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NCATT workload March 1999 to February 2000

For the 12 months to the end of February 2000, 4374 referrals were received, 1422 were assessed and 384 were taken on for ongoing NCATT care. The mean duration of contact for those taken on was 10.7 days (s.d. 10.9 days; range 1–72 days). Of those taken on, primary ICD–10 (World Health Organization, 1992) codes were:

(a) F10–19 (mental disorders due to psychoactive substance use): 12 (3.1%)
(b) F20–29 (schizophrenia, schizotypal and delusional disorders): 173 (45.1%)
(c) F30–39 (mood disorders): 110 (28.6%)
(d) F40–48 (neurotic, stress-related and somatoform disorders): 51 (13.3%)
(e) F60–69 (disorders of adult personality and behaviour): 20 (5.2%)
(f) Z code (no psychiatric diagnosis): 18 (4.7%)

Ensuring effective team working

Various problems can arise in the functioning of multidisciplinary community psychiatric crisis teams. Failure to maintain a clear focus can result in services being flooded by minor emotional and social problems, to the detriment of those with severe mental illness. Idiosyncratic therapeutic practices on the part of individual clinicians can undermine the team approach to care. Working at the acute, sharp end of a service is often stressful and 'professional burnout' is therefore a risk. The NCATT has generally managed to avoid such difficulties. The low percentage of referrals taken on for intensive home treatment suggests that less serious problems are being effectively filtered out. Team hand overs, which are overseen on a daily basis (Monday to Friday) by the consultant psychiatrist, help to harmonise treatment approaches.

Team morale has generally been excellent. There are several possible reasons for this. All clinicians are experienced practitioners and feel confident in their abilities to work as independent, responsible practitioners within a team. An atmosphere of mutual respect is encouraged and differences of opinion are freely expressed before consensus is reached. More formally, the team manager conducts annual confidential appraisals of all staff at which performance is evaluated and future goals identified. 'Team building' days also take place each year, where the future goals of the team are discussed.

Conclusion

The CATT model of care has facilitated the move from an institutional model of care to safe community-based care and is considered locally to have been a great success. After 8 years there are remarkably few who would advocate a return to a more traditional style of service.

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LOUIS APPLEBY

Consultant advisers in every service

Summary report from the working group on the role of consultants in implementing the National Service Framework and NHS Plan

Shortly after taking up my appointment as National Director for Mental Health, I convened a working group of consultant psychiatrists to consider how to involve psychiatrists more in the current process of changing mental health services. This was in recognition of the fact that, while psychiatrists are central to modernising services, their skills and experience are insufficiently used. It is one of the most frequent complaints that I hear from clinicians.

This paper summarises the conclusions and proposals of the group. First, it proposed the appointment of a 'consultant adviser' in every local service; with dedicated time for service development, linked to National Service Framework (NSF) local implementation teams. The consultant adviser will have no managerial responsibility and will reflect the perspective of front-line clinical practice on how a local service puts current policies into

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effect. Similar posts at the regional level will help to coordinate the work of consultant advisers.

Second, the group supported the abolition of the current system of local homicide inquiries on the grounds that they are a key factor in increasing occupational stress. Third, the group proposed that the Department of Health and the Royal College of Psychiatrists should work jointly to increase the consultant workforce and reduce vacancies.

Summary of discussion

The group considered three questions:

- Were psychiatrists well informed about the content of the NSF and the NHS Plan?
- Were they sufficiently involved in the process of effecting and monitoring change in clinical services?
- What were the features of clinical practice that made it difficult for psychiatrists to play a full role in service development?

Most consultant psychiatrists are aware of the general content of these two key policy documents (NSF and NHS Plan). However, knowledge of their details varies widely. Dissemination of the main points could be improved as current channels of communication, for example, through trust chief executives or journals, tend to be slow and tend not to highlight the points of greatest interest to medical staff. The wide press coverage of the launch of the NHS Plan gave little attention to the mental health aspects. The general principles of the NSF were broadly accepted but there were concerns that the specific clinical initiatives in the NHS Plan could disrupt the existing good practice of community mental health teams.

For several years psychiatrists have felt marginalised by the process of service development and performance management. This is resented by clinicians, who feel that their experience, knowledge, responsibility and awareness of the strengths and weaknesses of a local service are not being recognised or adequately exploited. It also has the effect that services develop in ways that do not reflect the priorities of clinical staff working at the front line, or of the people for whom they provide a service – patients, carers, general practitioners and others.

The role of the consultant psychiatrist, particularly in adult psychiatry, is increasingly complex, difficult and stressful. Adult psychiatrists lack a clearly defined role that is accepted by service managers and that places clinical practice at its core. They often feel overwhelmed by multiple demands, with administrative tasks competing with urgent clinical duties. The vital role of training future mental health professionals can become impossible. Many adult psychiatrists feel that specialist services are selective about the patients they will treat, leaving them to be responsible for the most intractable clinical problems.

