The consequences of negative media images for people who have a mental illness are profound. They impair self-esteem, help-seeking behaviours, medication adherence and overall recovery.[1] The Royal College of Psychiatrists, healthcare professionals working in mental health and mental health charities such as Mind and Rethink work hard to challenge the stigma and negative attitudes towards mental illness. How disappointing therefore that the scriptwriters of this soap, a programme watched by millions of viewers, see fit to contradict these efforts by using such a derogatory term to describe someone with bipolar affective disorder.

Negative media reports have been shown to contribute to negative attitudes towards people with mental illness.[2] As adults, we have the presence of mind and sound judgement to recognise that the use of the term 'mentalist' is both socially unacceptable and insulting. But the minds of the younger generation are more impressionable. We do not want children thinking it is all right to describe someone with mental illness as 'a mentalist' because they have heard the term used on the television and come to believe it must be acceptable to use in everyday life. The writers of television programmes watched by both young and old alike have an important role to play in 'shaping the minds' of the youngsters of today. They should seek to show mental illness in a positive rather than negative light and thus help to eradicate rather than contribute to its stigmatisation.

1 Stuart H. Media portrayal of mental illness and its treatments: what effect does it have on people with mental illness? *CNS Drugs* 2006; **20**: 99–106.

2 Thornton JAA, Wahl OF. Impact of a newspaper article on attitudes towards mental illness. *J Community Psychol* 2008; **24**: 17–25.

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Psychiatry, religion and spirituality: a way forward

Recent correspondence in *The Psychiatrist* suggests that there are conflicting, or perhaps polarised, opinions about the role of spirituality and religion in UK psychiatric practice. In their latest contribution to the debate, Cook *et al*[1] state that 'it is important not to rely only on impressions derived from clinical experience but also to refer to evidence-based research and reviews. If we cannot eliminate bias in our interpretation of these findings, we can at least minimise it.' We agree.

However, although rhetoric and the selective interpretation of evidence are an intrinsic part of scientific discourse, spirituality and religion cause particular problems. Most professionals have deep-seated views that are unlikely to be affected by evidence, no matter how compelling. For example, whereas Koenig's review of the literature[2] suggests 'modest positive effects of religious faith', we prefer Richard Sloan's review[3] of similar literature, the conclusions of which can be paraphrased thus: efforts to integrate religion into medical practice are based on bad science, bad medicine and bad religion. We find Sloan more convincing than Koenig, but we note that Sloan's conclusions resonate with our pre-existing attitudes and beliefs.

We have previously argued that psychiatry should only attempt to resolve problems that cannot be dealt with effectively by other means. Although mental health professionals have demonstrable skills in the relief of suffering caused by mental disorders, there is no evidence that we have any answers to problems of human happiness. There are other, non-clinical, routes to happiness. Thus, we agree with Sloan *et al*,[4] who have argued that even if the evidence shows that religious faith promotes well-being, it is still inappropriate for clinicians to actively promote religion or to unnecessarily interfere in spiritual matters.

These ideas are more closely related to modern medical values than to science. In any case there is no reliable evidence with regard to the consequences of integrating spirituality/

religion into routine psychiatric practice in the UK. Nonetheless, there is growing controversy on the subject. We believe that a number of statements, including the previous president's apparent support for Koenig's proposals (e.g. praying with patients or consultation with clergy) create a real and undesirable ambiguity as to the limits of generally acceptable clinical practice with respect to religion and spirituality. In a paper presently in press,[5] we argue that Koenig's proposals are in breach of General Medical Council guidance. It would be unrealistic to expect to resolve all of the current issues of dispute in the immediate future, but we would suggest that it would be possible to identify the boundaries of acceptable clinical practice with regard to the points of greatest controversy.

In 2006, the American Psychiatric Association published guidance on 'religious/spiritual commitments and psychiatric practice' (www.psych.org/Departments/EDU/Library/APAOfficialDocumentsandRelated/ResourceDocuments/200604.aspx). It would be timely for the Royal College of Psychiatrists to develop similar guidance. We call on the president to establish a working group to produce guidelines on broad principles and, in addition, to address a narrow range of specific issues.

