Interview with Professor Louis Appleby

1. **What is the impact of the changes that happened through the NSF and the NHS Plan? What do you see as the role of the psychiatrist in mental health services now?**

The changes were about strengthening community care. Famously a previous Secretary of State said community care had failed; consultant psychiatrists were upset by that, but it did reflect the public perception that this was a misguided policy. The government asked what can we do to make community care work? The DH answer was to strengthen it where it was weak: in the care of people who were otherwise in danger of drifting out of services through treatment refusal or as a result of illness not being able to accept what was being offered to them; having better access to care for young people in their first episode of serious illness; and providing alternatives to an inpatient bed for people developing an acute illness. I was a general psychiatrist and had the prejudices of psychiatrists about the 'beds problem'; we needed to take the pressure off our existing beds. Often people came into hospital and certainly they stayed longer because of the lack of alternative to an acute bed. The changes translated into new services: Assertive Outreach, Early Intervention and Home Treatment teams.

2. **Within current community services, what do you see as the role of the consultant psychiatrist?**

I linked the role of the psychiatrist to the development of specialist teams. I brought my own experience into policy as I had a community team, a ward, a day hospital, I took GP referrals and if I could be persuaded, I did home visits. I had a fragmented and relatively chaotic working life and it was difficult to develop specialist expertise. Many of my colleagues felt that they were doing too much, but not having the time to do the things they were good at. The amount of work people do is a minor reason to feel overworked; changing the way people worked was more important. Consultants could have a specialist role in relation to teams such as Home Treatment or Assertive Outreach, or with an in-patient team rather than a fragmented working life; care co-ordinators and CPA would provide continuity. New Ways of Working was not an attack on doctors but an attempt to shore up what I saw as a failing in the general psychiatry role model.

3. **What do you think now? There has been debate about the role of the psychiatrist in relation to physical health care, and the skills needed and what they should be doing about that?**

People got worried about the high rates of physical illness and early mortality in users of specialist mental health services. A review of nursing in mental health set out the role of the modern nurse and it included better physical health care. We developed new guidance for the CPA to include this broader role, not for psychiatrists to be physical health specialists but they needed to know about a patient's physical health care. Part of the intention was to bring primary care closer to specialist mental health care. There was a feeling that all the problems end up in general psychiatry because everyone else cherry picks. The role of the general psychiatrist is crucial to make sure the signposts are right for people to move around in the system and the roles have to be right, training has to be right, and the system – what people now call the care pathway – must be right whatever your problem.

4. **For the psychiatrist, what is their role in prescribing? There has been discussion here about actually how much expertise do psychiatrists have in prescribing, and what do we expect from them?**

We have to constantly redefine the role of the psychiatrist; nurse prescribing is still quite limited and often under the supervision or written direction of the doctor. Prescribing is a natural territory for us. Following my argument about developing our expertise it follows that this applies to prescribing which done well is quite complex. I get uneasy if it starts to sound as if doctors have a natural entitlement to a unique place in mental health care. We have the same requirement as everybody else to define our role based on our expertise.

5. **What do you think about the feasibility of moving patients from secondary to primary care in line with where the resources are and what service commissioners want?**

There is a movement in policy terms towards primary care and whole population mental health which will have an effect on how services operate. That is a positive shift for us. You could argue that until we have addressed the problems in specialist mental health services it is not possible to take a broader look at population issues – how mentally healthy is the population and what are the consequences of depression or complex morbidities of lower grade problems on society? These are questions for public mental health and primary care; in the end the mental health of society will be best addressed by a population approach. But we will still need specialist services: beds, strong community services, as well as continuing care for people with the most severe complications of mental disorder.

6. **How do you think mental health providers can best work with Local Authority and voluntary sector providers?**

Commissioning groups will want to commission the best possible mental health services. The Health and Social Care Bill recognises Commissioners must take expert advice from other people, in particular the service providers. The same argument applies to public health. The Local Authority, proposed Director of Public Health and the Health and Wellbeing Board will have responsibility for local public mental health development to address the broader mental health needs of the public. That is new territory for them; nor is it natural territory for those who work at the harder end of mental health care, but we still know more about it than anybody else and are the people to be round the table of the Health and Wellbeing Boards, to link strongly with Directors of Public Health in understanding need and to turn this into providing the best models of care.

