



Acknowledgements

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References

- APPLEBY, L. (1999) *Safer Services*. Department of Health.
- ATKINSON, R. L., ATKINSON, R. C., SMITH, E. E., et al (1996) *Hilgard's Introduction to Psychology* (12th edn). Harcourt Brace.
- BYRNE, P. (2000) Stigma of mental illness and ways of diminishing it. *Advances in Psychiatric Treatment*, **6**, 65–72.
- CORRIGAN, P. W. & PENN, D. L. (1999) Lessons from social psychology on discrediting psychiatric stigma. *American Psychologist*, **54**, 765–776.
- CORRIGAN, P. W. & WATSON, A. C. (2002) The impact of stigma on people with mental illness. *World Psychiatry*, **1**, 16–19.
- CORRIGAN, P., MARKOWITZ, F. E., WATSON, A., et al (2003) An attribution model of public discrimination towards people with mental illness. *Journal of Health and Social Behaviour*, **44**, 162–179.
- CRISP, A. H., GELDER, M. G., RIX, S., et al (2000) Stigmatisation of people with mental illnesses. *British Journal of Psychiatry*, **177**, 4–7.
- CRISP, A. H., GELDER, M., GODDARD, E., et al (2005) Stigmatization of people with mental illness: a follow-up study within the Changing Minds campaign of the Royal College of Psychiatrists. *World Psychiatry*, **4**, 106–113.
- CUMMINGS, E. & CUMMINGS, J. (1957) Closed ranks – an experiment in mental health education. Harvard University Press.
- DIEFENBACH, D. L. (1997) The portrayal of mental illness on prime time television. *Journal of Community Psychology*, **25**, 289–302.
- DOCHERTY, J. P. (1997) Barriers to the diagnosis of depression in primary care. *Journal of Clinical Psychiatry*, **58**, 5–10.
- GATHERER, A. & REID, J. J. A. (1963) *Public Attitudes and Mental Health Education*. Northamptonshire Mental Health Project.
- GRANELLO, D., PAULEY, P. S. & CARMICHAEL, A. (1999) Relationship of the media to attitudes towards people with mental illness. *Journal of Humanistic Counseling, Education and Development*, **38**, 89–110.
- JUREIDINI, J. N., DOECKE, C. J., MANSFIELD, P. R., et al (2004) Efficacy and safety of antidepressants in children and adolescents. *BMJ*, **328**, 879–883.
- KNOX, T., SMITH, J. & HEREBY, H. (2003) Risk of suicide and related adverse outcomes after exposure to a suicide prevention programme in the US air force: cohort study. *BMJ*, **327**, 1376–1378.
- LINK, B. G., CULLEN, F. T., STRUENING, E. L., et al (1989) A modified labelling theory approach to mental disorder: an empirical assessment. *American Sociological Review*, **54**, 400–423.
- LUTY, J., FEKADU, D., UMOH, O., et al (2006) Validation of a short instrument to measure stigmatised attitudes towards mental illness. *Psychiatric Bulletin*, **30**, 257–260.
- MAYVILLE, E. & PENN, D. L. (1998) Changing societal attitudes towards persons with severe mental illness. *Cognitive and Behavioural Practice*, **5**, 241–253.
- MONAHAN, J. (1992) Mental disorder and violent behaviour: perceptions and evidence. *American Psychologist*, **47**, 511–521.
- OFFICE OF THE DEPUTY PRIME MINISTER (2004) *Action on Mental Health – A Guide to Promoting Social Inclusion*. TSO (The Stationery Office).
- PAYKEL, E. S., HART, D. & PRIEST, R. G. (1998) Changes in public attitudes to depression during the Defeat Depression Campaign. *British Journal of Psychiatry*, **173**, 519–522.
- PENN, D. L. & MARTIN, J. (1998) The stigma of severe mental illness. Some potential solutions for a recalcitrant problem. *Psychiatric Quarterly*, **69**, 235–247.
- PENN, D. J., GUYNAN, K., DAILY, T., et al (1994) Dispelling the stigma of schizophrenia: what sort of information is best? *Schizophrenia Bulletin*, **20**, 567–578.
- PENN, D. J., KOMMANA, S., MANSFIELD, M., et al (1999) Dispelling the stigma of schizophrenia: II. The impact of information on dangerousness. *Schizophrenia Bulletin*, **25**, 437–446.
- PENN, D. L., CHAMBERLIN, C. & MUJESER, K. T. (2003) The effects of a documentary film about schizophrenia on psychiatric stigma. *Schizophrenia Bulletin*, **29**, 383–391.
- PINFOLD, V., TOULMIN, H., THORNICROFT, G., et al (2003) Reducing psychiatric stigma and discrimination: evaluation of educational interventions in UK secondary schools. *British Journal of Psychiatry*, **182**, 342–346.
- RITSHER, J. B., OTILINGAM, P. G. & GRAJALES, M. (2003) Internalized stigma of mental illness: psychometric properties of a new measure. *Psychiatry Research*, **121**, 31–49.
- THORNTON, J. A. & WAHL, O. F. (1996) Impact of a newspaper article on attitudes towards mental illness. *Journal of Community Psychology*, **24**, 17–24.
- WAHL, O. F. (1995) *Media Madness: Public Images of Mental Illness*. Rutgers University Press.
- WOLFF, G., PATHARE, S., CRAIG, T., et al (1996) Public education for community care. A new approach. *British Journal of Psychiatry*, **168**, 441–447.

