the columns

correspondence

Reforming emergency care

Harrison & Bruce-Jones (*Psychiatric Bulletin*, July 2003 correspondence, **27**, 276) have misrepresented much of our editorial (*Psychiatric Bulletin*, March 2003, **27**, 81). We fully recognise the limitations of emergency psychiatry, and support the development of more flexible and responsive services for patients in crisis. None-the-less, the accident and emergency (A&E) department is, and will continue to be, a major interface between mental health services and acute trusts – a fact recognised in the National Service Framework for Mental Health (Department of Health, 1999).

As our locality is well served by home treatment teams and a 24-hour psychiatric emergency clinic, significantly less than 50% of A&E attenders are known to psychiatric services, although importantly many are known to A&E. That homeless patients, refugees, patients who have self-harmed and are intoxicated, and those not registered with primary care, will continue to seek help from A&E is just the way of the world – especially in inner cities. Here too, the police will continue to bring individuals they find disturbed in a public place. Increasingly sophisticated and complicated community services may only have a limited impact on many of these presentations.

It is precisely because we believe that psychiatric patients in A&E should expect the same level of service as other patients that we raise our concerns about the 4-hour wait. We did not advocate 'resistance' to the 4-hour target, nor did we suggest that there is a correlation between the length of an assessment and its quality. We do, however, advocate a thorough and sensitive assessment of the patients' difficulties and there are times when this will conflict with the need for the patient to have left the department within 4 hours. Mental Health Act 1983 assessments take time if due process is to be followed. Were Harrison & Bruce-Jones advocating more frequent use of Section 4?

We agree (and stated in our editorial) that adequate resourcing of general hospital liaison psychiatry is important. However, Harrison & Bruce-Jones sidestep key questions – who should pay for this? and who should be penalised if the targets are not met? Our experience in inner-London leads us to doubt that enhanced community psychiatry will impact greatly on these problems. We suggest that it is vital for psychiatry as a whole to respond to the fundamental issues raised by the imposition of the 4-hour wait in A&E.

DEPARTMENT OF HEALTH (1999) *National Service Framework for Mental Health*. London: NHS Publications.

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Using DVLA guidelines

In this age of litigation, we are increasingly concerned to fulfil our duties and follow guidelines when they are available. An example of such a duty is to advise drivers about driving in accordance with Driver and Vehicle Licensing Agency (DVLA) Guidelines (2001).

Humphreys & Roy (1995) found that 25% of psychiatrists never gave any advice about driving to patients with psychiatric illness and Elwood (1998) found that 13% of psychiatric patients who continued to drive did not fulfil DVLA standards of fitness to drive.

We carried out a survey of all in-patients on the acute wards of a 200-bedded psychiatric hospital to determine what they recalled about information given about driving. Of the 88 patients surveyed, 56 (64%) completed the questionnaire and 39 (70%) were drivers. Twenty-six drivers (67%) remembered discussing driving with a professional. We found documentation about driving in medical records in only three case-notes.

Possible reasons for these results were that patients were unable to remember conversations about driving due to the severity of their symptoms. They might not have wanted to admit their knowledge because they were suspicious about the aims of the survey. However, with the lack of documentation in the notes, it seems likely that many patients had not discussed driving with a professional. Failure to discuss driving might have been an oversight, or even deliberate. Either would not be too surprising, as we ourselves find the Guidelines (2001) confusing. Diagnoses do not correspond to ICD–10 or DSM–IV. It is not always clear what professionals should be advising; for example, whether a patient should cease driving immediately or not. Some professionals may even decide that it is not in a particular patient's best interests to discuss driving, as it may interfere with the therapeutic relationship and/or compliance with treatment.

However, many professionals are worried about the possible legal consequences of giving incorrect or inadequate advice about driving. The medical adviser at the DVLA has reassured us that there have been no successful legal challenges in the UK to date. However, this is not the case in the USA (Hollister, 1992). Increased clarity in the guidelines would enable us to be sure we can fulfil our duties. We have decided to give written information about driving to all in-patients and will audit the results of this intervention.

DRIVER AND VEHICLE LICENSING AGENCY (2001) *At a Glance Guide to the Current Medical Standards of Fitness to Drive*. Swansea: DVLA.

ELWOOD, P. (1998) Driving, mental illness and the role of the psychiatrist. *Irish Journal of Psychological Medicine*, **15**, 49–51.

HOLLISTER, L. E. (1992) Automobile driving by psychiatric patients. *American Journal of Psychiatry*, **149**, 274.

HUMPHREYS, S. A. & ROY, L. (1995) Driving and psychiatric illness. *Psychiatric Bulletin*, **19**, 747–749.

