Cost-effective prescribing

Singh et al’s discussion of cost-effective prescribing is timely. Small changes in prescription writing habits can produce significant savings without noticeable change in clinical practice. A clear example is that of venlafaxine modified release which is produced in both capsule and tablet form. These are bioequivalent but vary widely in cost. It has been calculated that switching from capsule to tablet would save our local healthcare economy about £148,000 a year. The only change required of doctors would be to specify tablets on the prescription, thus ensuring the more cost-effective preparation is dispensed. The twice-daily formulation is cheaper still but would require a greater degree of change and perhaps affect adherence. Fluoxetine provides another example: fluoxetine 10 mg, a dose often used in child and adolescent mental health services, is not available in tablet form in the UK. Importing a supply can result in a single prescription cost of several hundred pounds, but specifying fluoxetine syrup ensures the cost remains less than £10.2

Clearly, significant savings are to be had without compromising patient care or clinical autonomy. With regular support from a vigilant chief pharmacist and medicines management committee, the vagaries of the drug tariff could be navigated and the drug budget spent more cost-effectively.


Making a noise

Tom Burns’ rightly draws our attention to the quiet revolution that removed continuity of care from consultant psychiatrists with the ‘functional split’ between in-patient and community services. Despite my initial vocal resistance to the model, now that it is established in my place of work, I would not want to go back to being the prime focus for hundreds of patients throughout their mental healthcare journey. Since the functional model was introduced, I have felt more able to do a good job. Service users may be less worried about this change than many service providers.2

Continuity of care through one person can reduce patient choice and lead to overdependent relationships. Second opinions are much easier to get when patients transfer between hospital and community. Care coordinators are slowly taking on continuity of care, although they sometimes struggle with the authority of consultants and managers. We can help ameliorate that by working in a cooperative and consultative style. Some psychiatrists fear that the removal of consultant-centred continuity could help make psychiatrists redundant. Surely we need to value our expertise more than our personal carrying capacity. In future, we need to demonstrate our expert role by the good outcomes we achieve in collaboration with our teams, not simply by having lots of patients on our caseloads. We are better employed as consultants than care coordinators.

Locally, the functional model has enabled me to develop myself, my team and my service. The patient suicide rate has not increased. The more serious National Patient Safety Agency incidents (levels 3, 4 and 5) are less frequent. Patient and staff satisfaction is getting better. We could do more to address communication across the interfaces, but overall, my personal experience of the functional model has been positive.

I would prefer to improve the functional model, rather than re-combine hospital and community work. It would be satisfying to get it working well, before the next upheaval. In-patient consultants should give themselves leave in the community and community consultants should visit their colleagues in hospital. We should disentangle history taking and examination from engagement, so patients do not have to repeat their stories as they move between services – we could review our colleagues’ notes with the patient rather than start afresh. It is a different way of working that allows us to be involved in the care of many service users, but as part of a team.

A US politician, Pauline R. Kezer said, ‘Continuity gives us roots; change gives us branches, letting us stretch and grow and reach new heights.’ There is value in continuity and value in change. The Royal College of Psychiatrists Occasional Paper, Looking Ahead, calls for a systematic review of models of mental healthcare using standardised outcomes.3 However, at no point does the paper recommend that consultant psychiatrists again take on the central role of personally providing continuity of care for all patients. Instead, Looking Ahead explicitly values the expertise of consultant psychiatrists, our availability for rapid review and the advice we give to others (recommendation 3). That is something worth making a noise about.

1 Burns T. The dog that failed to bark. Psychiatrist 2010; 34: 361–3.


David Yeomans is Community Consultant Psychiatrist with Leeds Partnerships NHS Foundation Trust, email: d.yeomans@virgin.net
doi: 10.1192/pb.34.12.537a

Pessimism

Professor Burns is right to draw attention to possible damaging effects of separating consultant responsibility for in-patient and out-patient care. My past experience of both overall and out-patient-only responsibility supports the points he makes. Particularly striking was distress for patients at having to get to know a new consultant and go back over long-term histories at the particularly fraught time of admission, as
well as intractable problems of communication between consultants, and misunderstanding of the different impacts of symptoms and behaviour in the hospital and home settings.

