original papers

DEPARTMENT OF HEALTH (1999) *Effective Care Co-ordination in Mental Health Sevices – Modernising the Care Programme Approach.* TSO (The Stationery Office).

DEPARTMENT OF HEALTH (2003) *Personality Disorder – No Longer A Diagnosis Of Exclusion.* TSO (The Stationery Office).

FIRST, M. B., GIBBON, M., SPITZER, R. L., *et al* (1997) *Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID–II).* American Psychiatric Association.

FOA, E. B., OLASOV ROTHBAUM, B. (1997) *Treating the Trauma of Rape: Cognitive–Behavioral Therapy for PTSD.* Guilford Press.

LINEHAN, M. M. (1993) *Cognitive Behavioral Treatment of Borderline Personality Disorder.* Guilford Press.

McGLASHAN, T. H. (1986) The Chestnut Lodge follow-up study; long term outcome of borderline personalities. *Archives of General Psychiatry*, **43**, 20–30.

PARIS, J. (2005) Borderline personality disorder. *Canadian Medical Association Journal*, **172**, 1579–1583.

PRIEBE, S., HUXLEY, P., KNIGHT, S., *et al* (1999) Application and results of the Manchester Short Assessment ofQuality of Life (MANSA). *International Journal of Social Psychiatry*, **45**, 7–12.

STONE, M. H. (1993) Long-term outcome in personality disorders. *British Journal of Psychiatry*, **162**, 299–313.

ZANARINI, M. C., VUJANOVIC, A. A., PARACHINI, E. A., *et al* (2003) Zanarini Rating Scale for Borderline Personality Disorder (ZAN–BPD): a continuous measure of DSM-IV borderline psychopathology. *Journal of Personality Disorders*, **17**, 233–242.

***Martin Zinkler** Consultant Psychiatrist, East London and the City Mental Health NHS Trust, Newham Centre for Mental Health, Glen Rd, London E13 8SP, email: martin.zinkler@elcmht.nhs.uk, **Amy Gaglia** Project Manager, **S. M. Rajagopal Arokiadass** Specialist Registrar, **Eldad Farhy** Senior Psychologist, Newham Psychological Therapies Service, Francis House, London E13 9PJ

Psychiatric Bulletin (2007), **31**, 252–255. doi: 10.1192/pb.bp.106.011650

ALEX MEARS, SARAH PAJAK, TIM KENDALL, CORNELIUS KATONA, JIBBY MEDINA, PETER HUXLEY, SHERRILL EVANS AND CLAIRE GATELY

Consultant psychiatrists' working patterns

AIMS AND METHOD

To explore relationships between different styles of working and measures of occupational pressure in consultant psychiatrists. A random sample of 500 consultant psychiatrists were sent a questionnaire about working patterns and lifestyle factors, with other sections using validated tools (such as the 12-item General Health Questionnaire; GHQ).

RESULTS

There were 185 useable questionnaires returned (an adjusted response rate of 39%). Significant relationships were identified between job content and GHQ and burnout scores, indicating that occupational pressures are rendering some consultant posts 'problem posts', leading to problematic levels of psychological distress among some consultants.

CLINICAL IMPLICATIONS

Although consultant psychiatrists are more satisfied than not with their jobs, steps need to be taken to address the causes of 'problem posts', to reduce attrition in the most pressured individuals.

This project was commissioned by the Department of Health as part of a rolling programme of research to investigate recruitment and retention issues affecting psychiatry.

There has been a shortfall in psychiatrist numbers in the order of 12% in England (Royal College of Psychiatrists, 2004), with geographic and sub-specialty peaks well in excess of that figure. The Department of Health has been well aware of these issues, and commissioned a series of research projects in collaboration with the Royal College of Psychiatrists. One of these projects, carried out with the support of the College's Research and Training Unit, investigated workload and working patterns for consultants, with the aim of better understanding the pressures under which they are working, and what particular stressors are most in need of occupational interventions.

Method

A questionnaire was designed with the help of three specialty-specific focus groups (general adult psychiatry, old age psychiatry and child and adolescent psychiatry) and was sent to a randomly selected group of 500 consultant psychiatrists. This sample was generated using the random sample-generating functionality of SPSS version 11.5 for Windows. Non-responders were sent two reminder letters, the second included a further copy of the questionnaire.

The questionnaire included sections for demographic data, work patterns, roles and responsibilities, job content and work environment. Other sections used validated tools: the Karasek Job Content Questionnaire (JCQ; Karasek *et al*, 1998), the Maslach Burnout Inventory (MBI; Maslach & Jackson, 1993) and the 12-item version of the General Health Questionnaire (GHQ; Goldberg, 1992). The data were analysed using SPSS version 11.5 for Windows.

