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# NHS psychiatry: the need for constructive debate. Invited commentary on . . . The trouble with NHS psychiatry in England†

**SUMMARY**

Two recent articles, 'The trouble with NHS psychiatry in England' and 'Wake-up call for British psychiatry' have levelled severe criticisms against the NHS provider systems for people with mental disorders. In response, we argue that such severe criticisms are not fully justified. We propose that there are six areas for debate: ideological matters, policy intentions, empirical questions, operational issues and professional activities. Under this simple six-point taxonomy it might be possible to have a more sophisticated debate about how all parties should work together to achieve the best outcomes for patients.

The starting point for 'The trouble with NHS psychiatry in England'[1] is the authoritative but widely disputed 'Wake-up call for British psychiatry' by Craddock *et al*,[2] whose central arguments the authors of the former have extended and embellished. Before entering the particulars of the debate, it is relevant to reflect on the overall socioeconomic context within which it is occurring. As a nation, we enjoy a level of affluence, privilege and liberty unimaginable to our recent forefathers and unfamiliar in many countries worldwide. Consequentially, we can afford a health service that is widely effective in providing adequate healthcare, free at the point of the need. Furthermore, National Health Service (NHS) resources for the care of individuals with mental disorders increased substantially in the 9 years from 1997. For example, there has been a 42% increase in the number of general psychiatrists, a 100% increase in psychiatrists for older persons and an 18% increase in psychiatric nurses.[3,4] We offer the view that the debate joined by St John-Smith *et al*[1] is about the equitable and rational distribution of privileges and not the failure to meet essential, natural rights.

## Is British psychiatry under threat?

The 'Wake-up call for British psychiatry'[2] was undoubtedly polemical in tone, and justifiably so, given its express intention to be a stimulus for debate about the way psychiatric and mental health services might best be organised. St John-Smith *et al*[1] continue in a similar voice and enumerate a variety of threats, actual or perceived, to English psychiatry including:

- reforms – too many centrally directed reforms;
- audit – targets and measurements irrelevant to clinical care;
- medical regulation – intrusive over-regulation;
- spin – attempts to manipulate attitudes through language;
- New Ways of Working – marginalising psychiatrists from patient care;
- 'functional' teams – lack of continuity and consistency in care;
- training – training in the process of care, rather than its substance;
- reductionism – complex matters oversimplified.

Although the reader is confronted with such complaints, little is offered by the authors on how so many matters might be the subjects of deliberation, debate or constructive solutions. The authors enjoin the Royal College of Psychiatrists to champion a manifesto for psychiatry. Although each of the points in the manifesto could be a starting point for debate, we feel it is hard to espouse many of them as they are currently presented. For example, point three reads: 'The excessive use of targets is ineffective and undermines good clinical care'. Leaving aside the rhetorical device that anything excessive must be bad, railing against targets in a general sense is unhelpful. A psychiatric practitioner's work is greatly influenced by targets – lithium therapy must be monitored in a certain way, clinics must be attended on time and general practitioners expect clinic letters to arrive without undue delay. These targets may not feel as such because they are implicit, habitual or internalised. Equally well, a chief executive has to run an organisation within the budget available, which too is a target.

†See special article, *Psychiatric Bulletin* 2009; **33**: 219–225.

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Whether specific clinical performance targets do more harm than good is an important argument with voices on both sides.[5,6] We suggest that a more modest declaration would be appropriate, perhaps calling for increased sophistication in the use of outcomes and measures, as supportive as possible of clinical practice.