Most fundamentally, a return to the earlier psychiatric pessimism about long-term illnesses is likely on the part of hospital consultants who deal only with those who relapse.

Burns T. The dog that failed to bark. Psychiatrist 2010; 34: 361–3.

David Abrahamson is a retired Consultant Psychiatrist formerly based in east London, email: david.abrahamson855@gmail.com
doi: 10.1192/pb.34.12.537b

The dog didn’t bark because it was usefully occupied

An instinctive medical conservatism compromising the ability of psychiatry to adapt for the future has perhaps been inadvertently exposed by Professor Burns.1 Very little of his article really stands up. The focus is on the ‘in-patient/ community ‘split’. He assumes that the split has or is likely to remain at the ward door. Dysfunctional relations between egocentric psychiatrists reminiscent of the most troubled splitting and projection associated with ‘psychopathology’ sound like a ‘mess’, and would be, if they were to become established or even desired practice. No doubt there are some examples of fractured systems like this. Burns may know of hard-bitten consultant psychiatrists favouring community treatment orders (CTOs) without proper clinical consensus between colleagues; but it is not logical to condemn a movement, a ‘silent revolution’ or otherwise, by reference to its worst exemplars. His reasoning is reminiscent of the Dangerous Dogs Act.

Why is the role of the in-patient consultant ‘obvious nonsense’? It is no such thing. The task of the in-patient consultant is to think clearly about the best interests of the patient in context: doctors should not be in-patient consultant psychiatrists unless they possess the skills to communicate with their community colleagues and hold their confidence. Burns is pessimistic about human nature and consultants in particular. He fears that they will not work well together, and culturally never have. Consider surgeons and anaesthetists. I can recall some examples of pretty odd behaviour; but out of necessity, either would accept or cope with the consequences of decisions taken by the other. Burns’ attachment to sustaining individual medical autonomy across the whole process of patient care is just not helpful and necessary. He refers to the Oxford Community Treatment Order Evaluation Trial (OCTET) study highlighting the need for psychiatrists to demonstrate tolerance and collaboration as if this were an unreasonable suggestion. These are characteristics that should be developed in all doctors, but especially psychiatrists. Is that a problem?

A further misunderstanding concerns bed numbers and pressure. I would contend that acute bed numbers have reduced for a variety of reasons in recent years, one being that the introduction of crisis teams has reduced the admission rate by managing the route into acute beds and offering a preferred alternative to admission for many, thereby of necessity setting a different threshold. The in-patient mix has consequently changed. Is this an argument for re-expanding in-patient care? Surely not, the idea that we take people into hospital to dilute the experience of others is absurd. There has been pressure on beds for as long as I can recall it first hand, since 1986, long before the changes Burns contests. He rightly dislikes confusing multiple ward rounds. It is hard to fathom why this is his experience in contemporary systems, other than through eccentric implementation of change. Is something strange happening in Oxford? If there is one in-patient consultant, there will be one ward meeting, or at least if there are more, they will feature the same consultant. This contrasts with old-style sector ward rounds, several per week, each to do with a small number of patients managed in contrasting ways quite arbitrarily by disconnected consultants interacting at times only to argue about what sector someone lives in. I recollect strong views being expressed about a patient moving over the road. That particular problem should be consigned to history.

Burns alludes to a continental professional and service model. The reason for the arguable historical success of the British approach, in so far as it has been a success, is not in the location or otherwise of splits in the system. It is in the existence of a social healthcare system in the NHS and a now strained sense of collectivism. It is in Anglo-Saxon empiricism, sceptical of medical obscurantist elitism feared by Burns, and an excellent and ever-necessary defence against pomposity and hierarchy building.

Finally, it is invidious to infer increased suicide rates from studies of discharge from examples of private sector units with no interest in supported discharge, or indeed follow-up. Considering NHS in-patient services, what is the evidence that suicides have become more prevalent, let alone that there is a causal link?

