Correspondence

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Time to change – let’s end mental health discrimination: the challenges ahead

October 2007 marked the launch of another programme in England to tackle stigma and discrimination. ‘Time to Change’ models national initiatives from New Zealand and Scotland drawing on an expanding stigma evidence base as well as lessons from past projects, including the Royal College of Psychiatrists’ ‘Defeat Depression’ and ‘Changing Minds’ campaigns.

How might this programme succeed where others have stalled? The programme is resource rich with £18 million from the Big Lottery Fund and Comic Relief to channel into 35 linked programmes. It has 4 years to prove change among targeted audiences within a 30 million adult reach. It is a four-party coalition with a desire to learn from organisations across health and disability fields. It is adopting an evidence-based approach – national social marketing, service user leadership and engagement, local direct action, multiple targets using ‘stick and carrot’ approaches – but this does not guarantee success.

Key challenges are identifiable. Preparatory consultation during February 2008 using a pragmatic, non-systematic survey method through the membership networks of 18 organisations generated responses from 3038 service users and 661 family or friend carers.

This consultation emphasised first, that stigma and discrimination are widespread and their impact far-reaching.

(a) Seventy-one per cent reported to have stopped doing things – accessing employment, making friends, joining groups, engaging with health professionals.

(b) Seventy-three per cent reported anticipated discrimination including one in two who fear disclosing their health problems because of the negative reactions they might receive.

(c) Carers reported fewer personal effects but 85% felt that the person they supported was affected.

(d) Time to Change will need to target its efforts to have a meaningful impact in any one area.

Second, that combating stigma and discrimination is not straightforward. Service users and carers warned that the entangled nature of mental illness and their own and other people’s reactions make generic solutions difficult to find. Pinpointing exact goals for the 35 Time to Change programmes in terms of what needs to change will be central to proving any success.

Third, that Time to Change must set realistic goals. Variation in experiences particularly relating to physical health disabilities, sexuality, severe mental illness diagnosis and ethnicity of carers were found. Stakeholders will not equally benefit from Time to Change and the programme must be open and honest about its limitations from the outset. There is a danger that if it ‘fails’ to have an impact on lived experience of stigma and discrimination, people will give up hope that any change is possible.

Health professionals have a key role to play. General practitioners and psychiatrists were listed as stigma-generating agents, while National Health Service mental health trusts were prioritised by one in ten as the key target location for the social marketing campaign. However, the role goes far beyond being a target for interventions. Alongside Time to Change, momentum behind recovery-driven services is gathering pace. 

Joining initiatives across psychiatry that have an impact on stigma and discrimination will assist this programme. For more information, please visit www.time-to-change.org.uk.

Declaration of interest

V.P. is employed by Rethink, one of the Time to Change partners.


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Neuropsychiatric systemic lupus erythematosus associated with neuroleptic malignant syndrome

Neuropsychiatric manifestations such as anxiety, mood disorders, and psychosis are frequent features of systemic lupus erythematosus. A psychosis prevalence of 5% has been reported.1,2 Neuroleptic malignant syndrome is a life-threatening complication of treatment with antipsychotics.2 High-potency antipsychotics increase the risk.

We report the clinical case of a 23-year-old woman presenting early-onset neuropsychiatric systemic lupus erythematosus with interstitial pneumonopathy, glomerulonephritis and malar rash. When she was 20 years old, she had been hospitalised for her first episode with acute psychotic symptoms (mystic delusions) and agitation. The introduction of droperidol led to a neuroleptic malignant syndrome with high creatinine phosphokinase levels, muscular rigidity, hyperthermia and blood pressure dysregulation. The droperidol was stopped and benzodiazepines were used.

The patient was rehospitalised when she was 23 years old in a similar state because she had not observed the immunosuppressant treatment. No new gliotic cerebral lesions appeared on cerebral magnetic resonance imaging. The psychiatrist decided to introduce valproic acid and benzodiazepines in order to avoid antipsychotics. However, the mental state of the patient quickly led to delirium with repetitive, delusional and incoherent speech and behaviour. Despite the risk of neuroleptic malignant syndrome, a one-shot intramuscular injection of clotiapine was administered. Once again, we observed muscular rigidity, dehydration (148 mEq/l natrium) and systolic hypertension. Her
clinical state became serious with lethargy, aspontaneity, disinhibition and executive dysfunction.

Biological features were abnormal with elevated creatinine phosphokinase (3415 UI/l), increased C-reactive protein (3.7 mg/dl) and hepatic cytolysis. Her treatment consisted of cyclophosphamide and methylprednisolone, and the introduction of a titrating-dose (up to 600 mg) of quetiapine for the psychiatric symptoms was decided upon. Her creatinine phosphokinase levels returned progressively to normal, and no signs of neuroleptic malignant syndrome were observed. Six weeks after continuing this treatment, biological and clinical features were normalised.

