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Psychiatric Bulletin (2006), **30**, 140–142

NICK AIREY AND STUART McLAREN

Drug services in England and Wales: a survey of treatment providers and their medical leads

AIMS AND METHOD

We undertook a postal questionnaire survey of drug action teams in England and Wales with the aim of clarifying the nature of statutory specialist drug services.

RESULTS

Of 159 drug action teams, 110 (69%) responded; 64 (58%) reported that mental health trusts exclusively provided their specialist drug services. Other providers were primary care and acute trusts, the non-statutory sector and social services. The majority of medical leads were psychiatrists (123 senior posts with 20% vacant/occupied by a locum), then general practitioners (GPs) (42) and other specialists (4).

CLINICAL IMPLICATIONS

Specialist drug services are offered by a range of treatment providers, with the medical lead being taken by GPs and other specialists in some areas. In view of the current difficulty in recruiting psychiatrists, we propose that alternative training pathways are considered for addiction specialists.

The past 10 years has been a time of great change for both the commissioning and provision of substance misuse treatment in Britain. In 1995, the commissioning of drugs services became the responsibility of local drug action teams (Central Drugs Co-ordination Unit, 1995). In 2001, the National Treatment Agency was formed (http://www.nta.nhs.uk). This has the status of a special health authority and it is to this body that the drug action teams are now responsible. The Department of Health published its consultation document *Models of Care for Substance Misuse Treatment Promoting Quality, Efficiency and Effectiveness in Drug Misuse Treatment Services* in 2002, and this is essentially the National Service Framework for drug treatment providers.

The provision of substance misuse treatment has also changed considerably over the years and the landscape today bears little resemblance to that of even a few years ago. Statutory substance misuse treatment was, at one time, the preserve of psychiatrists. Much care was provided in the primary care setting but with a few notable exceptions this was unplanned and uncoordinated. Psychiatrists had a recognised training route into the specialty. General practitioners (GPs) have been interested in the provision of drug services for a number of years but have recently become more organised and have an active special interest group attached to their College, the Substance Misuse Management in General Practice.

The 'traditional' model of service delivery would be a mental health trust providing the statutory drug treatment in a particular locality under the medical supervision of a consultant psychiatrist. However, other treatment providers have moved into the field; these include primary care trusts and non-statutory organisations. These agencies require a doctor to have medical responsibility, but there is no requirement for this doctor to be a psychiatrist.

We have conducted a survey of drug action teams to investigate the nature of statutory provision of drug services in England and Wales. We asked who is providing this care at present, who medically manages these services and the specialist background of the medical lead. In the UK these statutory services treat mainly opiate-dependent patients, often with a background of polysubstance misuse.

Problems in the recruitment and retention of psychiatrists are of major concern to the Royal College of Psychiatrists and this is a not infrequent subject for discussion in the *Bulletin*. The College itself publishes data on vacant posts (Royal College of Psychiatrists, 2002). Hence, as part of our survey we also asked the drug action teams to comment on whether posts were occupied or not.

Method

In 2003, we sent questionnaires to all coordinators of drug action teams in England and Wales by e-mail. Non-responders were then followed up by letter. They were asked to provide details of statutory specialist drugs services in their area, who managed these services, the specialty of the medical lead and whether these posts were filled, vacant or occupied by a locum.

Results

Questionnaires were sent to 159 drug action teams (of which 5 were in Wales). Usable replies were received from 110 (of which 4 were in Wales), yielding a response rate of 69%.

