

Correspondence

Measurement of environmental complexity by CAMHS

Thompson *et al*¹ considered the use of the Paddington Complexity Scale² to quantify the case complexity of their child and adolescent mental health service (CAMHS) attenders, but discarded it largely because their study was based on CAMHS records which did not record systematically information on diagnoses or other items relevant to multi-axial formulations, such as physical health and cognitive/developmental status of children and young people seen.

I would like to clarify that – to allow for the fact that CAMHS vary in the extent to which diagnostic and other detailed comprehensive information is obtained on cases seen by different professionals – the Paddington Complexity Scale has, in addition to a summative total score, two complexity subscores and scales: clinical (in itself subdivided into psychiatric, incorporating diagnosis, severity/duration, comorbidity items, and physical/development, scoring information on physical health and intellectual disability) and environmental (with items on family status and attitudes to the use of the service, type of school and multi-agency involvement). These subscales, in particular adaptations of the environmental subscale which is made up of items that will be known to most CAMHS workers, can and have been used on a stand-alone basis, as a measure of psychosocial case complexity.³

- 1 Thompson AE, Nadkarni A, Nazir SA, Sorour W, Owen V, Buggineni SK. Professional life in child and adolescent mental health services may be getting more complicated, but cases are not. *Psychiatrist* 2013; **37**: 326–30.
- 2 Yates P, Garralda ME, Higginson I. Paddington Complexity Scale and Health of the Nation Outcome Scales for Children and Adolescents. *Br J Psychiatry* 1999; **174**: 417–23.
- 3 Audit Commission. Children in Mind: Child and Adolescent Mental Health Services (National Report). Audit Commission, 1999 (<http://archive.audit-commission.gov.uk/auditcommission/subwebs/publications/studies/studyPDF/1350.pdf>).

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doi: 10.1192/pb.38.2.86

Quality assurance in mental health clustering for PBR or the 'national tariff' – a slave with many masters

I believe the quality assurance of the clustering process (using the Mental Health Clustering Tool (MHCT) incorporating the Health of the Nation Outcome Scales (HoNOS)) is a complex field. Bekas & Michev¹ have approached it from the MHCT 'red rule' perspective and the ICD-10 coding perspective. What the results show is that to comply with one you might potentially be in breach of the other. We face this in clinical practice; for example, bipolar affective disorder is considered to be a 'psychotic' condition, although as clinicians we all know there are times when patients with bipolar affective disorder are not psychotic. On such occasions, if you rate them on the MHCT they might score 'O' and then if you cluster them in a psychotic

cluster you breach the 'red rule' and if you do not, you breach the ICD-10 coding expectations.

There would be another layer of complexity added when all the 'care packages' are agreed between the commissioners and providers. I am sure there would be interest to ensure that the care provided or offered reflects the package agreed. The elusive 'gold standard' that the authors allude to, if developed, cannot be one-dimensional. It needs to clarify, when there are conflicting standards, that the clinician has to adhere to the one which takes priority and therefore in my opinion should be hierarchical. In fact, the authors of the MHCT might consider dropping the 'red rules' which might have outlived their usefulness when there are agreed care packages in place. Until then the MHCT and the clustering process remain imperfect tools that clinicians have to navigate to communicate with the commissioners.

Declaration of interest: R.B. is one of the clinical leads in payment by results for East London NHS Foundation Trust.

- 1 Bekas S, Michev O. Payment by results: validating care cluster allocation in the real world. *Psychiatrist* 2013; **37**: 349–55.

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doi: 10.1192/pb.38.2.86a

Not everything that counts can be counted and not everything that can be counted counts

In their excellent paper, Bekas & Michev¹ present a sober assessment of the inherent weakness of the Mental Health Clustering Tool and ICD-10 coding. Although clustering has already been used for many years in acute care, what is suitable for acute care is not necessary applicable to psychiatry. We are expected to cluster patients with similar symptoms, needs and disabilities in 21 clusters which are used as the basis for financial funding.

However, subjectivity in psychiatry is a fact and it does not really matter how many tools and scales we implement to change this. The chance of subjectivity may be reduced but never eliminated. Diagnosis and formulations vary between clinicians within the same profession and even between members of the same team. One can identify quite easily a sizeable number of patients with an ever-changing diagnosis over a number of admissions. It follows that clustering is not a static tag but a changeable process that ought to be regularly updated.