This case illustrates the importance of differentiating delirium caused by a neuropsychiatric systemic lupus erythematosus, a steroid-induced delirium1 (which was not the case here as the patient had not been receiving any steroids when she developed the second psychotic episode) and an alteration in the consciousness level due to neuroleptic malignant syndrome, which was the case here.

Although there are no guidelines for the treatment of the psychiatric manifestations of systemic lupus erythematosus, it usually includes immunosuppressants associated with second-generation antipsychotics.2 The diagnosis of neuroleptic malignant syndrome is based on muscle rigidity, hyperthermia, delirium and autonomic disturbances.3 The dopaminergic hypothesis of the syndrome is well documented.4 Neuroleptic malignant syndrome is not an absolute contraindication for further antipsychotic treatment and some factors can reduce that risk: avoiding the long-term use of antipsychotics, using low-potency agents, adjunctive treatments and slow titration.5 In this case, we suggest that the introduction of quetiapine—a lower D2-affinity antipsychotic—was an interesting alternative.

Are antidepressants safe during pregnancy?

Ramos et al4 report that the use of antidepressant medications by women during the first trimester of pregnancy is not associated with an increased risk for major congenital malformations in children. The authors have a good database to study this topic but have described and analysed it using a case–control framework. They assembled two cohorts, with and without exposure to antidepressants during pregnancy. They then observed the various outcomes in both groups. We calculated the relative risk (RR) for major congenital malformations following use of antidepressants during first trimester of pregnancy as 1.13 (95% CI 0.86–1.48) from their published data. Estimating such relative risk and population attributable risk (5.76%) would have bolstered their arguments, as a cohort design is superior to a case–control strategy.

However, we suggest caution in generalising these findings because of two important limitations that were not acknowledged in their paper. If antidepressants are associated with more spontaneous abortions and an increased number of minor congenital anomalies, their lack of association with major congenital anomalies will not imply safety. A previous meta-analysis of 3567 women established a significantly increased RR of 1.45 (95% CI 1.19–1.77) for spontaneous abortions following use of antidepressants during pregnancy.2 Individual antidepressants such as selective serotonin reuptake inhibitors3 and other newer antidepressants4,5 have led to more miscarriages when compared with unexposed control groups. As Ramos et al have included exclusively women who had their pregnancies ending in delivery, they do not add any information regarding spontaneous abortions. In another study of 482 pregnant women,6 fluoxetine caused significantly more prematurity (RR=4.8, 95% CI 1.1–20.8), more admissions to special care nurseries (RR=2.6, 95% CI 1.1–6.9) and worse neonatal adaptation (RR=8.7, 95% CI 2.9–26.6) after adjusting for all potential confounders. A total of 15.5% of infants exposed to fluoxetine had three or more minor congenital anomalies compared with 6.5% of infants who were not exposed to fluoxetine (P=0.03).3 However, Ramos et al excluded minor congenital anomalies during case ascertainment without any explicit justification. Absence of association between use of antidepressants and major congenital malformations will not make a clinician confident to continue antidepressants during the first trimester of pregnancy if there are concerns over spontaneous abortions, prematurity and minor congenital anomalies. Hence, we encourage cautious interpretation of these findings as well as judicious use of antidepressants for women of reproductive age.


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Authors’ reply: The nested case–control approach that we used is the most effective design to study rare outcomes such as major congenital malformations. This is even truer since it was performed in a well-established cohort of women with pre-pregnancy diagnosed psychiatric disorders. We disagree with Rajkumar & Jacob that a cohort approach would have been better, based on the fact that it lacks power for research in perinatal pharmacoepidemiology. This was clearly apparent when several small human cohort studies published in the 1990s did not suggest...
an overall increased risk for birth defects with first-trimester exposure to any selective serotonin reuptake inhibitors but later studies with more efficient designs such as the case–control approach started showing low-to-moderate increased risks for the more commonly occurring birth defects such as heart defects, neural tube defects and oral clefts. Therefore, using a cohort approach would have resulted again in a null finding, contrary to Rajkumar & Jacob’s comments.

We excluded pregnancies ending with abortion or miscarriage per design since malformation outcomes of these foetuses were not available in the Quebec Pregnancy Registry. We agree that this resulted in prevalent cases of malformations in our study but this is highly comparable to studies performed in similar populations. We do not, however, agree that this methodological choice resulted in biasing our study estimates towards the null. Indeed, although Hemels et al3 reported an association between antidepressant use during pregnancy and risk of spontaneous abortion, this was based on women’s self-report and likely resulted in an overestimation of the rate of miscarriage and an underestimation of the rate of abortion, hence a significant association.

Major congenital malformations are structural abnormalities that affect the way a person looks and require medical and/or surgical treatment. Minor defects are abnormalities that do not cause serious health or social problems. Major defects were the focus of interest in our study and, although the risk of minor malformations is interesting, it is a different research question. Several other authors have previously made this distinction.4,5

We agree that results from observational studies always need to be interpreted with caution. However, given that from an ethical point of view it is almost impossible to randomise pregnant women to receive medications not known to be safe for the foetus, the collection and follow-up of observational data is the only ethical way to close the knowledge gap between the limited value of animal studies and human pregnancy exposures.

