*Advances in Psychiatric Treatment (2000), vol. 6, pp. 226–237*

# Support systems. 1. Introduction

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> "Employers have a key role to play in safeguarding the mental health of their workforce, both by providing a supportive work environment and by encouraging the use of the workplace to provide health education and health promotion activities" (Department of Health (DoH), 1998*a*, 4.64)

There is a continuing crisis in the recruitment and retention of consultant psychiatrists in the UK (Storer, 1997), which is mirrored by problems within the training grades. In a speciality which experiences staff shortage, premature loss of capable staff represents a significant failure and, within an individual hard-pressed service, a potential disaster. Kendell & Pearce (1997) collected comments from consultant psychiatrists retiring prematurely. These vividly reflect the difficulties that the consultants experienced in their professional life that contributed towards their decision to retire. Common issues for retirees – other than ill health and a positive desire to devote more time to other interests – were the increasing workload faced by consultants, Government mental health policy and interference by management in clinical matters. More poignant are the 'other' reasons for early retirement given by respondents in the survey (Kendell & Pearce, 1997) (see Box 1). These comments appear to result from either failures of general management or from lack of support from colleagues. They represent a powerful argument for taking the introduction of adequate support systems for consultants very seriously indeed.

We will discuss the stresses and difficulties that psychiatrists and mental health professionals in general experience and the systems of support that can be deployed to deal with these stresses. The authors are respectively a clinical director, a medical director and a clinical psychologist who work in the field of adult mental health in deprived inner-city catchment areas. We combine an academic interest in the field of staff stress with the practical demands of providing and managing mental health services, supporting our colleagues and surviving as professionals within a demanding environment. The focus of this paper is on support systems for the consultant community psychiatrist, because that is where our practical experience largely lies. We have attempted to adopt an evidence-based approach to the topic. We have reviewed the literature on the stresses experienced by psychiatrists, although, with the exception of old age psychiatry (Benbow & Jolley, 1997), this literature does not provide meaningful data about sub-specialities.

Even less satisfactory is the literature on systems of support for psychiatrists. It is vaguely located within an extensive corpus of knowledge about the management of health services and the sociology of the health and social care professions that is difficult to access systematically and may appear to the untutored eye to combine statements of the obvious with anecdote and intellectual fashion. Thus, this paper is a mixture of an evidence-based approach and opinion, albeit refracted by considerable experience, and should be read with appropriate caution.

## Context

The pressures experienced by community psychiatrists in the UK are graphically described by Deahl & Turner (1997): violence and the fear of violence; limited resources; overcrowded in-patient wards; problems of recruitment and retention within

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https://doi.org/10.1192/apt.6.3.226 Published online by Cambridge University Press

**Box 1. Selected reasons for early retirement given by consultant psychiatrists who retired prematurely in 1995 and 1996 (from Kendell & Pearce, 1997)**

- A consultant colleague committed suicide in 1994 – I did not want to be next
- A recurring feeling that I was failing despite working long hours
- I had no wish to be 'crucified' in a future hospital inquiry into a suicide/homicide
- Persistent awareness of a disaster about to happen at any time…I realised it was only a matter of time before I was in the dock (i.e. a homicide inquiry) despite all my best efforts
- Stress, stress, stress
- I feel I let a patient down…with serious consequences
- I was tired – I had nothing left to give
- I was unable to give enough time to many needy people because of imposed changes in practice
- Increasing fears for personal safety
- The level of violence against staff…and the level of violence committed by my patients
- The night work got too demanding
- A total disregard for the views of the clinical team in planning services
- An impossible medical director
- Unable to meet the conflicting demands of National Health Service work and university work
- Appointment of a colleague as clinical director for whom I had no respect
- I was always in crossfire between medical colleagues and non-medical managers
- I was deeply disenchanted by the fact that I did not have any influence over long-term or day-to-day plans, although ultimately I carried the can
- Only negative feedback from managers
- The main reason was a feeling of being unappreciated or unsupported by management – an atmosphere of alienation – 'us and them'
- Appalling attitude of the purchasers (hostility and grossly inadequate funding) to psychiatry

all mental health professional groups; and a culture of blame. Policy seeks to divert patients from the criminal justice system into mental health care and places duties on psychiatrists to provide discharge planning, risk assessment and continuity of care but does not (yet) allow for compulsory community treatment. Homicides by patients automatically result in an independent inquiry with a report which becomes a public document and which not infrequently allocates blame to individuals, reflecting the 'moral panic' associated with care of the mentally ill in the UK.

