

Newsletter

Faculty of General and Community Psychiatry
Royal College of Psychiatrists

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This is a publication of the Faculty of General and Community Psychiatry. The views expressed here are not necessarily those of the Royal College of Psychiatrists.

From the editor

With the much-awaited publication of the Mental Health Bill in September 2004, we will be further discussing how this is likely to change our practice. We have in the last few issues published a series of articles on the main issues and the work on the draft Bill from Tony Zigmond, and the newsletter editorial board are grateful to Tony for these. There have been quite a few controversial issues and heated discussions on the Bill. Ultimately what we can hope for is a clearer understanding of the roles of the adult psychiatrist in dealing with issues of capacity and consent and for patients to be offered ethical and humane care. We invite your comments on the Bill for discussion in future issues of the newsletter.

The document on the roles and responsibilities of adult psychiatrists is nearing completion. Much discussion and debate has preceded the preparation of this document as well, with the complex system of care in mental health services, and we hope that this document will be useful in clarifying the boundary issues between different specialties. This issue of the newsletter has some relevant articles on some specialist services and

the newly formed faculty of liaison psychiatry with regard to their links with adult psychiatry. Dinesh Bhugra in his article analyses the way in which the College functions and examines if we are ready to take on new challenges in the 21st century. It will be clear that we have much work to do in developing the role of the College further.

In the next few years the psychiatric training system is set to undergo a significant change in its structure and this is likely to be well debated. This is an issue that will affect not just the training and existing services but also the future of recruitment and perhaps how we will be working in future. We hope to hear from trainees their views on the new EU working time directive as well as the proposed changes in training.

Finally, the annual residential meeting of the faculty will be held at the De Vere University Arms in Cambridge on 14th -15th October 2004. We hope to see many of you there and hope to have interesting workshops discussions and debates at the conference.

Contents

From the editor	1	Standard care	7
Contents	1	Home treatment teams	8
From the chair	2	The curious incident	9
Carers' campaign	2	SHO research	10
Mental Health Bill	3	Clinical excellence awards	11
College: fit for the 21 st century?	5	Medical student essay prize: winning entry	13
Liaison psychiatry	6	Faculty executive	14

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From the chair

Jed Boardman

In our last newsletter I raised the issue of keeping up with the debate and publications on the future of the consultant psychiatrist. The interim report of the National Steering Group, chaired by Mike Shooter (Guidance on New Ways of Working for Psychiatrists in a Multi-disciplinary, Multi-agency Context) has now been published and is on the Department of Health website (www.dh.gov.uk). The main points of this report can be summarised as:

- The move to a 'consultant advisor' approach may reduce stress, burnout and improve the working lives of consultant psychiatrists
- This will have implications for all staff groups in Mental Health Services
- Training, education and CPD across all mental health professionals are not yet sufficient to support these new ways of working, and working environments must change

More work is to be done and pilot sites are being set up to test new ways of working. A final report is due in 2005. It is also hoped that the GMC will produce a clear statement about the responsibilities of consultants in the near future. This document supports our own Faculty report on 'Roles and Responsibilities of the Adult Psychiatrist'.

The other matter of current importance to all psychiatrists is the publication of the new Mental Health Act Bill, which is now undergoing pre-legislative scrutiny. This links to the future roles via the numbers of consultants in the workforce, which are presently believed to be inadequate to meet the demands of the new Act (in addition to the demands of the future implementation of modern high-quality psychiatric services). Two documents relate to this: Recommendations to increase the recruitment of and the overall numbers of consultant psychiatrists and to improve their retention (a report to the Mental Health Caregroup Workforce Team and the Recruitment and Retention Sub-group of the RCPsych" – January 2004)

and the Mental Health Care Group Workforce Team report on the National Mental Health Workforce Strategy (August 2004) (all on www.dh.gov.uk).

Remaining with the theme of official documents, earlier this year the Department of Health published its standards for health services (National Standards, Local Action – on the DH website) which sets out the standards which all healthcare organisations should achieve in delivering care and links to the NHS Improvement Plan. These standards will form the central component of the Health Commission's (new CHI) annual report on healthcare providers in England, which will contain the new ratings to replace the current star ratings. I am aware that few people are aware of these standards. While these affect health services as a whole in England, they will have inevitable implications for all mental health service providers and will form a driver to improve the quality of services.

Two further reports bear a mention. One is the report from the Social Exclusion Unit (in the Office of the Deputy Prime Minister) Mental Health and Social Exclusion (June 2004 – www.socialexclusionunit.gov.uk) which focuses on adults with mental illness. This is an important report for adult mental health services and its implications will be taken up by NIME. Regrettably, there are no clear funding streams attached to this work. The second report is the new NSF for Children and Young People. While this may have no direct impact on adult psychiatry, it does contain important plans for Child and Adolescent Mental Health Services and thus improve the provision of mental health services as a whole. The interface between CAMHS and adult services is crucial if we are to improve the services given to young adults and their families, one example of which are the modernisation teams for first onset psychosis, which question the logic of traditional age ranges for services and address many of the issues raised in the Social Exclusion Report.

Carers' campaign

Nick Kosky

Most of the members of the faculty will be aware that once every year the College identifies a campaign to put its efforts behind, to improve the lot of those with mental health problems. Campaigns in the past have included the anti-stigma campaign - recently taken up by NIMHE – and the 'Defeat Depression' campaign. This year the theme is carers, and the College has linked up with the Princess Royal Trust for Carers for this year's campaign, 'Partners in Care'.

The job of the campaign is to emphasise the carers' important role in looking after and promoting the wellbeing of people with mental health problems or learning disabilities.

