ELIZABETH JONES, CLARE LUCEY AND LIZ WADLAND

Triage: a waiting list initiative in a child mental health service

AIMS AND METHOD
Long waiting lists and failure to attend appointments are a common problem in child and adolescent psychiatry. We introduced a novel ‘triage’ stage waiting list initiative to decrease the long waiting time for a first appointment at our child mental health service.

RESULTS
The waiting time to first appointment was significantly reduced and increased satisfaction with this process was expressed by clinicians, the referred families and referrers.

CLINICAL IMPLICATIONS
The reduction in waiting time was sustained over time and the triage process has now been implemented as routine practice. Following this implementation, there is no longer a lengthy waiting list for treatment after initial assessment. We would recommend this initiative, which screened referrals more efficiently and accurately, as a successful model for other child and adolescent services with long waiting lists.

Failure to attend out-patient appointments is a well-recognised problem for psychiatric services, especially child mental health services. This can result in considerable wastage of staff time and compounds the problem of long waiting lists. Multiple factors are involved in non-attendance for first appointments, including a lower level of maternal education, older age of the referred child, parental belief that intervention may worsen the problem and unrealistic expectations for a rapid treatment response (Ewalt et al, 1972). A long waiting time has also been found to increase the rate of non-attendance (Subotski & Berelowitz, 1990). Jones & Bhadrinath (1998) found that general practitioners’ (GPs’) main concern regarding prioritisation of child mental health problems was the time taken for non-urgent referrals to be seen. Several initiatives to decrease waiting time to first appointment and improve attendance at child mental health clinics have been described recently (Munjal et al, 1994; Wenning & King, 1995; Geekie, 1995; Potter & Darwish, 1996; Roberts & Partridge, 1998). We report on our novel initiative to reduce our waiting time to first appointment.

Our service is a community-based child and adolescent mental health service for a population of children aged 0–16 years in west London. We receive around 850 referrals per year. A long waiting time from referral to first appointment had evolved as demand exceeded local resources. Up to 1997, referrals were dealt with by similar methods to those described by Roberts & Partridge (1998). Referrals were reviewed daily by team members and a prioritisation system for waiting list placement was used. This decision was made on clinical grounds using information provided by the referrer. This process used up a considerable proportion of staff time and resulted in a long waiting time and high rates of non-attendance at first appointment. Figures from 1995–1996 showed that average numbers on the waiting list were 200. While 25% of patients were seen within one month of referral, 30% waited longer than six months, with some waiting up to nine months. In early 1996, a preliminary project was successful in temporarily achieving a reduction in the waiting list. Staff enthusiasm was harnessed and a more focused, defined and team-based waiting list pilot project was developed.

The pilot project consisted of a ‘triage’ style assessment. Families were invited to a one-off appointment to more fully assess the presenting problem. The triage process had several aims.

(a) To lessen the waiting time from referral to first assessment. This was in response to increasing pressure from referrers and families to be seen sooner.

(b) To assess more fully and accurately the reason for referral. This would enable a better judgement to be made about the appropriateness, urgency and treatability of the referral, and facilitate clearer management planning.

(c) To improve attendance rates at first appointments. By reducing the waiting time to first appointment and judging motivation to attend, it was hoped less clinical time would be wasted and non-attendance rates would improve.

(d) To prevent a deterioration in symptoms which might occur with a prolonged waiting time.

The study
A sample of new referrals not requiring immediate allocation for assessment and treatment were allocated to a specific triage event-day. Waiting list cases were also directed into the triage system. A key feature was the structural organisation of the event. It began with a multi-disciplinary group meeting to generate hypotheses about the families attending. The day ended with a similar meeting outlining the assessments and action plans needed. This structure enhanced the sense of staff group participation.

Two triage days per month were set aside to see these families with each professional seeing one family per half-day. This structure allowed the clinicians’ other work to take place as well. The referred child, the parents and other family members were invited to attend this
initial appointment. A standardised letter explaining the purpose of the session was sent to each family, together with a Strengths and Difficulties questionnaire (Goodman, 1997) and a short departmental questionnaire routinely used which invites the parents to describe their view of the problem. The appointment was not conditional upon the return of these questionnaires. The parent was asked to confirm intention to attend. If no confirmation was received, the administration staff contacted the parent by telephone to ask if they still wished to attend.