There is a lack of flexibility and progresson in career pathways. Many adult psychiatrists lack a sub-speciality interest and the pressures of their clinical role make it difficult for them to take on new roles or training.

Staff shortages and concern over resources in general make the work of all clinical staff more difficult.

There are high levels of stress in health professionals. In mental health, stress in consultant psychiatrists can be made worse by the lack of structured support from peers or team members. Many psychiatrists in training do not learn about successful team working. Junior psychiatrists who are supervised by a stressed and disillusioned consultant may leave the speciality.

Although there is a problem of burnout among clinical staff, the solution should not be for senior consultant psychiatrists to move away from a clinical role. Instead, the pressures of the job should be addressed. This could be done through providing support and training in team leadership and by making the consultant's role more rewarding clinically. How this would be achieved might vary for each individual. For some it would mean the development of sub-speciality interests or training on areas other than the treatment of severe mental illness and the containment of high risk.

Clinical practice is characterised by substantial pressure of work but evidence shows that in itself this does not need to be stressful. One problem is that there is a lack of reward for doing the job well.

In particular, occupational stress in health professionals is linked to fear of litigation. Consultants in adult psychiatry fear that they will be held responsible for the actions of the patients, such as acts of violence, over which they may have no control. This fear has been greatly exacerbated by the current system of homicide inquiries.

Conclusions and proposals

In every local service a consultant adviser should be appointed. The consultant adviser would work closely with his or her local implementation team (responsible for putting the NSF/NHS Plan into practice). He/she will foster the active engagement of senior clinicians in NSF and NHS Plan implementation. He/she will ensure that the priorities, strengths and weaknesses of the local clinical service are taken into account and will therefore have close links with clinical staff of all disciplines, including psychiatrist colleagues. He/she will differ from a clinical director in having no managerial responsibilities. The consultant adviser will be expected to be aware of successful clinical innovations in other services and to receive training in leadership skills. He/she will have links with clinical governance leads, service managers, the regional College executive and local user/carer groups.

The consultant adviser should be released from clinical duties for 1 day per week (or equivalent). A number of services already have a consultant in an advisory role but this initiative will ensure that dedicated time is available to carry it out. One day per week is 20% of a consultant's time – in an average service, defined by the local implementation team, this is less than 2% of consultant time overall.

The consultant adviser should be nominated by local consultant psychiatrists. Ideally, the consultant adviser

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will carry out these duties in relation to one local service, either at trust or health authority level, depending on local service configuration. However, there may need to be some local flexibility so that he/she does not have to relate to several local implementation teams.

The appointment of a consultant adviser at local service level should be reflected in a similar position at regional level. At the moment, consultant psychiatrists may relate to regional offices in a variety of capacities, either as regional NSF champion, lead clinician or as a member of a regional modernisation board. In some regions, there is no lead psychiatrist. The important point is that every region should have a practising consultant psychiatrist who advises on clinical service development and who is consulted by regional office staff. The precise title and the other duties of the post are less critical, as long as the central function is presenting the clinical perspective.

A network of consultant advisers should be established with close working links to the regional clinical lead and two-way links to the National Director for Mental Health. The regional clinical leads should also form a national network linked to the National Director. At all levels, it will be important for there to be strong links with the College and its representatives.

There is a need to define the role of the consultant general adult psychiatrist, with emphasis on clinical practice, but taking account of the problems listed above, including lack of flexibility in clinical role, the importance of team working, etc. The College Faculty of General and Community Psychiatry has recently prepared a document on this, which should form the basis of individual job plans. Job plans should be as specific as possible and should give a true reflection of the time required for both clinical and non-clinical duties.

The College and Department of Health should work to increase the number of specialist registrars and senior house officers (SHOs), including psychiatry SHOs who are training to be general practitioners.

The working group supported personal development plans. Flexible career development should allow consultants to train in sub-specialities while remaining primarily in general adult psychiatry, and to change sub-specialities over time. Priority areas for continuing professional development should include team working and areas of major policy development. Team working should also be promoted as part of the training experience of junior psychiatrists.

There should be better dissemination of policy initiatives and a number of ways of achieving this now need to be considered:

- A policy information page on the College website.
- The MRCPsych exam to include questions on key policies.
- The consultant adviser should have a dissemination role.

There was support for current work in the Department of Health on new outcome measures for mental health services. These would cover local and national outcomes and focus on mortality, morbidity, quality of life and user/carer satisfaction. Local services would be able to use these outcomes as a way of demonstrating the benefits of their services.

A broader system for identifying and disseminating good clinical practice needs to be established. This should go beyond the current system of Beacon Awards, so that good local practice receives proper recognition.