Burns may overestimate the importance that individual psychiatrists should attach to their role. The flipside of ‘continuity’ is the patient who is shackled to a disliked consultant for years without fresh thinking and no automatic second opinion. Burns concedes potential advantages rather gamely. He acknowledges that we may all need a rest from each other, doctors and patients included. In past years this happened unofficially – let us recall without nostalgia the patients who revolted from one trainee to another for years on end without a shred of consultant continuity. They taught me a lot, but such practice is now hopefully extinct. The care programme approach (CPA) involving continuity with nurses or social workers as an alternative strand to the discussion bears mentioning. Indeed, CPA is probably the key to consultants having a consultant role rather than acting as a kind of parallel, ghettoised general practitioner for people with enduring psychosis.

People do, of course, need stability in their key relationships. I am not at all sure that psychiatrists should appropriate a role, which properly lies ‘out there’; our difficult job is to try to help make that a reality and then quietly withdraw. Good psychiatrists are quite capable of sharing thoughts and plans, do not unilaterally and thoughtlessly impose directives on their colleagues, are considerate of their own limitations and ultimately the very conditional nature of the impact that we personally should aim to have on peoples’ lives. When the water closes over us as if we were never there, we succeed. We have to see ourselves as less linear and more systemic, less unique and more integrated, and act humbly mindful of all,
which may involve a healthy modesty and ability to share and even to let go.

1 Burns T. The dog that failed to bark. Psychiatrist 2010; 34: 361–3.

Andrew Blewett is Consultant Psychiatrist, Devon Partnership NHS Trust, email: andrew.blewett@iphs.net
doi: 10.1192/pb.34.12.538

Two heads are better than one

An article starting with a quote from Sherlock Holmes always grabs my attention and Burns’ article is no exception.1

We made the in-patient/out-patient split in Greenwich in 2006, which resulted in my relinquishing my in-patient work. Initially, I was not at all keen on the idea, for the very reasons laid out by Burns. As time has gone on, however, I have completely changed my mind.

The main positive feature for me is that one has the benefit of a very experienced consultant colleague reviewing the case, including the diagnosis and the management plan. When there is agreement, I feel reassured and move on with improved confidence. When there is a difference of views, I have the opportunity to examine what is being said and to learn from it.

I thought many patients would hate it, but in the 4 years that have elapsed since the change, only one or two have complained to me about it. It has been a helpful change.

1 Burns T. The dog that failed to bark. Psychiatrist 2010; 34: 361–3.

Phil Steadman is Consultant General Adult Psychiatrist, Greenwich Recovery Team, Oxleas NHS Foundation Trust, London, email: phil.steadman@oxleas.nhs.uk
doi: 10.1192/pb.34.12.539

Towards integrated care in Europe

The split responsibility for in-patient and out-patient care is one of the most serious problems facing mental healthcare in Europe. It is a major obstacle in the continuity of care, particularly with severely mentally ill patients.

I have been involved in mental health services research for 30 years. During that time, I have observed increasing efforts to overcome this split responsibility. There are several ongoing evaluations of ‘integrated care’ all over Europe, which have been developed to overcome this divide. Britain has always set a good example in integrated care and it would be a great pity to see the benefits eroded by a return to the way it was.

Wulf Rössler is Professor of Clinical and Social Psychiatry, Psychiatric University Hospital Zurich, Switzerland, email: roessler@dgsp.uzh.ch
doi: 10.1192/pb.34.12.539a

Do we stand by the values upon which the College was founded?

The association between the non-restraint movement and the formation of the Royal College of Psychiatrists has never been formally acknowledged in either current or past literature. This movement was a significant step in the humane treatment of patients within the psychiatric system and a focus point for the development of other forms of treatment for aggression and mental disorder.

