CORRESPONDENCE

Crisis resolution/home treatment teams for people with learning disabilities

Bradley & Lofchy (2005) should be commended for their comprehensive summary of the assessment and management of people with learning disabilities presenting in a crisis to an A&E department. As the authors rightly point out, the whole process of attending A&E can be especially frightening and anxiety-provoking for learning-disabled people. This may further exacerbate the existing crisis of agitation or aggression, possibly leading to physical violence.

In the UK, services for people with learning disabilities are most commonly provided by community learning disability teams (Bouras & Holt, 2004). In Birmingham, where I have been training as a specialist registrar for the past 3 years, a crisis resolution / home treatment (CRHT) team provides out-of-hours support for learning-disabled people in crisis. The team usually consists of two community learning disability nurses. They can be contacted through NHS Direct and receive out-of-hours referrals from a number of sources, including families, care homes and general practitioners. The team manages the crisis in the community (at the patient's place of residence) and has direct access to the on-call consultant learning disability psychiatrist for management advice or a joint assessment. Such management has averted a number of individuals from the A&E department or admission to an in-patient unit.

If the individual concerned responds to neither non-pharmacological nor pharmacological (excluding rapid tranquillisation, which is only done in an acute psychiatric unit) interventions, admission to an in-patient unit is considered either informally or under the Mental Health Act 1983. If an individual is in significant immediate danger of harming him- or herself or others, the police are called to take the person into custody, where the crisis team and consultant psychiatrist jointly intervene, as described above.

Although we do not yet have a CRHT team specifically for people with learning disabilities that operates during working hours, we are in the process of developing one.

Bouras, N. & Holt, G. (2004) Mental health services for adults with learning disabilities. *British Journal of Psychiatry*, **184**, 291–292.

Bradley, E. & Lofchy, J. (2005) Learning disability in the accident and emergency department. *Advances in Psychiatric Treatment*, **11**, 45–57.

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A physical lesson for the clinicians?

In 2002, a colleague (P. Jeyapaul) and I conducted an audit on physical examination in psychiatric practice while we were working as senior house officers in a teaching hospital. The standard for the audit was that every patient should have received a basic physical examination within 72 h of admission. Of the 78 patients included in the audit, 17 (22%) received a complete examination and 27 (35%) were not examined at all. Of those who were not examined, 9 did not consent and 2 were agitated; no reason was given for the failure to examine the others. The remaining 34 (43%) received an incomplete examination, the most neglected area being the central nervous system. Out of the 78 patients, the records of only 1 mentioned that the skin was examined for evidence of self-harm and substance misuse.

Garden's (2005) article rightly stresses the need to keep up to date with these basic skills and the different areas of focus in the physical examination and their relevance to psychiatric disorders.

Garden, G. (2005) Physical examination in psychiatric practice. *Advances in Psychiatric Treatment*, **11**, 142–149.

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... and for their educators?

In response to the article by Dr Gill Garden (Garden, 2005) on physical examination in psychiatric practice, I would like to highlight some of the problems that trainees in psychiatry frequently encounter.

I certainly applaud the Royal College of Psychiatrists' increased awareness of physical illnesses and the importance of detecting them, but I fear that the level of teaching that juniors receive for this is extremely poor. Indeed, having come through a large SHO rotational scheme, I cannot recall a single lecture that was devoted to carrying out a physical examination and yet this is now an essential component of the OSCE in the MRCPsych Part I exam. Even in Part II, as many marks are set aside for the physical examination as for the mental state examination.

In a field such as rehabilitation psychiatry, patients' physical problems are even more important because individuals are often on high doses of medication (possibly with polypharmacy) and are usually older and less physically active. Fortunately at St Michael's Hospital in Warwick, a local GP has

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two allocated sessions a week to deal with any physical problems on the rehabilitation wards, and this shared-care approach, similar to that described in *APT* by Lester (2005), is valued by both patients and staff. It also ensures that long-term psychiatric patients receive adequate screening.

With new guidelines constantly being issued on the checks we should be performing on patients taking psychotropics and the ever-present threat of medico-legal implications, I feel it is time that more emphasis in our training be placed on physical examinations, with regular refresher courses – perhaps similar to advanced life-support courses – even after membership. This must also involve psychiatric nursing staff, who usually have only basic 'physical' training: perhaps the Royal Colleges of Nursing and Psychiatrists should jointly look into this. A combination of the shared-care approach by primary and secondary services and an increased emphasis on teaching psychiatrists and psychiatric nurses about physical illnesses is, in my opinion, the best way to look after the holistic well-being of our patients.

By the way, for those of you who always wanted to know how to calculate the QTc interval but were afraid to ask, I found this formula in Kumar & Clark's *Clinical Medicine*:

> QTc = QT interval divided by the square root of the R-to-R interval

Now you just have to know how to read an ECG!

Garden, G. (2005) Physical examination in psychiatric practice. *Advances in Psychiatric Treatment*, **11**, 142–149.

Kumar, P. J. & Clark, M. L. (eds) (1994) *Clinical Medicine: A Textbook for Medical Students and Doctors* (3rd edn). London: Baillière Tindall.

Lester, H. (2005) Shared care for people with mental illness: a GP's perspective. *Advances in Psychiatric Treatment*, **11**, 133–139.

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Author's response

Dr Kunar raises two main issues in his letter, namely maintaining psychiatrists' competence in physical examination and delivery of good physical care for patients with mental health problems.

Development of registers of patients with serious mental illness and proactive involvement of primary care clinicians in the physical care of patients with mental health problems are to be welcomed. However, notwithstanding input from primary care, Dr Kunar rightly emphasises the requirement for psychiatrists to understand and to monitor the medical effects of medication and the need to maintain skills in physical medicine in order to do so.

The complexity of the skills required to perform a proficient physical examination and the need to maintain or revive these skills present no easy task for psychiatrists. Trainees should have an advantage, being less removed from their basic medical training as students or house officers. However, without supervision, skills in physical examination dwindle. I suspect that many trainees have no training devoted to this subject in their educational programmes or posts.

How can this situation be addressed? A video of physical examination targeted at psychiatrists would undoubtedly be useful, and if funding is forthcoming, it is hoped that this possibility will become reality. However, just as with playing tennis or a musical instrument, knowledge of what to do is not synonymous with personal competence.

There is no substitute for carrying out regular physical examinations and having technique refined by expert (not peer) observation and assessment. Liaison with colleagues in medicine and primary care might allow training posts in old age, liaison and rehabilitation psychiatry to evolve to incorporate refreshment of physical examination skills. Alternatively, part of the formal teaching programme for trainees could include practical sessions with a local primary or secondary care clinician.

The question of maintenance of physical examination skills in consultant or non-career grade staff is altogether more contentious. Scepticism about the need to maintain competence in this area, the evolution of specialist mental health services and lack of time are likely to be significant obstacles. Realistically, there will be no comprehensive progress in this group unless a more holistic approach to patient care is valued, posts have realistic case-loads to enable such care to be delivered and maintenance of skills to deliver is enshrined in CPD.

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