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SUNIL MEHTA, ABHIJEETHA SALVAJI AND RIADH ABED

Roles of general adult psychiatrists in follow-up clinics

AIMS AND METHOD

Core features of New Ways of Working include concentrating on service users with complex needs, acting in a consultative role and carrying out interventions that are timely rather than routine. In this service-mapping exercise a retrospective analysis of 150 case notes was performed to evaluate clinical activity in general adult out-patient clinics and to attempt to measure the complexity of the workload.

RESULTS

Analysis of care programme approach (CPA) level revealed that 40% of patients were not on CPA and 16% of patients were on enhanced CPA. Only a third of the sample had a non-medical care coordinator. Absolutely no changes were made to the management plan in around half of the sample. A minority of patients needed to be seen acutely, within a month, or had their appointment brought forward.

CLINICAL IMPLICATIONS

Current out-patient activity of consultant teams does not appear to be consistent with New Ways of Working. Psychiatrists will be required to reflect on their roles in out-patient clinics to avoid 'routine' appointments and to use their time more efficiently.

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The 'New Ways of Working in Mental Health' initiative was set up jointly by the National Institute for Mental Health in England (NIMHE), the Department of Health and the Royal College of Psychiatrists following several years of murmurs of discontent from consultant psychiatrists. Kendall & Pearce (1997) had identified reasons for consultant vacancies and premature retirement by surveying over 100 consultant psychiatrists between 1995 and 1996. Rathod *et al* (2000) had found frequent reports of anxiety and depressive symptoms in psychiatrists related to the stress of working in psychiatry. An audit in London had revealed exceptionally large case-loads of community consultant psychiatrists (Tyrer *et al*, 2001).

Consultants have portrayed themselves as unattractive role models to junior doctors due to struggling with long hours, multiple demands, risk management and 'little time to practice the art of psychiatry' (Colgan, 2002). However, there have been some success stories, for example Hampson's (2003) restructured job plan in keeping with the new consultant role described by Kennedy & Griffiths (2001) who interviewed general adult psychiatrists to reveal emerging new roles for consultants in the climate of risk avoidance as well as reasons why others were unable to make similar changes to their work. The authors identified three types of consultant role: traditional, adapted traditional and the new role. The traditional consultant has an overwhelming number of out-patients on his books, whereas the new consultant has a low number of weekly follow-ups that are mostly reviews with keyworkers. With a greater degree of delegation, consultants are reported to be able to more rapidly support and supervise other mental health professionals dealing with emergencies.