Finally, our study was not designed to look at the effect of the duration of specific antidepressants on the risk of specific major congenital malformations. Therefore, we only looked at duration of antidepressant use during the first trimester of gestation and its risk for major congenital malformations, all types and all malformations combined. Results should be interpreted in this context.

Declaration of interest
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Structural equation modelling in developmental psychiatry
The paper Green & Dunn1 may prove to be of merit in the interpretation of causal relationships between interventions and outcomes. In particular, the recommendation that randomised controlled trial (RCT) methodology should be embedded within statistical methods from observation studies is long overdue. Such an approach would greatly assist in the interpretation of results which seem completely counterintuitive to those in everyday clinical practice. One such result is the finding of Byford et al2 that cognitive–behavioural therapy provides no added or separate advantage to selective serotonin reuptake inhibitors in the treatment of adolescent depression.

I have a quibble with the length of time it has taken for basic concepts on causality introduced by Green & Dunn to appear in psychiatric research. These concepts have been commonplace in social science research for more than 20 years and their section on causal inference in analysis is little more than a primer. For a more complete coverage of principles of causality, I can recommend Judea Pearl’s book, Causality: Models, Reasoning and Inference.3

Is there any particular reason why Green & Dunn, having put their toes in the water by introducing basic concepts on causality, have not taken their paper further or are we to await a follow-up? In particular, why is there no mention of structural equation modelling, otherwise known as covariance structure analysis? Structural equation modelling has been extensively used in social science research for the past 20 years and adaptations of the method such as multiple-indicator, multiple-cause (MIMIC) seem to address the issues on confounding variables adequately without the need to revert to RCT methodology. It would be interesting to hear from Green & Dunn their thoughts as to how necessary would RCT methods be in developmental psychiatry research whenever a structural equation model is being employed.


Authors’ reply: We thank Dr MacFarlane for his favourable comments on our views. The development of research designs that can rigorously test the complexities of mental health intervention and also have face validity to clinicians is at the centre of our concern. In a brief editorial we could do no more than whet the readers’ appetites. There was no mention of structural equation modelling because of lack of space, and not because we do not have sympathies with the technique. In fact, one of us (G.D.) has taught structural equation modelling for nearly 20 years.1 When used wisely and with correctly specified models, structural equation modelling approaches can be very powerful – but they do not obviate the need for good design (including the randomisation in an RCT). In particular, MacFarlane is mistaken when he suggests that the use of structural equation modelling (MIMIC)

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models can successfully address issues of hidden confounding in the absence of appropriate design. Although enthusiasts in the social and behavioural sciences have used structural equation models and ‘causal models’ interchangeably for many years, their naivety has frequently brought structural equation modelling into disrepute. Pearl’s book covers structural modelling in the appropriate way, but many readers of this journal will find it a bit heavy going. We do indeed plan to publish on these issues in much greater detail in the near future.

Declaration of interest

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The most undeserving poor?

The Secretary of State for Work and Pensions, James Purnell, proposes removing payment of benefits from unemployed persons with addiction to crack cocaine and heroin.2,3 The proposed Green Paper3 sets a remarkable precedent in terms of official, inter-agency response to that common mental disorder described as ‘drug addiction’. It focuses on benefits (to an estimated 267 000 individuals in England alone) for those ‘dependent on drugs’ or ‘problematic drug users’.4 Little attempt is made to distinguish between degrees of dependence or recreational use. The Green Paper claims that ‘this is around three-quarters of all the people who are ‘dependent on these drugs’.5

It states ‘we believe that drug misuse is a serious cause of worklessness and that individuals have a responsibility to declare it and take steps to overcome it’ (section 2.40). At present only 0.05% of people on jobseekers allowance declare an addiction.5

All applicants will be required to declare whether they are addicted to heroin or crack cocaine (section 2.39) with investigations for fraud against those who ‘mislead’ and they will ‘be required to enter treatment’ (section 2.41–2.43). Proposals include new powers to force agencies such as ‘drug workers’ (section 2.38) to disclose clinical information. It seems inevitable that at least forensic and prison doctors will have to ‘share information’, and National Health Service psychiatrists will become complicit in informing job centres as part of multidisciplinary teams.

Given the known morbidity of addiction,5 we know of no other psychiatric disorder that excludes citizens from access to statutory services!

For practising clinicians, the proposed legislation strikes at the core of the doctor–patient relationship, destroying medical confidentiality and grossly interfering in treatment. Therapy is often episodic and incremental but in future doctors will hesitate to end an episode of failing treatment for fear of depriving their patients of food and sustenance. How will clinicians establish working relationships with their patients while simultaneously policing the state benefit system? Politicians, high on prejudice, are driving a coach and horses through the subtle art of treatment. Where is the dissenting outcry from the profession and the Royal College of Psychiatrists? If doctors do not speak up for their most vulnerable patients, who will?