The movement originated in York Asylum in the early 1800s, started by Pinel and Tuke, and was then taken up by Lincoln Asylum’s lead physician, Edward Charlesworth. From 1828, also the time of Parliament attempts at passing legislation to improve monitoring of madhouses, Lincoln Asylum had gradually reduced the use of mechanical restraints, until their complete abolition in 1838.2 By 1839, interest had been generated, and Dr John Connolly visited from Hanwell Asylum in Middlesex. After witnessing Lincoln’s progress, Connolly set about abolishing the use of mechanical restraints in Hanwell.3 By 1841, Lincoln was not the only asylum to abolish the use of restraints: Hanwell, Montrose and Northampton (now St Andrews Hospital) had joined the non-restraint movement.3

In early 1841, Samuel Hitch, resident superintendent of the Gloucestershire General Lunatic Asylum, proposed the establishing of an association of ‘Medical Gentlemen connected with Lunatic Asylums’.4 He sent a circular to 88 resident medical superintendents and visiting physicians in 44 asylums in June 1841, requesting their participation in his proposed association. The first annual meeting of the Association of Medical Officers of Asylums and Hospitals for the Insane took place on 4 November 1841, where it was announced: ‘The members here present have the greatest satisfaction in recording their appreciation of, and in proposing a vote of thanks to those gentlemen who are now engaged in endeavouring to abolish [mechanical restraint] in all cases.’4

This association later became the Royal College of Psychiatrists (1971) and this clear statement supporting the abolishment of the use of mechanical restraints heralded a new era.

The use of mechanical restraints remains current given the specific references in both the Mental Health Act Code of Practice and National Institute for Health and Clinical Excellence guidance, despite the extremely limited evidence base. It is helpful to be reminded that the College began with such benevolent principles: challenging the status quo and striving for the very best for our patients.


Jaspreet Singh Phull is ST6 in Forensic Psychiatry, Nottinghamshire Healthcare NHS Trust, Leicester, UK, email: jas.phull@notts.nhs.uk
doi: 10.1192/pb.34.12.539b

Defining coercion

To define coercion as a subjective response to a particular intervention that is an unfortunate but necessary part of the care of people with psychiatric illness is astonishing!7 This Orwellian definition cannot go unchallenged.
Dictionaries define coercion as: ‘the act of compelling by force of authority; compulsion’; ‘the act, process, or power of coercing - . . . arm-twisting, force, compulsion, constraint, duress, pressure; ‘power based on the threat or use of force’; and so forth.

‘If slavery is not wrong, nothing is wrong’, declared Abraham Lincoln. Slavery is depriving a person of liberty because of who he is, not because of what he does or has done. If psychiatric slavery — involuntary mental hospitalisation — is not wrong, nothing is wrong.2


Thomas Szasz is Professor of Psychiatry Emeritus, State University of New York Upstate Medical University, USA, email: t.szasz@aol.com
doi: 10.1192/pb.34.12.539c

Why are psychosocial assessments following self-harm not completed?

Mullins et al’s study of accident and emergency (A&E) presentations following self-harm added to the evidence for poor uptake of psychosocial assessments in the initial management of self-harm.1 Of particular concern was the finding that single men under 45 represented 39% of those not assessed. Although suicide rates among men in the UK fell between 1992 and 2007, the 2008 figures show a rise to 17.7 per 100,000, with highest rates seen in men aged 15–44.2 A young man’s presentation to A&E following self-harm is a valuable opportunity to offer interventions which reduce his risk of repetition. The paradox is that with many of these opportunities being missed researchers cannot evaluate the effectiveness of interventions to reduce repetition in this group.

Those who discharge themselves from A&E before completed assessment are 3 times more likely to repeat self-harm in the following year than those who are assessed.3 It is possible that impulsive personality traits are more heavily implicated than the lack of an assessment, but we need to know more about this group’s behavioural characteristics so that we can learn how to engage them as soon as they present. From the Mullins et al study it is not clear whether patient factors or staff factors were more influential in determining completion of a psychosocial assessment. The National Institute for Health and Clinical Excellence (NICE) recommends that patients who self-harm are ‘treated with the same care, respect and dignity as other patients’,4 and reforms to medical and nursing training in some areas of the UK have managed to achieve cultural change.5 This is crucial because a humiliating or uncomfortable experience in A&E is likely to dissuade a patient from presenting should they self-harm again, and in cases of overdose this may increase mortality risk.