After the multi-disciplinary group meeting, the clinician met with the family for an hour-long assessment session, using a semi-structured interview, to gain a relevant overview of the presenting problem. All cases were then discussed with the consultant child psychiatrist and other team members as outlined and decisions were made on further management. The options included immediate allocation, priority or routine position on the waiting list, closure or referral to another more appropriate agency. The details of the interview and resulting decision were recorded by the clinician. The GP and family were informed of the decision by letter. At the end of each triage day, the participating clinicians completed a log of the information gained and discussed the individual clinician’s experience of the process.

The outcome of the triage initiative was compared with the activity in 1995–1996.

Findings
Over a six-month period, a total of 155 patients were allocated to the triage initiative. This ran alongside the original system for all other cases not allocated to the triage sample.

Of the 155 allocated 139 (89.7%) confirmed they would attend the appointment offered, 16 (10.3%) declined the appointment, of the 139 who confirmed, 126 (81.3%) attended, 13 (8.4%) did not.

The outcome decisions of the triage appointment were as follows (see Fig. 1): 13 (8.4%) were considered to require further assessment and were offered a second triage appointment; 39 (25.2%) were considered to require immediate allocation; 37 (23.9%) were placed back on the routine waiting list and 15 (9.7%) were given a prioritised place on the waiting list. Fourteen (9%) were considered not to require a further appointment and the case was closed while eight (5.2%) were referred on to a more appropriate service. Of those who did not attend, five (3.2%) were closed and eight (5.2%) were held for a further appointment. Thus, a total of 43 (27.7%) cases were closed.

At the end of the six months, the waiting list to first assessment averaged 56. Of the original 155 cases, 82 were removed from the waiting list.

Discussion
Of those who confirmed, an unusually high percentage of patients attended the first appointment (81.3%). This may have been due to a decrease in waiting time, but it should be noted that a considerable proportion of these patients had already spent some time on the waiting list. The higher rate of attendance is likely to have been affected by the efforts of the administration staff in telephoning those families who did not respond to the initial request to confirm attendance.

Slightly higher numbers than the pre-triage process were assessed as requiring immediate allocation. In triage, reasons given by the clinicians for deciding on immediate allocation included the judgement that useful work had already emerged out of a session with some families and this should continue without further delay. Some cases had already waited their full time on the waiting list and were therefore immediately allocated. Some were deemed urgent or complex and in a small proportion of cases family pressure may have prompted a decision to immediately allocate.

The triage process had the following outcomes: 43 cases were closed and a total of 82 cases were removed from the waiting list.

The families expressed satisfaction with the process overall and clinicians’ concern that those families placed back on the waiting list or closed would be dissatisfied was not realised.

The clinicians felt they were able to assess the appropriateness of the referral more accurately and therefore implement the correct course of management sooner. Team morale also improved as the structure of the process provided a sense of team activity and allowed the opportunity to share views on the cases and further management plans. This felt supportive and facilitated shared learning among staff.

The referrals also judged this initiative as worthwhile with the resulting reduced waiting list volume and time. The triage initiative resulted in a much shorter waiting time to first assessment for new referrals to the service.

This triage initiative has been implemented as standard practice for all referrals to our service. All new referrals are now assessed within 13 weeks of referral being received. Further spin-offs have also been realised: in the six months following the trial period the waiting list to first assessment averaged 56 and now there is no longer a waiting list for treatment following this initial
assessment. We would recommend this initiative as a successful model for others to use in decreasing waiting times and providing a more efficient and accurate screening process of referrals.

References


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POLASH M. SHAJAHAN, ANDREW M. MCINTOSH AND JONATHAN T. O. CAVANAGH

Admission patterns by psychiatric trainees
Are women patients as likely as men to be admitted for major mental illness?

AIMS AND METHODS
We hypothesised that the increased admission rate for men with major mental illness may be the result of men being preferentially admitted by psychiatrists. A questionnaire survey was devised and sent to all psychiatric trainees on the South-East Scotland rotation. The questionnaire contained a series of psychiatric vignettes representing conditions varying in severity of risk.