Wake-up call for British psychiatry: responses

The paper by Craddock et al2 and the subsequent eLetters illustrate the variety of opinions that attracted me to psychiatry. I work in a multi-agency service and our assessments and interventions can be carried out by professionals in Mind, in social services and in the National Health Service (NHS). In our service we share responsibilities. This allows me (a consultant psychiatrist) to pursue a resurgent interest in psychopharmacology, treatment adherence and the harm caused by side-effects of medication. Although I appreciate the academic endeavours in biomedical science, I believe it is very important to contextualise them for non-academics. Randomised controlled trials don’t speak to clinicians as well as naturalistic studies. I have noticed that some of my psychiatric colleagues (and myself at times) shy away from precise diagnosis, acutely aware of how diagnoses are deliberately used to stigmatise people by individuals outside mental health services (as well as within). This is happening at a time when case definitions are becoming important to health service managers. Perhaps some psychiatrists are uncomfortable in their traditional territory. However, if psychiatrists step back too far, then others will move in. I expect that senior managers, rather than other clinicians or service users, are likely to move into the spaces that we vacate. Psychiatrists should not support the replacement of ‘doctor knows best’ with ‘manager knows best’. New Ways of Working may end up doing exactly that. Instead of being a shot in the arm, it may be a shot in the foot. Four trusts in the north of England are already constructing their own diagnostic systems to use alongside or instead of existing diagnostic schemes as a currency for payment by results. Assigning patients to pseudo-diagnostic ‘care clusters’ could be something all staff do, not just the doctors. If psychiatrists step back from diagnosis, then diagnosis may change from a clinical concept with an associated evidence base, to a financial planning tool. There are other drivers of change too. In the prevalent atmosphere of anxiety and blame, risk assessment, not diagnosis, is now arguably the main gateway into acute mental health services. This means that some very ill people may have to wait for treatment, while people who seem to be at acute risk are attended to first.

Times change and if psychiatrists of any persuasion want to retain some influence they have to put up, not shut up; so well done for making the biomedical case. Biomedical psychiatry complements psychosocial psychiatry and is uniquely part of
Craddock et al’s ‘Wake up call for British Psychiatry’1 is a timely reminder of the need for our profession to reassert its essential qualities, particularly in view of the current low recruitment rate into psychiatry from UK graduates. The Psychiatric Trainees’ Committee (PTC) agrees with the observation that the medical component of psychiatry is being devalued. Indeed, this is apparent in many of the recent changes associated with psychiatric training.

The European Working Time Directive has in part contributed to reduced exposure to emergency psychiatry. This has resulted in a reduction in the recognition and management of biomedical aspects which are often key in acute psychiatric presentations. This has been exacerbated by financially stretched trusts gradually reducing the out-of-hours contribution from trainee psychiatrists in favour of cheaper alternatives.

New Ways of Working remains contentious. Specific consideration is required to ensure that postgraduate training adapts both in substance and in delivery to ensure that future psychiatrists have the necessary skills to fulfil the changing role of a consultant. Trainees are increasingly anxious that the rapid evolution of New Ways of Working has become a driver for preventing essential continued expansion in the numbers of consultant psychiatrists. Indeed, there is a growing political atmosphere suggesting that consultants will be needed less abundantly than at present.2 The PTC firmly believes that the introduction of a sub-consultant grade will diminish the end-point of training, further devalue the profession and not serve the needs of patients.

These issues, alongside the changes resulting from Modernising Medical Careers and the significant stresses of the Medical Training Application Service, are contributing to a cohort of trainees who perceive that they are not in a valued profession.

We believe that the new competency-based framework of psychiatric training, if robustly quality-assured, offers a solid opportunity to reassert the training needs of future psychiatrists, especially in regard to their unique medical expertise in the assessment and treatment of mental disorders. However, the current changes within mental health services threaten to undervalue our role as medical specialists. This is likely to further alienate medical undergraduates and compound the current recruitment crisis.

Urgent work needs to be done by our profession to re-engage with both the government and the public as a whole to ensure that the essential contribution psychiatrists make in providing a high-quality mental health service to our patients is not further devalued.

One cheer at least for Craddock et al’s1 polemic. Critical of the de-medicalisation and role-diffusion which they see as characterising contemporary British psychiatry, they argue that those with severe mental illnesses are best served by an initial consultation with a professional with the diagnostic skills of the consultant psychiatrist. Without such an intervention, they claim, the patient is likely to be psychopharmacologically disadvantaged, possible physical disorders may be overlooked and scientific advances not brought to bear on their illness.

Nevertheless a neutral observer might be tempted to see their ‘wake-up call’ as a tendentious attempt to regain hegemony by the psychiatric establishment. Their ad hominem ‘thought experiment’ – inviting readers to ask themselves whether they would be happy for ‘a member of their family’ to be cared for under the ‘distributed responsibility’ model – seems unworthy of such illustrious academics, a hostage to the possibility that many will take the contrary view. The two absent cheers are for the missing psychosocial components of Mayer’s bio-psychosocial triad, first proposed a century ago, midway between Reil2 and Craddock et al. Indeed, that lack exemplifies the narrowness of vision which has arguably led to the very crisis which they bemoan. Nowhere do the authors consider the social forces driving de-professionalisation: the need to contain burgeoning healthcare budgets; flattening of social hierarchies, with leadership to be earned rather than role-bestedowed; and technology-driven fragmentation of care.