Emerging Government mental health policy is predicated on the view that "care in the community has failed" (DoH, 1998*a*, Chapter 3), a statement that is hardly designed to encourage a beleaguered workforce and is at best a sweeping generalisation (Thornicroft & Goldberg, 1998). At the time of writing, major reviews of policy are in train to underpin the strategic framework spelt out in *Modernising Mental Health Services. Safe, Sound and Supportive* (DoH, 1998*a*), including a National Service Framework for adult mental health (DoH, 1999), a review of the Mental Health Act 1983, radical revision of policies on care management and the Care Programme Approach and a new structure for managing people with severe antisocial personality disorder. These reviews will add further turbulence to the health and social care system as it attempts to digest the implications of the development of integrated health/social services mental health teams, the introduction of clinical governance and the evolving role of primary care groups.

The medical profession is regulated in the UK by the General Medical Council (GMC), which has taken an increasingly active role in recent years as concern over professional standards has increased (Irvine, 1997). Providers are required to have in place procedures for identifying under-performing doctors and taking appropriate remedial action, including, if necessary, referral to the GMC. The public are encouraged to report their concerns to the GMC Fitness to Practice Directorate, which will investigate all complaints about competence and invite the doctor concerned to provide a defence against the complaint. All complaints remain on file, whatever their motivation and justification. The GMC procedure is separate from the existing National Health Service (NHS) Complaints Procedure. This mandates the rapid but formal investigation of complaints, with the opportunity for escalation from a managerial response through local resolution to independent review and with a final option of involvement of the Health Service Ombudsman.

A further seismic event in the medical profession has been the Bristol case involving cardiothoracic surgeons with an unacceptably high mortality rate for complex procedures (Smith, 1998), which has brought into question the viability of professional self-regulation. There is an increasing demand for what has been termed 'controls assurance' to identify and manage clinical risk (DoH, 1998*b*) and by

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**Table 1. A model of the stress process (from Fagin *et al*, 1996)**

| | | |
|---|---|---|
| ***External stressors*** | Occupational stressors, hassles or uplifts and major life events | |
| ***Mediating or buffering factors*** | *Positive mediators* | *Negative mediators* |
| | High self-esteem | Low self-esteem |
| | Good social support | Lack of social support |
| | Hardiness | Vulnerability |
| | Coping skills | Restricted coping |
| | Mastery and personal control | External control |
| | Emotional stability | High neuroticism |
| | Good physiological release mechanisms | Poor physiological release mechanisms |
| ***Stress outcomes*** | *Positive outcomes* | *Negative outcomes* |
| | Psychological health | Psychological ill-health |
| | Low burn-out | High burn-out |
| | High job satisfaction | Low job satisfaction |

implication identify and weed out the 'risky' practitioner. Clinical governance can be seen as an attempt to ensure that there will be no more 'Bristol's' that might embarrass the Minister.

# Stress in mental health professionals

## *A model of the stress process*

There is accumulating research evidence for the stressful nature of the health and social care professions (Guthrie & Black, 1997) and consequently a growing interest in interventions that will decrease stress (Carson & Kuipers, 1998). This large and confusing literature often lacks a theoretical grounding. Fagin *et al* (1996) have put forward a three-stage model of the stress process (Table 1). External stressors, which comprise specific occupational stressors, minor 'hassles' and 'uplifts' and major life events, impinge on the individual. Mediating or buffering factors such as self-esteem, social support and individual coping skills determine the effect of the ubiquitous external stressors on the individual in terms of stress outcomes. These outcomes are generally measured in terms of psychological ill-health, burn-out and job satisfaction.

A model of the stress process needs to be an interactive one: the poorly-functioning doctor who lacks appropriate coping mechanisms and ends up working in an improverished service may well experience more occupational stresses than his or her more successful peer working within a well-resourced and professionally rewarding service ("Unto them that have more shall be given.") Overwhelming personal or professional life events (e.g. a patient homicide) may lead to the decompensation of even the most resilient and best-supported professional. The model also requires modification to take account of a range of positive 'motivating' factors for workers – sources of job satisfaction for the individual. These will include recognition for work done, responsibility for others, personal advancement and salary (Benbow & Jolley, 1998), opportunity for working autonomously using specialist skills, variety in the job, physical security and a valued social position (Warr, 1987).

