COLUMNS

Correspondence

The Mental Health Recovery Star: great for care planning but not as a routine outcome measure

Dickens et al’s paper reporting on the internal validity of the Mental Health Recovery Star provides evidence for its internal consistency and factor structure. The authors state that it is assessing a single underlying recovery-related construct. However, there is a problem with this statement, since recovery in this context is, by definition, a subjective construct. For this reason, the application of any predetermined constructs (the ten domains of the Recovery Star) can only be considered to be assessing an individual’s recovery if those domains happen to coincide with an individual’s own priorities. A separate study (currently under review for publication) has investigated the external validity of the Recovery Star and found interrater reliability of nine of the ten domains to be below the generally accepted level (intraclass correlation coefficient > 0.7).

Dickens et al present findings from routinely collected data and suggest these are evidence of the Recovery Star’s sensitivity to change in an individual’s progress over time (i.e. its responsiveness). The problem is that unless the same member of staff was involved in repeat ratings, these findings are likely to be invalid given the issues with interrater reliability. In addition, responsiveness to change needs to be corroborated by an established measure. Finally, if earlier ratings were discussed between the staff and service user before re-rating (as is encouraged through the training and manual accompanying the Recovery Star), then neutrality is likely to have been reduced, as both may have an investment in showing that progress has been made. One further, fundamental issue is that the ‘ladder of change’ used to assess progress in each of the ten domains has not been validated psychometrically.

The Recovery Star is very popular and has merit as a tool to enhance discussion of recovery goals between staff and service users. However, although Dickens et al’s findings have helped with understanding some of the Recovery Star’s psychometric properties, they do not provide evidence for its adoption as a routine outcome measure.


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Authors’ response: Dr Killaspy and colleagues make some important points about the Mental Health Recovery Star, but they adopt a surprisingly dismissive tone about this innovative user-led tool and about our study. With careful caveats, we have argued from naturalistic data that the tool is measuring an underlying construct, and that it has the potential to record reported change. Killaspy et al criticise claims that we simply have not made. Our analysis was not intended to put the psychometric properties of the Mental Health Recovery Star beyond doubt. The development of the tool has employed a user-based approach and, as such, has lacked some of the formal and restrictive academic rigour associated with traditional psychometric testing. We would welcome further research and development to address this.

It is our understanding that the interrater reliability testing cited by the authors is largely based on staff-only ratings of service users’ recovery journey. This is not how the tool is intended to be used. It is surprising that Dr Killaspy and colleagues would choose to evaluate a tool in a way which goes against the directions for its use. That intraclass correlation coefficient results fall short of the required 0.7 could reflect the inherent inaccuracy and instability of having sensitive personal recovery dimensions estimated by professionals without discussion with the service user. It is unclear how this fits with recovery as a construct built on individual service users’ own priorities. Surely user involvement in the measurement of recovery should be central to the definition of their outcomes.

In relation to sensitivity, it is true that there is a lack so far of proven external validity for the Recovery Star. Again, our paper makes no claims about external validity but merely comments on the fact of change between readings and the promise that this holds. We agree that reported changes are small and that the underlying ‘ladder of change’ model remains untested. However, it is useful to provide a clear and accessible model of change, which is supported by training and the Recovery Star Organisational Guide. Importantly, this instructs that second readings are taken without reference to the first.

We would like to see future versions of the Recovery Star and other recovery tools that are both psychometrically robust and, crucially, of practical use and relevance to mental health service users and their carers. There is little point in adopting a scientific gold standard for tracking recovery outcomes if it eschews the involvement of people in appraising their own recovery.

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Psychiatric in-patients and the criminal justice system: are there any downsides?

The paper by Wilson et al highlights the serious issue of in-patient violence. The potential benefits of involving the criminal justice system are well laid out and the suggested
approach is likely to be useful in practice. Unfortunately, the paper fails to look at the possible downsides of such a practice.

Potential adverse outcomes include short- and long-term stigma for the individual patient and loss of therapeutic relationship between the patient and clinician. These are likely to result in poorer services and longer periods of detention. The critical step in deciding whether to refer a patient to the criminal justice system will be the clinician’s judgement of non-trivial violence. Good training can reduce lack of consistency but long-term follow-up and critical examination of this practice will ensure that adverse outcomes are kept to a minimum as we juggle to find the ethical balance here.


