the columns

correspondence

ICD–11 and DSM–V: time to revisit the introversion/extroversion debate?

Given the volume of work which now exists on this, it is striking how extroversion/introversion plays no real part in either ICD–10 or DSM–IV. These are well-used and well-understood terms which are easily measured using the Myers–Briggs Type Indicator. With the development of ICD–11 and DSM–V, is it now time for this to be reviewed and perhaps included in a more substantial way?

There is also a wider issue here apart from diagnosis. Should introverts have different treatment approaches from extroverts? Are different types of drugs likely to be more successful? How does being an introvert compared with an extrovert change the way an individual perceives and deals with mental illness?

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New Ways of Working: time to abandon the phrase

Christine Vize *et al* (*Psychiatric Bulletin*, February 2008, **32**, 44–45) advise us against any loss of momentum in this revolution of our working practice. Previous debates on community care and home treatment were clear and based on significant background information, whereas New Ways of Working is unclear what it is about (other than the abandonment of traditional out-patient clinics) and is not supported by evidence.

It would be easier to join this bandwagon if it was clear where it was coming from and heading to. The movement originated from recruitment and retention problems in psychiatry but has moved on to attempt to optimise functioning of multidisciplinary teams. The real stress in adult psychiatry never came from dysfunctional multidisciplinary teams but rather emerged from unrealistic expectations about our ability to curb violent patients. Nothing in New Ways of Working will address this.

The term has become divisive with its denigration of previous patterns of service and its unwillingness to let the evolutionary processes that have worked well over the past 20 years continue to take their course. I do not agree that the body of the profession has been 'one of the biggest single drivers' of New Ways of Working which is about changing professional roles on a wide scale. The College will not be able to control New Ways of Working either. It is time for a more cautious approach to the change incompatible with such a phrase as 'new ways of working'.

Declaration of interest

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Safety for psychiatrists

Dibben *et al* (*Psychiatric Bulletin*, March 2008, **32**, 85–87) clearly address the importance of safety for both trainee and consultant psychiatrists within the work environment.

I recently undertook a similar survey, using an anonymous postal questionnaire, among all medical staff (consultants, *n*=6; trainees, *n*=10) working in a mental health unit based in a major general hospital in Ireland, likewise adapted from safety guidelines drawn by the Royal College of Psychiatrists (2006).

Our findings contrasted with those of Dibben *et al* (2008), with consultants giving more consideration to safety issues than trainees: attendance to breakaway training (100% *v.* 20%), awareness of local safety policies (100% *v.* 0%), use of personal alarms (100% *v.* 20%) and perception of vulnerability (80% *v.* 20%). Direct inspection of all the interview rooms in the psychiatric unit (*n*=15) found out that none of them met all the predetermined safety criteria.

Inadequacy of safety standards in the mental health setting indeed appears to be a widespread phenomenon (Chaplin *et al*, 2006). Safety in the clinical environment is thus an issue that needs to be taken with utmost importance by clinicians and adopting a degree of vigilance about sound safety measures lies to a certain extent within one's own responsibility. Nevertheless, health managers must not mismatch their priorities and should ensure the implementation of useful recommendations derived from audits regarding staff safety. Ultimately, this would also avoid the trap of such audits merely ending up as an exercise in systematic inquiry.

CHAPLIN, R., McGEORGE, M. & LELLIOTT, P. (2006) The National Audit of Violence: in-patient care for adults of working age. *Psychiatric Bulletin*, **30**, 444–446.

ROYAL COLLEGE OF PSYCHIATRISTS (2006) *Safety for Psychiatrists* (CR134). Royal College of Psychiatrists.

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The global issue of the National Health Service (NHS) staff safety was prioritised in 2005 by Department of Health's documentation *Promoting Safer and Therapeutic Services* which placed an expectation upon the Security Management Service to provide safety training for all frontline staff by March 2008.

I conducted a survey, similar to the one by Dibben *et al* (*Psychiatric Bulletin*, March 2008, **32**, 85–87), within the Birmingham and Solihull Mental Health Trust, examining personal safety awareness among staff and associate specialists and consultant grades (*n*=64). This revealed that 85% of staff and associate specialists, and 78% of consultants had received breakaway training within the past year; 36% of consultants were aware of local trust protocols and 100% of those surveyed believed medics of all grades should routinely receive safety training. This differs from the published study

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which found many senior medics regard such training as potentially worthless.

It should be remembered that it is senior colleagues who conduct Mental Health Act assessments on acutely disturbed patients within the community. Indeed, my study revealed that a quarter of consultants had been directly involved in incidents of patient aggression within the previous year.