Providers

The majority of drug action teams (88/110) had at least one mental health trust providing drugs services in their local authority area. Of these, 64 had the service provided exclusively by one or more mental health trusts. The remaining 24 had a mental health trust provider alongside either a primary care trust (PCT) (20) or a non-statutory or social services provider (2 each). Thirty-four had services provided by PCTs, of whom 11 had the service provided exclusively by one or more PCT provider,

https://doi.org/10.1192/pb.30.4.140 Published online by Cambridge University Press

Table 1. Number and occupancy of medical lead posts (all types of provider)

	Total *n* (%)	Filled *n* (%)	Locums *n* (%)	Vacant *n* (%)
Psychiatrists	118 (–)	94 (80)	13 (11)	11 (9)
General practitioners	32 (–)	31 (97)	– (–)	1 (3)

20 in combination with 1 or more mental health provider and 3 in combination with a non-statutory provider. Nine drug action teams had services provided by non-statutory services, of whom three had services provided exclusively by this sector, with the remainder in combination with other providers, such as a community trust, mental health trust or PCT. One drug action team had services that were provided by a combination of social services and mental health trust. The four Welsh drug action teams which responded indicated that their statutory provision was provided by acute trusts.

Medical leads

The largest group of medical leads (in posts both vacant and filled) were psychiatrists. There were 123 senior psychiatric posts, of which 99 were with a mental health trust, 12 a PCT, 6 the non-statutory sector, 1 a community trust, 2 social services and 3 acute trusts in Wales. The next largest group were GPs, the total number of posts being 42, of which 11 were with mental health trusts, 22 PCTs, 7 in the non-statutory sector, 1 in a community trust and 1 an acute trust in Wales. Three public health specialists were medical leads (one in a mental health trust and two in PCTs) and one community trust employed a genito-urinary specialist as their medical lead.

Post occupancy

Table 1 shows whether posts were filled, vacant or occupied by a locum. For psychiatrists employed by mental health trusts, occupancy figures were slightly lower than those in Table 1 with 75 posts occupied (77% of the total), 10 vacant (10% of the total) and 12 occupied by a locum (12% of the total). In PCTs, occupancy was better, with 10 out of 12 posts occupied (83%). For GPs, 20 posts out of 21 were filled when the PCT was an employer (95%), and 11 out of 11 for mental health trusts (100%).

Discussion

This survey reveals the diverse nature of providers of drug treatment services. Mental health trusts are still the main providers, but PCTs are significantly represented. At least nine non-statutory agencies are now involved in running prescribing services, which is in marked contrast to the role they occupied not so long ago. Indeed, the future may see a blurring of the distinction between statutory and non-statutory drug service provision, perhaps organised under one managerial umbrella. These changes may have implications for psychiatrists in terms of their professional practice with issues around, for example, the risk of increased professional isolation in hybrid provider organisations. They may also have an adverse impact on service delivery for patients with complex problems, particularly for those with dual diagnoses (i.e. substance use plus severe mental illness), where there is a danger of deepening the divide between addiction and mental health services.

Currently, the conventional route into the specialty of addiction medicine is through higher psychiatric training, but our survey indicates that there is diversity in the professional background of doctors now involved, including GPs and public health doctors. They presumably have a very different depth and breadth of training experience thus raising major issues of clinical governance. As a possible way forward in the UK, we would put forward the Australasian model of a Chapter of Addiction Medicine under the aegis of a Royal College. Under this system, a training programme would be open to members of any College, while providing some exemption to psychiatrists who have undertaken prior addiction training as part of their higher professional training. This would have the advantage of broadening the entry into the specialty, ensuring some uniformity of training, and raising and maintaining educational/training standards in the field. Although a lengthy process requiring approval by the Secretary of State for Health, development of training programmes might eventually lead to agreement to a Certificate of Completion of Specialist Training (CCST) in addiction medicine.

The vacancy and locum rates among consultant psychiatrists revealed in this survey are very high and possibly increasing. The Royal College of Psychiatrists' *Annual Census of Psychiatric Staffing 2001* showed a combined vacancy and locum rate among substance misuse psychiatrists of 14%, compared with our figure of 20%. This contrasts starkly with occupancy of GP posts of over 95%. Although the reasons for these differences in occupancy are likely to be complex they must partly be a result of the relative lack of suitably trained psychiatrists and perhaps the creation of new GP posts linked to the presence locally of interested GPs. A College Research Unit study that is currently underway may clarify some of these factors (http://www.rcpsych.ac.uk/cru/hsrp/addictionpsychiatricservices.htm). However, these high vacancy rates add further weight to the need for radical changes in the routes into addiction medicine training and a corresponding broadening of the background of addiction specialists.