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Prosecuting violent in-patients: the importance of staff attitudes

The editorial by Wilson et al1 highlights important dilemmas faced by mental health professionals in relation to reporting violence perpetrated by mentally disordered patients. We welcome the proposals made by the authors, but unless there is a significant change in staff attitudes to reporting non-trivial violence perpetrated by psychiatric patients, progress in this area is unlikely to occur.

Our observation is underpinned by the results of two surveys which we carried out in a medium secure unit in Middlesbrough in 2006 and 2008. There were 80 incidents of assaults on staff by in-patients, the majority of incidents in Middlesbrough in 2006 and 2008. There were 80 incidents of assaults on staff by in-patients, the majority of incidents in Middlesbrough in 2006 and 2008.

In both surveys, approximately a third of respondents considered being assaulted as an ‘occupational hazard’, but encouragingly this attitude was reported only by a quarter of respondents in 2008. Although 84% of nursing staff understood that they had a ‘right to report’, a fifth believed that reporting incidents was a bureaucratic exercise without any benefits and for 60% the required reporting forms and procedures were difficult to complete. Staff were more likely to report incidents perpetrated by patients with personality disorder than those with other mental illness. About 20% of staff stated that they would only report incidents which resulted in physical injury. Only 40% believed that reporting incidents would strongly deter patients from re-assaulting. Some of these free-text comments capture the ambivalence in this area: ‘I came to the nursing profession to help patients, not to be a punch bag’; ‘I would report only if the assaults were due to “badness” not “madness”’; ‘Disillusioned towards the police dealing with incidents’; ‘Waste of time’; ‘Zero tolerance should mean zero tolerance’.

In summary, whereas we acknowledge the value in developing robust policies, procedures and systems to address this important issue, significant progress in this area is unlikely to occur unless considerable efforts are made to shift attitudes of mental health professionals. Campaigns and systems to report and reduce violence are akin to taking a horse to water. Making a change will require a change of attitudes in relation to reporting violent incidents to the police. We propose that this can be achieved by discussing patient assaults in staff induction training, appraisal, supervision sessions and trust audits.


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Discrimination between psychotropic and non-psychotropic treatment by patients

Perecherla & Macdonald1 state that they found no evidence that patients discriminated between psychotropic and non-psychotropic treatment. Elsewhere, a lack of concordance with psychotropic medication has been reported to be as high as 75% over the course of a year.2 Although this may be on a par with adherence to non-psychotropic medications, there were significant factors which were not taken into consideration in Perecherla & Macdonald’s study.

Only patients who could communicate in English were included. This may have excluded patients from ethnic minority groups and other backgrounds, thereby ignoring their cultural and religious beliefs regarding medication. This surely must reduce the relevance of the results to populations with a significant proportion of ethnic groups. Further, the authors were unable to ascertain the duration of treatment in participants. This is an important factor as adherence improves with development of insight.3 The opposite is true of acute relapse.

In addition, it is not clear whether the sample was drawn from acute or long-stay wards and whether it consisted of patients who were stable on psychotropic medication and had insight or were acutely unwell. It is quite possible that most of the sample were patients who were stabilised on a drug regime, had insight and knew the purpose of their psychotropic medication. However, this may not be the case in acute episodes of care where the patient often lacks insight and questions the need to continue psychotropic medications. The authors state that in case of participants on more than two psychotropics, the ‘longest-term treatment option’ was selected. We fail to understand how this was established if duration of treatment was unknown. In the example given of a patient with bipolar disorder, the mood stabiliser was selected rather than the antipsychotic as the primary treatment; this was based on the assumption that mood stabilisers had been used first. However, it is well known that many patients are treated with antipsychotics as first-line medication. It is quite
possible that antipsychotic medication was the initial intervention used and the patient took it as a matter of routine.

In summary, medication adherence is a complex issue that can be affected by various factors, such as lack of insight, religious and cultural beliefs, level of education and socio-economic status, comorbid alcohol misuse, to name a few. We believe further studies are needed in this area.