The focus of New Ways of Working is primarily on consultant psychiatrists, but if implemented will inevitably involve the whole multidisciplinary team. The initiative concerns supporting and enabling consultants to deliver effective and person-centred care. It attempts to address dissatisfaction, burnout, and difficulties in retaining and recruiting staff in psychiatry by radically changing the role of the consultant through promoting distributed responsibility and allowing doctors to act as consultants to multidisciplinary teams. Not everyone is comfortable with the newer emerging roles as described in *New Ways of Working for Psychiatrists* (Department of Health, 2005). Ingram & Tacchi (2004) identify reasons for some of the barriers to accepting distribution of responsibility, including opposition to the cultural shift in medicine towards non-medical disciplines taking over roles that a traditional consultant would have otherwise assumed.

The core aims of New Ways of Working are making effective use of the skills of consultant psychiatrists for those service users with the most complex needs, to allow consultants to act in a consultative role, and to deliver interventions that are timely rather than routine. One way of assessing time spent in direct clinical care against these standards is to examine the activity of consultants in general adult out-patient clinics. Once New Ways of Working is implemented 'routine' follow-ups would be expected to decline or possibly be eliminated.

The aim of this service-mapping exercise was to attempt to identify and define what takes place within general adult out-patient clinics. Routine and infrequent appointments have been used as a proxy measure, admittedly imperfect, of the inappropriate use of consultant time on non-complex interventions that could have been delivered by another professional.

Method

The setting of this service-mapping exercise is Rotherham Mental Health Service in South Yorkshire, which is part of Doncaster and South Humber Healthcare NHS Trust. The trust has identified several ways in which New Ways of Working is to be implemented and is part of the national

Table 1. Results of data collection

	n (%)
Months since last appointment	
< 1	4 (2.7)
1–3	61 (40.7)
> 3–5	33 (22)
> 5–8	34 (22.7)
> 8	18 (12)
Appointment brought forward/urgent	4 (2.7)
Appointment requested by patient, carer or worker	6 (4)
Diagnosis	
Schizophrenia, schizotypal and delusional disorders	39 (26)
Depression	79 (52.7)
Bipolar disorder	13 (8.7)
Neurosis	8 (5.3)
Stress-related and somatoform disorders	1 (0.7)
Eating disorders	2 (1.3)
Disorders of adult personality	5 (3.3)
Other	5 (3.3)
Years of contact with services	
< 1	18 (12)
1–5	55 (36.7)
> 5	77 (51.3)
Patient has a non-medical care coordinator	55 (36.7)
Management plan	
Review of diagnosis	2 (1.3)
Review of medication	
No change	89 (59.3)
Change in dose	28 (18.7)
Change of drug	24 (16)
Physical healthcare intervention	27 (18)
Psychological intervention	11 (7.3)
Social intervention	8 (5.3)
Referral to community mental health team	3 (2)
Monitoring of risk	23 (15.3)
Admission to ward	0 (0)
Discharge from case-load	1 (0.7)
Mental Health Act assessment	1 (0.7)
Months before next appointment	
< 1	4 (2.7)
1–3	60 (40)
> 3–5	50 (33.3)
> 5–8	27 (18)
> 8	10 (6.7)



pilot for the initiative. There are eight general adult consultants covering a population of around 250 000. A data collection tool was designed to be as objective as possible in capturing the type of clinical activity and case-load in general adult out-patients in keeping with New Ways of Working. This tool was presented at a clinical effectiveness meeting, providing an opportunity for feedback and amendments. Criteria were agreed and a modified version was used for data collection (see Table 1).

Data collection was by retrospective case-note analysis of notes prepared for a forthcoming clinic. The last documented clinic session was the point of reference for data collection. Out-patient notes for six out of eight consultant teams were examined using the data collection tool as the notes for two consultant teams were prepared off-site and therefore excluded for convenience. New patient appointments were excluded since the primary focus was on 'routine follow-up' cases. The possible outcomes and interventions listed in the management plan in Table 1 are not mutually exclusive (i.e. each patient could have received one or more interventions).