St John-Smith *et al*, as well as Craddock *et al*, seem particularly exercised by concerns that needful patients will be deprived of the opportunity to have the benefit of an expert psychiatric opinion. Both articles use real or imagined case scenarios to emphasise the adverse consequences were this to be the case. But a rational debate cannot proceed far on the basis of anecdote, because example can be readily met with counter-example. The matter should be considered probabilistically: psychiatric assessment/consultation is a healthcare procedure that can be modelled as carrying with it rates for being false/true × positive/negative. The benefit of a true positive for psychiatric consultation is that relevant treatment or attention is provided. However, a false-positive identification may result in a person receiving attention that was, at best, not needed or, at worst, aversive or harmful. Thus, the accuracy of a psychiatrist follows Bayesian principles – it will be best where the prior probabilities are highest. It follows that highly skilled psychiatrists do not need to concern themselves with all cases of psychiatric illness as the accuracy and cost-effectiveness would be low. But equally, they cannot concern themselves with no cases. Somewhere in the middle is the case-mix for a psychiatrist that will yield the best probability of accuracy, benefit and cost-effectiveness. Achieving this balance, either in general or in a specific psychiatrist's case, is a matter of considerable subtlety and worthy of detailed debate.

## Psychiatrists' new ways of working

St John-Smith *et al* appear sympathetic towards the general principles of New Ways of Working for psychiatrists (NWW).[7] Indeed, far from disparaging the role of the psychiatrist, NWW upholds that it is a precious, if limited, resource and needs to be deployed accurately. Thus, at a policy level, NWW does not intend to be a driver towards 'cutting the numbers of medical staff and for reducing the psychiatric orientation of the service'.[1] However, the authors appear to accuse trust boards of using NWW as a fig leaf to disguise such intentions and actions. We consider this a sweeping and precarious accusation. If it is true, some substantiating evidence is very much required, perhaps demonstrating that there has been widespread reversal in the growth of the number of psychiatrists from 1997. The core of NWW is to be found in its 16 implications for service design, which we have reproduced in Box 1. These are described as being aspects of service design of which some have been beneficial in some localities; there is no prescription for 'one size fits all'.

We could cautiously speculate that what has really fired up St John-Smith *et al* and many others is the perception of NWW as a threat to all that is historical and cherished in psychiatric practice. Whereas St John-Smith *et al* call upon the Royal College of Psychiatrists to lobby for certain points of view, we would prefer to call for all concerned policy-makers, employers and professionals in particular, to increase the sophistication of debate about how we deploy the privileges afforded by the NHS; NWW represents one potentially useful vehicle for this. However, the reference point for any debate cannot be a supposed 'golden age' of psychiatry, because we doubt such an age ever existed.

**Box 1. New Ways of Working: implications for service design[a]**

- Make use of the review of programmed activities in the consultant contract
- Consider the whole system of care across the primary/secondary care interface
- Clarify anticipated care pathways for patients through the care system
- Clarify the tasks expected of particular teams and the boundaries or interfaces between services
- Expect consultant psychiatrists to integrate into teams and share their identified and explicit function
- A single point of receipt of referrals to a team is more effective than multiple entry points, including to a named consultant
- Triaging of individuals referred should be undertaken by a senior practitioner
- Initial/core assessment before allocation, if carried out by experienced professionals on a planned basis, can improve DNA rates, increase speed of care programme approach, completion and improve care planning and onward referrals
- Joint working in carrying out assessments can help develop confidence and an improved appreciation of the other professions' perspectives
- Reviewing out-patient work and particularly routine follow-ups in clinics can help reduce or eliminate them, thereby freeing up time for consultants to address other tasks
- Establish emergency clinics to increase responsiveness and reduce waiting times
- Review time spent on ward/team meetings – could they be done differently?
- Crisis teams should gate-keep in-patient beds and facilitate early discharge
- Training of junior doctors can be improved through joint work with other disciplines
- Promote electronic referral and prescribing as it becomes available
- Reduce long-term case-loads, for example by developing a 'graduates' group

a. Adapted from *New Ways of Working for Psychiatrists*. Department of Health, 2005.