RESULTS
Seventy-eight per cent responded to the questionnaire. Trainees were more likely to admit patients representing a greater degree of risk irrespective of the gender of the patient.

CLINICAL IMPLICATIONS
The increasing admission rates for men with major mental illness is unlikely to be due to admission bias by trainees.

Findings
In-patient resources in psychiatry are increasingly limited, with only the most seriously ill or at risk patients being admitted in many regions throughout the country. Evidence is emerging for increased admission rates for young men with major mental illnesses in Scotland (Cavanagh & Shajahan, 1999). There may be many potential reasons for this, including increased morbidity in men, changing diagnostic patterns or even preferential admission of men. We hypothesised that the increased admission rate for men may be the result of men being preferentially admitted by psychiatrists, even though their ‘severity’ of illness may be the same as that of women.

The study
A questionnaire survey was devised and sent to all junior and higher psychiatric trainees (SHOs) and specialist registrars (SpRs) in the Lothian Region/ South-East Scotland rotation. The questionnaire contained four psychiatric scenarios or case vignettes (see Appendix). These vignettes represented a range of severity of risk in terms of self-harm. At one end of the range (Scenario 1) the risk of self-harm could be perceived as relatively low. At the other end (Scenario 4) the risk could be considered substantial. The psychiatrists were asked to rate along a five-point scale (definitely to definitely not) how likely they were to admit the person that the scenario related to. Half the psychiatrists received a questionnaire where Scenarios 1 and 3 related to female patients and Scenarios 2 and 4 related to male patients. The other half received a questionnaire where Scenarios 1 and 3 related to male patients and Scenarios 2 and 4 related to female patients.

One hundred and fourteen questionnaires were sent out randomly to 79 SHOs and 35 Registrars. Eighty-nine were returned representing a response rate of 78%. Figures 1a to d show the response patterns for the various case scenarios. The distributions did not follow a normal distribution and non-parametric statistics (Kruskal–Wallis) were used to analyse the data. The Kruskal–Wallis test showed a significant effect of admission by scenario ($\chi^2=244, P<0.0001$), but no overall effect on admission due to the gender of the patient ($\chi^2=0.86, P=0.35$). Figure 1a, Scenario 1, shows that the majority of psychiatric trainees were unlikely to admit the patient concerned irrespective of whether they were male or female. At the other extreme (Fig. 1d, Scenario 4) all trainees were either
'definite' or 'very likely' to admit, irrespective of whether male or a female. Scenarios 2 and 3 represented a more 'grey' area where there was a greater difference of opinion as to whether admission was appropriate or not. If anything, a trend was seen in a more likely admission for a woman than a man for Scenario 3.

Comment

Our hypothesis was not supported. Admission patterns for men and women are approximately the same. We managed a satisfactory response rate in terms of questionnaire surveys which represents the views of the majority of psychiatric trainees in this region. It is not surprising, and indeed reassuring, that psychiatric trainees are more likely to admit those patients with serious illness and who are obviously at risk of self-harm, and that there is no bias when it comes to assessing a man or a woman. It is of interest that there is less consensus when the case (Scenario 3) is less clear cut in terms of clinical risk of self-harm.

The increased first admission rate for men with major mental illness is unlikely to be due to preferential admission by psychiatrists and is more likely due to other reasons such as increased morbidity of major mental illness in men.

Appendix

Scenario 1

A 22-year-old male is referred with an eight-month history of low mood and feeling that life is not worth living. He has disturbance of sleep and appetite. On questioning he is not psychotic and does not have immediate suicidal plans. He has not responded to first-line antidepressants.

How likely are you to admit this patient?
- Definitely
- Likely
- Unsure
- Unlikely
- Definitely not

Scenario 2

A 20-year-old female is referred with a two-month history of low mood and feeling that life is not worth living. She has disturbance of sleep and concentration. On questioning she feels people are talking about her and she is contemplating suicide. She has been on fluoxetine 40 mg/day for the last four weeks.