Understanding these processes, and knowing how to work productively with the rivalries and distortions they create, is as essential to the psychiatrist’s repertoire as the latest psychopharmacology update. Nor are these issues confined to psychiatry, not excluding the cardiology model so dear to their hearts. The good general physician who takes an overview of a whole patient, including psychological aspects, and is not merely a technical expert in the minutiae of a malfunctioning organ, is as rare a species as the putative ‘superlative’ psychiatrist.

Craddock et al’s view of the science relevant to psychiatry is similarly limited, confining itself to molecular biology and neuroscience. There is no mention of recent advances in developmental psychopathology3 which illuminate the psychological deficits of psychiatric illness, and the interpersonal skills needed by therapists to ameliorate them, or of psychotherapy process-outcome research which is beginning to tell us which kinds of therapy work best for which kinds of condition and personality. Waking up is the instant when dreams momentarily enter consciousness. Behind their grumpy growling, Craddock et al’s reverie sounds like regressive nostalgia for an idealised past – as opposed to wishes – for the future.

A more hopeful straw in the wind is the recent Royal Colleges of Psychiatry and General Practitioners joint document on psychological therapies.4 This argues the case for structured training in psychosocial skills for psychiatrists and general practitioners. Craddock et al might consider the possibility that a psychotherapeutically informed psychiatrist – whose abilities


include dream interpretation – is more likely to regain a key role in the surely here-to-stay multidisciplinary team than one whose expertise is narrowly confined to ‘excellence’ in prescribing, desirable though that no doubt is.


There are a number of key issues which those who have criticised the 'Wake-up call for British psychiatry'1 have failed to address.

(a) In order that any illness be treated, proper assessment and diagnosis is necessary. Is there definitive evidence that complex problems such as very early psychotic illness (at-risk mental states) or type II bipolar disorder can be properly identified by non-medical staff without specific training? Is there a possibility that cases may be missed – and how big is this risk?

(b) How certain can any doctor – or indeed any person – be that they can assess ‘service users’ appropriately based only on the reported assessment of others? This is different from asking other respected professionals for their considered opinion in a multidisciplinary meeting.

(c) Why is psychiatry the only medical specialty where many seem to feel that we can accept ‘patient choice’ to take or not take medication with entire equanimity, even though we know that antipsychotic medication and antidepressants do actually help treat symptoms . . . and then why do we suddenly become concerned when tragedy happens because of non-concordance with medication?

(d) Why do we in the UK expect other professions to deliver all psychological interventions, while we simply seem to provide biological treatment? Why do we not provide psychotherapy as well as medication as many of our colleagues in Europe do? Should there not be one standard for how psychiatric help is delivered across the continent of Europe . . . and should this not obviously be holistic?

(e) Having been a GP for many years before going into psychiatry, I would ask, why are psychiatrists and their teams happy to dispense with the common courtesy of expecting the person addressed to answer a GP referral: in what other profession is ‘sending the referral back because it is inappropriate’ after a brief discussion in a multidisciplinary meeting considered an appropriate response? When this happens, is it not the service user who suffers because their problem is not dealt with?

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On the other hand, as a GP, I would certainly consider carefully who to refer to secondary care and would use all my skills, as acquired in my GP training, before referral. I would also consult my liaison community psychiatric nurse or other attached mental health professional if I had one, and if necessary consult the consultant psychiatrist over the phone. However, a good GP will expect to be able to refer problems which they cannot solve to secondary care, and then expect the referral to be treated with respect by the consultant psychiatrist colleague with an adequate response, for GPs are specialists in their own right.

Finally, in all of this debate, we have entirely forgotten that the reason service users consult doctors is the doctor–patient relationship, which is a relationship based on trust in another person, who may or may not have a greater or lesser knowledge of psychology and neuroscience, but who most of all is a person to be confided in during difficult times. This is what we must be as doctors, and all our discussions about ‘the role of the consultant’ pales into insignificance before this.

We must remember how Sir James Spence defined the consultation: ‘The occasion when, in the intimacy of the consulting room, a person who is ill, or believes himself to be ill, seeks the advice of a doctor whom he trusts. This is a consultation’. If we forget this, then what indeed is the point of our being doctors?

We welcome the debate initiated by Craddock et al\(^1\) and agree that the role of the psychiatrist is key to the delivery of high-quality services, and may be currently threatened. However, we believe that their proposals would be restrictive and counterproductive. If the psychiatrist has to assess all those referred to secondary services, access to such care would be restricted increasing the burden of unmet need. To deploy services effectively the psychiatrist needs to utilise the ideas of recovery\(^3,4\) (a term regrettably omitted from Cradock et al’s paper) to negotiate and facilitate the types of goals and outcomes valued by service users and to allow people with mental disorders to participate more fully in their communities and society.