Karasek Job Content Questionnaire

The JCQ (Karasek *et al*, 1998) permits the measurement of three aspects/dimensions of job strain:

- job control/decision latitude
- psychological job demands
- social support.

original papers

We predicted that low job control/decision latitude along with high job demands might elicit job strain. This relationship between job control and demand might be counteracted by good/high levels of social support (Karasek *et al*, 1998).

Maslach Burnout Inventory

The MBI (Maslach & Jackson, 1993) is a 22-item, 6-point fully anchored Likert scale which asks respondents to rate statements (on a 0–6 scale) such as 'I feel emotionally drained from my work', 'I have accomplished many worthwhile things in my job' and 'I worry my job is hardening me emotionally'. This range of questions assesses the three aspects of burnout – emotional exhaustion, depersonalisation and personal accomplishment. It is important to emphasise that burnout is a continuous variable in which degrees of experienced feelings range from low, to moderate to high, and is not either present or absent. The validity of the MBI has been illustrated in a number of ways: convergent validity, external validity and discriminant validity (Maslach & Jackson, 1993).

General Health Questionnaire (12-item version)

The GHQ–12 (Goldberg, 1992) was designed to give an indication as to whether the respondent is exhibiting psychological distress (i.e. that they may be suffering from some kind of psychological illness). A score above the threshold level is indicative that some kind of problem might exist. For the purposes of this report, the threshold is taken as 4 or above. It should be noted that the GHQ–12 is not a diagnostic tool.

Results

There were 185 questionnaire forms returned, giving an adjusted final response rate of 39.1% (after non-responders and late returns are removed from the denominator).

The mean age of the sample was 47 years; 40% were male; 14% trained part-time or working flexibly; 96% worked for the National Health Service, 77% of these working full time. The mean length of time as a consultant was 10 years, and the mean length of time at current trust was 6.6 years. There were 19% of the sample who worked in child and adolescent services, 39% in general adult psychiatry, 14% in old age psychiatry and 27% in other specialties. Two-thirds of the sample worked in in-patient services, 80% in out-patient services, 56% in a community mental health teams (CMHTs) and 8% in assertive outreach.

The working week

The total mean hours worked per week by the consultants in the sample was 44.2 (s.d.=12.8), excluding on call. Consultants worked a mean of 1.9 evenings per week (s.d.=1.6) and 1.7 weekends per month (s.d.=1.4). The mean case-load was 286.9 (s.d.=1419.6).

Table 1. Percentage of time spent according to activity

Activity	Time spent, %
Patient contact	30
Writing/administration	23
Meetings	19
Research/training/development	15
Other (e.g. travelling)	9
Assessments	3
Family member contact	1

The data provided by respondents enabled working time to be broken down into principal activities (Table 1).

Job satisfaction

Respondents were asked to rate their job between 1 'satisfying' and 5 'disappointing'. The mean satisfaction value was 2.4, a little below the midpoint on the scale. The data show, however, that 55.8% of respondents scored either 1 or 2, and 21% scored 4 or 5.

General health

Consultants took a mean of 6 days sick leave (s.d.=22) in the previous 12 months. The distribution was, however, markedly skewed, with the median value 1 and the mode 0. They consumed a mean of 12.6 units of alcohol per week (s.d.=11); 16% were consuming more than the recommended weekly allowance; 8% of respondents smoked a mean of 9 cigarettes per day (s.d.=6.7); 6% were taking stress-relieving medication; and 72% reported taking regular exercise (mean of 3.3 times per week).

The mean GHQ–12 score for the sample was 2.2 (s.d.=2.9). There were 25% of respondents who scored greater than the threshold (4), indicating possible psychological distress. The proportion of the general population reaching this threshold is 17% (Department of Health, 1996).

Job content and perceived burden

On the MBI, 17.1% of the sample exhibited a high propensity for burnout overall (high emotional exhaustion, high depersonalisation and low personal accomplishment); 1.1% of the sample show low emotional exhaustion, low depersonalisation and high personal accomplishment. Scores on the MBI were also significantly associated with a high score on the GHQ (high emotional exhaustion: $r=0.528$, $n=176$, $P<0.01$; high depersonalisation: $r=0.279$, $n=177$, $P<0.01$; low personal accomplishment: $r=-0.17$, $n=177$, $P<0.05$).