Results

A total of 150 case notes prepared for general adult out-patient clinics between November 2005 and January 2006 were examined. The majority of patients (57%) had their previous appointment more than 3 months ago and 58% were being followed-up more than 3 months later.

A breakdown of care programme approach (CPA) levels revealed the following: 40% of patients were not on CPA, 44% were on standard CPA and 16% were on enhanced level. In terms of interventions and activity during the appointment, 59% of patients had no changes made to their medication and 51% had no changes made to their care plan.

Discussion

Defining what makes a case routine, complex or urgent is not straightforward. These concepts are not constant and may fluctuate during the course of a patient's condition. However, we believe that regular appointments that are 3 months or more apart do not suggest urgency. Features such as standard or no CPA level and lack of objective clinical activity imply low complexity. These parameters are by no means perfect, but when considered together allow us to provide an estimate for the proportion of cases that might not have required consultant time.

The results of this service-mapping exercise suggest that only a small proportion of work taking place in adult out-patient follow-up clinics could be classified as complex. The majority of patients were either not on CPA or were on standard level. It is notable that around half the sample (51%) had no changes made to their care plan whatsoever, which raises the possibility that a consultant review might not have been required.

Only 3% of patients were seen on an urgent basis. This figure reflects those appointments brought forward for clinical need where there was documentation to this effect. However, we appreciate this may be an underestimate of the true number. It is possible that patients are not seen sooner owing to non-urgent patients blocking clinics or perhaps urgent patients are being more appropriately directed to other teams, such as the crisis resolution and home treatment team.

One weakness of this study, as with all retrospective case-note analyses, is the reliance on adequate recording and clinical documentation. Consultant appointments may offer something that is valuable to the patient, or indeed to the service, but this has proved difficult to measure objectively and is hence unlikely to be looked upon sympathetically by commissioners of services. It has been assumed that medication and mental state were reviewed routinely as these are basic functions of an out-patient clinic, however, these are not always documented. Moreover, interventions such as supportive counselling may well have been delivered more frequently without being documented, but we would still question whether such an intervention would require a consultant. In addition, we appreciate that reviewing the entry of a single appointment does not reveal the full complexity of a case. This could be better gained from a review of the whole case record. Also, the authors acknowledge that neither patient nor carer views have been taken into account in the discussion of the potential implications of this study on consultant clinic lists.

Suggestions for future work include obtaining the clinician's response as to whether the clinical activity could have been performed by another professional and the duration of the appointment as included in an out-patient clinic audit tool from one pilot site (Department of Health, 2005). However, disadvantages with the latter tool are that it is time-consuming because it requires several participating clinicians and needs to be filled in during the clinic, and its lack of parameters that attempt to capture complexity and urgency.

In conclusion, consultants will be increasingly required to reflect on their practice in order to ensure they work more efficiently and that their skills are directed at the more acute, complex and high-risk cases. We suggest that this study supports the contention that follow-up clinics in their existing form are an inefficient use of consultant time and hence in need of a radical overhaul along the lines of the New Ways of Working initiative.

Declaration of interest

The Doncaster and South Humber Healthcare Trust is one of the consultant development sites for New Ways of Working.

References

- COLGAN, S. M. (2002) Who wants to be a general psychiatrist? *Psychiatric Bulletin*, **26**, 3–4.
- DEPARTMENT OF HEALTH (2005) *New Ways of Working for Psychiatrists*. Department of Health.

original
papers

HAMPSON, M. (2003) It just took a blank sheet of paper: changing the job plan of an adult psychiatrist. *Psychiatric Bulletin*, **27**, 309–311.

INGRAM, G. & TACCHI, M. J. (2004) Service innovation in a heated environment: CATS on a hot tin roof. *Psychiatric Bulletin*, **28**, 398–400.

