

columns

College's reply: I am grateful to Dr Veasey (2000, this issue) for raising this matter. The College has to balance its obligations to members with its main purpose of raising standards in psychiatry. Sometimes this is a difficult balancing act.

Members will be aware that Council has recently agreed to establish an External Clinical Advisory Service. This will offer expert external advice to NHS trusts on any psychiatric service which is not functioning effectively. Further details of the service, which will be of assistance to College members as well as protecting patients, will appear on the College's website. Dr Peter Snowden has been appointed Director of this service.

You will be glad to know that the College has made a robust response to the recent Tilt Report and copies of this response will also be available on the College's website in the near future.

VEASEY, D. A. (2000) Further comments on inquiry panels (letter). *Psychiatric Bulletin*, **24**, 393.

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Psychotherapy within old age psychiatry

Sir: Murphy (2000) looked at the provision of psychotherapy services for older adults by sending questionnaires to psychotherapy departments. She reported that respondents felt, largely on the basis of low referral numbers, that the needs of this group were not being met. The survey did not address the provision of psychotherapy within old age psychiatry departments. The NHS review of the psychotherapies (NHS Executive, 1996) highlighted the underrepresentation of older people and people with chronic illness and physical disabilities among those treated with psychotherapies. Garner (1999) has already argued that attitudes are slowly changing and she herself exemplifies the inclusion of psychoanalytic psychotherapy within old age psychiatry. Our own service includes a clinic offering systemic therapy to older adults and their families (Benbow & Marriott, 1997).

One possible criticism of psychotherapies within old age psychiatry is that older adults may be offered a second-rate service. This implies that therapists working in these areas are not properly trained, or supervised, or experienced. Might they, in fact, provide a better service? They combine psychotherapy training and expertise with understanding and practical expertise in the area of late-life mental health. This inclusive model may have other benefits, by facilitating referrals and incorporating psychotherapeutic understanding within the day-to-day work of an old age psychiatry service. We do indeed need to hold in mind the needs of older adults, as Murphy writes, but we should also recognise that needs can be met in different ways.

BENBOW, S. M. & MARRIOTT, A. (1997) Family therapy with elderly people. *Advances in Psychiatric Treatment*, **3**, 138–145.

GARNER, J. (1999) Psychotherapy and old age psychiatry. *Psychiatric Bulletin*, **23**, 149–153.

MURPHY, S. (2000) Provision of psycotherapy services for older people. *Psychiatric Bulletin*, **24**, 181–184.

NHS EXECUTIVE (1996) *A Review of Strategic Policy on NHS Psychotherapy Services in England*. London: DoH.

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Home treatment teams

Sir: The survey by Owen *et al* (2000) exemplifies the difficulties involved in researching home treatment teams, because of the multiplicity of definitions and wide nomenclature for services serving similar functions. Such diversity cannot be assessed adequately using a short survey and broad definition of the subject matter.

The definition of home treatment in the paper is much briefer than the broad definition in the questionnaire and the questionnaire refers to "access to community staff on a 24 hour basis", whereas the paper reports on "availability on a 24-hour basis". Such inconsistencies may give rise to inaccurate representations of what was surveyed. Furthermore, the questionnaire is internally inconsistent in referring to home treatment services both as an alternative to hospital admission and as a supplement to hospital-based services, which does not help identify the kinds of service being examined.

A similar but much more extensive recent (1998) survey (Orme, 2000) of nationwide crisis services found a wider penetration of services. Of 152 self-defined crisis services, 22 were identified as home treatment services offering an alternative to admission. Of these, eight offered a 24-hour service (seven of which were available only on an on-call basis out of office hours) and eight were staffed by nurses only.

Owen *et al* report high expectations for new developments in home treatment. However, during the period of data collection regarding crisis services, 10% ceased operating or were being considered for closure. Will home treatment services go the same way?

ORME, S. (2000) Intensive home treatment services. In *Acute Care in the Community* (ed. N. Brimblecombe). London: Whurr Publishers.

OWEN, A. J., SASHIDHARAN, S. P. & EDWARDS, L. J. (2000) Availability and acceptability of home treatment for acute psychiatric disorders. A national survey of mental health trusts and health authority purchasers. *Psychiatric Bulletin*, **24**, 169–171.

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Authors' reply: We welcome the letter from Sandor and Orme (2000, this issue) and await with interest the results of the study to which they refer. Without access to further information concerning this work it is difficult to comment upon their finding that some crisis services have ceased operating. Our study revealed an enthusiastic support for crisis services (Owen *et al*, 2000), and our own experience working in inner-city Birmingham has demonstrated that home treatment is an effective intervention, which is more acceptable to clients than hospital admission and is sustainable over many years.

The suggestion that it is inconsistent to refer to home treatment as both an alternative and an adjunct to hospital admission betrays a common misconception about crisis services. Many people who would otherwise have been admitted to hospital are able to be successfully supported during crisis by home treatment, yet hospital admission remains an essential part of acute psychiatric services. Clients of home treatment services not infrequently require admission to hospital, although the length of stay is often short, with early discharge and community support. It is also important to point out that home treatment makes use of other crisis residential alternatives to hospital, such as crisis houses or family sponsorship schemes, with good effect.

There remains a wider issue concerning the reluctance of psychiatrists to embrace developments in community mental health services despite the evidence of its efficacy and general acceptability (Smyth & Hoult, 2000). We strongly recommend that the debate in this area should focus on the opportunities that are becoming available in developing innovative crisis services in the context of the National Service Framework. Our failure to do so would once again result in psychiatry being left behind in the development and implementation of modern systems of psychiatric care.

OWEN, A. L., SASHIDHARAN, S. P. & EDWARDS, L. I. (2000) Availability and acceptability of home treatment for acute psychiatric disorders. A national

https://doi.org/10.1192/pb.24.10.394 Published online by Cambridge University Press