It is important not to polarise this crucial debate, nor to retreat into restrictive medical modes of thinking. To meet the challenges of the 21st century will mean an important shift in our ways of working, which can be of enormous value to our professional roles and to the service users that we work with.

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The interpretation in The Times\(^5\) of Craddock et al\(^2\) risks alienating multidisciplinary colleagues and patients alike, turning a call for quality services into an appeal for primacy for the psychiatric profession.

New Ways of Working is similarly open to misinterpretation, including by Craddock et al. A fundamental principle of New Ways of Working is free ing the appropriate staff to work with the patient. That means consultant practitioners working with those with the most complex needs – exactly what these doctors ordered.

Yet Craddock et al appear defensive, undermining their own call for self-confident progress. Why get exercised about...
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use of the term ‘mental health’ rather than ‘mental illness’? The
government has stressed repeatedly in the National Health Service
Next Stage Review that maintenance of health and well-being is its
job just as much as treatment of illness. Performance management,
outcome measures and payment by results drive vague ‘support’
out of the system, promoting more structured, evidence-based
care delivery.

The Future Vision Coalition, comprising leading mental
health charities, directors of social services, the Mental Health
Foundation and, crucially, the network of our employer trusts,
has just published A New Vision for Mental Health,1 bringing
health and social models together, focusing more on health
patients have been prescribed medication. The National Institute
not been over-provided or over-used to date, whereas 93% of
therapies demonstrates how those evidence-based services have
as biological determinants of mental ill health, rather than harking
future, but only by embracing teamwork, abandoning hegemony
are appropriately skilled, competent and take responsibility for
only trusted to give ‘support’; now they may be prescribing as well
when other professions were the handmaidens of psychiatrists,
other experts are similarly important. ‘Jollying along’ was seen
after other professions were the handmaidens of psychiatrists,
only trusted to give ‘support’; now they may be prescribing as well
delivering other therapeutic interventions.

Politically correct terms like ‘service user’ have arisen
because of stigma, which psychiatrists have played their part in
perpetuating, being accused of low expectations, making
assumptions about behaviour based on diagnostic labels,
patronising or unhelpful letters, using patients as ‘cases’ for
training, and promoting the ‘medical’ model while dismissing
side-effects as ‘psychological’.

Our answer to their ‘thought experiment’ question – would
you opt for a distributed responsibility model if a member of
your family was the patient – is a resounding ‘yes please’. Going
back to a psychiatrist with a case-load of hundreds, or awaiting
the arrival of yet another locum for a decision, is neither safe
nor satisfactory. Lord Darzi2 heralds a ‘new professionalism’ based
on teamwork, teams can only be efficient and effective if members
are appropriately skilled, competent and take responsibility for
what they do.

We agree with Craddock et al that psychiatry can have a great
future, but only by embracing teamwork, abandoning hegemony
and accepting the importance of social and psychological as well
as biological determinants of mental ill health, rather than harking
back to a past which was actually far from ideal.

1 Hawkes N. Mentally ill are ‘jollied along’ rather than treated by psychiatrists.
The Times 2008; 27 June.


Craddock et al3 present a compelling argument for retaining the
biomedical model of psychiatric illness, while acknowledging that
evidence-based psychosocial interventions do have an important
place in management and treatment.

It is their discussion about New Ways of Working that
particularly struck a chord with me. As a third-year specialist
registratar who will soon be looking for consultant jobs, I find
myself in a dilemma: am I for New Ways of Working or against it?
Case-loads of 300 patients seen briefly in 15-min ‘routine’ out-
patient clinics; one urgent appointment after another; the
community team, day unit and GPs all wanting their patients to
be seen only by the consultant;2 shouldering responsibility for
patients not seen or advised on by me; to me, all of this sounds
like a certain recipe for early burnout. Is it any surprise that I
do not want any of this?

On the other hand, my medical training has taught me to
diagnose and treat appropriately and I do this well. When other
members of the team ask me to see someone who they think
may have depression, my training enables me to not only exclude
depression but to pick up the drowsiness, slurred speech and small
pupils of morphine addiction, and to then manage the patient
appropriately. As Craddock et al point out, having a broad-based
assessment by a doctor at the first point of contact is likely to
ensure that the patient gets the most appropriate treatment.

Craddock et al think we should be arguing for better resources
and increased workforce. This is very reasonable but is it realistic?

Is the choice, then, have between one’s personal well-being and that
of one’s patients? I have not found the answer to this dilemma yet.
It is reassuring to see that experienced psychiatrists have strong
views on both sides, illustrated by the heated debate over the past
few months. Perhaps I should sit on the fence just a little while
longer.3


We strongly support the views expressed by Craddock et al.1 In
our opinion, their perspective is shared by many NHS consultant
colleagues and is not limited to academic psychiatry.