## Other concerns – general or specific to psychiatry?

St John-Smith *et al* write from a psychiatric perspective, but are the matters under consideration ones that affect only psychiatrists and psychiatry? Considering the key problems enumerated in their paper, would psychiatric nurses, for example, also feel that 'functional teams' have weakened continuity and consistency of care? Or would



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psychologists feel that their complex skills are subject to reductionism in just being seen as the delivery of cognitive–behavioural therapy? We suspect that all the professions could raise similar complaints and that the matters are not unique to psychiatry. The case of social work might be particularly instructive. Historically, social work had distanced itself from healthcare practice and saw itself as having quite a different theoretical orientation and therapeutic approach from the healthcare professions.[8] This distinction was explicit in that social workers were employed by the social services departments and not the NHS. The incorporation of mental health social workers into the partnership trusts in the early 2000s represented a fundamental change in their context for practice. Additionally, the amended Mental Health Act divested social workers of the approved social worker role that had been their exclusive preserve for 50 years. Some suggestions have been made that mental health social work might itself become subsumed within the generic role of the mental health worker. Thus, in as much as there may be some troubles, they do not just beset psychiatry but are profound issues for the entire provider system and all who have a part to play in it. Psychiatry need not feel it has been singled out for special treatment.

## Categorising the complaints

We find ourselves ambivalent towards 'The trouble with NHS psychiatry in England'. It is a significant and valuable text, in that it draws attention to a body of psychiatric opinion that has profound discomforts about the environment in which clinical practice is currently conducted. If the tone is voluble, perhaps even excessive, we take that to mark heartfelt concerns hitherto unheard. But, on the other hand, the text is reminiscent of the blind man shooting at the world – the complaints are about all and sundry and form no coherent thesis. Also, there appears to be conflation in who is being complained to and about what. Consider, for example, the complaint that 'this has resulted in services that are not capable of offering psychiatric assessment'. Is this an assertion that the overall policy is misguided, a complaint about the operational implementation of policy intention, or simply a comment that in a particular service the local result has been an unfavourable one?

However, by hearing the complaints raised in the text, it might be possible to offer a taxonomy of them and in doing so, be clearer about the types of issues at hand as well as having a more structured framework in which debate can occur. We would propose that the complaints raised by the authors can be categorised as ideological, policy, empirical, operational and professional.

1. Ideological questions are broad and general. For example: What do we understand mental and behavioural disorders to be and where are the boundaries of definition? To what extent should the State intervene in the citizens' lives? In relation to mental health and psychiatric practice, is the State only responsible for 'illnesses' or does it feel obligations to a wider range of mental adversities or states of unhappiness?
2. It is unavoidable that there must be policy for the mental health services in England. One senses that St John-Smith *et al* would like psychiatric practice to proceed unencumbered by policy influences. However, even a highly libertarian position of practitioners all following their own light would, in itself, represent a policy position. In this critique we avoid any comments on what the best policies might be, but suggest that we are further forward if we clarify which debates are about policy as opposed to ideology or operations.
3. Many of the complaints could be considered to be, or be framed as, empirical questions. For example, whether or not treatment guidelines directed at psychiatrists have value, or whether 'functional', as opposed to integrated, teams are better for patients, are questions that could be interrogated through research. Perhaps St John-Smith *et al* should add to their proposals for a manifesto a call for a greater commitment to research in service delivery and organisation when restructuring initiatives are under consideration.
4. By 'operational' we would mean 'the practical application of principles or processes'. For example; although the National Audit Office makes specific recommendations about the principles of crisis resolution home treatment services, there is, none the less, some latitude in how those principles are applied according to local circumstances.[9] Whether those operations are felt by practitioners, and psychiatrists in particular, to be effective may depend to a great extent on those local circumstances. Thus it is important in structuring debates not to infer the general from the specific. A matter that is a local problem for a psychiatrist is unlikely to get solved if it is misattributed as being a policy or ideological problem.
5. The professional question for the consultant psychiatrist is which functions to perform on a daily basis. It seems pitiable that St John-Smith *et al* feel they have to claim that 'psychiatrists and psychiatric assessment add value to mental health services'. The four case scenarios advanced in support of this assertion are examples of making an accurate evaluation and deciding on the right management. And so one would hope! But the work of a senior psychiatrist extends far beyond clinical decision-making at the patient interface. The role of a doctor (psychiatrists included) is eloquently set out in the recent publication from the British Medical Association Health Policy and Economic Research Unit (two extracts from the guidance in Box 2 are illustrative of its general tone).[10] The roles described, beyond direct patient encounters, include team leadership, education, research, managing uncertainty and taking overall responsibility under complex clinical circumstances. If the psychiatric body achieved, or at least aspired to, all that is set out in *The Role of the Doctor*,[10] its 'added value' would be entirely beyond dispute.

