

## A plea for re-illusionment

Burns' *cri de coeur*<sup>1</sup> about the thoughtless severing of in-patients from community responsibility will strike a chord in colleagues of his demographic. Our generation saw the special contribution of the consultant psychiatrist as encompassing continuity of care across time and space in ways unique to our discipline. We hoped to see our patients holistically through the vicissitudes of illness, recovery, health and relapse, creating, when things went well enough, a deep life-enhancing mutual knowledge. Yes, we were spread thin, the workload was tough at times, and Jacks of all trades (psychotherapy, group and systemic therapy, psychopharmacology) must sometimes give way to master-craftsmen. But has psychiatry traded an easier life for a diminishing and less satisfying role? How long before an impoverished state finds our profession largely redundant? Are we in danger of becoming our own grave-diggers? Or is all this merely nostalgia seasoned with generational grumpiness? Re-illusionment please!

1 Burns T. The dog that failed to bark. *Psychiatrist* 2010; **34**: 361–3.

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## Because of the mental disorder . . .

Short-term detention for mental disorder under the Mental Health (Care and Treatment) (Scotland) Act 2003 requires an approved medical practitioner to certify that a condition specified in Section 44(4)(b) of the Act is met: namely that 'because of the mental disorder, the patient's ability to make decisions about the provision of medical treatment is significantly impaired'.

Many practising clinicians will realise that there are myriad reasons why patients with mental disorder will not, for example, take necessary medication. These include family attitudes and previous adverse experiences, as well as factors caused by the mental disorder itself such as delusional beliefs. Clinical discussions surrounding a recent tribunal I attended have crystallised this for me.

Was it really the view of the Scottish Parliament that a patient who refuses medication for a severe psychotic exacerbation on grounds not actually caused by this illness should remain untreated?

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## How many is too many?

I write in response to the letter from Neelam & Williams.<sup>1</sup> The authors are responding to the paper by Singhal *et al*,<sup>2</sup> who elicited the views of service users and providers with regard to separate consultant teams for in-patients and out-patients. Neelam & Williams described the use of a third team – the crisis resolution home treatment team (CRHTT), saying that this team performs a vital role in the period between discharge from the in-patient team and the patient being sufficiently well for safe and effective transfer into the community mental health team (CMHT).

The most consistent theme that emerged from Singhal *et al*'s study was the difficulties in continuity of care and maintaining the therapeutic relationship when patients moved from the in-patient to the CMHT. It seems rather bizarre that Neelam & Williams contend that the problem can be ameliorated by introducing yet a third team into the discontinuity between in-patient and out-patient care. Neelam & Williams note that patients often asked to remain permanently under the care of the CRHTT and it seems probable that these patients are seeking a return to the more traditional model of continuity of care from one single team.

I write as a trainee psychiatrist who has worked only in generic psychiatric teams that care for patients whether they are in-patients or living in the community. In my experience, these teams provide high-quality care and encounter no difficulties in continuity and maintaining therapeutic relationships. Perhaps an advocate of New Ways of Working<sup>3</sup> could explain to me the advantages of an ever-increasing 'specialist team' approach as opposed to the 'one patient, one team' model?

1 Neelam K, Williams F. Three consultants for one patient. *Psychiatrist* 2010; **34**: 357.

2 Singhal A, Garg D, Rana AK, Naheed M. Two consultants for one patient: service users' and service providers' views on 'New Ways'. *Psychiatrist* 2010; **34**: 181–6.

3 Department of Health. *Mental Health: New Ways of Working for Everyone*. Department of Health, 2007.

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## Psychiatrists behaving badly?

The reason why many of us choose psychiatry as our specialty is that we like the human touch of medicine. To a large extent this is our strongest attribute, but as O'Leary *et al*<sup>1</sup> have demonstrated, quite perversely it is this affinity that also leads to our failing in the areas we should excel in, namely relationships with colleagues and patients as well as good clinical practice. The implications of the numbers of psychiatrists being referred to the National Clinical Assessment Service (NCAS) should not be underestimated not least to themselves but also to mental services as a whole. Coupled with the recruitment problems in junior training posts and the relative inability to make our specialty attractive to medical undergraduates,<sup>2</sup> we are likely to store further problems of recruitment to consultant posts, something that has dogged our profession for many decades but none more so than in the 1980s and 1990s. Elsewhere in the journal, Burns articulates his concerns on how the consultant's role lacks definition,<sup>3</sup> a factor that might well influence our performance and our attitude to others, as well as others' to us. My sense is that we need some creative thinking around how we might promote our specialty, while simultaneously ensuring that our colleagues are supported in the right manner during their stressful years of practice. In this regard, O'Leary *et al*'s call for the College to review the continuing professional development (CPD) programme is not inappropriate, but as the CPD Committee has just set out a new policy<sup>4</sup> it could be some time before the next policy comes round. There is evidence