All three JCQ scales were significantly associated with GHQ scores:

- the higher the psychological work demands placed on the consultants, the higher the GHQ–12 scores ($r=0.325$, $n=179$, $P<0.01$)

https://doi.org/10.1192/pb.bp.106.011650 Published online by Cambridge University Press

original papers

Table 2. Variables associated with better job satisfaction

Variable	*R*	*n*[1]	*P*
The higher the consultants' reported satisfaction level the . . .			
more delighted they feel about their current job	−0.644	168	<0.01
less strong (or otherwise) is their desire to leave their present post	0.526	179	<0.01
lower they score on the emotional exhaustion sub-scale of the MBI	0.497	178	<0.01
higher they score on the social support dimension of the Karasek JCQ	−0.446	170	<0.01
higher they score on the decision latitude dimension of the Karasek JCQ	−0.434	179	<0.01
less they feel professionally isolated	−0.425	177	<0.01
lower they score on the depersonalisation sub-scale of the MBI	0.407	179	<0.01
less defensive they consider their work in its current context	−0.385	177	<0.01
less isolated they consider their work in its current context	−0.375	180	<0.01
more autonomous they consider their work in its current context	0.363	180	<0.01
less they feel their role being squeezed by other agencies or professionals	−0.336	174	<0.01
higher they score on the personal accomplishment sub-scale of the MBI	−0.330	172	<0.01
less their clinical work spills over into their non-clinical time	−0.309	176	<0.01
lower/better they score on the GHQ–12	0.308	179	<0.01
lower they score on the psychological job demands dimension of the Karasek JCQ	0.257	181	<0.01
less their personal case-load is rising	−0.226	173	<0.01
more valued they feel at work	0.610	178	<0.05
the larger their WTE team is	−0.199	146	<0.05

GHQ–12, General Health Questionnaire 12-item version; JCG, Job Content Questionnaire; MBI, Maslach Burnout Inventory; WTE, whole-time equivalent.

1. *n* is the number of respondents included in the analysis, with missing cases removed.

- the lower the level of job control (decision latitude), the higher the GHQ score ($r=-0.239$, $n=168$, $P<0.01$)
- the lower the level of social support, the higher the GHQ scores ($r=-0.239$, $n=168$, $P<0.01$).

Reported job satisfaction is also significantly associated with a number of key variables (Table 2).

Discussion

Although the findings from this study are instructive, there may be an element of self-report bias, inherent in any survey using self-report as the basis for data collection. The response rate indicates that more consultants did not respond than those who did, and thus the findings must be seen as illustrative rather than definitive. In addition, it might be hypothesised that those suffering from burdens are more likely to respond, to give an outlet to their issues.

Job satisfaction, we would hypothesise, is a useful proxy for job quality and therefore occupational pressures, since it is inversely associated with all of the key negative outcomes of a poor job. A poor or 'problem' post will put its owner under levels of stress and burden that are ultimately likely to lead to ill health and thence attrition. Commissioners and managers must identify these problem posts, and act to reduce the burdens if they are to prevent the loss of key staff.

The findings from the Karasek JCQ show that a significant minority of psychiatrists are operating under the very worst of conditions: high job demands coupled with low support and poor autonomy (as described by the 'job strain' model). This pressure is likely to lead to health problems (Karasek *et al*, 1998), and this is evidenced by the significant association between the Karasek sub-scales and GHQ–12 caseness.

The data from this study show that consultants are about 1.5 times more likely than the general population to be above the threshold for psychological distress on the GHQ–12. This is not, however, any higher than the equivalent for the primary care workforce of 23%, and lower than that for all doctors and managers of 30% (Calnan *et al*, 2001) and community mental health nurses of 35% (Edwards *et al*, 2000). A significant minority of respondents scored a high propensity for burnout on the MBI. This is in itself a cause for concern, but the levels scoring poorly on the depersonalisation scale is a particular issue given the nature of the work they do. Low levels of personal accomplishment were surprising. It had been assumed that reaching a consultant post would be an accomplishment enough to yield higher scores on this scale. It could be hypothesised, however, that the lack of appreciation and recognition from managers, trusts and patients might be having a detrimental effect on respondents' feelings of self-worth, and this is reflected in the personal accomplishment scale.

Findings from this study reported elsewhere (Mears *et al*, 2004) show that more progressive approaches to working can alleviate the occupational burdens faced by consultants. It is also perhaps testament to the resilience of the consultant psychiatrist that the GHQ scores for this group are lower than for other groups, in spite of working in similarly challenging environments. Finally, the role of the consultant psychiatrist is reviewed in *New Ways of Working for Psychiatrists* (Department of Health, 2005). Parts of this document accord with Mears *et al* (2004), encouraging more devolvement of responsibility within the multidisciplinary team, and might, therefore, reduce burdens. This paper also, however, indicates that

https://doi.org/10.1192/pb.bp.106.011650 Published online by Cambridge University Press

original papers

the consultant role might become more generic in nature, with the potential that this might compromise job satisfaction, as Pajak *et al* (2003) have shown that general adult psychiatrists demonstrate significantly lower levels of job satisfaction.

Declaration of interest

This project was funded by the Department of Health.

References

CALNAN, S., WAINWRIGHT, D., FORSYTHE, M., *et al* (2001) Mental health and stress in the workplace: the case of general practice in the UK. *Social Science and Medicine*, **52**, 499–507.