I agree wholeheartedly with Bekas & Michev that the final arbiter should be clinical judgement. It is not uncommon practice for clinicians such as myself to override the cluster concluded by other members of the team, relying on and trusting my clinical judgement.

- 1 Bekas S, Michev O. Payment by results: validating care cluster allocation in the real world. *Psychiatrist* 2013; **37**: 349–55.

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doi: 10.1192/pb.38.2.86b

Unfair playing field

I fully agree with the change of the name of *The Psychiatrist* to the *Psychiatric Bulletin*.¹ The phrase 'unfair playing field' is very important. For the past 50 years in psychiatric publishing it would appear that there were serious conflicts of interest not declared. For example, an editor and reviewers have reviewed papers where they are competing for research funds in the same areas as the papers submitted. In addition, many of these same people have been on committees deciding on funding for research in the same area as the paper that is being submitted or have other associations with the authors of the paper of one kind or another. Serious conflicts of interest particularly related to the 'golden circle' of people who are both editors, submitters of papers and on funding bodies. This controls what is allowed to be published and what topics are allowed to be funded and has damaged research and publication in the past 50 years. In a way it seems as if 'might is right' – the mighty being inside the golden publishing circle. It would be interesting for somebody to do a review of publications in psychiatry journals for the past 50 years to see where these conflicts of interest occurred and were undeclared. It is probably a more sociological task.

1 Pimm J. Scientific publishing – an unfair playing field. *Psychiatrist* 2013; **37**: 281–2.

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doi: 10.1192/pb.38.2.87

Psychiatry 2014

I welcomed the October 2013 issue of *The Psychiatrist*.¹ The juxtaposition within it of the views of the Editor and the reprint of an interview with Professor Lishman gave me hope that there may be a stronger attempt to address the 'complete disconnect between research and clinical practice, with a relentless tendency over many years to downplay the medical and biological aspects of mental healthcare'. These are the words of Peter Tyrer, then Editor of the *British Journal of Psychiatry*, in its bicentennial volume.²

The nearer mental illness – not mental health – can be made congruent with the position in society held by other physical illnesses, the sooner will its stigmatisation lessen. This happened with cancer, tuberculosis, epilepsy, and now belatedly is being applied to AIDS. As indicated in the Editor's critique, the same standards must be applied to the criteria used to select matter for the *Psychiatric Bulletin* as are used in other medical scientific journals.

Prior to this edition I was consistently dismayed by the preponderance of matters related to quantitative differences in services and individual traits rather than research for reliable, generalisable tools of diagnosis and treatment. Psychiatry is to do with the qualitative analysis of disease, not supporting the vagaries of personalities within society. The latter are the province of education, psychology, sociology and the law. Of course, all the professionals of these disciplines require the sort of psychotherapeutic skill that Professor Lishman uses – distributive – that helps people to be brought into useful relationship with the therapist and his special tools. His career epitomises to me what psychiatry, psychological medicine, is properly about.

Incidentally, my own slight difference with Professor Lishman relates to his view of Wilhelm Greisinger. Greisinger throughout his book emphasises that humanitarian care is a given in serving the needs of the mentally ill. In the first paragraph of his chapter on therapeutics he applauds the 'great principle of humanity' in psychiatry. However, he made it clear that in the light of the increasing knowledge of the 'morbid action of the brain' humanitarianism will not of itself correct the abnormalities of brain function that underlie disease.

Sadly, this has proven true. Mental illness has remained one of the last areas to develop effective treatments. This is the basis of the remaining stigma. Furthermore, the overarching use of the term 'mental health' has unfortunately set psychiatry into a 'non-disease' ecology and has thus in my view obfuscated the way of progress within the specialty. We need to address this 'relentless tendency . . . to downplay the medical and biological aspects of mental health care'.²

1 Pimm J. Dear Editor, why have you rejected my article? *Psychiatrist* 2013; **37**: 313–4.

2 Tyrer P, Craddock N. The bicentennial volume of the *British Journal of Psychiatry*: the winding pathway of mental science. *Br J Psychiatry* 2012; **200**: 1–4.