Inadequate environmental safety provision for psychiatric staff is commonplace. It is unfortunate therefore, that Dibben *et al*'s study discovered many medics avoid wearing personal alarms even when available, instead relying upon defensive skills of colleagues in an emergency. The Royal College of Psychiatrists and NHS trusts should jointly seek to improve safety provisions. However, I believe 'personal safety' is just that – the responsibility of individual healthcare workers, regardless of discipline or seniority and one should not expect to defer this entirely to colleagues or their employers.

NHS SECURITY MANAGEMENT SERVICE (2005) *Promoting Safer and Therapeutic Services.* Department of Health (http://www.cfsms.nhs.uk/doc/psts/psts.implementing.syllabus.pdf).

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NICE guidance on joint decision for treatment of acute mania: completed audit cycle

In 2003, National Institute for Health and Clinical Excellence (NICE) recommended that, 'The choice of drugs prescribed in acute mania should be made jointly by the individual and the clinician(s) responsible for treatment. [It] should be based on an informed discussion of the relative benefits and side-effect profiles of each drug, and should take into account the needs of the individual and the particular clinical situation. In all situations where informed discussion is not possible, advance directives should be taken fully into account and the individual's advocate and/or carer should be consulted when appropriate' (NICE, 2003).

We completed an audit cycle to examine the compliance with this recommendation. After discussion with the clinicians locally, it was agreed that any documentation indicative of a discussion on drug selection between the clinician and the patient or his/her advocate/carer, or reference to the advance directives, will be accepted as the standard.

The first phase of the audit cycle was conducted in 2004. The in-patient notes of the adult patients admitted with acute mania were searched for the above information or documentation of capacity assessment.

The results and the recommendations from the first cycle were presented at the local educational meeting and a report was submitted to the trust audit department to be circulated to all the clinicians and made available on the intranet. The re-audit was conducted in 2006.

In 2004, out of a total of 38 case notes examined, only 13% had any documentation towards joint decision on drug selection. In 2006, 32 case notes were examined and 40% of these had joint decision documentation. None of the case notes (in 2004 and 2006) had any reference of capacity to consent, advanced directives or discussion with carers.

It is possible that the joint discussions on the selection of drugs are held but not documented for various reasons, for example lack of time or ignorance. The patients might lack capacity due to severity of their illness and the relative or carer might not be available to give consent. In both phases of audit cycle, more than half of the patients (55% in 2004 and 66% in 2006) were detained under the Mental Health Act 1983 and about a third (29% in 2004 and 37% in 2006) required admission to the psychiatric intensive care unit reflecting the severity of illness. Nevertheless, the Mental Health Act code of practice clearly indicates that a detained individual is not necessarily incapable of giving consent and the interview at which their consent for treatment was sought as well as assessments of their capacity should be fully documented in the patient's notes.

It will be interesting to hear views and experiences of other clinicians in this area.

NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE (2003) Olanzapine and valproate semisodium in the treatment of acute mania associated with bipolar I disorder. TA66 Bipolar disorder - new drugs: Guidance. NICE.

DEPARTMENT OF HEALTH & WELSH OFFICE (1999) *Code of Practice. Mental Health Act. HMSO.*

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Opportunity for training beyond the NHS in the voluntary sector

Nimmagadda *et al* (*Psychiatric Bulletin*, February 2008, **32**, 41–43) argue for psychiatric trainees to have more exposure to training opportunities in the independent sector. We agree with their arguments but would specifically encourage trainees to consider training opportunities in the voluntary sector. In our experience voluntary training sessions at the Medical Foundation for the Care of Victims of Torture in London have been an experience rewarding both professionally and personally.

At a time when there are concerns about the quality of job plans and special interest sessions, time spent with the Medical Foundation provided valuable experience in psychotherapy not routinely available in the NHS – for example, working with former child soldiers.

The voluntary sector can also provide experience in working outside of the NHS management systems. Looking from the outside in at various parts of the service can positively inform future dealings with the independent sector (Nimmagadda *et al, 2008).*

Burnout among medical specialists has been found to be experienced as a combination of a high level of stress and a low level of job satisfaction, rather than as stress alone (Visser, 2003). By allowing the trainee to contribute to a worthwhile cause relevant to them, voluntary work can increase a trainee's overall sense of job satisfaction and prevent burnout.

Recent concerns have also been raised about the return of a career bottleneck for psychiatric trainees (Goldberg, 2007). Voluntary work allows the trainee to take responsibility for their own training and will increase their career prospects by enhancing their CV.

The possibilities for psychiatric training in the voluntary sector are many and varied. We would encourage trainees and the College to embrace these opportunities.

GOLDBERG, D. (2007) Improved investment in mental health services: value for money? *British Journal of Psychiatry*, **192**, 88–91.

VISSER, M., SMETS, E. M., OORT, F. J., *et al* (2003) Stress, satisfaction and burnout among Dutch medical specialists. *Canadian Medical Association Journal*, **168**, 271–275.

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