It is striking that of the 341 patients in Mullins et al’s study who did not receive a psychosocial assessment, 141 (41%) subsequently presented within the year of data collection having self-harmed, of whom 74 (52%) slipped through the net a second time. We are unclear of the demographic characteristics of this subgroup, or whether there was a tendency for these individuals to leave A&E at the same stage in the referral process. However, if a study of this kind was repeated across a larger geographical area, it could be sufficiently powered to reveal valuable predictors which would help A&E staff decide which patients to fast-track.

Finally, NICE recommendations on the communication of findings after self-harm assessments require auditing in future similar studies. A patient’s general practitioner (GP) or community mental health team may remain completely unaware of their presentation to A&E following self-harm unless a copy of the assessment is communicated to the relevant professionals. Even if the full psychosocial assessment was not performed, an outline of the presenting complaint would be of value. Armed with this information, a GP or key worker would be able to discern any patterns emerging in self-harm presentations, sometimes to many different hospitals, and would be in a unique position to manage apparent escalations in risk.


Alexandra L. Pitman is MRC Research Fellow, Department of Mental Health Sciences, University College London, email: a.pitman@medsch.ucl.ac.uk
doi: 10.1192/pb.34.12.540

Let’s target screening more effectively

I was very interested in the paper by Gumber et al,1 which examined the monitoring of metabolic side-effects of anti-psychotics in patients with schizophrenia. I commend them for their attempts to follow guidance for this monitoring and I agree that metabolic side-effects are important considerations for this group of patients. However, my critical review of the evidence of risk to patients with mental illness does not support the use of such widespread monitoring.

I will use the example of lipid monitoring to illustrate this. A large general practice study in the UK2 found that the relative risk of death from cardiovascular disease in people with mental illness when compared with controls was highest in younger people and reduced with age to a point that was not statistically significant in people over the age of 75. The authors of that study claim that the three-fold increase in deaths for people under the age of 50 is the most worrying. This may be so, but the finding is worthy of closer scrutiny, especially when the implications for screening are being considered. In fact, the absolute risk of death from coronary heart disease in people with mental illness aged 18–49 was 0.1% over a median follow-up period of 4.7 years.

European guidelines for prevention of heart disease3 recommend monitoring of lipids only when the 10-year risk reaches 5% or more. It would seem difficult therefore to justify routine monitoring of mentally ill people aged 18–49.
Also of concern is the lack of evaluation of harm to patients caused by what is essentially a screening programme of high-risk individuals. Such programmes are known to be associated with harm in a variety of forms. These include overdiagnosis, overtreatment and anxiety concerning the illness being investigated.1

Last, for a patient to give informed consent to participate in this kind of programme, they should be informed of the uncertainties inherent in it and the likelihood or otherwise of benefit to them of such a screening.

It is time to take stock and critically review which, if any, of these investigations are necessary for our patients.


Paul F. Reed is Consultant Psychiatrist with Lancashire Care NHS Foundation Trust, email: paul.reed@lancashirecare.nhs.uk
doi: 10.1192/pb.34.12.540a

Scarcity of evidence base on management of acutely disturbed patients

Brown et al give a useful insight into the practice at seven intensive care units all over the country.1

Their results show that 22% of patients were given rapid tranquillisation using the intramuscular route and 68% were not given any rapid tranquillisation medication at all. The results table is confusing and the numbers do not add up; 3% appear not to have been given any medication at all, which causes concerns about the referral process to psychiatric intensive care units (PICUs) and whether patients were appropriately placed.

The study does not clarify the legal status of the patients and does not throw any light on the level of aggression of the patients in PICUs.

The most common diagnosis was schizophrenia/schizoaffective disorder (54%), followed by mania (19%) and substance misuse (8%). The diagnosis for 19% of patients has not been provided in the study.

