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Qualifications in clinical education for psychiatrists

We were interested to read the article by Dinniss *et al* (*Psychiatric Bulletin*, March 2007, **31**, 107–109) on qualifications in clinical education for psychiatrists. We wish to draw attention to postgraduate programmes in medical education (including MSc, PGDip and PGCert) run by Durham University, which did not feature in the list. These are particularly relevant in that Dinniss *et al* identify a number of deficiencies in the course they undertook: some modules only had marginal relevance to their needs, and they would have valued greater opportunities to develop practical skills in delivering teaching and supporting learning. Our programmes have a strong bias towards practical approaches as opposed to being focused on research, although of course good teaching practice is also research informed. Details of our courses are available from the Durham University website at <http://www.dur.ac.uk/school.health/postgraduate/taught/medicaleducation>

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New Ways of Working threatens the future of the psychiatric profession

I sometimes wonder if I am the only psychiatrist who has misgivings about the direction our professional body is heading under New Ways of Working for Consultant Psychiatrists. Its impetus came from recruitment and retention problems in the profession some time ago, but the climate has now changed and many candidates are clambering for posts that trusts would have previously struggled to fill. In some areas there is a real threat of redundancies among doctors.

Out-patient clinics have largely been condemned by the new system as being

purposeless and inefficient. I am not sure that service users would agree and the perspective of primary care has yet to be obtained. Most people who have an illness want a humane assessment by somebody who understands their problem, has seen it before and knows how to treat it. The professional status to deliver this only comes with experience and training. Assessment, diagnosis and treatment of people newly referred to psychiatric services can therefore not be so easily delegated to other professional groups who are not trained in diagnostic theory or nationally assessed for their ability to perform this important task.

If we, as a consultant body, see a small number of cases, while supervising others who are seeing vastly more people than ourselves, it is only a matter of time before we lose respect, credibility and competence. We are the most highly paid professional group within the mental health services and questions will be asked about whether we offer value for money.

A major service that consultant psychiatrists have offered in the past has been continuity of care. Patients have been seen at a point where their illness begins, through a period of turbulent in-patient care, back out into the community, through remission, relapse and, hopefully, recovery. The fact that there is somebody who knows their history, and has seen them through thick and thin, is I suspect of vital importance to most service users. With the functionalisation of services and division of in-patient and out-patient services, we are destroying this continuity, leading to a situation where bits of care are being individually managed in a limited way with nobody overviewing the case as a whole. It is my view that quality of care is suffering as a direct result of this.

There is no other professional group currently that has the academic background status in society, or the infrastructure for continuing professional development to take forward evidence-based psychiatry and to improve the quality of care for people with mental health problems. Nobody wishes to see burnt-out or ill psychiatrists, but psychiatrists of the future have to maintain substantive, direct contact with the

patients for professional survival and, indeed, to have anything significant to offer the health service.

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Specialist psychiatric rehabilitation teams – a historical anomaly?

For many years, psychiatric rehabilitation teams worked to resettle patients from the long-stay 'asylums' into the community. This process is now virtually complete and with rising financial pressures in the National Health Service specialist rehabilitation services are under threat in many parts of the UK (Holloway, 2005).

In 2004 a review was undertaken of all people in high-support placements, largely residential homes, funded by the London Borough of Newham, and 30 people, most with chronic schizophrenia, were felt to no longer need the level of support they were receiving. Community mental health teams were encouraged to refer these people to the Newham Rehabilitation and Recovery Team, with aim of aiding their resettlement in more independent accommodation.

Two years on we reviewed the case notes of the 30 people that were originally identified. Nine had successfully moved on, mainly to housing schemes offering a few hours of support each week. Two placements had failed within a short period; both people had alcohol problems. Cost savings were estimated to be in excess of £200 000. Team members felt that a person's enthusiasm to move was related to the likely success. Close links with the council housing department were also thought to be important.

Our small study suggests that specialist rehabilitation teams can be effective in moving people with mental health problems into more independent placements. This can produce substantial financial savings and fits the College's vision for rehabilitation services to reduce



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secondary handicap and promote social and cultural reintegration (Royal College of Psychiatrists, 2004).

HOLLOWAY, F. (2005) *The Forgotten Need for Rehabilitation in Contemporary Mental Health Services*. Royal College of Psychiatrists. http://www.rcpsych.ac.uk/pdf/frankholloway_oct05.pdf

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Simulated patients

As a former professor of psychiatry and a current simulated patient I was interested in the paper of Eagles *et al* (*Psychiatric Bulletin*, May 2007, **31**, 187–190). I have been doing such (voluntary) work for about 5 years, simulating psychiatric and general medical/surgical patients both for teaching sessions and in objective structured clinical examinations (OSCEs). I have also participated in OSCEs for higher exams for occupational health medicine but not yet for psychiatry. I find it a very interesting experience, and so far have not succumbed to the stress mentioned by Eagles *et al*. There is a bank of some 400 of us in Sheffield, a mixture of volunteers, actors, 'real ex-patients' and former clinicians of various specialities.