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Authors’ response: We agree that adherence to medication is important and subject to complex influences. We thought that understanding of medication was a neglected factor and set out to study this rather than adherence. We had hoped that this was clear. We were surprised to find that, broadly speaking, patients understood psychotropics and non-psychotrophic medication to the same degree. We confirm that patients from ethnic minorities who were able to speak English were included; patients were in acute wards and not long-stay wards (of which we have none). In the example of how we chose which medication to ask about, we do not say that we selected the mood stabiliser over the antipsychotic because it was given first. We chose it because it was likely to be used for the longest time. We agree that our sample was not representative of all older psychiatric patients and say as much in the discussion.

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Recruitment in psychiatry

Those concerned about the dearth of young doctors applying to train as consultant psychiatrists might usefully consider the motives of those who make this choice. I am a recently retired general adult consultant psychiatrist who worked in England. I chose to undertake training because I wished to emulate senior consultants whom I met while acting as a medical student or junior doctor. I admired their determination and aspiration to improve the lives of those suffering from serious mental illness and their central role in the clinical care of those referred to mental health services. However, I fear junior doctors will now find it difficult to meet such inspirational and dynamic clinicians. In England the blame culture consequent on the repeated internal, coroner and external enquiries, reconfiguration of services, the provisions of the amended Mental Health Act and New Ways of Working for consultants psychiatrists (and others) have all undermined morale. This last development left me without responsibility for my in-patients, the autonomy to arrange urgent admission when I thought this necessary or, in some cases, to refer for appropriate psychological therapy. Working became an increasing challenge. Our junior doctors notice these developments and their effect on senior colleagues’ attitudes. It does not surprise me that the number opting to train remains worryingly low.

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Retaining trainees in psychiatry through a more mindful practice

Barras & Harris’s survey on retention difficulties in psychiatry1 in provoking further discussion about the state of psychiatric training is an important piece of work. The systemic effects of the current economic crisis cannot be separated out from implications to services and in turn their impact is felt by those working and training within the system. Having myself recently completed higher training in psychotherapy, and through my experience of facilitating trainee case-based discussion groups, many of the trainees’ comments picked up by Barras & Harris felt all too familiar.

In terms of trainee concerns over the attitude of others towards psychiatry, I very much agree with the thinking of the authors that better integration of psychiatry with other specialties may increase understanding of both the contribution of psychiatry and challenge of mental health difficulties. Alongside this, I also think it is important to recognise that to bear with the projected ‘madness’ of others, which may mean we are seen as unsettling and to be kept a distance from perhaps by devaluation, is an important function of psychiatrists. Trainees’ function as containers can be fostered, for example, in case-based discussion groups, enabling them to begin to understand and tolerate some of these processes as they are played out in their day-to-day work.

In Barras & Harris’s study, when asked about work and patient care, trainees complained about too much paperwork and a pressure to appear to be ‘doing things correctly’, which both undermine the real patient care. The concept of social defence, as described by Menzies-Lyth in her study of poor medical nursing staff retention in hospitals,2 is helpful in thinking about some of these difficulties. In mental hospitals, working practices which reduce contact with patients, such as the care of an individual patient being split into tasks or reduplication of checks to eliminate or share the responsibility of decisions, are used by staff/managers because of a fear of being in contact both with patients’ and their own ‘mad violence’ and fragmentation. Further to this, the additional pressures of restructuring may both add to and be part of the same process. Ballatt & Harris’s survey on retention difficulties in psychiatry1 is also frustrating, which may mean we are seen as unsettling and to be kept a distance from perhaps by devaluation, is an important function of psychiatrists. Trainees’ function as containers can be fostered, for example, in case-based discussion groups, enabling them to begin to understand and tolerate some of these processes as they are played out in their day-to-day work.

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The Royal College of Psychiatrists’ Faculty of Medical Psychiatry has recently been working towards an education strategy for the renewal and development of a more psychotherapeutic psychiatry, with the aim of bringing psychotherapy to the heart of psychiatry. I think that the model of meaning and mind that psychotherapy brings to the practice of psychiatry is crucial in enabling us to work with our disturbed patients, and as such it should be embedded into training.


