special articles

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LOUIS APPLEBY

Waste paper

One of my favourite publications does not even appear on my curriculum vitae because I am not sure how to classify it. It is a photograph of two of my research staff standing beside floor-to-ceiling piles of paper – all the forms that now have to be completed for a local ethics committee before you can get started on a national study. After the butter mountain and the wine lake, it is the paper avalanche.

The NHS has a passion for paper – some of it vital, some of it pedantic if not pointless. At first glance, you could be excused for thinking we run a waste paper industry, just as the Sopranos look at first like dealers in waste disposal. Too many guidelines, too many forms, or, as the political slogan goes, too much bureaucracy and red tape.

But is this really what is happening and does it have to be this way? Could form-filling be good? Two new pieces of work will tell us the answer.

The first is a study of workload among psychiatrists. Everywhere I go, people talk about workload and there is no doubt that many psychiatrists face unreasonable demands on their time. But what do we really know about this? What, apart from the volume of work itself, makes us feel overworked? The multiplicity of tasks? Curmudgeonly colleagues? A rundown office? Or is it too much bureaucracy and red tape? In fact, how much time do we actually spend on form-filling, administration and other non-clinical duties?

The workload study is a census of psychiatrists' working time, which also covers social workers, and by the time this article appears it should already have happened. The Department of Health is funding the College Research Unit to carry it out. The results should strengthen the arguments of those of us who want to see the morale and motivation of the profession restored.

The second piece of work is on outcomes, and here is the crucial question: how do we know that our patients get better? At the moment, we measure many things about mental health services, but not that. Instead, performance indicators and other data-sets tell us useful things like what services do – admissions, re-admissions, prescriptions – but not what they achieve. The aim of the outcomes project is to introduce routine outcome measurements into clinical practice, to measure what matters to patients and reflect the priorities of clinical care. The outcomes that matter fall into three categories. First, symptom change, including any change in substance misuse. Second, quality of life – do patients get jobs and decent places to live? Third, satisfaction with care for patients and their families.

Collecting data can seem wasteful of time and paper, so outcomes have to be measured in a way that is part of clinical care, not a tiresome extra. And the information has to be useful. A pilot study, now up and running, will help us get the practicalities and the usefulness right.

The benefits should be numerous. Staff will have evidence of a job well done. Services will be responsive to patient needs. For the first time we will be able to show that mental health care leads to improvements in patient health and well-being, both in a local service and nationally. This is invaluable if we are under fire from the press or called to account by the Treasury. And the arguments for much-needed universal IT systems to support clinical care and data collection will, at last, be hard to ignore.

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Psychiatry in post-apartheid Namibia: a troubled legacy

I recently spent 6 months in Namibia as a Fellow of the John Simon Guggenheim Foundation. The purpose of my visit was twofold: the establishment of a database for trauma-related mental health disorders and the development of a validated, self-report screening instrument for mental illness. In the process, I was able to meet with Namibian colleagues and visit a number of health care centres in the country. This article will focus on my impressions of psychiatry in Namibia that were formed during my visit. A brief summary of Namibian history, in particular the country's relations with neighbouring South Africa, will help place my observations in a more meaningful context.

Background

Namibia, a member of the Commonwealth, occupies a land mass one-and-a-half times the size of France. It is sparsely populated, the majority of the 1.8 million people

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