How likely are you to admit this patient?
- Definitely
- Likely
- Unsure
- Unlikely
- Definitely not

Scenario 3

A 21-year-old male is referred with a four-week history of worsening auditory hallucinations and anxiety. He states that his mood is low. On questioning he feels neighbours are discussing him. He does not have any suicidal ideas. He was started on chlorpromazine 100 mg/day by his GP two weeks ago.
How likely are you to admit this patient?

- Definitely
- Likely
- Unsure
- Unlikely
- Definitely not

Scenario 4

A 20-year-old female is referred with a six-month history of bizarre behaviour and social withdrawal. She has boarded up the windows in her flat saying that people are spying on her. She has impaired sleep and appetite. On further questioning she has paranoid delusions and third person auditory hallucinations. She states that she is seriously contemplating suicide.

References


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An audit of anti-muscarinic drug use at the State Hospital

AIMS AND METHOD

This paper is based on two audits carried out in 1996 and 1998 at The State Hospital, Carstairs. Each audit looked at anti-muscarinic drug use within the hospital, in relation to approved prescribing standards issued in 1996. All patients within the hospital on anti-muscarinic drugs were identified at the time of each audit. These prescriptions were compared with the approved prescribing standards. In the 1998 audit additional information was obtained from the case notes and the consultants, when the approved standards were not met.

RESULTS

The percentage of patients on regular anti-muscarinic drugs, falling outwith the prescribing standards, reduced between the two audits. However, in 1998 a small number of patients were still outwith the approved prescribing standards set in 1996.

Anti-muscarinic drugs are intended for short-term use only (World Health Organization, 1990; Barnes, 1990; Bazire, 1998). They are widely used in psychiatric practice for the treatment of neuroleptic induced extrapyramidal side-effects (Barnes & McPhillips, 1996). However, these drugs have their own side-effects (British National Formulary, 1999) and in the long term may exacerbate serious movement disorders (Perris et al, 1979). In addition such drugs are sometimes misused by patients (Crawshaw & Mullén, 1984; Marken et al, 1996). Therefore, monitoring of anti-muscarinics in psychiatric practice would seem to be of considerable importance.

Two audits of anti-muscarinic use were carried out at the State Hospital, Carstairs – the sole provider of psychiatric care, in conditions of special security, in Scotland and Northern Ireland (Snowdon, 1995). The audit in 1996 indicated that some patients were prescribed these drugs for extended periods without clear indication. Approved standards for the correct usage of these drugs was circulated in 1996. The audit was repeated in 1998 and compared with these standards.

Although patients are reviewed regularly at the State Hospital, there is a system for a more comprehensive multidisciplinary review of the whole treatment/care package of each patient, at three monthly intervals. For this reason the standards that relate to anti-muscarinic prescribing focus on their continued prescription beyond three months.

CONCLUSIONS

An improvement in the prescribing practice of anti-muscarinics occurred following the introduction of prescribing guidelines. However, the guidelines were not fully met in the 1998 audit. This demonstrates the need for further audit and continued monitoring of anti-muscarinic prescription at the State Hospital.

Approved standards

1. After three months regular anti-muscarinic treatment, a reduction in dose or complete discontinuation of the anti-muscarinic should be considered at the patients case review. Following the
initial review, the continued use of the anti-muscarinic should be considered at subsequent case reviews. Patients taking a uniform dose and type of anti-psychotic, and an anti-muscarinic for three months or more, must be reviewed.

2. Only one anti-muscarinic should be prescribed in each patient.

3. The dose of anti-muscarinic should not exceed British National Formulary guidelines.

4. An anti-muscarinic should not be prescribed with clozapine unless an additional anti-psychotic is prescribed, or it is being used to treat hypersalivation.

5. The anti-muscarinic of choice at the State Hospital is procyclidine.

Objectives

(a) To assess adherence to the standards set for the use of anti-muscarinic drugs in 1996, and identify if a problem of inappropriate usage exists.

(b) To assess if the extended use of anti-muscarincs is occurring and if so, what reasons for this are given in the clinical notes or by the consultant.

(c) To see if the introduction of an approved standard improved prescribing practice.