Rupali Acharya CT2 Psychi atrist, Trafford, Manchester, email: rupa_acharya@hotmail.com, Khurram Tanveer Sadiq Locum Consultant Psychiatrist, Trafford, Manchester

doi: 10.1192/pb.34.12.541

Authors’ reply

We are keen to encourage a wider discussion of the issues around the treatment of patients admitted to psychiatric intensive care units (PICUs) and welcome the opportunity to address points raised by Acharya & Sadiq. In writing the paper1 we made a series of judgements about how best to present a large volume of data in an easily assimilated form and we are sorry if some of these decisions led to a lack of clarity.

One of the main findings of the study was that most PICU patients are safely managed without recourse to forced intramuscular (IM) medication, indeed that some patients are managed without any psychotropic medication at all. The study only collected data about treatment while the patients were in a PICU (this was a pragmatic decision as many patients came from and returned to distant units where data collection was not feasible). We suspect that some of the patients who did not receive any psychotropic medication in the PICU had received medication before transfer, possibly in the form of medium- or long-acting antipsychotic injection. Others will have received medication after transfer to the acute ward. The diagnoses of those patients who did not receive any medication were: schizophrenia (1), depression (2), drug-induced psychosis (1), substance dependence (2), personality disorder (2), anxiety (1) and adjustment disorder (1). The numbers in Table 1 do not always add up to 100% because some patients appear in several categories, for example: they were given IM rapid tranquillisation and IM zuclopenthixol acetate. All figures were rounded to the nearest 0.5%; with this caveat we are confident that the appropriate figures (from text and table) do add up to 100%.

The primary diagnoses of patients aggregated into the category ‘other’ were: learning (intellectual) disability, dementia, Asperger syndrome, obsessive–compulsive disorder, anxiety, adjustment disorder, and intoxication with drugs or alcohol.

We address the legal status of the patients and the level of behavioural disturbance more fully in a companion paper.2 With respect to the legal status of the patients, the findings were: 10 informal (3%), 7 on Section 5 (2%) 123 Section 4 (37%), 158 Section 3 (48%), 1 Section 4 (<1%), 9 Section 37 (3%), 19 a range of forensic sections covering different transfers from prison (6%).

With respect to measurement of behavioural disturbance and mental state, we used the Brief Psychiatric Rating Scale (BPRS) and those subscales (hostility score, three-item Factor V cluster and five-item hostility cluster) which focus on behavioural disturbance. The mean BPRS score fell from 58.2 to 39.8 on transfer from PICU; the respective figures for the hostility score, Factor V and hostility clusters were: 4.2 to 1.8, 9.2 to 5.5 and 17.3 to 11.1.

We hope that these details clarify the points raised by Acharya & Sadiq.


Steve Brown is Consultant Psychiatrist, Hampshire Partnership NHS Trust, email: Steve.Brown@hantspt-sw.nhs.uk
doi: 10.1192/pb.34.12.541a

Comment on the evaluation of the Time to Change anti-stigma campaign

The study by Abrah am et al1 suggests that a single exposure to selected Time to Change campaign material (those including the ‘1 in 4’ message) delivered via post was not effective at improving attitudes towards people with mental illness.
Findings were based on a sample of 250 adults recruited through various adverts. The study showed that attitudes were not significantly better than in a group of the UK general public previously recruited for scale validation.

We are undertaking the overall evaluation of the campaign. Our evaluation design is based on a conceptual framework which describes stigma as problems of knowledge (ignorance/misinformation), attitudes (prejudice), and behaviour (discrimination). Therefore, in addition to measuring prompted campaign awareness, our evaluation included measures of mental health-related knowledge (measured by the Mental Health Knowledge Schedule), attitudes (measured by the Community Attitudes towards Mental illness scale) and behaviour (measured by the Reported and Intended Behaviour Scale). To address the multifaceted nature of the campaign, we use several levels of evaluation, including assessments of: the overall programme at a national level, specific target groups (e.g. medical students, trainee teachers) and regional and local interventions.