At the heart of the debate is the progressive downgrading of
the role of the consultant psychiatrist in diagnosing and managing

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severe mental illness as opposed to 'mental health problems'. The latter may not require specialist psychiatric input as medicalising problems of living is clearly undesirable.

The centrally driven 'one size fits all' approach to 'modern' service delivery has left many patients with serious psychiatric illness bereft of the clinical expertise and leadership to effectively manage their condition. Notions of complexity (undefined) and risk have superseded diagnostic context. The 'diffusion of responsibility' as conceptualised in New Ways of Working often leads to unfocused care plans and risk management assessments without the one element essential to modifying any risks – that is, effective psychiatric treatment based on a comprehensive diagnostic formulation and understanding of the nature of the illness. Accurate diagnosis not only allows appropriate treatments for individual patients but also prioritisation of resources in service delivery. Furthermore, a diagnostic threshold is an essential requirement of the Mental Capacity Act in the assessment of capacity of our most vulnerable patients.

Major changes in psychiatric management and service structure have been introduced that are mostly not evidence based and certainly not consequent upon real advances in treatment. The political dimension to this process makes constructive criticism difficult. The letter to The Times from Kinderman and members of the New Ways of Working Care Services Improvement Partnership and National Institute of Mental Health exemplifies this. In response to the article by Craddock et al. they refer disparagingly to the 'traditional medical model' in contrast to 'modern mental healthcare' which is a 'collaborative team effort' as if the medical model concerns itself only with medical matters in the most narrow sense. They also suggest that some psychiatrists are unable to 'cope with the loss of hegemony' and refer by implication to Craddock et al. as demonstrating 'intellectual arrogance' . . . and assumptions of superiority'. Their response to it mildly offers little basis for constructive debate and has previously been described as 'messianic' in tone.3

Like many psychiatrists engaged in the treatment of serious mental illness and organic brain disease we look to our professional body the Royal College of Psychiatrists for a lead but find our views are not adequately represented.

I would like to provide a medical student’s perspective on the paper by Craddock et al. I am about to enter my 4th year of medicine (having just completed an intercalated BSc in psychology and medicine) and will soon have my first real exposure to clinical psychiatry. Although I am keen on psychiatry, the majority of my fellow students are happy to express disdain at the thought of a psychiatric career. It is obviously difficult to say why this might be the case but something is clearly amiss in the way that psychiatry is being presented to tomorrow’s doctors.

During my BSc, it was interesting to gain insight into the opinion that psychologists have of psychiatry, which unfortunately was one of ‘over-medicalisation’ and neglect of psychosocial factors. For me, this reiterated the importance of early positive interaction between the two professions and a need for better understanding of each others’ strengths. Perhaps this interaction is best initiated during undergraduate training?

More importantly, and from the angle of a card-carrying wannabe psychiatrist, this paper has confirmed that clinical psychiatry is attractive to me not because it is excessively reductionist but because it deals with the complex interplay between psychiatric (and non-psychiatric) illness and countless important psychosocial factors. Furthermore – and this may be the blind optimism of youth talking – I hope to become an excellent physician who is trusted and respected by her patients. Because of this, I am not discouraged by those who fail to consider psychiatrists as 'proper doctors', although it is clear to me that this negative view by other doctors acts as a deterrent for some of my colleagues who might have been interested in a psychiatric career.

Finally, on a more anecdotal note, I have the perspective of someone who has lost a relative because of failure in psychiatric and non-psychiatric care and social support. Had an appropriate (and properly functioning) multidisciplinary team been in place, both in assessment and management, I believe that the outcome would have been very different. So in response to the question 'if a member of your family were a patient, is a distributed responsibility model the one for which you would opt?' my answer would be an uncertain ‘ummm, I think so’, so long as this included the appropriate level of assessment and involvement of a senior psychiatrist alongside other professionals.

Craddock et al.1 call for the restoration of the ‘core values’ of biomedicine – diagnosis, aetiology and prognosis – evidence that such concepts have delivered little more than stigma and helplessness.2 A generation ago, Mosher demonstrated that contrary to received opinion, the recovery of people with schizophrenia could be enabled with no more than sophisticated psychosocial support.3 Since then the role of personal, social and environmental factors in generating ‘breakdown’ and ‘fostering recovery’ has become widely accepted. The ‘mental well-being’ train has left the station and in many places is close to its destination.

Craddock et al. advocate a ‘more positive and self-confident view of psychiatry’, but complain that ‘many people . . . have developed exaggerated and unrealistic expectations’. Clearly, psychiatry’s reticulation of diagnosis, with the implication of effective treatment, fostered such expectations. The comparison of mood disorders with heart disease serves as an illustration. Much of the emergent distress within high-income nations has more to do with lifestyle, values and other psychosocial factors,
than anything resembling biomedical pathology. If the global burden of depression is to be lifted, it will require more than specifying more ‘clearly the key role of psychiatrists’.