The study

All patients on anti-muscarinic drugs on the 5 May 1998 were reviewed. These patients were identified with the assistance of the hospital pharmacist. Using the prescription kardexes, anti-muscarinic drug use was compared with the approved Standards 1–5. Where the approved standards were not met, the case notes were reviewed. If reasons for prescribing outwith the standards were not documented, the responsible consultant was approached to try and determine the reasons, if any. The results of this audit were compared with those from the earlier 1996 audit. In the 1996 audit, all patients on anti-muscarinic drugs were identified, on a given day, by the hospital pharmacist. Once again the prescription kardexes of these patients were used to compare with the Standards 1–5. However, in this first audit the case notes were not examined, nor were the consultants approached, regarding findings outwith the standards.

Findings

Adherence to the standards for the use of anti-muscarinic drugs

Standard 1 (see Table 1)

Standard 2

No patients were prescribed more than one anti-muscarinic in either the 1996 or 1998 audits.

Standard 3

No patients exceeded the recommended British National Formulary dosage guides in either the 1996 or 1998 audits.

Table 1. Numbers of patients on anti-muscarinics falling outwith the Standard 1 at the State Hospital

<table>
<thead>
<tr>
<th>Year</th>
<th>Total no. of patients in the State Hospital</th>
<th>Patients on anti-muscarinics, n (%)</th>
<th>Patients on anti-muscarinics outwith the standard n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996</td>
<td>227</td>
<td>74 (32.6)</td>
<td>36 (15.9)</td>
</tr>
<tr>
<td>1998</td>
<td>242</td>
<td>70 (28.9)</td>
<td>23 (9.5)</td>
</tr>
</tbody>
</table>

1. Without reference to case notes or consultant.

Standard 4

All patients on clozapine alone and on an anti-muscarinic had had problems of continuing hypersalivation in both the 1996 and 1998 audits (see Table 2).

Standard 5

The preferred anti-muscarinic drug was procyclidine in both the 1996 and 1998 audits (see Table 3).

Assessing if the extended use of anti-muscarinic drugs occurs and the reasons for it

A review of the last case conference on each of the 70 patients on anti-muscarinics in 1998 was made. Out of the 70 patients, three did not have a case conference as they had not been in the hospital long enough. For the remaining 67 patients the medication the patient was on, including anti-muscarinics, was documented clearly in the case conference notes. Medication changes made at the time of the case conference and proposed future changes were also documented. However, out of the 67 cases, specific reference to neuroleptic induced side-effects and continued prescription of anti-muscarinics was made in only three cases. Reasons for continued anti-muscarinic prescriptions outwith Standard 1 were sought from the relevant consultant (see Table 4).

Complex reasons given for prescribing outwith the standards at the State Hospital included:

(d) Previous experiences of severe extrapyramidal side-effects in patients when their anti-muscarinics were reduced.

(e) Short-term future plans to change a patients neuroleptic or dosage.

(f) Difficulty with particular patients being controlling over their medication/treatment. In these cases the benefits of neuroleptic medication were felt to outweigh the risks of non-adherence if the anti-muscarinic was reduced as dictated by the standard.

(g) Movement of patients within the State Hospital meaning they have acquired a new clinical team and are awaiting a case conference with that team.

Comment

The proportion of patients at the State Hospital on regular anti-muscarinics has fallen slightly since 1996.
Table 2. Use of clozapine in combination with anti-muscarinics and additional neuroleptics at the State Hospital

<table>
<thead>
<tr>
<th>Year</th>
<th>Patients on clozapine n (%)</th>
<th>Patients on clozapine alone and an anti-muscarinic, n (%)</th>
<th>Patients on clozapine, anti-muscarinic and an additional neuroleptic, n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996</td>
<td>25 (11.0)</td>
<td>2 (0.9)</td>
<td>Not available</td>
</tr>
<tr>
<td>1998</td>
<td>34 (14.0)</td>
<td>4 (1.6)</td>
<td>2 (0.8)</td>
</tr>
</tbody>
</table>

Table 3. Numbers of patients on various types of anti-muscarinics used at the State Hospital