## *Stressors for psychiatrists*

There are a number of broad categories of job-related stress: intrinsic characteristics of the job; organisational structure and climate; relationships within the work setting; and the demands of and opportunities for career development (Benbow & Jolley, 1998).

Drawing on the results of the NHS Workforce Study (Borrill *et al*, 1996), Thompson (1998) has identified a range of stressors experienced by psychiatrists, including: high work demands and insufficient resources; ambiguity of the consultant role, which is experienced as combining medical responsibility with lack of authority over non-medical colleagues; role conflict, when the perceived priorities of employers may conflict with the perceived interests of patients; poor social support, consequent on the dispersal of consultants into community teams; lack of feedback on job performance; and lack of influence over decisions at work.

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These issues are reflected in the comments of consultant psychiatrists who retire prematurely (Kendell & Pearce, 1997) (see Box 1). Themes identified in a detailed qualitative study of sources of stress for mental health professionals working within a well-resourced community service were strikingly similar. In rank order, these were: administrative demands (79% of respondents); lack of resources (75%); work overload (58%); responsibility for patients (54%); patients relapsing (37%); fears of violence (33%); time management (33%); and working with demanding patients (29%) (Reid *et al*, 1999*a*). Similar stressors were identified by Guthrie *et al* (1999) in a study that compared the sources of stress identified by trainee and consultant psychiatrists, although the impact of stressors was rated quite differently between junior trainees, specialist registrars and consultants. One striking finding was that 47% of consultants reported that their relationship with consultant colleagues was moderately or very stressful. Old age psychiatrists have reported their major stressors to be: overwork (56% of respondents); management issues (43%); resource issues (38%); personal stressors (33%); lack of time (30%); changes in the health service (22%); and changes in community care (17%) (Benbow & Jolley, 1997).

The day-to-day demands on the consultant psychiatrist are many and various. Community psychiatrists are expected to deal rapidly and effectively with a wide variety of clinical risks (Holloway, 1997). The risks presented in one difficult but not atypical day to one of the authors are shown in Box 2. In addition to clinical risk, the consultant may experience a wide range of professionally adverse experiences: a set of such experiences directly or indirectly encountered by the authors is shown in Box 3. Each of these is likely to require formal or informal support for the average psychiatrist.

**Box 2. One day's risk decisions at the team base (from Holloway, 1997)**

**Patient with history of making threats with a knife fails to attend out-patient appointment**
**Patient who is relapsing reported to have knives under her pillow and to be threateing in demeanour**
**Patient who is alcoholic and psychotic and has previously been verbally abusive in the clinic rings to say he is coming to the team base after receiving a letter from the housing department**
**Former patient who stabbed a psychiatrist while psychotic rings asking for an urgent appointment**
**Urgent request from a prison medical officer to take a youth who had previous contact with the service and is now assessed as acutely psychotic under section 47**
**Telephone call from a neighbour stating that a patient with psychosis who has assaulted people when acutely ill is shouting to himself in his flat**
**Request from a child care social worker for a report about a patient conditionally discharged under s37/41 who is now pregnant: all children from previous pregnancies have been taken into care**
**Information from community psychiatric nurse that a woman with a bipolar disorder is refusing treatment and has taken to her bed**
**Recently discharged patient who has been assaultive when ill fails to attend out-patient appointment having previously announced a refusal to accept treatment**
**Patient with a bipolar illness and history of crack cocaine use reported to be threatening to family**

## Stress outcomes for mental health professionals

Stress outcomes are commonly measured in three dimensions: psychological distress (e.g. using the General Health Questionnaire (GHQ)); 'burn-out' (using standardised measures such as the Maslach Burnout Inventory); and job satisfaction. To these can be added objective data on staff sickness and staff turnover. The NHS Workforce Study identified high rates of 'caseness' using the GHQ–12 in a large sample of staff. The highest prevalence of caseness by occupational group was in managers (33.4%), followed by nurses (28.8%) and doctors (27.8%) (Wall *et al*, 1997). There is evidence that, using the GHQ, consultants in general are more likely to be psychiatric cases than trainees (Kapur *et al*, 1998), although this difference was not found in a survey of psychiatrists (Guthrie *et al*, 1999). Consultant psychiatrists work fewer hours than consultant physicians and surgeons, but report more emotional exhaustion and more depression (as measured in the GHQ–28) than their colleagues (Deary *et al*, 1996). A survey of community mental health teams (CMHTs) found that psychiatrists scored highest in the burn-out categories of emotional exhaustion