The main limitations of this study are the possible inaccuracy of the coordinators' perceptions of their services provider and medical lead, and the 69% response rate.

Declaration of interest

None.

https://doi.org/10.1192/pb.30.4.140 Published online by Cambridge University Press

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Psychiatric Bulletin (2006), **30**, 142–145

RICHARD DUGGINS AND IAN SHAW

Examining the concept of patient satisfaction in patients with a diagnosis of schizophrenia: a qualitative study

AIMS AND METHOD

Ten people with a diagnosis of schizophrenia were interviewed. The interviews were analysed qualitatively with the aim of examining the concept of patient satisfaction in the context of a recent in-patient admission.

RESULTS

The analysis identified two themes that influenced the expression of patient satisfaction: external factors and internal factors. The theme of external factors contained four categories: fear of violence, communication with staff, lack of autonomy and ward routines. The theme of internal factors comprised participants' conceptions and expectations.

CLINICAL IMPLICATIONS

This small study suggests the complexity of the concept of patient satisfaction should be respected in assessing experiences of people with a diagnosis of schizophrenia.

The *National Service Framework for Mental Health* (Department of Health, 1999) and the *NHS Performance Ratings 2003/2004* (Healthcare Commission, 2004) consider patient experience to be a key performance indicator in mental health services. The method of choice for assessment of patient experience is the evaluation of patient satisfaction, primarily using surveys (Department of Health, 2000; Healthcare Commission, 2004). Unfortunately, despite the growing popularity of patient satisfaction as a measure, there has been surprisingly little attention paid to examining what the concept actually means. Powell *et al* (2004, p.17) state that evaluation of patient satisfaction in mental health has been mostly 'theory-free, assuming incorrectly that the concept of satisfaction is transparent and unproblematic'. There are specific theoretical concerns regarding the concept of patient satisfaction in patients with a diagnosis of schizophrenia, and these include the possible distorting effects of insight, delusions and interpersonal mechanisms such as transference (Lebow, 1982). The objective of this research was to use qualitative methodology to examine the concept of patient satisfaction in people with a diagnosis of schizophrenia in the context of a recent in-patient admission.

Method

Ethical approval was obtained from the Research Ethics Committee, University Hospital, Nottingham, and ten participants were recruited. All the participants had a diagnosis of schizophrenia, and had been discharged from an acute adult in-patient ward in Nottingham within the past year. A 'theoretical sampling' strategy ensured that the sample comprised participants admitted voluntarily and detained under the Mental Health Act 1983. Of the ten participants, six were male and seven were detained under the Mental Health Act 1983 during their most recent admission. The ages of the participants ranged from 20 to 54 years, and the number of previous admissions ranged from 0 to 20. Nine of the participants identified their ethnicity as White British and one as African-Caribbean.

One researcher (R.D.) conducted all the interviews at a venue chosen by the participant, usually the home. The interviews followed a depth interview format and the researcher encouraged each participant to relate, in their own terms, experiences and attitudes. The interviews were aided by a brief interview guide containing three prompts: demographic details, history of contact with mental health services and experiences around in-patient stay. The interviews lasted between 40 and 110 min, with an average duration of 65 min.

The analysis ran concurrently with the data collection and this allowed the teasing-out of emerging themes in later interviews (part of the analytical induction process). The validity of the analysis was increased by collaboration between the researchers in the analysis of the transcripts.

The tool used for the qualitative data analysis was cognitive mapping (Jones, 1985). Cognitive mapping is a method of modelling a person's beliefs in diagrammatic form and seeks to represent a person's explanatory and predictive theories about those aspects of their world being described. An overview diagram of part of a map is provided in Fig. 1.

https://doi.org/10.1192/pb.30.4.140 Published online by Cambridge University Press