There should be changes to the current system of local homicide inquiries. The NHS is likely to set up new systems for detecting and responding to adverse incidents in line with the Chief Medical Officer's report *An Organisation with a Memory* (Department of Health, 2000). New NHS-wide structures should cover adverse incidents in mental health, including homicide.

Follow-up actions

Since the working group reported, all trusts have been asked to appoint a consultant adviser. Clinical leads have been identified in each region. A new working group has been established, with Department of Health and College representation, to address problems in the recruitment and retention of psychiatrists. The mental health branch in the Department of Health continues to contribute to putting *An Organisation With a Memory* into practice.

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Appendix

Membership of the working group

Louis Appleby National Director for Mental Health, Department of Health
Nick Brown Lead Psychiatrist, Mental Health Development Team, West Midlands NHS Executive
Tom Burns Professor of Community Psychiatry, St George's Hospital Medical School
John Cox President, Royal College of Psychiatrists
Jenny Firth-Cozens Professor of Clinical Psychology, University of Northumbria
Alain Gregoire Consultant Psychiatrist, Salisbury Healthcare NHS Trust
Anna Higgitt Senior Policy Adviser, Department of Health
Matt Muijen Director, The Sainsbury Centre for Mental Health
Trevor Turner Consultant Psychiatrist, Homerton Hospital NHS Trust
Tim Webb Consultant in Adult Psychiatry, Local Health Partnerships NHS Trust, West Suffolk

In attendance

Elaine Edgar and Liz Gass (Department of Health).

Meetings

The group met on three occasions: 25 May, 18 July and 16 November 2000.

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Presentations were made by Professor Jenny Firth-Cozens on occupational stress in health professionals, and on 'burn-out', and by Dr Matt Muijen on the pressures on in-patient beds.

A paper entitled *An Analysis of the Concerns of Consultant General Psychiatrists About their Jobs, and of the Changing Practices that may Point Towards Solutions* by Dr Peter Kennedy and Dr Hugh Griffiths (2000) of the Northern Centre for Mental Health was circulated to the group.

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ARTHUR CRISP

Changing Minds: Every Family in the Land

A campaign update

Our 5-year long campaign to reduce the stigmatisations of and discriminations against people with mental illnesses, launched as an outline endeavour in October 1998, is now in its third year. This update is intended to reveal that since 1998 we have been constructively busy and are poised to 'go public' in major ways. We are now therefore appealing to the membership at large to join in the tasks. To this end we have been busy generating a tool kit that you may wish to draw upon and a series of proposed projects, some of which are already underway and some of which you may be able to pick up on or adapt for local purposes, in addition to any of your own initiatives.

Tool kit

The management committee hopes that this is now sufficiently developed to provide a useful resource of instruments to advance the campaign. We shall continue to add to this kit.

The central campaign website is part of the College website and can be accessed directly (http://www.changingminds.co.uk/campaigns/cminds/index.htm). It is now being robustly developed and is intended as an engine continuing to promote the objectives after the campaign itself has come to an end in 2003. Its current contents include the controversial and much sought after 2-minute '1 in 4' film (which has been adopted by the World Health Organization (WHO) for its own mental illness anti-stigma purposes). The campaign website provides links to other recommended relevant websites. The other campaign-related website (http://www.stigma.org/everyfamily/) holds a 200 000-word, 400-page electronic book addressing stigmatisations of people with any of the six mental disorders being addressed by the campaign. These are examined from a variety of perspectives – historical; contemporary (e.g. experiences of users and of those working within health care systems); legislative; the nature of basic mechanisms within the stigmatising and discriminatory processes; relationships to creativity, spirituality and to personality disorders; and types of interventions. The 80 contributors include Anthony Clare, David Goldberg, Kay Redfield Jamieson, Roy Porter, Lewis Wolpert and many other well-known and respected experts. A CD–ROM version is available and it is also hoped a conventionally printed and bound text will be produced.

Printed materials within the tool kit include periodic campaign updates and posters. We hope that members will use the campaign posters, which are A3 size. They include the campaign logo and outline message and have plenty of blank space that can be used to advertise local meetings and to elaborate on the campaign's goals.

Finally, the kit includes a listing of videotapes, in particular the campaign video (available respectively at a cost of £5 and £10 from the campaign administrator, Liz Cowan, Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG), a video of the '1 in 4' film and, as well as a listing of other recommended videotapes and information about how to obtain them.

Projects

Working parties have so far generated proposals for 17 potential projects targeting four main areas – the general public, children and young adults, employers and doctors and other healthcare workers. Their universal implementation is dependent upon funding. There has been one fundraising event sponsored by Saatchi and Saatchi and another is planned for Autumn 2001. So far, nearly £150 000 has been raised in addition to the invaluable core financial support that comes from the College and the substantial donation of resources and expertise by WCRS, a major advertising company, necessary for the making of the 2-minute cinema film.

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