Carers themselves suffer significant mental health problems, often because of lack of support.

Help is available to carers of someone with a mental health problem or learning disability from a number of voluntary sector as well as statutory agencies.

The 'Partners in Care' campaign covers a number of activities. These include a booklet on confidentiality; research on carers; a checklist for carers, patients and mental health professionals; leaflets on mental health problems; a commitment by the College to prepare a code of conduct for professionals on issues relating to carers; a variety of training material; and regional and local activities.

I would stress that the thing that makes a difference to carers is not ultimately the College's commitment to a campaign, but the commitment of its individual members to the patients they look after and their families and carers. General adult psychiatry has a tradition of treating the patient as an individual. This is important but unless thoughtfully managed can lead to a split between patients and carers. For most people with mental health problems, the most important support

does not come from a psychiatric outpatient clinic or even the Community Mental Health Team; it comes from their family, friends and GP. A slight shift in clinical practice – perhaps making sure that services routinely meet carers rather than the more usual case of exceptionally so – can make a substantial difference.

The College has re-issued some leaflets for carers and patients and questions to ask their psychiatrists. There is also a checklist for psychiatrists to ensure that they have touched on all the areas that are usually important to users and carers.

For further information about 'Partners in Care', in particular local activities, contact Deborah Hart, Head of External Affairs at the Royal College of Psychiatrists, or Nicola Edwards, Public Relations Manager, the Princess Royal Trust for Carers, 142 Minories, LONDON EC3N 1LB telephone 020 77091319 e-mail nedwards@carers.org

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Revised draft Mental Health Bill, Letter From Campaign Headquarters, Number 6 Tony Zigmond

I'm sorry if this article on the draft Mental Health Bill is not up to the usual standard (you may feel the phrase 'up to' isn't appropriate). I am extremely busy trying to read the 300 pages of the revised Draft Mental Health Bill, 140 pages of explanatory notes and several other accompanying documents. Made worse because the Bill is very difficult to read and some of the 'easier to read documents' aren't entirely truthful (e.g. ECT cannot be given to a person who retains capacity and refuses – this is wrong. The capacitous patient can be given ECT in an emergency.) In addition I have undertaken numerous press/media interviews and written 2 articles in the last 6 days. This isn't strictly relevant but my schedule was such on the day the Bill was published that our President got up at 5.00a.m. to make my breakfast!

The Bill (published 8th September) is available from the Department of Health website. The publication was brought forward from the previously specified date to the same date as the first day of the Michael Stone appeal. Coincidence? Interestingly, the news media did not relate the two items.

There are a number of differences from the first draft Bill. I cannot list them because of space, time and the fact that I haven't completed my reading of the Bill (but your editor has ordered me to write this promptly).

Some differences:

1. The definition of mental disorder has been amended so that it now reads that mental disorder *'means an impairment of or a disturbance in the functioning of the mind or brain resulting from any disability or disorder of the mind or brain'*.

I am not convinced that this difference in definition is meaningful.

2. The criteria have changed:

The first condition is that the patient is suffering from mental disorder.

The second condition is that that mental disorder is of such a nature or degree as to warrant the provision of medical treatment to him.

The third condition is that it is necessary –

- a) *For the protection of the patient from –*
 - i) *Suicide or serious self-harm, or*
 - ii) *Serious neglect by him of his health or safety, or*
- b) *For the protection of other persons, that medical treatment be provided to the patient.*

The fourth condition is that medical treatment cannot lawfully be provided to the patient without him being subject to the provisions of this Part.

The fifth condition is that medical treatment is available which is appropriate in the patient's case, taking into account the nature or degree of his mental disorder and all other circumstances of his case.

The fourth condition does not apply in the case of a patient aged 16 or over who is at substantial risk of causing serious harm to other persons.

For the purposes of this Part, a determination as to whether a patient is at substantial risk of causing serious harm to other persons is to be treated as part of the determination as to whether all of the relevant conditions appear to be or are met in his case.

It can be seen that the threshold in relation to risk to self has been significantly increased. There has been no change in respect of risk to others. Rather oddly, this now means that if a person lacks capacity but resists medical intervention (and so the Mental Capacity Act cannot be used) then we will not be permitted to interfere solely in the interest of the person's health.

The fifth condition seems rather unfathomable. Is this 'treatability' or 'therapeutic benefit' by another name? Professor Appleby says it gives clinicians clear grounds for refusing to make an order if this criterion isn't met. It was unclear at the Department of Health briefing if anyone fully understands this paragraph. One interpretation is that it means that the decision rests solely with the psychiatrist, thus enabling a clear apportioning of blame should there be any adverse event.

The final statement (you will note it is not listed as a condition) talking about substantial risk of causing serious risk to other persons being treated as part of the determination as to whether all of the relevant conditions appear to be met, would appear to suggest that dangerousness *per se* must be seen as mental disorder.

There continues to be no exclusion criteria. There is no criterion of impaired decision-making by reason of mental disorder.

In relation to Community Treatment Orders, the proposal for compulsion in prison has been removed. The explanatory notes accompanying the Bill suggest that patients will only be able to be put on a Community Treatment Order after they have had at least one admission to hospital (it is unclear whether or not this has to be within a defined time of the proposal for the Community Treatment Order) but this is absent from the Bill itself. It is stated that these additional conditions relating to CTOs will be in regulations.

Clinical supervisors, appeals, membership of Tribunals and expert panels are unaltered.

Minors aged 16 and 17 are treated as adults. For those under 16, first reading suggests that the Act may not be used if one parent consents on behalf of the child. Sue Bailey is investigating further.