The usual practice is to be given a script about a week before, and once learnt one can usually trot it out realistically about 10–15 times in a day, spread over 4 or 5 sessions. I have been prepared to take on more or less any condition – the only one I drew the line at was that of a 27-year-old with schizophrenia; it wasn't the schizophrenia which troubled me, but I just could not satisfy myself I could act the 27 years convincingly. It was taken on by a younger actor.

We also lend ourselves for standard physical examination – blood pressure, temperature, chest examination, etc. In these days of MRSA, I was undergoing a chest examination in a rather draughty room; the young lad came in his white coat, duly washed his hands with alcohol rub, said 'Oh my hands are cold' and proceeded to rub them on his white coat to warm them before he put them on my chest. Does he get failed for poor hygiene, or a distinction for concern for the patient's comfort?

Another heart-warming incident occurred at the end of a lecture in which I was demonstrated as a widowed hypertensive patient living alone who was worried in case he collapsed and fell down

the stairs. A young student came up to me and said, 'I hope you don't mind me telling you, but my granny is like you, but she has an alarm round her neck and she can call for help if she needs to.' Another distinction.

On one occasion I was there for an abdominal examination when one of the demonstrators was called away for an emergency. I found myself taken out of bed and reverted to being a doctor, teaching for the rest of the morning.

You can appreciate I find it a rewarding, entertaining and amusing experience, perhaps repaying some of the satisfaction I achieved during my teaching and clinical career. I think it is true to say that the majority of my fellow simulators, whatever their background, feel the same way, putting something back into the system in return for whatever help they have gained in the past – it is our National Health Service.

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Work-related stress

Murdoch & Eagles (*Psychiatric Bulletin*, April 2007, **31**, 128–131) list a number of stress factors identified by consultant psychiatrists. Conspicuous by its absence is any reference to stressful relationships with colleagues. Are we a profession in denial? Any internet search for information regarding causes of work-related stress (e.g. <http://www.bbc.co.uk>) will indicate that a well-recognised cause is relationships with colleagues. This was alluded to by Mackirdy (*Psychiatric Bulletin*, August 2006, **30**, 283–285). Specifically, she cautioned that specialised teams can lead to 'boundaries which can deepen into dangerous chasms unless energy is specifically directed into border diplomacy and efficiency.'

Murdoch & Eagles quite rightly suggest that given our understanding of stress it would be 'unfortunate if we do not utilise these skills to our mutual benefit in combating work-related stress.' Of course, as anyone with a basic grasp of problem-solving knows, clearly identifying the problem is key to solving it.

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Goldberg and Huxley's model 27 years on

Over 25 years ago Goldberg & Huxley (1980) proposed a widely recognised pathway to psychiatric care. This model,

which has since been refined (Goldberg, 1995), predicts that 20.8 adults per 1000 population per year will be in contact with specialist mental health services. We have previously demonstrated that this model underestimated the utilisation of specialist psychiatric services in North East Edinburgh in 2003 (O'Sullivan *et al*, 2005). We decided to resurvey referrals in the same area for 2005 to attempt to replicate our findings.

We recorded all new referrals from general practitioners (GPs) to mental health services among those aged 18–64 years in our sector. This included general and specialist psychiatric services, namely clinical psychology, psychotherapy, addictions and eating disorder services. Given the emphasis on social factors in the original model, we checked for a correlation between the levels of deprivation as measured locally by the Scottish Index of Multiple Deprivation (SIMD; <http://www.scotland.gov.uk/Topics/Statistics/SIMD/Overview>) and referral rates from individual GP practices.

There were 1541 new individual referrals of those aged 18–64 years, which is equivalent to 24.6 per 1000 catchment population per year (95% CI 24–26). New referrals alone exceeded the number predicted in the model. Spearman's rank correlation coefficient between the SIMD score of individual practices and referral rate was 0.44.

In an atmosphere of continual change in the National Health Service, we urge service planners to be mindful of the gross underestimation of current referral to psychiatric services by Goldberg and Huxley's model.

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O'SULLIVAN, T., COTTON, A. & SCOTT, A. (2005) Goldberg and Huxley's model revisited. *Psychiatric Bulletin*, **29**, 116.

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Policing psychiatric units

As clinicians studying outcomes of violence by patients admitted to hospitals, the benefits of the scheme described by Mann *et al* (*Psychiatric Bulletin*, March 2007, **31**, 97–98) appear initially impressive. We are aware of the benefits