Correspondence

Anticipatory obedience

I fully agree with Dr Hakeem.[1] There seems to be a wrong perception among nursing staff as well as occasionally medical staff that a patient's choice to overeat is a human right. The opposite is the case. There is no 'human right' to eat as much as one wants to. Article 3 of the Human Rights Act 1998 forbids degrading and humiliating treatment (as part of the right to be free of torture), but this relates to seriously degrading practices. It does not at all mean that we need to allow any choices a patient wants to make. It does even allow a degree of institutionalisation as long as it is not deliberately degrading. If it did not, hospitals would not be able to function properly, as certain routines have to be maintained to allow the running of a hospital. Giving unnecessarily large amounts of food to patients could even be seen as a neglect of our duty of care, especially if the patient lacks capacity. If I was diagnosed with schizophrenia and started on clozapine under Section 3 (of the Mental Health Act), I would hope that the people treating me would have enough sense to stop me from eating three times as much as necessary, even if I did ask for it. So, rather than being defensive in anticipatory obedience and the wrong understanding of human rights legislation, we should use our common sense and duty of care, and prevent patients from doing serious harm to themselves by overeating while they are in our care.

1 Hakeem A. No physical health, only mental health. *Psychiatrist* 2010; **35**: 156–7.

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Is it worthwhile having a home treatment or crisis team after all?

As ardent devotees of home treatment teams (HTTs), we were encouraged by the findings reported by Barker *et al*.[1] It was exciting to note that the crisis resolution and home treatment (CRHT) service in Edinburgh had reduced admissions by 24%. Sadly, this excitement was short lived because of the criticisms that poured in soon after lambasting the authors for failing to factor in the impact of the local crisis house.

Not long ago, Forbes *et al*[2] reported (also from Scotland) that the introduction of an HTT did not lead to any reduction in overall admissions; in fact, there was an increase in the rates of detention. Earlier studies have demonstrated either an increase[3] or no significant impact[4] on levels of detention following the introduction of a CRHT. We worry these findings will leave both the commissioners of services and service providers confused to such an extent that they may end up questioning the rationale of ongoing funding for such teams.

The expectation that HTTs will provide an alternative mode of treatment to individuals who are so unwell that they are refusing treatment and need detention is counter-intuitive. The issues of mental capacity and consent as well as individual clinical risks need to be considered in interpreting these findings. Overall, there has been an increase in detention under the Mental Health Act in recent years. However, we do not believe an increase in detention in a local in-patient unit is a marker of failure for HTTs, although reduction in voluntary admissions can be associated with their local effectiveness. This association is obviously not straightforward, as it would depend on the availability of other local alternatives such as crisis houses; it would further be influenced by need, deprivation and social capital of the local population.

Bed usage or application of the Mental Health Act are poorly related to urgent response and crisis resolution as such. Although HTTs and crisis teams are often used interchangeably, they evolved with different ethos and priorities. Crisis teams preceded HTTs by a couple of decades, and aimed to provide crisis resolution and care in the community, improve patient choice and reduce stigma. On the other hand, the National Service Framework-driven HTTs were implemented later, primarily as an attempt to reduce the number of hospital admissions and bed usage. Provision of these services varies greatly across the country, making data generated from local studies poorly generalisable. These services are likely to be even more different from one another in the future, in absence of the national *Policy Implementation Guidelines*,[5] which provided some benchmarking around CRHT teams. It is interesting, if not ironic, that suddenly there seems to be an interest in research into the efficacy of these services, only after the *Policy Implementation Guidelines* lost its teeth. The contradictory findings indicate how these results can only be interpreted in terms of local effectiveness and not generalised efficacy. We believe that HTTs and crisis teams do offer patients an alternative, and thereby improve patient experience and choice. Absence of these teams would definitely be a step backwards!

1 Barker V, Taylor M, Kader I, Stewart K, Le Fevre P. Impact of crisis resolution and home treatment services on user experience and admission to psychiatric hospital. *Psychiatrist* 2011; **35**: 106–10.

2 Forbes NF, Cash HT, Lawrie SM. Intensive home treatment, admission rates and use of mental health legislation. *Psychiatrist* 2010; **34**: 522–4.

3 Tyrer P, Gordon F, Nourmand S, Lawrence M, Curran C, Southgate D, et al. Controlled comparison of two crisis resolution and home treatment teams. *Psychiatrist* 2010; **34**: 50–4.

4 Johnson S, Nolan F, Pilling S, Sandor A, Hoult J, Mckenzie N, et al. Randomised controlled trial of acute mental health care by a crisis resolution team: the north Islington crisis study. *BMJ* 2005; **331**: 599–602.

5 Department of Health. Crisis resolution/home treatment teams. In *The Mental Health Policy Implementation Guide*: 11–25. Department of Health, 2001.

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