The 'forensic' sections are generally welcomed. There are more opportunities for treatment without recourse to an additional civil section. Concerns include the even wider criteria for compulsion (than for other people) and the Courts authorising care plans. John O'Grady is advising.

One issue not mentioned in the first draft is that of Section 139. It may not be appropriate to worry about protections for staff at this stage. Nevertheless, this is the change. Section 139, you will recall, protects staff in two ways. First by requiring the patient to prove that the member of staff was not acting in good faith. Secondly by requiring the permission of the Director of Public Prosecutions prior to a criminal prosecution or a High Court judge prior to civil proceedings. The new clause excludes entirely protection for staff in relation to criminal proceedings, it reverses the current process so as to place the onus on the person complained against to prove that they acted in good faith and with reasonable care and it removes the need for High Court approval in relation to civil proceedings.

There are many other issues to discuss but, for the moment, I will have to leave it there. What happens next?

This draft Bill will go before a Joint Select Committee of both Houses of Parliament for pre-legislative scrutiny. Membership of the scrutiny committee can be obtained from the Parliamentary website. The Committee's first meeting, in private, should take place on 15th September. Following this we should hear who is to chair the committee and dates in relation to written and oral evidence. To give some time frame, we expect the written submission to be required by the end of October and oral evidence to be taken from mid-November (but please remember these are guesses). The Committee have to report by the end of March 2005. It is extremely unlikely we will get a Mental Health Bill (as opposed to the draft Bill) before the next general election.

The College's submission to that Committee will be available on the College website once it has been submitted. We have requested that we have the opportunity to submit oral evidence.

When membership of the Committee was first published I wrote to each MP and peer asking if the College could assist them with the important work they faced. I'm pleased to report that a number of them have requested written information and personal meetings – these are currently being arranged.

Finally I must mention that Roger Freeman, Agnes Wheatcroft and I will be doing the usual round of

lobbying - sorry, educating - at the party conferences. Then there's the Queen's Speech - don't ask.

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The College: Fit for 21st Century? Will it pass an approval visit?

Dinesh Bhugra

This is the first Approval Visit Report on the College since its inception in its current incarnation. The twentieth century is over and in its first thirty-plus years what has the College achieved? It has entered middle age and unfortunately its thinking has become jaded and stuck. First visit to inspect the College functioning studied the following:

1. College structures
2. College processes
3. College's impact on services
4. College's impact on training
5. College's impact on the public
6. College's support for its members.

The ratings for each section were three categories as prescribed by the General Medical Council:

a = acceptable
b = unacceptable
c = cause for concern

College structures: with nine faculties - general adult psychiatry (till recently the youngest Faculty); child and adolescent psychiatry; forensic psychiatry; learning disability psychiatry; old age psychiatry; psychotherapy; substance misuse; and liaison and rehabilitation (the two youngest Faculties) - and one sections and numerous special interest groups, it is ironic that all Faculties act as special interest groups to safeguard their interests in training and policy. The overarching view and support for psychiatry as a profession and psychiatrists as Collegiate individuals has been patchy to say the least. The sure sign of growing up is individuation but individualised arguments and spats have weakened the profession in the eyes of the politicians and public alike, who do not take it seriously. With devolution of policy development to Divisions, a new geographical competition may be seen as emerging.

c = cause for concern

College processes: the main purpose of the College is to set and assess standards of training and consultant functioning. The consultation processes have often meant that going through all the structures of the College will take months, if not years. While setting up the curriculum for Specialist Registrar training, some Faculties produced competences which were in excess of 50 closely typed pages, making a mockery of the

process of learning competences. The assessment of such competencies becomes even more problematic. The relationship between the politicians and the College has been always uneasy and so it should be. The College has to fight for the profession. A significant example has been putting the current Government on the back foot following the draft Mental Health Act. However, there are other instances where the College is seen as too close to the seat of government.

c = cause for concern

College's impact on services: with close to 100 Council Reports on various aspects of service development and organisation of services, it should have been possible for the College to support its Members and Fellows. This is the weakest area of functioning for College thus far. The training approval visits virtually never look at the consultant workload and the conditions in which services are being provided. The concerns with training are vital but without appropriate services and resources it is impossible to deliver good quality training. The development of NICE guidelines has meant additional strains on resources and the College's role in helping develop these guidelines has been useful. The emphasis on job description has been fruitful but the College has no way of knowing whether the job has remained the same, altered drastically or poorly once appointment has taken place.

c = cause for concern

College's impact on training: the College has been most successful in this. By and large training across the UK is at a similar level and has similar components although pass rates for the Membership examination do vary. The rigidity in the training of Specialist Registrars in particular is frightening.

The apocryphal story goes: when an eminent professor wanted to switch specialties she was told that she needed to go back to basics to do two years of SpR training in the new specialty.

a = acceptable

College's impact on the public:

Two public campaigns - Defeat Depression and Reducing Stigma - have been conducted in the last few

years. The impact on the public has been variable to say the least. Depression has not been defeated and stigma has not been reduced! However, both campaigns highlighted the existence of the College in the public's eye. More needs to be done in terms of engaging the public.

c = cause for concern

College's support for its members

The College support for its members at the present time is patchy. The College rightly does not see itself as a trades union concerned with terms and conditions of services, but without adequate resources good quality training cannot be delivered. Furthermore, as a body giving membership and fellowship, the College must strengthen its disciplinary procedures. The College has a clear duty and responsibility towards its members who need support. The return of sick doctors to work, as well as recruitment and retention, needs more emphasis than is being currently given.

c = cause for concern

Mandatory requirements

1. Devolution and recognition of Divisions in the region with dear two-way communication with the central College is essential.