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**Box 3. Hypothetical scenarios where a consultant psychiatrist might require support**

**A patient makes an explicit threat to kill you**
**A former patient commits a homicide. You are called as a witness in the subsequent external inquiry**
**A complaint against you has gone to independent review. You are called to a meeting by the service manager to discuss the 'shortcomings' in the patient's care as identified by the review**
**You are in conflict with the community nursing team leader who has taken a grievance against you because of your 'high-handed behaviour'**
**You receive a letter from the GMC Fitness to Practice Directorate relating to a complaint that they have received from a patient's mother about your care**
**Your waiting time for new out-patient appointments has increased to 10 weeks. The local general practitioners have complained to the Trust Chief Executive about your 'poor service'**
**You have been in post for 20 years. Although conscientious in following the literature, you lack some of the skills of your more recently appointed colleagues. You are becoming disillusioned and depressed**
**You are told informally of concerns about the clinical performance of a consultant colleague**
**You receive a briefing from the Trust Board that following the implementation of clinical governance all consultants are required to participate in clinical audit. You feel you have no time for this and doubt its utility**

(63.4%) and de-personalisation (47.5%) out of all the professional groups within a CMHT (Onyett *et al*, 1997). Interestingly, studies of community mental health workers have found that despite high levels of caseness and burn-out, reported job satisfaction is consistently high (Carson *et al*, 1995; Onyett *et al*, 1997; Prosser *et al*, 1996). There is some evidence that job satisfaction protects doctors in jobs they perceive as stressful from psychological morbidity (Ramirez *et al*, 1996).

## *Mediating factors*

Carson & Kuipers (1998) list mediating factors that might buffer the effects of occupational and life stresses. These include the individual's self-esteem, social support networks, hardiness, coping skills, mastery and personal control, emotional stability and physiological release mechanisms (such as humour, the ability to relax and the ability to let-off steam). Some of these appear to reflect temperament or personality traits which might be enduring or resistant to change. There is some evidence that psychiatrists differ from other doctors in terms of personality traits (Deary *et al*, 1996) and that these differences have been apparent since before the initial choice of specialisation (Firth-Cozens *et al*, 1997). Other mediating factors reflecting the environment or coping strategies, might be more amenable to change.

The one factor outstandingly and regularly referred to by mental health staff as being important in coping with work demands is talking with colleagues within the work setting, who are also perceived as the major source of support (Reid *et al*, 1999*a*). The potentially isolated position of the consultant within a mental health team and the frequency with which consultants cite their relationship with their peers as a source of distress are both issues which deserve attention.

# Support systems

## *Managing workplace stress*

Strategies to deal with the stresses of working life can be divided into those centred around the individual worker and those focused on the organisational characteristics of the workplace (Carson & Kuipers, 1998). Individually-based interventions include improving the coping skills of the worker (e.g. social skills training, stress management interventions, social support, training in time management and encouraging staff to alter their lifestyle, particularly the balance between work and home life). These 'therapeutic' interventions are reviewed in detail by Carson & Kuipers (1998), who quote Reynolds & Briner (1994):

> "occupational stress reduction is…one of the many fads initiated by academics, commercialised by consultants and embraced by managers that ultimately fail to deliver the panacea-like solutions which they promise".

One popular stress management technique in mental health services is the staff support group, although support groups are not necessarily

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perceived as valuable or even supportive by a significant proportion of staff (Reid, 1999*b*).

The occupational literature identifies a range of workplace interventions that might decrease stress. These consist of attention to a number of domains:

- *role characteristics* – issues of clarity of role and workload
- *job characteristics* – attending to the design of the job
- *interpersonal relationships* – improving communication systems within the workplace
- *organisational structure and climate* – encouraging decentralisation and participation by the workforce in decision-making
- *human resource management* – recruitment and selection policies that select staff for the task in hand, effective mechanisms for supervision, appraisal and performance management
- *physical aspects of the work environment*

All these are at least partially remediable within an effective management culture.