Our initial evaluation of the campaign in Cambridge used a pre/post-evaluation design among the campaign target population. These findings suggested modest but significant changes in this group. An important finding was that although campaign awareness was not sustained following the first phase of activity, significant and sustained shifts occurred for knowledge items 2 weeks following the campaign. There was a 24% (P < 0.001) increase in the number of persons agreeing with the statement ‘If a friend had a mental health problem, I know what advice to give them to get professional help’, and a 10% (P = 0.05) rise in the number of people agreeing with the statement ‘Medication can be an effective treatment for people with mental health problems’. Over this short-term activity, changes were not evident for attitudinal or behaviour-related questions.

Another difference between our evaluation and that of Abraham et al is that we found familiarity with mental illness to be associated with less stigmatising responses. Therefore, our findings suggest the possibility of significant further progress via more openness, disclosure and social contact. It is clear from these studies that further investigation is needed to address the most effective dissemination and communication of anti-stigma messages. Additionally, evaluation of the maintenance of changes over time and the additive effect of subsequent bursts of campaign activity will help us understand more about the effectiveness of this campaign in the long term. We are currently analysing data collected over the first year of the campaign.

Abraham et al also cite our paper comparing public attitudes in England and Scotland, and state: ‘Unfortunately, there have been reports that national anti-stigma campaigns are not particularly effective’. In fact, this paper shows the opposite, namely that ‘the results are consistent with early positive effects for the See Me anti-stigma campaign in Scotland’.

Declaration of interest
G.T. has received grants for research purposes for stigma-related research in the past 5 years from Lundbeck UK and from the National Institute for Health Research, and has acted as a consultant to the UK Office of the Chief Scientist. S.E.L., D.R., C.H. and G.T. are part of the independent Time to Change Evaluation Team and are supported by a grant from Big Lottery, Comic Relief and Shift. The funding sources had no role in the writing of this Comment.


Role players’ experience of psychiatric examinations
Professional role players are increasingly being employed in psychiatric training. There have been several studies of their experience. A Dutch study showed an ‘unexpectedly high’ rate of reported mild stress in those playing psychiatric roles. An American study found that role playing mania and depression could be exhausting and that being more than 40 minutes in role with more than three or four repetitions was stressful.

We were interested in the experience of UK professional role players. We conducted semi-structured interviews with ten professional role players, six women and four men, followed by two focus groups with the same individuals. They were taking part in local mock Objective Structured Clinical Examinations (OSCEs) and had between 5 and 10 years’ experience of simulating patients with psychiatric disorders several times a year. They were recruited and trained by a professional trainer with a background in psychiatry.

Generally, the role players we interviewed felt appreciated and well looked-after at psychiatric OSCEs. They emphasised the value of seeing the full scenarios beforehand, including the instructions to candidates and examiners as well as examiners’ score sheets. These inform their training sessions. Guided, collective training is crucial; they prefer not to rely on their imaginations to work out how a particular patient would behave. Role players’ instructions should include directions on how to act the role; they felt that portraying the appropriate affect is important. Too long a history can make them anxious lest they forget bits; this detracts from their capacity to think and feel themselves into role.

Thinking and feeling oneself into role is a key aspect of method acting. The researchers in the Dutch study thought that method acting may have contributed to their role players’ reported stress. They played ‘emotionally and psychologically complex roles’ only occasionally. Another study reported that role players find it difficult to ‘turn off characterisation’.