- Is it acceptable to pray with patients? If so, under what circumstances and with what safeguards?
- Should a spiritual history be taken from all patients? Should this include atheists?
- Is it acceptable for psychiatrists to challenge unhealthy religious beliefs? How can this be assessed reliably? How can it be distinguished from proselytising?
- Should members of the College who write scientific papers for journals concerning religion or spirituality declare their religious aliation as a conflict of interest?

Given the depth of feeling expressed in recent correspondence, the task may appear daunting. However, this subject demands serious and immediate attention exactly because it is difficult and contentious. A carefully composed and well-chaired working group that had credibility with all shades of opinion could produce guidance that would allow us to move on from simply restating our disagreements. It would allow service users to know what to expect when they consult us.

Declaration of interest
R.P. is an atheist. R.H. is a Buddhist.

1 Cook CCH, Dein S, Powell A, Eagger S. Research in spirituality and mental health. *Psychiatrist* 2010; **34**: 304.

2 Koenig HG. *Handbook of Religion and Mental Health*. Academic Press, 1998.

3 Sloan RP. *Blind Faith: The Unholy Alliance of Religion and Medicine*. St Martin's Griffin, 2008.

4 Sloan R, Bagiella E, Powell T. Religion, spirituality and medicine. *Lancet* 1999; **353**: 664–7.

5 Poole R, Higgo R. Spirituality and the threat to therapeutic boundaries in psychiatric practice. *Ment Health Relig Cult* 2010, in press.

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Inexperienced trainees doing more Section 136 emergency assessments

Opportunities for emergency assessments by junior trainees are certainly being reduced, largely as a result of rota merges to comply with the European Working Time Directive for doctors[1] and New Deal.[2] However, rather paradoxically, in areas where Section 136 suites have been created as an alternative to police custody, there is now often an expectation that such assessments are undertaken by these same juniors who have little experience of risk assessments and management of acute psychiatric presentations. When similarly detained patients are taken to police custody they automatically see the senior, Section 12-approved doctor on call.

Although the Mental Health Act Code of Practice states that the doctor examining a patient detained under Section 136 should 'wherever possible be approved under Section 12 of the Act', considerable national variation exists in the interpretation of this statement. Therefore, patients detained under Section 136 who are brought to a Section 136 suite are frequently assessed by a junior doctor with minimal (and ever reducing) experience of acute psychiatry or the Mental Health Act, potentially even doing their first ever on-call in the specialty. Training around the Mental Health Act is patchy, supervision is often poor and documentation of these assessments is variable.

Although the Code of Practice suggests that the examining doctor should discuss the patient with both the approved mental health professional and senior doctor on call, for a variety of reasons this does not always happen and the Code is clear that the decision is that of the assessing doctor and not that of the Section 12 doctor. Even where the senior doctor is consulted by telephone, they will base their advice on the information presented by the junior trainee.

In addition, the Code states clearly that where the assessing doctor fails to detect any form of mental disorder the person should be discharged from detention immediately, with no requirement to be seen by the approved mental health professional. So these inexperienced junior doctors are doing complex assessments typically out of hours, often with limited support and training and at times taking sole responsibility for discharging patients.

Ideally, trainees in the first few months of their psychiatry rotation should not be undertaking Section 136 assessments at all. With good supervision, a clear policy and adequate training it may be appropriate for juniors with more experience to do these assessments within a hospital setting but senior input should be expected. Patients detained under Section 136 deserve to be seen in an appropriate environment, which, wherever possible, should not be police custody, but above all they deserve a robust assessment by an appropriately experienced psychiatrist.

1 Waddell L, Crawford C. Junior doctors are performing fewer emergency assessments – a cause for concern. *Psychiatrist* 2010; **34**: 268–70.

2 Department of Health. *Reducing Junior Doctors' Hours Continuing Action to Meet New Deal Standards Rest Periods and Working Arrangements, Improving Catering and Accommodation for Juniors, Other Action Points* (HSC 1998/240). Department of Health, 1998.

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Junior doctors are performing fewer emergency assessments

Waddell & Crawford[1] have demonstrated very clearly that trainees are becoming more and more limited in their experience of emergency psychiatry. This is, to use their own

words, a very real cause for concern. The same may, however, also apply to their experience in day-to-day psychiatric practice. With so called functionalisation, clinical teams and their members may be dealing with an increasingly narrow range, if any at all, of patients, most of whom might have the same diagnosis. This is not to deny the need and requirement for individual care pathways and treatment plans, but it may severely limit learning opportunities. Of no less concern, and possibly even more so as it may eventually effect early interest in and recruitment to our specialty, is the influence that these changes in service organisation have had on undergraduate medical students' experience of psychiatry.