## Support systems for psychiatrists

A range of support systems that might impact on the work experience and performance of consultant psychiatrists is presented in Box 4. Clearly, consultants going into post must have adequate training for the roles they will undertake. This will include both clinical and managerial skills (including the assessment and management of risk), specific training in the role of the doctor within a multidisciplinary team and a firmer grasp of mental health law than is currently required. Trainees require a solid understanding of the principles and practice of health service management. Arguably, active engagement with the manifold ethical dilemmas that arise in psychiatric practice (Szmukler & Holloway, 1998) might prepare the trainee for the pressures of the consultant role, which are ubiquitously experienced but rarely systematically analysed. 'Calmanisation', with its strict curtailment of the length of training, has, in these respects at least, done the aspiring consultant psychiatrist no favours.

Given that tasks, technologies and expectations within health services change rapidly, there is a clear central role for continuing professional development (CPD) and the opportunities it offers for the maintenance of knowledge, skills and professional attitudes, the acquisition of new skills and supportive contact with peers. There is a rhetoric of 'lifelong learning', which may be at odds with the reality of hard-pressed consultants reluctantly finding time for external and internal CPD events of dubious educational quality. There are financial implications for employers if CPD is to move from rhetoric to reality: good training costs professional time and, therefore, money.

**Box 4. Potential remedies for the stresses experienced by consultant psychiatrists**

**Adequate training for the role: clinical and managerial skills**
**Appropriate job design: clear and achievable job description with adequate supports to carry out the required tasks**
**Continuing professional development opportunities for maintenance of knowledge and skills and acquisition of new skills**
**Informal support by consultant colleagues (requires regular contact, preferably by co-location of offices)**
**Formal meeting structure: participation in regular clinical and non-clinical meetings**
**Support from multi-disciplinary team**
**Formal appraisal mechanisms and opportunities for mentoring**
**Wider professional contact: membership of College groupings or other professional organisations**
**Special interests: specialist clinics, academic sessions and private practice**
**Capacity to negotiate with management: access to senior managers and contact with purchasers**
**Opportunities for second opinions and risk-sharing with colleagues**
**If necessary, access to the General Medical Council's health procedures**
**In future, access to teleconferencing to obtain rapid access to specialist opinion**

To function effectively, the consultant psychiatrist requires his or her job to be designed appropriately. This requires a clear and achievable job description and adequate support to carry out the required tasks. A key role for the medical manager is to ensure that all consultants have a well-defined job description and person specification. One important managerial skill, which can be supported by the College, is to use a vacancy to review job descriptions and ensure that advertised posts have realistic expectations of the post-holder that reflect current good practice. Both the applicant and the employer must be clear that the job is the right one for the potential post-holder (a difficult rule to follow in a shortage speciality where some services face complete

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breakdown owing to difficulties in recruitment and retention).

It is clear that mental health workers in general derive most support from peers, although this is not necessarily the experience of consultant psychiatrists. The opportunities for the consultant to receive support from non-medical colleagues are real but rarely discussed in the literature, which tends to focus on the isolated 'leadership' role of the consultant. Informal support by consultant colleagues, which requires day-to-day contact, is highly desirable. We have encouraged the co-location of offices for consultants in a highly community-oriented mental health service on the hospital site. This does not have to undermine the consultant presence within the CMHT, particularly in urban catchment areas. Consultant colleagues may develop concerns over performance or health of a peer that cannot be resolved informally. In this case, they have an ethical duty to take appropriate action, which should usually be through the medical director, if necessary involving the GMC health procedures. Anecdotally, the first years of the consultant role are particularly difficult. Within a large trust in an inner-city area, we have successfully facilitated the formation of an informal group of new consultants who have met regularly for peer support: similar initiatives may be feasible on a multi-trust basis.

It is important that consultants participate in a formal meeting structure, which includes participation in regular clinical and non-clinical meetings. Non-clinical meetings should enable consultants to be active participants in the day-to-day running of their services and to be actively involved in the strategic direction of the services within which they work. Clinical meetings are traditionally focused on the training of junior medical staff, but they might usefully be structured towards addressing the emerging agenda of risk assessment and risk management, and in particular the neglected element of risk-sharing.

Consultants should have access to, and be prepared to make use of, second opinions in problematical clinical situations, if necessary using expertise outside the local provider trust. In the near future, access to teleconferencing may allow the consultant to obtain rapid access to specialist opinion.

One very significant support mechanism is the opportunity for wider professional contact outside the local service. Membership of College groupings and other professional organisations can offer the consultant vital opportunities for reinforcing professional skills, enjoyable contact with peers and clarifying issues of concern or difficulty with peers. Similarly, consultants are well-advised to maintain special interests, which might include specialist clinics, academic sessions or private practice.