2. The College needs to focus more on international links, especially in terms of training and support for users, carers and mental health professionals in their countries.
3. The training needs to shift towards more flexible, less rigid interpretation of needs, and modular assessments and training must be available on the web.
4. The restructuring of the College with fewer committees, more trainee involvement and recognition of teleconferencing and web based chat rooms for reaching rapid decisions.
5. The Central Approval Panel must also highlight pressures on trainers regarding service delivery.
6. The campaigns for public education should be ongoing.

Desirable improvements

1. The disciplinary procedures need to be strengthened.
2. The support for its members should be available promptly.
3. The focus of training and assessment should be on delivery of services with clear competence objectives.
4. The College must be proactive in offering teaching, training and relevant courses and placements for all levels from sixth-formers to CPD.

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Who is afraid of liaison psychiatry? Gopinath Ranjith

Liaison psychiatry has finally been recognised as a Faculty of the Royal College of Psychiatrists, thus elevating it to the status of other specialties. Some adult psychiatrists, concerned about the increasing trend of sub-specialisation within their specialty in the form of early onset teams and assertive outreach teams, have seen this development as another example of the fragmentation of adult psychiatry. The divisive nature of this issue was evident in a debate organised on this topic last year jointly by the London Division and the (then) Section of Liaison Psychiatry, which saw three adult psychiatrists arguing against granting specialty status to liaison psychiatry and three liaison psychiatrists arguing in favour.

The struggle to get liaison psychiatry recognised as a valid specialty has been slow and arduous even in the US where the specialty has a much wider base, succeeding only last year. In the rest of the article, I will try to persuade doubters in the adult psychiatry camp that there are adequate grounds for liaison psychiatry acquiring specialty status in the UK and that

far from being a rival to adult psychiatry, there is enough scope for the two Faculties to work in tandem.

The case for the speciality of liaison psychiatry

Psychiatric specialties are usually defined by the unique group of patients treated by the specialists and /or the special settings in which they work. Liaison psychiatry qualifies on both counts. The patients treated by liaison psychiatrists have co-morbid physical and mental illnesses or do not have physical or (formal) psychiatric diagnoses. The patients are seen in a setting unique to the specialty, the general hospital. The therapeutic skills, both psychopharmacological and psychosocial, need specialist adaptation to be used in a general hospital setting.

The case for dedicated liaison psychiatric services to deal with psychiatric morbidity in the general hospital is overwhelming. Sharpe and Mayou (*British Journal of Psychiatry*, 2004, 184: 465-467) have recently presented their vision of a world where physicians manage both physical and mental health problems, but it is unlikely to be realised in the near future. With adult

psychiatrists moving away from general hospitals to community team bases, their ability to respond to referrals from general hospitals has diminished. Whatever one's views about the four-hour wait times, it is undeniable that a responsive liaison psychiatry team improves the quality of care received by mentally ill patients in accident and emergency departments. Many of the psychiatric problems encountered in general hospitals present acutely, making prompt response essential. There are also a large group of patients with disabling medically unexplained symptoms who are poorly served by community mental health teams and could be helped by liaison services. A good liaison psychiatry service is able to represent psychiatry in general hospitals, educate junior (and often not-so-junior) doctors about mental health issues, and help in recruiting high-quality trainees into psychiatry.

Should adult psychiatry fear liaison psychiatry?

It is my belief that most adult psychiatrists would welcome the development of specialist liaison psychiatry teams in their local hospital. Many patients belonging to community psychiatric teams are frequent visitors to the A&E departments and are not infrequently admitted to medical wards. Adult psychiatrists will be relieved that their patients will be cared for by a dedicated team. The presence of

psychiatric teams on-site will also reduce the discriminatory attitudes often faced by our patients in general hospitals. I have also not detected much enthusiasm among community psychiatrists in interrupting their busy clinics to rush to a general hospital miles away to manage a patient with delirium.

There are plenty of opportunities for the two Faculties to collaborate in the future. The organisation of accident and emergency mental health services, particularly in managing deliberate self-harm, is an obvious example where the Faculty and the Section worked together and one hopes this work will be taken forward by the two Faculties. The field of primary care mental health is an area of interest common to many adult and liaison psychiatrists and seems to be another fertile ground for co-operation. The physical health of patients with severe and enduring mental illnesses is a neglected area where the expertise of specialists from the two Faculties can contribute to better patient care. One hopes that the leaders of the two Faculties will seize this opportunity to build strong bridges as well pool their resources in working with other bodies such as the Royal College of Physicians and the Royal College of General Practitioners.

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Maybe we do a good job after all!

Rajesh Mohan

Assertive Community Treatment (ACT) teams are among the highly rated specialist teams for the management of severe mental illness. A large number of studies have looked at the efficacy of these approaches and the initial research evidence pointed to its greater effectiveness in the management of psychotic disorders when compared to standard care. There is evidence that this model of care is more cost-effective and is preferred by patients and users. Some of the key features of the ACT include assertive engagement, persistent followup, meeting basic needs/entitlements, focus on improving functioning, medication/symptom management, multi-disciplinary teams etc.

However, a number of more recent randomised controlled studies in the UK have failed to find that this model can lead to significantly better outcomes compared to standard care. Interestingly one large study even found that it increased the inpatient days slightly. Researchers have looked into reasons to explain why ACT was not shown to be superior to standard care in the UK unlike in the USA. Amidst all this, the fact that standard care leads to equally good outcomes has been relatively ignored.

