



the columns

correspondence

Difficulties with timely SOADs visits

As we all know, if 3 months have passed from the day on which medication for a detained in-patient was first administered during their current period of detention, incapacitated or refusing patients cannot be given medication to which section 58 applies unless a second opinion approved doctor (SOAD) certifies that the treatment is appropriate. Since the recent amendments to the Mental Health Act came into force,¹ it has been our experience on one occasion that due to the SOAD being unable to visit the patient on time to allow the T3 form (used by a SOAD to certify that medication for mental disorder treatment is appropriate in the case of a detained patient who is either refusing or incapable of giving consent)² to be completed, it was necessary to complete section 62. This was to enable treatment of an incapacitated patient who would otherwise have been likely to have deteriorated and to behave aggressively and potentially violently. Two other consultants working in our trust have had to resort to using section 62 in similar circumstances. We can only conclude that the government-led changes in the Mental Health Act, including the introduction of supervised community treatment, have led to these difficulties in obtaining SOADs.

1 Department of Health. *Code of Practice: Mental Health Act 1983*. TSO (The Stationery Office), 2008.

2 Care Quality Commission. *Guidance for SOADs: Consent to Treatment and the SOAD Role under the Revised Mental Health Act*. CQC, 2009.

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New Ways not Working and the consultoid

There are many concerns about how psychiatrists' workloads are managed,^{1,2}

At times, however, the real issues of underfunding and, in old age psychiatry, increasing pathology in an ageing population, are ignored.

I was recently informed that I need to function as a 'consultoid' rather than as a consultant. This sounded rather sci-fi, perhaps like an android or robot, and very surreal. Unfamiliar with the word, I suspected a clever neologism used in a very authoritative way. I checked the online Oxford English Dictionary; it is not there. I thought that perhaps I might try using it when addressing a patient: 'Good morning Mrs X, I'm Dr Hilton, your consultoid'. But it did not sound right. So I searched the internet; consultoid appears to be an imprecise term including people training to be consultants,³ general practitioners wanting to keep a hand in hospital work⁴ and health service developments being made without consultation with clinicians.⁵ Indeed, far from sci-fi it is quite an old word, dating at least as far back as 1929.⁴

New Ways of Working with increasing workloads, doctors being removed from the diagnostic, assessment and treatment roles for which they were trained and being 'consultants to the team' is perhaps reconstructing a modern, 'virtual' mental asylum: relatively few medical staff, risk of inadequate diagnoses, almost all work delegated to lower paid staff and where possible offering social care rather than active medical intervention. Perhaps somewhere, sometime, consultoid work will actually be imposed on us from above. But for the moment, just beware if you are asked to be one. It probably implies lower status, less funding, an android-like telepathic sci-fi diagnostic method and mind-reading relationship with the clinical team, plus a superhuman effort to keep up with the workload.

1 Dale J, Milner G. New Ways not working? Psychiatrists' attitudes. *Psychiatr Bull* 2009; **33**: 204–7.

2 St John-Smith P, McQueen D, Michael A, Ikkos G, Denman C, Maier M, et al. The trouble with NHS psychiatry in England. *Psychiatr Bull* 2009; **33**: 219–25.

3 Dunea G. Consultants and consultoids. *BMJ* 1984; **288**: 923–4.

4 Anonymous. The renaissance of general practice (editorial). *Lancet* 1929; **214**: 933.

5 Dr Rant. *Would You Still Trust This Lot?* Dr Rant, 1 May 2007 (<http://www.drarrant.net/2007/05/would-you-still-trust-this-lot.html>).

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We need to learn from other doctors

The analysis of current trends in English psychiatric services by St John-Smith *et al*¹ outlines some real problems but does not provide the jobbing clinician (or manager) any practical solutions. I believe other front-line medical services, notably military and primary care, do provide some solutions to help with quality, safety and accessibility in our field.

There needs to be a robust triaging service for urgent referrals, readily accessible to general practitioners (GPs) and other referrers. Consultants should be available on a shift basis to review joint assessments carried out by two (ideally multidisciplinary) staff, also working shifts. This approach has a greater likelihood of avoiding biases in judgements (diagnosis, risks) and decisions (when and where to refer). The UK military field hospitals have much to offer in triaging expertise, as it utilises multidisciplinary assessment and prompt specialist review. The equivalent to field hospitals could be local accident and emergency sites, providing safety and logistic support. Urgent triaging is currently carried out by crisis and home intensive teams, who thereby get put off their main role of avoiding inappropriate psychiatric bed use.

Furthermore, there is an emerging debate whether (or not) a mental health polyclinic staffed by GPs with special interests jointly with non-medical mental health staff would be useful in triaging cold referrals such as anxiety or depression, medically unexplained symptoms and cognitive or memory problems. The relevant experiences stem from musculoskeletal clinics held in primary care or at cottage hospitals around the UK, staffed by GPs with special interests and physiotherapists. A mental health



polyclinic could contact a dual-trained consultant for advice or consultation, possibly via a telemedicine link. A polyclinic should be able to provide a second opinion to a GP with the patient returned with a diagnosis and treatment plan (including a risk or relapse plan).

St John-Smith *et al*¹ are right to point out the finite number of community mental health team (CMHT) staff. Perhaps CMHT staff and primary care mental health staff would need to be seconded for these triaging duties including an appropriate shift pattern to avoid burnout. General practice registrars will find triaging experience particularly relevant for their future role (which might include competency to work as a GP with a special interest).