   While on this matter of professionalism, we would take significant issue with the assertion (point 12 of the St John-Smith *et al*'s manifesto) that medical directors should be 'explicitly assessed by the College' lest they



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**Box 2. The role of the doctor[10]**

'The doctor's role as diagnostician and the handler of clinical uncertainty and ambiguity requires a profound educational base in science and evidence-based practice as well as research awareness. The doctor's frequent role as head of the healthcare team and commander of considerable clinical resource requires that greater attention is paid to management and leadership skills regardless of specialism. An acknowledgement of the leadership role of medicine is increasingly evident' (p. 2).

'In this respect we welcome the sentiments, expressed in the recently published *High Quality Care for All*,[a] which stress the importance of clinical leadership. The report's pledge to strengthen the involvement of clinicians in decision making at every level of the NHS must be supported with the necessary action to ensure the lasting engagement of doctors in the leadership of health services. To fail in this would be to ignore the proven value and unique contribution doctors have to offer' (p. 15).

a. Department of Health. *High Quality of Care for All: NHS Next Stage Review Final Report*. TSO (The Stationery Office), 2008.

'inappropriately act to de-professionalise practice and place patients at risk of poor clinical care'. Quite apart from the fact that the College is a representative body and not a regulatory one, to propose for others a level of intrusive regulation from which the authors themselves would wish to be exempt is lacking in perspicacity, and medical directors will rightly recoil at the strength of the implicit accusation.

## Conclusion

'The trouble with NHS psychiatry in England' is an important text, not because it is reasoned, coherent or dispassionate, but because it says what has not been said elsewhere. The authors are grappling with something quite profound, but diffuse and difficult to define – it is not easy to provide 'evidence' for the values, principles and meanings that a psychiatrist wishes to bring to their work. Both papers[1,2] would appear to indicate that at least some, and perhaps many, psychiatrists are disaffected, disenchanted and possessed of a significant strength of feeling. If so, there is a lot to be done in allowing such feelings to be safely expressed and taken forward into an enlightened discourse. How such a discourse could occur and with whom would, in itself, be a matter for debate. But we doubt it is as simple as the College launching a 'pro-psychiatry' campaign with the government, clinical colleagues or the community, nor do we think that promoting an 'anti-management' stance is helpful. We see the question as being how to convert concerns and complaints into positive statements of aspiration and then to use such aspirations to help create better services. To this end, participation is required, as is perhaps a certain degree of modesty. Although we suggest that a 'doctor knows best' attitude tends to lead to isolation and alienation, we could imagine St John-Smith *et al* responding that a 'management knows best' attitude can be equally unproductive.

In our introduction we sought to draw attention to the enormous privileges afforded to us by the NHS in England as citizens, patients and employees. Although resources can be described as limited, they are, on the other hand, extensive. Mental health services (excluding dementia) in England drew on the public purse to the tune of £8 billion in 2007. We take 'The trouble with NHS psychiatry in England' to indicate a need for a systems-wide debate about how we should work together, collectively, to achieve the best outcomes for all patients within the not-inconsiderable resources at our disposal.

## Declaration of interest

None. The views expressed are those of the authors personally and severally and not those of any organisation or institution.

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