<table>
<thead>
<tr>
<th>Year</th>
<th>Patients on anti-muscarinics, n (%)</th>
<th>Anti-muscarinic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Procyclidine, n (%)</td>
</tr>
<tr>
<td>1996</td>
<td>74 (32.9)</td>
<td>63 (27.9)</td>
</tr>
<tr>
<td>1998</td>
<td>70 (28.9)</td>
<td>65 (26.9)</td>
</tr>
</tbody>
</table>

Table 4. Reasons for prescribing anti-muscarinics outside Standard 1 at the State Hospital

<table>
<thead>
<tr>
<th>Year</th>
<th>Patients on anti-muscarinics in last 3 months n (%)</th>
<th>Recent starts on anti-muscarinic in last 3 months n (%)</th>
<th>Neuroleptic dose increase or neuroleptic type changed within last 3 months (n)</th>
<th>Continued hypersalivation on clozapine prescribed at constant dosage for longer than 3 months (n)</th>
<th>Complex reasons – longer than 3 months on static neuroleptic dosage (n)</th>
<th>No reasons evident from case notes/consultant (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996</td>
<td>74 (32.6)</td>
<td>3 (1.3)</td>
<td>35 (15.4)</td>
<td>–</td>
<td>–</td>
<td>36 (15.9)</td>
</tr>
<tr>
<td>1998</td>
<td>70 (28.9)</td>
<td>3 (1.2)</td>
<td>44 (18.2)</td>
<td>4 (1.7)</td>
<td>4 (1.7)</td>
<td>5 (2.1)</td>
</tr>
</tbody>
</table>

1. Only applicable to longer than 3 months on static dose neuroleptic and anti-muscarinic as previous audit did not review case notes or medical staff information. EPS, extrapyramidal side-effects.

Perhaps more significantly, there has been a reduction in the percentage of prescriptions of anti-muscarinics, which fall outside Standard 1, between the 1996 and 1998 audits. This may be a reflection of an increasing awareness of the prescribing guidelines or it may be a reflection of the increasing use of certain atypical neuroleptics which have fewer extrapyramidal side-effects. It may be the case that some anti-muscarinic prescriptions that fell within the standards are not clinically required, but this is outside the remit of this audit.

A direct comparison of patients outwith the anti-muscarinic prescribing Standard 1 in the 1996 and 1998 audits cannot be made other than to compare the initial number. This is because the 1996 audit did not look at case notes or seek medical staff opinion. In the 1998 audit it would seem that 10 out of the 23 patients outwith the Standard 1, have no clear clinical reason to continue their anti-muscarinic at its present dose without review. The remaining 13 have reasons given for the extended continuation of the anti-muscarinic at its present dose. Reasons such as continuing extrapyramidal side-effects or hypersalivation (clozapine only) would seem pharmacologically valid. Other reasons given, relate to other aspects of the treatment ‘package’ as a whole and their validity would be a matter for debate.

In terms of medical documentation at the State Hospital, it is the case that the three monthly reviews document all medications prescribed. They also record changes to medication at the time of the review, and for the short-term after the review. As stated before specific reference to anti-muscarinic prescription is rarely made. This is a problem which could easily be addressed, and doing so would aid prescribing practice.

Referring back to the objectives, it would seem there was an improvement in the practice of prescribing anti-muscarinics since the 1996 audit, and the introduction of the prescribing standards at this time. In both audits Standards 2–5 were adhered to rigorously. However, extended use of anti-muscarinics still occurred in 1998, although to a lesser degree than in 1996. This problem, which relates to Standard 1, involves a small but nevertheless, important, number of patients. In the 1998 audit reasons for the extended prescription of anti-muscarinics are given in over 50% of these cases. However, 10 patients are left requiring immediate review. The introduction of standards in 1996 may be responsible for this improvement although it is well recognised that despite publication of prescribing surveys/audits there is a general inertia of change to prescribing habits (Clarke & Holden, 1987).
**Recommendations**
There is a need for greater attention to anti-muscarinic prescribing at case conferences and the alteration of case conference treatment plans to incorporate this at the State Hospital. There is also a need for further audit or monitoring of anti-muscarinic prescribing practice at the State Hospital.