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Pre-registration house officer training in psychiatry

I was struck by Rebecca Mason's claim (*Psychiatric Bulletin*, October 2003, **27**, 394–395) that, in 1981, she was involved in one of the first pre-registration house officer posts in psychiatry in this country. In fact, in 1960, at the Sefton General

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Hospital in Liverpool, I held the post of pre-registration house physician in psychiatry for 9 months. Next, I moved to Walton Hospital, also in Liverpool, where I was a pre-registration house surgeon in neurosurgery and following this, in the same hospital, I held the post of senior house officer in neurology. From then on, I did nothing but psychiatry. I have never held a general medical or a general surgical post and I have never regretted this. Even as an undergraduate, I was passionately interested in psychiatry, and I took every opportunity that came my way to gain additional experience in it. I have always held the view that psychiatry is a profession in its own right, and that its true foundations are psychology and neurology. Psychiatry is becoming ever more influenced by these two areas of study, and we should be directing prospective psychiatrists towards them and away from general medicine.

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the college

Remedies for work overload of consultant psychiatrists

Consultant psychiatrists and specialist registrars – your views are invited

Dear Member,

The Royal College of Psychiatrists and the Department of Health have jointly set up a steering group and two sub-groups to develop the mental health workforce so that it is able to deal with modern service conditions. The task of one sub-group (co-chaired by Professor Richard Williams for the College and Mr Barry Foley of the National Institute of Mental Health Changing Workforce Programme) is specifically related to the future roles of consultant psychiatrists. Also, the College has set up a Scoping Group on the Roles and Values of Psychiatrists, chaired by Richard Williams with Professor Bill Fulford as its Secretary.

The President and senior officers of the College, who are involved in these discussions, are convinced that these are not-to-be-missed opportunities to address the serious work overload of many consultant psychiatrists. The GMC is listening and has signalled that it is willing to consider developing guidance. This may allow consultants a wider range of options about the ways in which they work. We think that this is likely to be better for patients, and could give consultants more fulfilling jobs.

Negotiations are starting on what realistic options are available, so please take the opportunity to let us know what you and your colleagues (in all disciplines) think, and help to shape the negotiations. The Scoping Group would be grateful if you would draw this article to the attention of your colleagues, so that as many members as possible have an opportunity to comment before this consultation closes, early in February.

Richard Williams

Please e-mail comments to awoolf@rcpsych.ac.uk
or send a hard copy to Andrea Woolf, Royal College of Psychiatrists,
17 Belgrave Square, London SW1X 8PG

Introduction

The Royal College of Psychiatrists' Scoping Group on the Roles and Values of Psychiatrists has initiated five main strands of exploration or 'action research'. One of them is to consider the way forward with clarifying and developing what is meant by 'consultant responsibility'. In the spring, the Group will report to the Council of the College.

The College Scoping Group is also feeding its work into the project on 'New Ways of Working in Mental Health' set up jointly by the National Institute for Mental Health in England (NIMHE) in the Department of Health and the College.

Background

The purpose of this paper

This paper has been prepared on behalf of the College's Scoping Group with the intention of getting closer to the experience and opinions of members of the College. We would like your views so that we can base our conclusions on members' wishes for the future.

The Scoping Group has found that many consultant psychiatrists are overburdened and under stress (Rathod *et al*, 2000). Many consultants report that their case-loads are too large and still rising (Tyrer *et al*, 2001). A range of other tasks has been added in recent years. Time to deal adequately with emergencies and high-risk situations is compressed as expectations for risk avoidance increase (Kennedy & Griffiths, 2001). The pressures on consultants are compounded by recruitment and retention problems with high vacancy levels (Kendell & Pearce, 1997). Many members think that services for patients are suffering because, in these conditions, psychiatrists cannot do a good job.

Everyone agrees that people with mental health problems should have help from professionals who are working in conditions that allow them to operate competently and maintain their own good health. But plainly, this is not the present position.

This consultation paper identifies a key issue and the realistic choices that are available. It applies to all psychiatric specialties, and aspects that are particular to one are elaborated in Appendix 1. The main consequences of each option are spelled out. Thus, this paper attempts to make clear what are the main elements for debate, so that the views of all concerned can inform the conclusions of the Scoping Group and lead to a transparent rationale for the negotiating stance of the College.

The role of the College

The foundation charter of the Royal College of Psychiatrists (Royal College of Psychiatrists, 2001) requires it 'to promote amongst its members and others working in allied and related disciplines the achievement and maintenance of the highest possible standards of professional competence and practice'. Therefore, the College has an obligation to ensure that

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