7. **Within mental health services, what do you see the role of the psychiatrist in terms of medical leadership?**

Medical leadership is key. There is no government process to undermine it; this may come across differently because arguments can arise over things like the consultant contract and there has been much debate about the White Paper and current Bill. Government knows we are probably the most powerful people in the health system and recognises that the public are responsive to what doctors tell them; in the end, the success of health services and any reforms depends on the right clinical leadership, nationally and locally. I see a bright future for us. I have never had the impression government is 'out to get' doctors. We are paid more, our caseloads have been reduced and we have had key roles in the reforms (my posts are an example of that).

8. **How do you think the College can best work with the Department of Health in terms of looking at policy changes and current legislation more generally?**

There has been a reduction in the way that government directs the health service and it is unlikely to set out the same amount of detail as we had in the NSF and NHS Plan. This is a fantastic opportunity for Colleges – including our own because we work in such a controversial area – to provide leadership. The government will state the general principles for the direction of policy, leaving a gap between that policy outline and the creation of services on the ground. Local organisations understanding local needs can fill that gap, but equally there is room for professional leaders and professional organisations. In my new area of offender health, I hope the College will provide clinical descriptions of how offender services can best run, for example, in an area like diversion which the government has decided is vital but has not given detail for commissioners.

9. **So that's a clear role for the College. What about a role for individual members?**

The College will have to rely on clinical experience as well as research evidence and the views of patients; this clinical experience needs to be properly harnessed and applied to College documents and College guidance which is

going to be an important driver in the future. At a local level, clinicians can influence commissioners and there is a real opportunity for us to say we can tell you what a diversion service should look like and so on. Workforce development will depend to some extent on what clinicians say is needed in frontline services. There is a real chance for people to lead developments which maybe in the past was not there.

10. Thinking about your academic work around suicide and homicides, how has that influenced your thinking around policy development?

I assume I came into the job in the DH partly because of the work I had done on the safety of services. Inevitably I see the role of services from that perspective – you could argue developing Assertive Outreach teams is part of that. A focus on safety influenced my approach to the Mental Health Act. Some people thought the Mental Health Act should be about mental capacity which is a legitimate point of view but not one I hold; I think it is about the safety of vulnerable people and our responsibility as a society and as a profession for their safety. My work on suicide and homicide brought me into contact with the families of these people, and understanding how mental health care looks from their point of view is a sobering experience when they describe the interaction they have with mental health organisations, service leaders, and sometimes psychiatrists. As professionals we can feel misunderstood; you can see how a stand-off happens as the families' questioning confirms our view that we need to defend ourselves and say serious incidents are difficult to predict and prevent; this can sound complacent if we say these serious incidents, particularly homicides, are rare but the public hears there are 50 to 60 a year by current mental health patients and they think we are not worried about risk and so they worry more. The way we talk to the public and the press on issues of risk, could be improved. I'm with the rest of the profession on making sure that people are not too critical of mental health services on this issue. It needs better understanding from the public and the press, and we need to get into an honest dialogue about what we can achieve which acknowledges that sometimes we come across as too defensive, if the public are going to understand what we are saying.

11. You mention the Mental Health Act changes. I would be interested in your views on the CTO and its impact on services and how it is being used.

I think the CTO is essential. It will protect individuals who are very vulnerable, potentially very risky, and therefore protect their families and protect society. Everything else about the workforce impact is secondary. There is no 'right' number for how often we should use a CTO because what counts is our clinical judgement and the Mental Health Act and the Community Treatment Order are ways to back up that judgement.

12. Thinking about your previous and current roles, what are you taking from your previous role into what you do now?

I am a general psychiatrist, not a forensic psychiatrist, and I see offender health as a mainstream mental health issue. The role of mental health services here is to work better with the criminal justice system and to address the needs of people who have complex co-morbidities of which mental ill health is a part. This is not to undermine the importance of forensic psychiatry which has a crucial leadership role in offender health, but it does reflect that most offenders are treated by general psychiatrists and what they need is good general mental health care.

Dr Rosalind Ramsay