Various explanations for the lack of differences have been suggested. There were concerns that the model of

ACT that was being offered was different and the practice models may vary from place to place and this could account for the difference. A number of studies followed which looked at the components of care and scales were devised to measure model fidelity of these treatments. There have been transatlantic comparisons of model fidelity, which ascertained that the treatment offered as ACT in the UK was not markedly different from the ACT offered in the USA. Some researchers have suggested that the comparison (standard care offered) in the UK is significantly better than the standard care offered in the USA. This perhaps may explain why the difference in efficacy between ACT and standard care is less in the UK. This has not been adequately verified by research.

It has also been argued by some researchers that models like ACT and Intensive Case Management (ICM) are different approaches. However, what is important is that these two models are not actually treatments as such but are methods of delivering care in a systematic and effective way, and what is perhaps more significant are the components of care offered in these models. Specialist teams like ACT are costly and resource - intensive. Setting up specialist teams alongside locality teams creates a situation of resources being diverted towards these. Another important factor is that these

specialist teams tend to attract highly skilled staff from generic teams, as there are opportunities for further training and perhaps better grades. It is also likely that the prospect of smaller caseload sizes in specialist teams is another incentive. It is not clear whether this actually leads to reduced stress levels and less burnout in staff working in specialist teams. One area that remains unclear is the full impact of these specialist teams on the locality mental health teams.

Leaving the research aside, it is perhaps fair to assume that the psychiatrists who work at the grassroots level are also aware of new developments in the field, and are quick to integrate them into practice where possible and where they are not unduly restricted by guidelines on practice. Clinicians have a keen interest to offer the best available care, reduce admissions, avoid crisis in the patients, and also to see patients improving and after appropriate follow-up, being discharged from their services.

It is difficult to draw any conclusions from these observations, as the fact that research is being conducted may in itself affect the findings of the study (the Hawthorne effect). But as psychiatrists working in

the community, looking after those with mental health and a variety of social problems, in an under-funded, under-staffed system, we may be allowed to take pride in the fact that research has indeed shown (although indirectly) that what we offer as routine does not fare poorly in comparison. Holding onto large caseloads, looking after offenders with mental illness, keeping risk levels down and working with all sorts of agencies including the Multi Agency Public Protection Arrangements (MAPPA) and trawling through endless paperwork, we still succeed in delivering what we set out to do.

The point of this article is not that there is anything wrong with specialised interventions like ACT. But the preoccupation with specialist teams and specialisation should not take away any kudos from the excellent work that many clinicians deliver in ordinary conditions. The psychiatrists who look after their patients in difficult and under-resourced conditions, offering best available care and ensuring that the outcomes are as good as those achieved by the more endorsed specialist teams, do have certain unique skills. Perhaps it is the ability to improvise and provide the best level of care leading to good outcomes in rather trying conditions!

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Home Treatment Teams

CT Sudhir Kumar

Teams to provide intensive treatment for individuals with acute mental health problems in their own home settings are being developed in the UK mainly in response to the National Health Service Plan (Department of Health, 2000). The priority to offer care in the least restrictive settings can be achieved by ensuring that it is available in the home environment, with little disruption to social networks and ensuring that the emphasis is on recovery and maintaining functionality. The initiative to establish Home Treatment Teams (HTTs) is expected to reduce the usage of acute psychiatric inpatient beds and prevent difficult transitions, as well as to provide a service aimed at managing patients with complex needs outside the hospital environment and to maintain social networks. HTTs can play a major role in situations where an inpatient admission is strongly determined by the social characteristics rather than the illness variables. They provide a time-limited multi-disciplinary intensive and targeted intervention with minimum disruption to patients' lives.

The neglect of usual social circumstances and an over-emphasis on medicalisation of mental disorders are valid criticisms towards inpatient treatments. The basic principles of home treatments include ensuring rapid assessment and intensive management, with a view to providing an effective alternative to hospital admission.

HTTs are able to conduct more personalised assessments of the clients in their own home settings. They are also capable of providing a safe service for clients after facilitating an early discharge from hospital, which would not have been possible otherwise. By the very nature of their work settings, they often have the opportunity to obtain and provide information to the family, which could be difficult in other circumstances. As the team members see the clients in their home environment, there will be a greater awareness of social difficulties, relationship problems and decreased chances of disengagement with services. In addition to their specific inputs, HTTs also carry out tasks like prescribing and dispensing, which would have been usually dealt with in the inpatient wards. Ideally HTTs not only undertake regular reviews of mental status, monitoring of medications and provide support by frequent visits, but they also provide psychological interventions and practical advice. To be highly effective, HTTs should be offering a 24-hour service, 7 days a week. They bring a rich mixture of skills and expertise from different professional groups, including doctors, nurses and social workers.

Most teams work on a collaborative whole-team approach, with key workers identified for each individual client responsible for co-ordinating the care plan. Continuity of care could suffer with involvement

by different teams and it may adversely affect the welfare of an already compromised and vulnerable individual. The role of the HTT should be clearly specified at the onset to avoid unrealistic expectations. A joint assessment of the client, with the referrer at the first instance, is recommended to help reach a consensus, to avoid duplication and to ensure quick decision-making. It would be productive if there were joint meetings with the community team representative periodically and at the time of discharge. To successfully enable an early discharge from the hospital to the care of the HTT there should be active collaboration with the ward staff as well as regular joint reviews.

A recent systematic review concluded that the empirical evidence base for home treatment in comparison with other community-based services is not strong as yet, although it does understandably show that home treatment reduces days spent in hospital compared with inpatient treatment. There is evidence that visiting patients at home regularly and taking responsibility for both health and social care needs reduces days in hospital. Research in this area is limited by a wide variation in definitions of the service and the differences in the components of care in the services that were compared.