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doi: 10.1192/pb.38.2.87a

Workplace-based assessments need trainer consistency

Despite their many criticisms, I am in favour of workplace-based assessments (WPBAs). They do, in theory, assess a range of important skills and do this outside of stressful examination conditions, thereby allowing trainees to perform to their greatest ability. The Assessment of Clinical Expertise (ACE) in particular covers many of the same skills assessed in the long case but avoids the snapshot examination the latter was often criticised for. The ACE overcomes this by assessing patients across multiple specialties with varying patient groups and attempts to minimise examiner bias by requiring completion from a number of different trainers. It also supersedes the long case by allowing full observation of the patient encounter and so in addition to assessing diagnostic and management skills, provides a more reliable means of assessment of communication skills and the ability of the trainee to develop a rapport with their patient.

As a trainee, however, I can clearly see that WPBAs are not without their problems. The main concern for myself and many trainees alike is not with their format or the skills they assess, but rather the rating and feedback. There is lack of consistency among trainers in completing these forms with no standards of reference to work to and so there is great subjectivity in their completion. Perhaps the introduction of external assessors who have received further training could be a step forward in overcoming such inconsistencies.

1 Michael A, Rao R, Goel V. The long case: a case for revival? *Psychiatrist* 2013; **37**: 377–81.

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doi: 10.1192/pb.38.2.87b

Agomelatine – is it another reboxetine? Another case of publication bias

I read the special article about agomelatine with interest.¹ The authors state that controlled studies have suggested a favourable efficacy and tolerability profile of agomelatine in depression. This statement is not entirely accurate.

The article has missed the negative studies and is a glaring example of publication bias, issues that have been highlighted in a recent meta-analysis.² This meta-analysis of placebo-controlled trials of agomelatine in depression included unpublished trials and concluded that agomelatine is unlikely to be clinically superior to placebo. I am part of a group which has recently submitted a systematic review for the Cochrane Collaboration where we compared the efficacy of agomelatine with other antidepressant drugs in depression. Agomelatine did not seem to provide any significant advantage in efficacy. We also found evidence of publication bias. We contacted Servier, maker of agomelatine, for the unpublished trials, but did not receive any response. Furthermore, Servier has not provided data to the National Institute for Health and Care Excellence (NICE); hence NICE has not recommended agomelatine use.³

The article states that more data are needed to assess the effectiveness of agomelatine in real-world conditions. However, the fact is that agomelatine's efficacy in controlled trials is not yet established. Almost all the studies have been sponsored by Servier or Novartis, the company which marketed it in the USA.

Reboxetine is a classic example of publication bias; in this case mostly positive studies were published. Many years after its introduction, in 2010, the unpublished data was accessed and a meta-analysis found reboxetine to be an ineffective and potentially harmful antidepressant drug.⁴ It is time that drug companies disclose all data from all trials irrespective of the outcome so the efficacy of a drug can be judged objectively.

- 1 Whiting D, Cowen PJ. Drug information update: agomelatine. *Psychiatrist* 2013; **37**: 356–8.
- 2 Koesters M, Guaiana G, Cipriani A, Becker T, Barbui C. Agomelatine efficacy and acceptability revisited: systematic review and meta-analysis of published and unpublished randomised trials. *Br J Psychiatry* 2013; **203**: 179–87.
- 3 National Institute for Health and Clinical Excellence. *Agomelatine for the Treatment of Major Depressive Episodes (Terminated Appraisal)* (Technology Appraisal TA231). NICE, 2011.
- 4 Eyding D, Lelgemann M, Grouven U, Hrter M, Kromp M, Kaiser T, et al. Reboxetine for acute treatment of major depression: systematic review and meta-analysis of published and unpublished placebo and selective serotonin reuptake inhibitor controlled trials. *BMJ* 2010; **341**: c4737.