It is important that consultants have the capacity to negotiate with management. This requires skills on the part of the clinician, particularly in the formulation of issues of concern and the development of potential solutions, but more importantly a commitment from management towards their workforce and an understanding of the reality of the problems that practitioners experience. Senior managers should be accessible to and respectful of consultants. There should be opportunities for clinicians to have contact with purchasers, possibly mediated via the Public Health Department.

## Formal 'appraisal' and support

Management texts underline the value of formal mechanisms for supervision and appraisal. Community mental health staff experience supervision very positively (Reid *et al*, 1999*b*), although this is not available routinely to the consultant psychiatrist (or, for that matter, the consultant clinical psychologist). Benbow & Jolley (1998) have asserted that there is a need to review how consultant psychiatrists are supervised and supported, but without articulating a mechanism that could offer this to practitioners who are defined by and fiercely defend their clinical autonomy. Introducing supervision and appraisal may become less difficult as the current generation of trainees, who have been subject to the more thorough contemporary methods of scrutiny and appraisal, come into post. The clinical director role offers opportunities for a senior clinician who has the general support of colleagues to provide advice and support when the many practical hassles of the consultant role (identified, in part, in Box 3) threaten to become overwhelming.

Currently, appraisal and mentoring of senior doctors only comes into play when there is a perception that the doctor's functioning is unacceptable, within a framework involving the local employer (mediated by the medical director) and, if necessary, the GMC (Irvine, 1997). It can be argued on general principles that similar mechanisms are required for all consultants, irrespective of performance, to maximise the individual's potential – although the evidence base for this assertion is not entirely clear. Perhaps more pressing is the expectation that professional self-regulation is failing, and it may be that the introduction of mentoring and appraisal will modify demands for re-accreditation of specialist status. Domains that should be covered within an appraisal system are the individual's knowledge, skills and attitudes (against current standards of good practice, which will be evolving continually) on the one hand and his or her performance, both clinical and non-clinical, on the

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other. The ultimate goal, within the overall context of clinical governance, is the not unreasonable one that professionals should be judged by their clinical outcomes. Mentoring, which is purely supportive, needs to be distinguished from the performance management aspect of appraisal.

Formal appraisal procedures for consultants are currently the subject of much discussion, and confusion. The clinical governance framework will demand their implementation. In our view, the difficulties around appraisal mechanisms turn on a lack of clarity of purpose. Appraisal is in danger of being an 'overburdened' concept. We can recognise at least five purposes linked to the term:

(a) Helping consultants continually to develop practice, improve performance, and achieve excellence: this is seen as a supportive process, occurring within a confidential relationship with the appraiser.
(b) Reviewing performance (e.g. using a set of indicators of minimum standards): this obviously needs to be taken into account in developing one's practice, but it raises the question of what should be done if standards are not met.
(c) Dealing with poor performance: here, standards are not being met. Remediation may be offered within a context of support, education and training, and perhaps it can be done within the same appraisal setting as that for continual development. However, if seriously poor performance is at issue, or 'supportive' remediation is not working (and someone needs to monitor this), and there is a threat of disciplinary proceedings, we believe it cannot be dealt with in the same 'appraisal' setting.
(d) Professional self-regulation and re-validation: there is a suggestion that local appraisal could be combined in some manner with external accreditation by a body such as a medical Royal College to form the basis for re-validation by the GMC. Results of appraisal must then to some extent become public.
(e) Reassuring the public that doctors are safe. It is not clear what would reassure the public; perhaps none of the procedures listed above would be effective.

A single annual 'appraisal' session with a clinical director or medical director cannot meet all of the purposes set out above. If we are serious about continuing development, it needs to be done in a supportive and essentially private setting (Standing Committee on Postgraduate Mental and Dental Education, 1998), more than once a year, and by someone whom the consultant trusts – perhaps a peer. Data about performance should be incorporated, as should a meeting with a service manager, so that the strategic direction of the trust and the business plan of the service are clear to both appraiser and appraisee. Dealing with performance failures and providing data for re-validation could be carried out by another type of 'appraiser', such as a clinical or medical director. Whatever the details, we would argue that if the supportive and developmental component is not to be lost, more than one type of appraisal procedure is required (with the consequent resource implications).