COLUMNS
Correspondence
However, an experienced UK role player has argued strongly in favour of method acting in order to give convincing performances. She considers these simulations appropriate even for amateur actors so long as they have a sense of humour and the capacity to ‘switch off’ afterwards.5

In keeping with American professional role players,4 ours liked their work and felt it had allowed them to develop greater empathy towards people with mental illness. They said they had come to appreciate the human exchange that seemed to them central to a psychiatric consultation and felt more able to deal with psychiatric problems experienced by friends and family. They felt that psychiatric role playing can be physically demanding, much of the simulation being non-verbal. They found some very intense scenarios distressing, disturbing and demanding, much of the simulation being non-verbal. They regarded psychiatric role playing as interesting and satisfying. Although they reported no continuing stress or adverse consequences from their work, they agreed collectively that only experienced role players should undertake psychiatric roles. So whether a role player is stressed or distressed by simulating may reflect his or her experience. The individual’s emotional stability and buoyancy may also be important. Their trainer writes that ‘an individual with baggage from personal experience may need more support when de-roling and, in our experience, may be unsuitable’.5

Ours is the first study of the experience of UK role players. Its main limitation is that it draws on a small number of role players from only one programme and may therefore not be representative of the UK as a whole. Also, OSCEs have now been replaced by Clinical Assessment of Skills and Competencies (CASCs) in the Royal College of Psychiatrists examinations. Nonetheless, there are sufficient similarities between OSCEs and CASCs to render our study still relevant.

Declaration of interest
S.M. has 6 years’ experience delivering mock OSCEs and CASCs, working with role players from RolePlay North.


Sally Mitchison is Consultant Psychiatrist in Psychotherapy, Cherry Knowle Hospital, Ryhope, Sunderland, email: sally.mitchison@ntw.nhs.uk, Priya Khanna is specialty registrar (ST6) in general adult psychiatry, Queen’s Medical Centre, Nottinghamshire Healthcare NHS Trust, Nottingham. doi: 10.1192/pb.34.12.542

Staff attitudes to recovery
We read the paper by Gudjonsson et al1 with interest. We wish to highlight the findings of our study in Ireland, which examined the knowledge and attitudes of mental health professionals (n = 153, nurses, doctors, social workers, occupational therapists and psychologists) to the concept of recovery in mental health across both in-patient and community settings.2 We used the Recovery Knowledge Inventory (RKI),3 an instrument developed in the USA but which we found useful for an Irish population, and which has also been found to be of use in European and Australian populations.5 The RKI was developed to gauge recovery-oriented practices among providers. It assesses four domains of understanding: roles and responsibilities in recovery; non-linearity of the recovery process; roles of self-definition and peers in recovery; and expectations regarding recovery. It comprises 20 items, each of which is rated on a 5-point Likert scale.

Our study findings concurred with Gudjonsson et al in finding that respondents viewed recovery positively as a philosophy of care for delivering mental health services. Participants in our study indicated their positive approach to recovery and expressed a need for more training, acknowledging the need for interprofessional learning as a team and the need for a multidisciplinary team approach to care. Respondents were less comfortable with encouraging healthy risk-taking.

However, whereas Gudjonsson et al report that experience of working in forensic services was not significant to total scores, in our study less experienced staff scored higher in having more positive attitudes and knowledge regarding recovery. Also of interest was that females and non-nursing professionals scored higher than nursing professionals in our study. We found no significant difference between in-patient or community-based staff; 22% of our staff had received training in recovery, compared with 37% in Gudjonsson et al’s study. We did not compare results of those with training and those without, sharing the concern that those who had received training may have been positive about recovery before training.

Both studies discuss decision-making and its challenges around choice and control, and both are in strong agreement regarding hope and optimism being central to the process. Finally, both studies support the idea that irrespective of the specialty (or indeed country), the delivery of a recovery approach to care can be implemented, and knowledge and attitudes of mental health professionals are key in this process.

We look forward to the findings of the prospective study on the recovery approach currently under investigation by Gudjonsson and colleagues, and further discussion on this important topic.

5. Anne Cleary is Advanced Nurse Practitioner (Candidate), Recovery and Rehabilitation in Psychosis, Galway Mental Health Services, Ballinasloe, Co Galway, Ireland, email: anne.cleary@hse.ie; Maura Dowling is Lecturer in Nursing, Postgraduate Coordinator, School of Nursing and Midwifery, National University of Ireland, Galway. doi: 10.1192/pb.34.12.542a