It is essential to have policy guidelines in place to ensure the safety of workers while working alone or at night. The work of HTTs should be integrated with that of inpatient units and emergency departments in order to be sufficiently effective. The medico-legal impact of the decision-making processes of these teams are still unclear. Situations in which the teams are not able to reach a consensus about appropriate management are not uncommon. This necessitates the need for locally agreed protocols. Clinicians may differ from the views of HTTs regarding the early discharge from inpatient units and the home treatment of clients whom they know better than others. The gate-keeping role of HTTs in inpatient admissions often brings them into conflict with the community mental health teams and staff working in highly stressful situations like casualties and

emergency clinics. Various reasons have been suggested for the resistance faced by these teams. and emergency clinics. Various reasons hve been suggested for the resistance faced by these teams. They include overlapping of clinical boundaries, vagueness about responsibilities, the applicability and generalis ability of these services especially in deprived areas, changing work patterns of consultant psychiatrists and patient risks. The success of any new intervention depends upon co-operation across the entire health care system.

Perhaps a key area is the selection of those patients who are most suitable for care that HTTs can provide. Clarifying the criteria for the appropriateness of care by HTT would be a step forward. Specialist teams are costly to establish and maintain, and there can be a problem in funding them in some areas. Specialist teams also tend to attract the most skilled professionals and this can lead to problems for community mental health teams, which increasingly tend to lose their experienced and skilled professionals. Lastly, with the stigma surrounding mental health problems, it is likely that some patients may not want staff coming into their homes and may see any intervention as an intrusion.

A co-ordinated research approach is essential to make any findings meaningful and, as recommended by the National Service Framework, there should be more government direction of research in the National Health Service. Over time, it would be essential to establish an adequate empirical base for the efficacy of these teams through systematic research. The research initiatives should look at the utilisation of services and patient satisfaction as well as the outcomes.

The increasing numbers of specialist teams may mean further fragmentation of mental health services and loss of continuity of care. It is therefore necessary to identify the best ways of co-operating with other services and working in a seamless manner. Integration of mental health and social services has already changed the way we work, but the increasing numbers of specialist teams does pose a challenge within the complex mental health services matrix.

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The Curious Incident

John Moriarty

The Whitbread Award-winning novel 'The Curious Incident of the Dog in the Night-Time' by Mark Haddon, which also secured the overall prize of 'Book of the Year', tells the story of a teenager with Asperger's Syndrome who discovers, following the death of a neighbour's dog, the complex web of emotions, jealousies and disappointments which surround him. The story is told entirely from the boy's perspective,

written as a therapeutic exercise in collaboration with his teacher at a special needs school. The poignancy and humour come from the fact that he remains necessarily uncomprehending of these emotions, while struggling to overcome his own needs for ritual and familiarity.

Reports from Royal College working groups are unlikely to win any literary awards and I'm sure the

College publications department would envy Haddon his readership. The needs of the protagonist are, however, germane to the report being prepared by an inter-faculty working group considering the needs of adults with autism spectrum disorders (ASD). The group, chaired by Tom Berney, has had lots of lively discussions about the nature of the disorder and is concerned particularly with trying to identify the role for our profession in helping people with it.

One of the claims (which can cause a degree of alarm) is that the prevalence of the disorder is greatly underestimated and may be as high as 1 in 200. Then there is the question of who should reasonably be expected to make the diagnosis. Should a doctor with a CCST in psychiatry be expected to be able to diagnose ASD? There seems to be a consensus that identifying developmental abnormalities of social cognition is not the preserve of psychiatry or medicine and that diagnostic assessments alone may not be part of a mental health service.

There may well be a need, however, to be able to recognise those individuals whose developmental disorder predisposes them to or affects the presentation of mental illnesses, especially affective disorders and psychosis or pseudo-psychosis. Diagnosis alone has its

limitations and the more difficult questions may be as to what constitutes appropriate 'autism-friendly' services and treatments, both pharmacological and psychological, for mental illness. At the level of service provision there are important questions as to what is needed within secondary mental health services and what is the role of specialised services.

The discussions around this topic bring us back to some of the basic conceptual issues in psychiatry. The fact that a psychiatric diagnosis is often a working hypothesis rather than a pathogenetic entity may need explicit consideration to avoid recommendations that focus on labels and not on needs.

Some of the rather arbitrary divisions of psychiatric services and specialisms based on age; IQ or offending seem particularly unhelpful for a group of people whose difficulties and needs cross the spectrum.

Like many working groups, our discussions often seem to expose and illuminate the problems; finding solutions is never as easy. If you would like to join in these discussions why not come to the workshop planned as part of our faculty's residential meeting in October in Cambridge?

If you wish to make a comment or respond to this article email us at adultpsychiatry@yahoo.co.uk

Senior House Officers and research: does it work?

Ajoy F Thachil

Senior House Officers (SHO) would love to do research, or at least, a significant proportion would. That much is clear from discussions at academic meetings and open fora. Considering the number of registrars who embark on full-time or part-time research, there is no reason to doubt the existence of such enthusiasm.

The NHS, today, considers evidence the bedrock of good practice and, consequently, the drive to improve overall quality. Research, of course, is one of the key contributors to this evidence. SHOs are told, almost from the minute they enter their training, that a practice that does not have an evidence base is of such limited value as to be practically worthless. The manuals and textbooks they are encouraged to follow are evidence-based i.e. based on high-quality research. Teaching programmes are loaded with information on how to sift the good from the bad evidence. Clinical governance, of course, earnestly professes to encourage and facilitate research towards achieving its objectives. So far, so good.