Although Craddock et al were clearly offended by talk of mental health and well-being, this focus is long overdue. Talk of ‘mental illness’ and ‘our patients’ is regressive and paternalistic. On the 60th anniversary of the NHS it should be unnecessary to advocate well-being as the purpose of healthcare. Mental health advocacy joins the abolition of slavery, votes for women, feminism and gay rights as another example of emancipation within Western society. The ‘service user’ title may be unsatisfactory, but is another linguistic step towards acknowledging that people are the agents of their lives. They must be addressed as persons if genuine emancipatory mental healthcare is to become a reality.

The learning disabilities field provides a precedent. A generation ago, most people with significant forms of ‘mental sub-normality/deficiency’ lived in hospitals under the care of psychiatrists. Today, despite the influence of genetic anomalies or organic disorders such people live in natural communities, albeit with broad-based psychosocial support. Some may have occasional need to consult physicians, but their lives no longer revolve around their diagnosis. This change in philosophy did not devalue psychiatry but did acknowledge that all problems in human living affect persons. All talk of psychiatric treatment should follow suit, embracing the word’s original meaning: the ‘manner of behaving towards or dealing with a person’.

Regrettably, Craddock et al’s rallying call will be offensive to many service users who have struggled to detach themselves from the more unfortunate aspects of traditional psychiatry. It will also be dispiriting to many of their colleagues. Craddock et al may be surprised to discover that nurses have already joined psychiatrists as statutory prescribers of medication,5 and some clinical teams recognise the virtue of electing the professional best qualified to inspire and nurture the team.6 Time, perhaps, to wake up and smell the coffee.

I thoroughly enjoyed the Editorial by Craddock et al,1 and would like to address the following points. First, the perceived ‘lack of recruitment and retention in psychiatry’. Though there has been considerable mention of this, anyone involved in psychiatric training or workforce planning recently will be aware of the changes in numbers in the years since systems such as New Ways of Working2 were conceptualised. What has not been mentioned (and what is more pertinent) is the effect of such changes on future recruitment and retention.

Second, the educational standards that we, as trainees, are expected to achieve are laudable, and (justifiably) a great deal of effort has been spent over the years by the Royal College of Psychiatrists to refine these (a recent example being the curriculum submitted by the College to the Postgraduate Medical Education Training Board). The delegation of assessment to multidisciplinary team members, without adequate, standardised assessment of competency, is worrying. Clinical experience has shown that GPs, when they refer patients, might not have conducted an exhaustive neurological examination or battery of tests to exclude organic causes, and would expect these to be picked up by secondary services. It is beyond the boundaries of reason (and team supervision) to expect multidisciplinary team members to be aware of organic presentations, neuroendocrine signs and symptoms, and subtleties on history and mental state examination that come with the experience (and training) of a psychiatrist. The equivalent would be a neurology service expecting a physiotherapist to assess patients referred with unexplained weakness and muscle atrophy; certainly the physiotherapist may have an important, specialised role in treatment, but the initial assessment should be by a physician, who will have a broad knowledge base, refined by training and experience.

Our patients present in complex ways and to reduce their assessment to rating scales, symptom checklists and risk management (as is currently the vogue) makes a mockery of the skills needed to practice psychiatry to an adequate standard. By delegating initial assessment to generic team members, the art of psychiatry appears to have been reduced to a ‘paint by numbers’ approach, that is anything but patient-centred. Looking at the fashion in which changes have been implemented, it is easy to make comparison with other Department of Health initiatives (such as the Medical Training Application Service/Modernising Medical Careers fiasco3). On this occasion, however, the College has the opportunity to effect change. The gauntlet has been thrown to the College to poll its membership on the implementation of New Ways of Working; this issue will not go away and needs to be resolved.


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**Authors’ reply:** We are pleased that our article has stimulated debate. This was our intention. We are disappointed that some correspondents dismiss our argument by attacking a stereotype of who they think we are or a caricature of what they think we might have said, rather than addressing what we actually did say. Such correspondents have missed, or ignored, the point of the article – namely, to ask whether the de-medicalisation that has taken place over recent years in British psychiatry is bad for the health of patients and the specialty. We believe this is a question that is worth taking seriously. It is clear from the substantial correspondence and other feedback that many psychiatrists share our concerns and wish for constructive debate.

This primary concern with the decline in medical standards of care and the deliberate politicisation of debates about service delivery does not imply that we cannot (a) embrace the importance of the full range of biological, psychological and social interventions for psychiatric illness and (b) value our non-psychiatric fellow professionals and their integral contributions to mental healthcare. We also believe to be self-evident that services should be informed by the experiences of patients, their relatives and carers, and that multidisciplinary teamwork is crucial for optimal management of psychiatric illness. We are not terribly interested in what is past. We are much more interested to look ahead.

Of the wide range of views expressed by respondents, we believe the voice of trainees and those contemplating a career in psychiatry should carry particular weight and we should like to hear more from them. They are the future of British psychiatry.

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The most undeserving poor?
Woody Caan and Mervyn London
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