The development of functional teams, the separation of in-patient care from community care, and the increasing specialisation within psychiatry mean that the clinical experience offered in undergraduate placements may not be providing either the depth or breadth of experience required to assure that students see common conditions, follow through the course of a single episode from inception to recovery, and understand the range of abnormal phenomena in psychiatry and the treatment options that are available. Most medical schools offer 6 weeks of placement in psychiatry within the 5-year course. This exposure is likely to be the only formal training in psychiatry for most doctors training in the UK.

The problems in specialist training highlighted by Waddell & Crawford extend beyond mere reduction in the number and frequency of assessments, to experience of presentation and management of anxiety-related disorders, obsessive–compulsive disorder and eating disorders, and will soon include assessment of memory disorders, most of which have been ceded to nurses or psychologists. These trends and changes will ultimately affect the clinical skills of future psychiatrists and recruitment to psychiatry from among UK medical graduates.

1 Waddell, Crawford C. Junior doctors are performing fewer emergency assessments – a cause for concern. *Psychiatrist* 2010; **34**: 268–70.

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Readability – writing letters to patients in plain English

One in six people in the UK struggle with literacy.[1] The Leitch Review found that more than five million adults lack functional literacy, the level needed to get by in life and at work.[2] This is particularly important as approximately 70% of adults with a self-reported mental health problem are either functionally illiterate or marginally literate. Furthermore, adults with mental illness who are literate read three to five grade levels below that expected by their level of education.[3]

The involvement of patients, carers and the public in health decision-making is at the heart of the modernisation of the National Health Service (NHS). Hence, in the good practice guideline, *Copying Letters to Patients*,[4] the Department of Health stressed the importance of using 'plain English' when sending copies of letters between healthcare professionals to patients.

We conducted an audit to assess whether clinicians were sending copies of letters to patients written in plain English. The secondary outcome was to see the differences between letters from doctors and nurses.

We used the Simple Measure of Gobbledygook (SMOG) to check for use of plain English. This measure of 'readability' estimates the years of education needed to completely understand a piece of writing. It is the outcome of research commissioned by the National Institute of Adult Continuing Education.

The data were collected retrospectively in April–May 2010 from letters sent by clinicians working in older people mental health services, 2gether NHS Foundation Trust.

We found that only 59% of letters in the sample were copied to patients. The average SMOG readability index was 17.2, with little difference between doctors and nurses. The sentence length varied, with a few examples of sentences with more than 40 words. Also, passive sentences and noun and adjectives in large clusters were frequently used.

The SMOG value of 14 corresponds to GCSE levels A–C, and to Adult Literacy Standard level 2. The SMOG values for editorials of the commonly read tabloids *The Sun* and *The Daily Express* are less than 14 and 16 respectively.[5]

It was painful to note that not a single letter in the audit sample had a SMOG value of 14 or less. This may mean that many of our patients may not be able to understand our letters.

We suggest that all letters sent by clinicians should be copied to patients unless there is a valid reason documented in notes not to do so. We should ponder on the layout and presentation of the letter, avoid long sentences, passive sense, and polysyllabic words.

1 Department for Education and Skills. *Skills for Life: The National Strategy for Improving Adult Literacy and Numeracy Skills*. Department for Education and Skills, 2003.

2 Leitch S. *Leitch Review of Skills: Prosperity for All in the Global Economy – World Class Skills*: 61. HMSO, 2006.

3 Christensen RC, Grace GD. The prevalence of low literacy in an indigent psychiatric population. *Psychiatr Serv* 1999; **50**: 262–3.

4 Department of Health. *Copying Letters to Patients: Good Practice Guidelines*. Department of Health, 2003.

5 National Institute of Adult Continuing Education. *Readability: How to Produce Clear Written Materials for a Range of Readers*. NIACE, 2009.

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CORRECTION

When to use DoLS? A further complication. *The Psychiatrist* 2010; **34**: 356. The 55-year-old lady described was the appellant and not the defendant. The publishers apologise for their error, and for any embarrassment caused to Dr Zigmond.

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Psychiatry, religion and spirituality: a way forward

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