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doi: 10.1192/pb.38.2.88

Authors' response: By taking part of a single sentence out of context, Sumeet Gupta misrepresents our article. We wrote: 'Controlled studies have suggested favourable efficacy and tolerability profiles; however, agomelatine is not without its controversies, with recent meta-analyses showing only marginal advantages over placebo' (our italics). We also stated that, 'although narrative reviews of the efficacy of agomelatine emphasise its superior efficacy relative to placebo and certain other antidepressants such as sertraline and fluoxetine, formal

meta-analyses have found these effects to be less convincing and of uncertain clinical significance' (the meta-analysis by Koesters *et al*¹ had not been published when we submitted our article, so we relied on that of Singh *et al*² which reaches similar conclusions). Merely reading the abstract is enough to encounter the phrase: 'Current meta-analyses show marginal clinical benefits of agomelatine relative to placebo'. Overall, our conclusion is similar to that of Koesters *et al*¹: 'The present systematic review found that acute treatment with agomelatine is associated with a difference of 1.5 points on the HRSD. This difference was statistically significant, although the clinical relevance of this small effect is questionable'.

Drug companies are often accused, with justification, of making exaggerated and misleading claims. Their critics should avoid emulating them.

Declaration of interest: P.J.C. has been a paid member of advisory boards for Eli Lilly, Lundbeck and Servier.

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- 2 Singh SP, Singh V, Kar N. Efficacy of agomelatine in major depressive disorder: meta-analysis and appraisal. *Int J Neuropsychopharmacology* 2012; **15**: 417–28.

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doi: 10.1192/pb.38.2.88a

A leaflet to improve knowledge and attitudes to help-seeking for mental illness among Muslims

Help-seeking for mental illness is problematic among Muslim communities in Western countries.^{1,2} We set out to develop a leaflet on attitudinal and knowledge barriers to help-seeking for mental illness in UK Muslims, working with a local voluntary organisation (SMART), the Royal College of Psychiatrists (RCPsych) and the Muslim Council of Britain. In the leaflet, we addressed known barriers to help-seeking such as cultural and traditional beliefs, knowledge of and familiarity with formal services, perceived societal stigma, and the use of informal indigenous resources.³ An Islamic religious leader checked the content for religious accuracy and we ensured the design was culturally consistent. A draft of the leaflet was piloted with a focus group of six Muslim men, then re-drafted using their feedback to produce the final version.

To evaluate the leaflet, we attended a London mosque at evening prayer time (Isha) and invited members of the congregation to complete a questionnaire before and after reading it. Twenty-five men aged 18–65+ volunteered; there were no women at the mosque at the time. All were Muslim UK residents: 32% Asian/Asian British Pakistani, 20% Asian/Asian British other, 44% other ethnicities combined, 4% gave no response. A statistically significant change was noted in response to two questions: 'I would see a doctor if I felt very sad, worried, scared or was having unusual experiences' ($P = 0.039$) and 'I know what treatments are available for mental illnesses' ($P = 0.010$). Furthermore, 72% of participants thought the leaflet helped them to understand mental illness better, 96% found it easy to read, 88% easy to understand and

72% felt more able to tell others about mental illness after reading it.

The leaflet was posted on the RCPsych website and results were collated from the online feedback. Respondents rated the leaflet on readability, usefulness, respectfulness and design on a scale from 1 (strongly disagree) to 5 (strongly agree). Overall, 103 respondents submitted feedback over a period of approximately 5 months: 10 service users, 6 patient relatives, 4 carers, 11 friends, 65 healthcare professionals, 8 healthcare students, 12 'others'. The mean score for 'readable' was 4.38 (88 responses); the mean score for 'useful' was 4.30 (94 responses); the mean score for 'respectful' was 4.11 (89 responses); and the mean score for 'well-designed' was 4.17 (89 responses), with a score of 4 meaning 'agree'.

Although the evaluation was limited by a small sample size of men only and the lack of follow-up, we concluded that after reading the leaflet, participants assessed themselves as more likely to seek medical help if they were experiencing symptoms of mental illness and more knowledgeable about what treatments are available. They found the leaflet helpful in improving their understanding of mental illness, easy to read and understand, and thought it enabled them to tell others about mental illness. From the online feedback, respondents agreed that the leaflet was readable, useful, respectful and well designed.

The leaflet is available on the RCPsych website: www.rcpsych.ac.uk/healthadvice/problemsdisorders/leafletformuslimsonstress.aspx

Acknowledgements: Thanks to Professor Thomas Craig and Zeeshan Hashmi, North London Islamic Centre and SMART.