**Acknowledgements**
Sincere thanks to Morag Wright, State Hospital Pharmacist and her staff, for identifying the patients for the audit. I am also very grateful to Dr David Reid for his encouragement and constructive criticism of subsequent drafts which led to this paper being written.

**References**


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**Part-time training: will it lead to part-time consultant?**

**AIMS AND METHOD**
To determine the preference of flexible trainees in psychiatry for consultant posts. A questionnaire survey was conducted among all flexible trainees in psychiatry in the West Midlands Region.

**RESULTS**
The overall response rate was 19 out of 21 (90%). The majority 15 out of 19 (68%) hoped to gain such a post at the end of their training. Of those wanting a consultant post, 15 of the 19 (79%) would only consider working part-time. If such a part-time consultant post was not available, 12 of the 15 (80%) said they would consider a non-career grade post.

**CLINICAL IMPLICATIONS**
In the West Midlands there has been an exponential growth in the number of flexible trainees. Approximately a third are within psychiatry alone and most wish to continue flexible working patterns as consultants. This has major workforce planning implications for the future.

**The study**
A one-page postal questionnaire, accompanied by a covering letter was sent to all 21 flexible trainees in psychiatry. Names and addresses were supplied by the Assistant Postgraduate Dean for Flexible Training within the West Midlands Region. After six weeks a second questionnaire was sent to non-responders.

**Findings**
Nineteen trainees’ completed questionnaires were returned giving a response rate of 90%. Twelve of the 19
(63%) of the sample were higher trainees with Certificate of Completion of Specialist Training dates ranging from the 2000 to 2005. The majority of respondents (17/19, 89%) had given some thought to future consultant posts. The remaining two were both junior trainees at senior house officer level. Thirteen out of 19 (68%) intended to apply for a consultant post at the end of their training, with only 1/19 (5%) wanting a non-career grade post, 5/19 (26%) were undecided. Those in the undecided group tended to be in the most junior grades. Most trainees (15/19, 79%) wanted a part-time or job-share consultant post; 1/19 (5%) wanted a full-time post and 2/19 (10%) were undecided. Of those trainees expressing a preference for part-time working, 12/15 (80%) said they would consider a non-career grade post if no suitable part-time consultant vacancy existed. Thirteen out of 19 (68%) thought it would be difficult to gain a part-time post, while 3/19 (16%) thought it would be easy. Careers advice regarding future part-time consultant work during their training had only been received by two of the trainees. Only one of the 19 (5%) was aware of any literature on the subject.

Comments

Although our study only covered the West Midlands it confirms our original suspicions that a significant gulf exists between trainee expectations for part-time consultant posts and current availability. The majority of trainees in our survey aspired to part-time consultant posts, but many of these would consider a non-career grade position if a suitable consultant job was not available.

Although our response rate was good (90%), the sample size was small and may not be representative of flexible trainees nationally. Given the popularity of part-time training it is not surprising that the majority of flexible trainees want to continue working part-time, as consultants, on completion of their training.

There is a paucity of literature with which to compare our results. What small amount there is supports our finding that women will choose part-time non-career posts in preference to full-time consultant posts when no part-time consultant option is available.

Davidson et al (1998) found that while approximately 50% of women work part-time within hospital medicine, only 20% of hospital consultant posts are part-time. Recent figures suggest that women are more likely to be offered a place at medical school (McManus, 1998). It is, therefore, conceivable that (given adequate funding) the number wishing to pursue flexible training will increase.

Currently, there is a failure of medical work force planning to acknowledge the demand for a change in working patterns (Richards et al, 1997). The issue of part-time working, especially at consultant level is likely to become a serious work force planning issue.

Interestingly, the medical specialities with the highest proportion of female doctors are those which have the most recruitment difficulties (Davidson et al, 1998). Psychiatry already fails to recruit sufficient numbers to fill consultant posts. This situation will be worsened if few current trainees are able to obtain the flexible consultant posts they desire, and opt instead for a sideways move into a non-career post. This may lead to professional disillusionment and job dissatisfaction which will have serious financial implications for both employee and employer. It would seem an inappropriate use of resources to train and then waste these valuable potential consultants in a time of recruitment crisis.

References


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