The provision of psychiatric treatment for mental health colleagues in the new market economy

Ray Brown and Hilary Russell

This article outlines a problem in the referral pattern for mental health workers on the Isle of Wight, when they require psychiatric or psychological help. The authors are concerned that treatments are offered by colleagues. A survey undertaken of 12 community mental health units in Wessex seems to indicate that there are no clear policies or financial arrangements for referrals to other units. The authors agree that the treatment of mental health workers everywhere may be compromised in the market economy, if trusts start to function, because of economic pressures, as islands.

The introduction of the purchaser-provider split and the market economy into the health service has led to an awareness that these changes will influence clinical decisions and the referral pathways for patients. On the Isle of Wight we have become concerned about a particular subgroup of patients referred: those who actually work in mental health services, and are, in effect, our colleagues. We have noticed that the same referral patterns that are applied to other patients are frequently applied to mental health staff as well. This often results in one colleague attempting to treat another within the same health area. There may be a number of reasons for this. From the psychodynamic point of view, there is a possibility of an unconscious collusion which undermines treatment, particularly psychotherapy, from the beginning. When these issues have been discussed with the management, another factor emerges. Financial pressures encourage trusts to behave as though they were self-sustaining, not only in terms of economic resources, but also in their ability to limit and contain staff distress. The Isle of Wight also has particular geographical features which mitigate against the easy transport and flow of patients from one area to another. We found ourselves wondering whether other trusts might effectively begin to function as 'islands', and whether this tendency might compromise the rights of mental health service staff to obtain appropriate treatment outside their own trust. For these reasons, we felt it would be interesting to conduct a survey by letter, to ascertain whether the mental health units in the Wessex Regional Health Authority had any clearly formulated policies.

Survey

We contacted the unit general managers of 12 community mental health units within Wessex region. We asked them about their policies concerning the referral of mental health staff who themselves require some form of psychiatric treatment. In particular, we asked whether such members were referred to in-patient or out-patient services, (including clinical psychology, and psychotherapy) within or outside their own area of practice. They were asked for their personal views on where staff members should be referred.

Findings

Eight of the 12 community units replied to our letter. We conclude from these replies that no trust had any clearly defined policy, and the majority did not have any personal views on appropriate arrangements for mental health staff to obtain psychiatric help. The overall impression was of a defensiveness about the *ad hoc* fashion in which such matters were handled. Only one respondent appeared to have considered the financial implications of enabling staff to be treated outside their own area, and expressed the following viewpoint.

> "I personally believe that staff working in clinical situations should have the choice whether to receive treatment inside or outside their own area. But the cost of such an arrangement would need to be identified and agreed as part of the contracting process with our purchasers through the extra-contractual referral process. Finally, this is a very difficult area, as the needs of the individual user need to be

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balanced against the needs of fellow workers, and the embarrassment and confusion of in-patients who might previously have been treated by a member of staff who has become a patient."

For staff members who have had psychotic breakdowns, the treatment of psychotic episodes seems to be clearer. Usually these individuals are treated outside their own area of work. However, there is greater certainty over the treatment of workers who need out-patient psychological or psychotherapeutic help, and who present difficulties above and beyond their GP's area of skill. Most unit general managers expressed their desire to accommodate a staff member's request for referral either inside or outside their own area. Only the manager quoted above seemed to question the appropriateness of in-area treatment, or ask what financial provisions need to be made.

Comments

We feel it is important for health authorities to study these problems, and to agree clearer policies in order to ensure that the treatment of staff is appropriate. GPs also need to be informed about appropriate referral routes for mental staff. It is clear that sufficient funds will need to be allocated, and proper purchaser-provider contracts made – *ad hoc* arrangements will quickly founder in the market system. If financially backed *quid pro quo* arrangements are agreed with a separate mental illness unit, then the staff can be provided with appropriate treatment outside their own area.

The issue of who should have the responsibility for setting in motion the referral of a staff member is a difficult one to clarify. We are aware that in some cases occupational health departments are involved, but managers or clinician colleagues may also be approached. Personal knowledge of the mental health problems of staff may result in a conflict of interests for managers who have responsibility for the staff's deployment and promotion. The entitlement of staff member to confidential treatment has to be protected by a careful consideration of who needs to know of their mental health problems; how much such people need to know; and who should be responsible for the mental health of staff in the service.

When mental health staff members become patients, their own judgements of where and by whom they are treated should not be the only factors considered. Equally, financial pressures alone should not dictate the location of that treatment. Clinical judgement should take precedence, as with any group of patients. For this special sub-group, the location of that treatment may have to be considered as carefully as the nature of the treatment itself, but the question of who should be responsible for such decisions in the first instance needs to be asked. One thing seems certain: the temptations to collude with in-area treatment and to deny the special needs of staff members will be all the greater in the new market-led health service.

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Comment

Fiona Caldicott

There is longstanding 'custom and practice' in the National Health Service that members of staff may not be treated in the same hospital or part of the service where they are employed. For many, and particularly minor ills, this is not necessary and most of us have sought specialised advice at some time or another from a colleague locally. Conversely, there are circumstances when this is inappropriate, and Brown & Russell have described some of them.

It may be of interest that the first example of a problem arising in psychiatric care, which was brought to the attention of the College when the NHS and Community Care Act of 1990 was implemented on 1 April 1991, was of a medical student from one provider unit, who was refused treatment in the unit with which there had been a reciprocal arrangement. This was taken up by my predecessor with the Chief Medical Officer and appropriately confidential treatment arranged.

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