But does an SHO who is interested in doing research get the kind of genuine support and encouragement that

would make those lofty ideals enshrined in clinical governance seem any more than just that? In most UK psychiatry rotations, the answer to that question is, unfortunately, no. The reasons for this are many. Some of these reasons are as mystifying as the others are understandable. Let us look into some of the more understandable ones first.

In the busier rotations, which are either metropolitan or based at prestigious universities, hectic work schedules are usually cited by the 'system' to subtly discourage an earnest SHO. It is another matter that these schedules are often made that much more hectic by paperwork and duties which are often beyond the pale of her/his 'official' responsibilities. But then, the paperwork buck usually stops with the SHO and she/he rarely has a choice in the matter. The irony in such rotations is that the junior doctor is usually steeped in a milieu where all other cogs in the wheel, from the full-time researchers and SpRs upwards, are engaged in high-quality research. This can be understandably hugely frustrating, especially if the SHO is doing some 'extra-curricular' paperwork as part of his/her 'unofficial' duties, knowing full well that such time could be utilised for research.

Now on to some of the more mystifying reasons. Most research-oriented, *ergo* high-profile, talked-about units (to whom the SHO eagerly applied for those very three reasons) have teams of full-time researchers, waiting in massed, orderly ranks to have a go at the research base i.e. the patients and case-notes, in order of predetermined hierarchy. Such teams, of course, have considerable funds/influence at their disposal, not to mention a concrete remit to further the research and academic reputation of the unit. They are the blue-eyed boys (and girls), of the local clinical governance establishment. No one messes with *their* research base. The SHO, when she/he comes to work with such a unit, is very much the raw, untrained outsider. A outsider without much available time to draw up (or even learn how to) a protocol, let alone collect/analyse data at the expense of important paperwork!

There, of course are a myriad other reasons for the issue at hand. One is certain that junior doctors across the land would have their own unique, related stories to share.

One cannot come up with instant solutions. Given the complex, practical realities of day-to-day clinical governance, that is clearly obvious. Allotting research days, utilising the extra time provided by the new EU

working rules more imaginatively, allowing SHOs far away from exams to make the choice between taking the MRCPsych course and pursuing research, protecting research time the way psychotherapy time is protected, and creating more research SHO posts are all possible solutions.

The Royal College, of course could make these *fait accompli* by making a research project or dissertation a compulsory requirement for the membership. That would be in tune with postgraduate training policies in other parts of the world. It would also mean that solutions to the above problems would *have* to be found. But this would mean a change in the way the MRCPsych exams are conducted and supervision would be more in tune with a postgraduate degree course. In the present scenario this would prove to be impossible to achieve and would burden trainees further with current workloads and pressures.

In the unlikely event of this happening anytime soon, there has to be a paradigm shift in the attitudes of consultants, teams and clinical governance groups towards the idea of their SHOs doing research as the natural, logical norm (as framed by clinical governance itself) rather than as an inconvenient exception.

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Clinical Excellence Awards: College nomination procedures in England and Wales

Vanessa Cameron

The Department of Health reviewed its procedures, operation and practice of the award scheme in October 2003. The following paper describes the College's current nomination procedure in England and Wales for 2004/2005.

The College's Clinical Excellence Awards Committee (CEAC) consists of representatives who have been elected to office. This includes those Honorary Officers who have awards and the Chairmen (or alternate representative) of Divisions, Faculties and Sections. If the Chairman of a Division, Faculty and Section does not have an award then the relevant Executive Committee, as the appropriate elected body, will appoint an alternate representative. The CEAC is chaired by the President.

Any member requiring the names of those on the College's CEAC should contact Sue Duncan on 0207 201 2600 or e-mail sduncan@rcpsych.ac.uk.

Statistics showing the gender and ethnic backgrounds of those consultants put forward for awards are produced each year by the College secretariat and posted on the College's website. Although awards continue to be

made on merit, Divisions, Faculties and Sections are asked to consider these statistics when submitting their list of recommendations.

Chairmen of Divisions, Faculties and Sections, in consultation with their Executive Committee, or in some cases at meetings of award-holders, will consider all eligible members and produce a list of nominations in rank order for their Division, Faculty or Section. These various nomination lists will then be sent to the College and are merged to form one composite list. This list is then sent to all the members of the College's CEAC, together with the CV questionnaires (but not the citations) shortly before the College's annual Awards Meeting. This is usually held at the end of January.

Only the names on the composite list of nominations are considered at the meeting and then only if the CV questionnaires and citations have been received in advance of the meeting. The Committee member who has made the nomination will speak briefly on behalf of each candidate. Some names are removed from the list at this stage. The Committee are given ample time to consider the paperwork, together with the relevant statistics, and finally to cast their votes.

The final list of College nominations is then submitted to the Advisory Committee on Clinical Excellence Awards. Further information of the awards procedures can be viewed at ww.doh.gov.uk/accea.

How to be nominated for an award

College Members who wish to be considered for an Award have the following options. They may submit a 2005 ACCEA CV questionnaire (these can be downloaded, when available, from the ACCEA website at the above address) to **one** of the following:

- The Chairman (or alternate) of their Division

- The Chairman (or alternate) of their Faculty
- The Chairman (or alternate) of their Section
- The Chief Executive of the College, for consideration by the Honorary Officers no later than 1st November, 2004. The Honorary Officers meet to consider individual nominations from College Members concerned that they have been overlooked.

When applying, Members must also give the name of a senior colleague willing to write a citation on their behalf.