We live and work in uncertain times. I suspect most of the politics that surround secondary care mental health is influenced by fears of job losses (particularly managerial) in this financial climate, worsened by lack of clarity on payment by results in terms of the relative priority given to new assessments compared with continuing secondary care. Hopefully, these matters will be resolved over the next 18 months, but in the meantime it is well worth studying successes in other medical fields to inform the next wave of reforms, most likely driven by a new set of clinical commissioners from primary care.

1 St John-Smith P, McQueen D, Michael A, Ikkos G, Denman C, Maier M, et al. The trouble with NHS psychiatry in England. *Psychiatr Bull* 2009; **33**: 219–25.

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New ways can work

Much is being made of the negative effects of New Ways of Working, to the extent that its future is now seriously threatened despite the fact that viable or palatable alternatives have not been proposed within an environment of increasing service demand.

Having experienced working in several trusts through the process of adopting New Ways of Working (in working and older age adults), my belief is that the current challenge lies in identifying which factors lead to success and which do not. The next question is whether the successful factors can be systematised (i.e. are not entirely dependent on individual skill, knowledge or enthusiasm). My view is that the following three factors are of key importance.

1. New Ways of Working needs to be clinically led and not perceived as being misappropriated by management for their own (financial?) agenda.

2. Strong team leadership to encourage and support care coordinators' increased responsibilities.
3. Boundaries between functional teams need to be explicit, without the gaps that general practitioners hate, and with great emphasis on excellent, protocolled communication standards. Universality and continuity of service delivery are thus ensured.

New Ways of Working remains in an experimental phase and shows promise. We cannot allow naysayers whose fear of obsolescence or displacement from power hold back real progress. New ways can work. Isn't it time for the College to canvass members to find out how?

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New ways of losing the art of psychiatry

As a consultant working in a tertiary service I see the results of New Ways of Working rather than participating directly myself. What emerges is a loss of diagnosis, let alone any attempt at a differential.

New Ways of Working assumes that it is easy to tell, at the moment of referral, whether or not a problem is complex or straightforward. In reality, overt psychosis can be relatively straightforward to spot but such individuals go to a psychiatrist. Left undiagnosed are complex personality disorder (borderline pathology reduced to 'depression') and subtle or unusual psychotic states such as encapsulated delusions or thought disorder, described as 'normal'.

I have been involved in an increasing number of cases where there have been serious consequences of misdiagnosis, of the type that used to shame a part 1 candidate for MRCPsych. Diagnosis is still considered a fundamental part of medicine, so why have we, apparently willingly, opted out of this aspect of our medical discipline? I concur with those who worry about the demise of psychiatry – what is the point of a discipline that seemingly anyone can practice? The loss of differentiation between the disciplines does not contribute to egalitarian practice, it only leads to non-specific and perhaps unhelpfully focused treatment.

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Problems in NHS psychiatry and recruitment chaos – are they related?

The article 'The trouble with NHS Psychiatry in England'¹ coincided with the Dean of the Royal College of Psychiatrists Professor Howard's interview on Channel 4 news on 4 June 2009.² The very fact that psychiatry is one of the least favoured specialties for UK medical graduates suggests that there is trouble with NHS psychiatry in the UK. Perhaps the College and its members need to look at the possible reasons.³

The College has already been dealing with stigma that psychiatry and psychiatry patients face. It appears that many recent medical graduates secured a psychiatry post as part of their foundation training on the basis of favourable placements as a medical student⁴ at the time of 'old' ways of working. Unfortunately, their subsequent experience with the 'new' ways of working for psychiatrists has been less reassuring. They have often noticed psychiatrists being marginalised and their role being reduced to firefighting with a lack of proactive interventions. This has led to many medical graduates deciding not to take up a career in psychiatry or even to seek higher training in psychiatry abroad.

Medical graduates are often attracted to various specialties by role models.⁵ We wonder whether a relative lack of role models is the reason for UK graduates not opting for psychiatry. In his interview on Channel 4 news, Professor Howard suggested that psychiatry is being forced to recruit trainees who just meet the minimum criteria. This might lead to fewer role models in psychiatry, further recruitment problems and more trouble.

Perhaps the College might consider introducing 'newer' ways of working, recruiting and training.

- 1 St John-Smith P, McQueen D, Michael A, Ikkos G, Denman C, Maier M, et al. The trouble with NHS psychiatry in England. *Psychiatr Bull* 2009; **33**: 219–25.
- 2 Hannam L, Wivell J. Psychiatry's UK recruitment crisis. *Channel 4 News* 2009; **4 June** (<http://www.channel4.com/news/article.jsp?id=3190557>).
- 3 Kerby J, Calton T, Dimambro B, Flood C, Glazebrook C. Anti-stigma films and medical students' attitudes towards mental illness and psychiatry: randomised controlled trial. *Psychiatr Bull* 2008; **32**: 345–9.
- 4 Eagles JM, Wilson S, Murdoch JM, Brown T. What impact do undergraduate experiences have upon recruitment into psychiatry? *Psychiatr Bull* 2007; **31**: 70–2.
- 5 Wright S, Wong A, Newill C. The impact of role models on medical students. *J Gen Intern Med* 1997; **12**: 53–6.

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