KENDELL, R. & PEARCE, A. (1997) Consultant psychiatrists who retired prematurely, 1995 and 1996. *Psychiatric Bulletin*, **21**, 741–745.

KENNEDY, P. & GRIFFITHS, H. (2001) General psychiatrists discovering new roles for a new era... and removing work stress. *British Journal of Psychiatry*, **179**, 283–285.

RATHOD, S., ROY, L., RAMSAY, M., et al (2000) A survey of stress in psychiatrists working in the Wessex Region. *Psychiatric Bulletin*, **24**, 133–136.

TYRER, P., AL MUDERIS, O. & GULBRANDSEN, D. (2001) Distribution of case-load in community mental health teams. *Psychiatric Bulletin*, **25**, 10–12.

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JOHNNY DOWNS AND MARTIN ZINKLER

Clozapine: national review of postcode prescribing

AIMS AND METHOD

We review the prescribing rates for clozapine among all mental health trusts in England and explore whether it has changed with the introduction of NICE guidelines, generic clozapine and the Healthcare Commission ratings. Data were collected from mental health trusts in 2005–2006 and compared with a

previous study from 2000. Mental health star ratings of 2004–2005 were taken from the Healthcare Commission.

RESULTS

We found a reduced inter-trust variability from 34-fold variation in 2000 to 5-fold variation in 2005–2006. There was a significant inverse

relationship between star rating and clozapine prescribing.

CLINICAL IMPLICATIONS

NICE guidelines and generic clozapine seem to have improved access to gold standard therapy for treatment-resistant schizophrenia. Star ratings have little bearing on the implementation of NICE guidelines.

Clozapine is a unique agent in the treatment of schizophrenia. It is significantly more effective in treating positive and negative symptoms than other antipsychotics but it can cause serious side-effects of agranulocytosis in a significant proportion (0.8%) of patients (Alvir *et al*, 1993).

It has received strong endorsement as a cost-effective therapy by the National Institute for Health and Clinical Excellence (NICE) in their guidance on the use of new antipsychotic drugs for schizophrenia (National Institute for Clinical Excellence, 2002). It is recommended for all patients who are treatment resistant (i.e. who have failed to respond adequately to a trial of two antipsychotic medications). This implies that around 18% of patients diagnosed with schizophrenia could be treated with clozapine.

Starting and stabilising a patient on clozapine has greater resource implications for mental health staff and patients than any other antipsychotic medication. Treatment usually requires initiation in hospital or intensive monitoring in the community (for example home treatment or day hospital).

Large variation in its utility has been noted in a previous study. In 2000 a 34-fold variation in prescribing practices was reported (Purcell & Lewis, 2000) among 12 trusts over 3 years, and this degree of maximum variation was stable over that period. Non-evidence-based practice was cited as the main contributing factor for low prescribing of clozapine, with cost and licensing restrictions compounding the reluctance to utilise the drug. A study in 2003 in the same region (Hayhurst *et al*, 2003) revealed a 16-fold variation per capita use of clozapine between local mental health trusts.

Since the publication in 2002 of the NICE guidelines on the treatment of schizophrenia, and the significant reduction of the cost of clozapine after it came off patent in 2004, we hypothesised that access to clozapine would increase and become more consistent. We are not aware of any further studies on the topic. We were also interested to explore whether, owing to the diverse clinical, logistic, and patient-orientated resources that are required to implement successful clozapine therapy, the overall performance of a mental health trust could be implicated in its delivery.

We believe that a trust's performance in making clozapine available to its population reflects on this trust's ability to:

- implement evidence-based treatment
- devolve resources to the people most severely affected by mental illness
- deliver interventions that imply a significant amount of active work with patients, negotiate informed consent and foster consistent engagement with services
- to sustain sound organisational structures in running clozapine clinics.

At the time of this study the only measure available to judge a trust's global performance on clinical, logistic and patient-centered service delivery was the Commission for Health Improvement (now Healthcare Commission) star rating scheme. The question emerged whether a trust's performance (star rating) correlated with the availability of clozapine to its population.