## Conclusions

Consultant psychiatrists are a small component of the mental health workforce. However, given their central role in the allocation of resources (through the decisions they make to treat and admit) and their capacity to influence the culture of the services within which they work, purchasers and trust managers should take their needs for support and professional development much more seriously than is currently the case.

The GMC has made it clear that the ultimate responsibility for maintaining an adequate standard of professional practice rests with the individual doctor. Above all, this is an ethical responsibility inherent in the medical role. The prevailing medical culture (and the day-to-day pressure of business) makes it very difficult for consultant psychiatrists to seek or receive support from their colleagues.

Developing appropriate support systems is the responsibility of many agencies (see Box 5), of which by far the most effective and user-friendly in our experience is the Medical Defence Organisation (other than your friendly local medical manager). Unfortunately, the Medical Defence Organisation, for which one pays, addresses only a restricted range of the issues that routinely distress the consultant psychiatrist. The introduction of clinical governance offers an opportunity for the enterprising medical director to ensure that systems are in place to provide support to the consultant body. These systems will be in the interests of practitioners, patients and carers and non-medical colleagues.

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https://doi.org/10.1192/apt.6.3.226 Published online by Cambridge University Press

**Box 5. Agency roles in support systems**

*Deparment of Health*
**Realistic policy framework**
**Abandoning the 'blame culture'**
**Delivering adequate resources for health services**
**Effective manpower planning**

*General Medical Council*
**Professional self-regulation**
**Overseeing training and registration of doctors**
**Health procedures**
**Fitness to practice**

*British Medical Association or other trade union*
**Negotiating appropriate national terms and conditions**
**Local negotiating committee**
**Trade union support when conflict develops with employer**
**Membership of peer group**

*Medical Defence Organisation*
**Medico-legal advice and support**

*Royal College of Psychiatrists*
**Professional examination**
**Training and accreditation of psychiatrists**
**Statements on the components of services and required resources**
**Approval of job descriptions**
**Organisation of CPD**
**Facilitation of specialist Faculties and Sections**
**Negotiation with the Department of Health/ NHS Executive**

*Health authority*
**Equitable local allocation of resources for mental health services**
**Negotiation of contracts with providers**
**Management of secondary/primary care interface**

*Employing trust*
**Effective and empowering management culture with ready access to senior managers**
**Requirements under health and safety law**
**Achievable expectations of practitioners**
**Reasonable job descriptions/timetables**
**Support for CPD, including study leave and support for clinical audit**
**Effective procedures for risk management and risk sharing**
**Via medical director – systems for appraisal and performance review effective intervention for the 'failing' or 'problem' doctor**
**Investigation of complaints**

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https://doi.org/10.1192/apt.6.3.226 Published online by Cambridge University Press

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## Multiple choice questions

1. Common stressors for community mental health staff include:
   a too much paperwork
   b conflict with colleagues
   c the physical environment of the team base
   d travelling to see clients
   e fears of violence.

2. The three occupational groups within the NHS with the highest prevalence of psychiatric caseness include:
   a occupational therapists
   b managers
   c social workers
   d doctors
   e clinical psychologists.

3. The role of the General Medical Council includes:
   a investigation of complaints about doctors by members of the public
   b regulation of undergraduate medical training
   c support for doctors under investigation
   d advice to medical directors regarding issues of fitness to practice
   e involvement in the management of the doctor whose performance is impaired owing to illness.

4. Consultant psychiatrists are:
   a less prone to burnout than other members of the community mental health team
   b likely to identify their colleagues as a source of stress
   c more likely to rate as psychiatric cases than juniors
   d identical to other doctors in terms of personality traits
   e likely to work longer hours than colleagues in other specialities.

5. Mediating factors that buffer occupational stress include:
   a pay levels
   b self-esteem
   c coping skills
   d job satisfaction
   e social support.

**MCQ answers**

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| a T | a F | a T | a F | a F |
| b F | b T | b T | b T | b T |
| c F | c F | c F | c F | c T |
| d F | d T | d T | d F | d F |
| e T | e F | e T | e F | e T |

# Commentary

Robert Hale & Sebastian Kraemer

This is a timely and useful start to a major debate that should now be taking place in mental health services. The authors have successfully woven the need for staff support into the themes of clinical governance and the national service framework for mental health and other Government initiatives.

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https://doi.org/10.1192/apt.6.3.226 Published online by Cambridge University Press