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- 3 Aloud N, Rathur A. Factors affecting attitudes toward seeking and using formal mental health and psychological services among Arab Muslim populations. *J Muslim Ment Health* 2009; **4**: 79–103.

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doi: 10.1192/pb.38.2.88b

Research ethics approval and discrimination

We read with envy Galappathie *et al's* study¹ of detained patients' awareness of the mental health review tribunal (MHRT). We applaud their decision to regard their study as part of service evaluation rather than as a research project requiring National Research Ethics Service Committee (NRES) approval.

We applied for NRES approval for a study asking patients detained under Section 2 or Section 3 of the Mental Health Act 1983 about their views on the chances of the MHRT rescinding their detention if they appealed. The crucial question was 'What do you think are the chances that you will be discharged by the Tribunal if you appeal?'

The NRES which reviewed the application did not have a mental health patients' representative, carers' representative or mental health professional as its member. Therefore, it sought expert opinion from a retired clinical psychologist. The NRES ruled that 'the study should not be done in the acute phase of treatment when participants are detained and it would be more appropriate once they have been discharged. This would remove concerns about the ability of the participants to give informed consent whilst under detention and in a vulnerable condition'.

We appealed against the decision and our application was referred to another NRES which also did not have a mental health patients' representative or carers' representative, but had a psychologist as a member. We attended the review and explained that we endeavoured to assess detained patients' views and that post-discharge retrospective assessment would be futile. We argued that the first principle of the Mental Capacity Act 2005 is the presumption of capacity. The General Medical Council guidance also states that one must not assume that a patient lacks capacity to make a decision solely because of their medical condition, including mental illness. We confirmed that patients who did not have capacity to decide whether to take part in the study will not be offered the opportunity to take part. This second NRES agreed with the first one for the same reasons, that is, detained patients don't have capacity to decide whether to take part in the study.

This is an example of ignorance and consequent stigmatising attitudes held by those in authority, resulting in discrimination against mental health patients, carers and professionals. Members of NRESs believing that those who are mentally ill lack the capacity to make simple decisions could significantly hamper research into mental illness and perpetuate the myth that psychiatry is the most unscientific medical specialty. Mental health professionals and patient groups may share part of the blame by not representing themselves on NRESs.

- 1 Galappathie N, Harsch RK, Thomas M, Begum A, Kelly D. Patients' awareness of the mental health tribunal and capacity to make requests. *Psychiatrist* 2013; **37**: 363–6.

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doi: 10.1192/pb.38.2.89

Mental health screening in police custody – acceptability among detainees

McKinnon *et al*¹ highlight the importance of effective screening of detainees in police custody for mental health problems and draw attention to the emerging provision of liaison and diversion services in police custody. In their study, approximately 28% of detainees from inner city London police stations declined to be interviewed by mental health professionals.

The experience of the criminal justice mental health team which provides liaison services to two police stations in rural North East Essex was similar. Of 573 detainees who were offered an assessment within 14 months of the newly

established service, 25% declined to be seen. Among the 430 detainees who were assessed in police custody: 41% needed no further action; 44% were already known to or needed referral to secondary mental health services; 3% required an assessment under the Mental Health Act 1983; 6% were referred to community drug and alcohol teams; and 3% were referred for counselling. The remaining 3% were followed up by the criminal justice mental health team.

McKinnon *et al*'s findings from inner city areas and our experience in rural areas suggest that services as proposed by Lord Bradley² would be acceptable to three-quarters of detainees in police custody across geographical areas.

- 1 McKinnon I, Srivastava S, Kaler G, Grubin D. Screening for psychiatric morbidity in police custody: results from the HELP-PC project. *Psychiatrist* 2013; **37**: 389–94.
- 2 Lord Bradley. *The Bradley Report: Lord Bradley's Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System*. Department of Health, 2009.

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doi: 10.1192/pb.38.2.89a

BJPsych
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Not everything that counts can be counted and not everything that can be counted counts

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Psychiatric Bulletin 2014, 38:86.

Access the most recent version at DOI: [10.1192/pb.38.2.86b](https://doi.org/10.1192/pb.38.2.86b)

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