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**MRCPsych CASC exam: is there a better choice?**

The basic intention behind the final membership exams is to test the abilities and competencies of the candidates at the consultant level. An ideal exam offers equal chance and challenge to all its candidates. It checks both elementary and higher knowledge in all the necessary domains of the subject. A final membership exam should ideally be exhaustive, with an intrinsic ability to test the range, width and depth of the candidate’s knowledge.

The Royal College of Psychiatrists’ exams have been globally known for their excellence and high standards. MRCPsych Paper 1, 2 and 3 check the theoretical knowledge of the candidate, but owing to the complex nature of mental disorders, a psychiatrist needs to have a much wider and in-depth understanding rather than mere theoretical knowledge of the subject. The Clinical Assessment of Skills and Competencies (CASC) mainly appears to be good at testing the communication skills, mannerisms, body language and the ability of a candidate to handle a situation. This is clearly reflected in the high passing rates in CASC of graduates from the UK and other countries where English is the primary language compared with candidates from other countries. If we look at the passing rates of the practical components of the old MRCPsych Part 2 (i.e. individual patient assessment and patient management problems), we will see that the gap between the passing rates of UK graduates (including candidates from countries with English as their first language) and of the candidates from other countries is much narrower.

To make matters worse for overseas candidates, there are so many variables in the present CASC exam that it is almost impossible for the candidates to understand where they are faltering. Some candidates seem unable to tell why they passed or why they failed. This has caused a lot of anxiety, discouragement and frustration, leading to a feeling of helplessness among overseas candidates who repeatedly fail at this exam despite scoring highly in their theory exams. On the other hand, CASC has its own advantages of being a fair deal to all examinees, covering various subspecialties at the same time, checking the ability of a candidate to handle a difficult clinical situation or for that matter the ability to control the interview. The local candidates seem to have an undue advantage when it comes to testing these skills. Being born and brought up in the UK (or in countries with English as the first language) gives them an upper hand when it comes to testing the doctor–patient interaction. For candidates whose primary language is not English, passing this exam seems to be comparatively a much more difficult task. In an attempt to ‘perform a task in 7 minutes or 10 minutes in an artificial situation’, the ‘performer’ just ‘spits’ out whatever he/she has crammed up, although in a sophisticated and palatable manner. There is no time to think, understand, plan or use any innovative strategies utilising the vibrantly balanced bio-psychosocial model embedded in the spirit of psychiatric management.

This is the final exam and we are testing the basic skills such as overdose, psychopathology and Mini-Mental State Examination (MMSE). The old-style MRCpsych exam Part 2 had great advantages. It presented the examinees with complex psychiatric situations (patient management problems) and offered them a chance to think, analyse, innovate and use a multidimensional biopsychosocial model when faced with questions directly from the consultants who had a much deeper knowledge in that field. It had the ability to analyse and evaluate the in-depth understanding of the system and the ways in which psychiatry works. The examinee’s attitude, competence and excellence could then be gauged in the right way. Old-style exams carried a great advantage of being ‘face to face’ viva with consultants (rather than with an actor and consultant being a silent watcher as in CASC) and provided a much more robust assessment of the quality and range of the candidate’s knowledge at both academic and pragmatic levels. Few disadvantages of the old style examination were that it involved the real patient (individual patient assessment) who might have been slightly drowsy or restless due to side-effects of medications and it was very difficult to standardise as candidates often saw different patients.

There can never be an ideal exam and people will always have complaints, but if we combine the present CASC style with the old style of MRCPsych exam, we can have the best of both.

Considering the highly acclaimed quality of exams conducted by the UK medical Royal Colleges, it is time to reconsider and realise that the exam should not put any of the candidates at a disadvantage just because of their language and be equally challenging not only to people whose primary language is not English but also to people who have a limited knowledge of psychiatry. It would be a fair and balanced exam if instead of having 16 CASC stations there were 8 CASC stations and 8 stations of patient management problems/vivas so that it could provide candidates with a platform to prove their substance in both domains, namely communication and a thorough knowledge of the functioning of psychiatry as a system. Therefore, if two of the above are integrated, it may come closer to an ideal exam.


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Discrimination between psychotropic and non-psychotropic treatment by patients
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