Last-minute registrations!

Faculty of General and Community Psychiatry Annual Residential Conference

DeVere University Arms Hotel

Cambridge

14 - 15 October 2004

Royal College of Psychiatrists
Medical student essay prize in general and community psychiatry

Topic: “The World Health Organisation have estimated that depressive disorders will be the leading cause of morbidity and disability in the world. Discuss the implications of this for health services in the future”

Thanks to all who participated in the competition. We had fourteen entries and three were short-listed. Special commendation to Sebastian Boo, who came a close second and congratulations to Kashif Siddiqui who won the prize. The summary of the winning essay is given below:

Introduction

The Global Burden of Disease study conducted by the World Health Organisation in 2000 identified depression as the fourth leading cause of disease burden (Ustun 2004). Successive governments have failed to address this growing problem and there is now an urgent need to develop and implement strategies to effectively manage and treat depression at all levels of care (primary, secondary etc). Traditionally, most health care professionals have not given sufficient attention to mental health disorders. This has led to the failure of illnesses such as depression from featuring on priority lists of public health significance (Ustun 2004). In the United States the cost of depression has been estimated at \$43 billion per year. In contrast to most other illnesses, only 30% of the cost is from medical care with the remainder from loss in workplace productivity and premature death.

Recognition of depression

Depression is a common mental illness and most patients are identified and treated in the primary care setting, and it is often the first point of contact for many patients with depressive disorders. The time constraints, within which general practitioners (GP's) operate, make it difficult for them to perform a full assessment of an individual's physical and psychological problems. Frequently, depression may be recognised by the GP, but the management can be hindered by the reluctance of some individuals to acknowledge that they are depressed. A recent survey of patients who were classified as being depressed found that more than a third of patients were reluctant to accept the diagnosis and more than half did not wish to see a psychiatrist. This may be because of the stigma attached to the illness and concerns about confidentiality. Indeed, thousands of people each year never consult any mental health professional because of the stigma attached to psychiatric illnesses (Byrne 1997).

Screening

Questions have been raised as to whether blanket screening would be effective in reducing the depression burden on health care services. The main concern appears to be the immense costs of operating such a scheme on a nationwide level. Perhaps a more suitable alternative would be to annually screen patients at high risk of a depressive episode. This would include those with a significant family history of depression, previous history of depression or those with a chronic illness. In the latter group, one study has shown that the prevalence of depressive illnesses was 13% compared to 3% of individuals with no chronic illnesses. There is limited research to suggest that such an approach would be effective, but Wilson (2004) has shown that targeted interventions to high-risk persons with HIV could for the same amount of money avert more infections than untargeted interventions.

The future

In the USA, a National Depression Screening Day is held every October and is one of several campaigns that have been launched with the aim of highlighting public awareness of depression. The National Association for Research on Schizophrenia and Affective disorders has adopted a slogan that captures the message that these campaigns are trying to convey: 'depression is a flaw in chemistry not character'. This can only be positive for depressed patients, whose needs have been traditionally neglected by health care services.

The structure of primary care has to be altered to accommodate the needs of the depressed patient, as currently there are poor arrangements for routine follow-up and regular assessment. The introduction of specialist clinics conducted by nurse practitioners and development of a formal protocol for managing depression, similar to those available for asthma and diabetes, would provide an opportunity for a periodical review of medications, assessment of symptoms and provide support.

Conclusion

By 2020 depression is predicted to become the leading cause of illness burden on society. Despite a widespread knowledge of the effects of depression on society, few meaningful steps have been taken to change practice. The time has come for policy-makers and health care professionals to implement long-term strategies to tackle this illness before the burden becomes insurmountable.

Faculty of General and Community Psychiatry: The Executive

Chair:	
Dr Jed Boardman	(Elected: 2003)
Honorary secretary:	
Dr Suresh Joseph	(Elected: 2003)
Finance officer:	
Dr Geraldine O'Sullivan	(Elected: 2001)
Executive committee members:	
Dr Pradeep Arya	(Co-opted: 2003 – CTC rep)
Dr Anne Bird	(Co-opted: 2002 - GOAPSAC)
Dr Alan Currie	(Elected: 2003)
Dr Lenny Fagin	(Co-opted: 2003 – academic secretary)
Dr Brian Ferguson	(Elected: 2003)
Dr Cliff Haley	(Co-opted: 2004 – Irish College of Psychiatrists)
Dr David Hall	(Co-opted: 2003 - CAP interface working group)
Dr Michele Hampson	(Elected: 2001)
Dr Anna Higgitt	(Observer: Department of Health)
Dr Stephen Hunter	(Co-opted: 2003 – Welsh Division)
Dr Robert Kehoe	(Elected: 2001)
Dr Nick Kosky	(Elected: 2001)
Dr Rajesh Mohan	(Co-opted: 2002 - communications)
Dr John Moriarty	(Co-opted: 2003 – inter-faculty working groups)
Professor Richard Morriss	(Elected: 2001)
Dr Paddy Moynihan	(Co-opted: 2003 – Northern Ireland Division)
Dr Stephen Pereira	(Elected: 2001)
Dr Salam Rashid	(Co-opted: 2002 – SpR rep)
Dr Brian Robinson	(Elected: 2001)
Dr Mark Taylor	(Elected: 2003)
Dr Trevor Turner	(Elected: 2003)
Dr Graham Wood	(Elected: 2003)
Professor Allan Young	(Elected: 2003)
Dr Tony Zigmond	(Co-opted: 2003 - legislation lead)

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Don't forget to mail or email us with your responses and articles for publication!