DEPARTMENT OF HEALTH (1996) *Health Survey for England 1994*. Department of Health.

DEPARTMENT OF HEALTH (2005) *New Ways of Working for Psychiatrists: Enhancing Effective, Person-Centred Services Through New Ways of Working in Multidisciplinary and Multiagency Contexts*. Department of Health.

EDWARDS, D., BURNARD, P., HANNIGAN, B., *et al* (2000) Stressors, moderators and stress outcomes for community mental health nurses: findings from the All Wales Community Mental Health Nursing Study. *Journal of Psychiatric and Mental Health Nursing*, **7**, 529–539.

GOLDBERG, D. (1992) *General Health Questionnaire (GHQ–12)*. nferNelson.

KARASEK, R., BRISSON, C., KAWAKAMI, N., *et al* (1998) The Job Content Questionnaire (JCQ): an instrument for internationally comparative assessments of psychological job characteristics. *Journal of Occupational Health Psychology*, **3**, 322–355.

MASLACH, C. & JACKSON, S. E. (1993) *Manual of the Maslach Burnout Inventory* (2nd edn). Consulting Psychologists Press.

MEARS, A., PAJAK, S., KENDALL, T., *et al* (2004) Consultant psychiatrists' working patterns: is a progressive approach the key to staff retention? *Psychiatric Bulletin*, **28**, 251–253.

PAJAK, S., MEARS, A., KENDALL, T., *et al* (2003) *Workload and Working Patterns in Consultant Psychiatrists*. Department of Health.

ROYAL COLLEGE OF PSYCHIATRISTS (2004) *12th Annual Census of Psychiatric Staffing 2004*. Royal College of Psychiatrists. http://www.rcpsych.ac.uk/pdf/census1.pdf.

***Alex Mears** Research Fellow, Royal College of Psychiatrists Research and Training Unit, Standon House, 21 Mansell Street, London E1 8AA, email: alex.mears@virgin.net, **Sarah Pajak** Research Worker, **Tim Kendall** Deputy Director, Royal College of Psychiatrists Research and Training Unit, **Cornelius Katona** Dean (1998–2003), Royal College of Psychiatrists, **Jibby Medina** Research Assistant, Royal College of Psychiatrists Research and Training Unit, **Peter Huxley** Professor of Social Work, **Sherrill Evans** Research Coordinator, **Claire Gately** Research Worker, Institute of Psychiatry, London

Psychiatric Bulletin (2007), **31**, 255–258. doi: 10.1192/pb.bp.106.014415

LEAH HUGHES AND NICK KOSKY

Meeting NICE self-harm standards in an accident and emergency department

AIMS AND METHOD

An audit in a general hospital accident and emergency (A&E) department and the subsequent development of a triage process for people presenting with self-harm is described. A random sample of 103 people attending with self-harm were selected and their treatment audited against standards derived from NICE guidelines.

RESULTS

The service provided by the A&E department was sub-standard. Of particular concern was the lack of processes addressing risk assessment and safe discharge. A pro forma was designed with the aim of improving assessment of self-harm. A repeat audit 3 months after introduction of the pro forma showed an improvement in the recording of relevant information underpinning risk assessment.

CLINICAL IMPLICATIONS

Procedures for those presenting to A&E departments with self-harm may not meet recommended guidelines. The use of a pro forma with staff training can improve risk assessment.

Dorset County Hospital is part of the West Dorset General Hospitals NHS Trust and is a modern hospital with 500 beds. The mean attendance rate of patients presenting with self-harm to the accident and emergency (A&E) department is 46 patients a month. Psychiatric services are provided in partnership with a neighbouring trust.

Self-harm is an umbrella term for causing harm to oneself. Allen (1995) explores the difficulty with definition of this term, and describes a very wide range of methods that people use to hurt themselves, including scratching, cutting, stabbing, scalding, burning themselves or overdose of prescribed medication. The self-harm may or may not have suicidal intent.

Dealing with self-harm has been a national priority for some time (Department of Health, 1992, 2002). Those who harm themselves remain at a substantially increased level of completed suicide for some time after the episode of self-harm (Eastwick & Grant, 2004). Self-harm accounts for 150 000 attendances at general hospitals each year, and is one of the top five causes of acute medical admissions in the UK (Royal College of Psychiatrists, 2006; http://www.rcpsych.ac.uk/crtu/centreforqualityimprovement/self-harmproject.aspx).

The National Service Framework for Mental Health (Department of Health, 1999) emphasised the need for a specialist psychosocial assessment following self-harm. The Royal College of Psychiatrists' view (2004) is that this can be done by trained A&E personnel and doctors working in the A&E department, although this has been debated by other authors (Hughes & Owens, 1996; Cook, 1998).