



special articles

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Service innovation: psychiatrists on call – the community at night

There have been significant changes in the provision of medical care in hospitals at night. The initial catalyst for this was the New Deal for Junior Doctors but more recently the European Working Time Directive requiring doctors' hours to be reduced to 56 in 2002 and to 48 by 2009. The reduced availability of junior doctors in hospitals at night has had a range of implications, including the necessity to train other health professionals to do work previously undertaken by doctors and a reduction in the number of specialist doctors available out of hours. The expectation is that staff in the hospital at night will be equipped to deal appropriately and safely with emergency work across specialties, rather than each specialty covering their own patients.

In psychiatry reducing the working hours of junior doctors and implementing the Hospital at Night programme (Department of Health, 2005a) have necessitated review of having resident junior doctors on call at night and the training of nurse practitioners to take on some roles of the on-call duty doctor. The extension of prescribing to nurses and other professionals will facilitate and hasten this process; prescribing has been a role which it has not been previously possible to delegate.

Although there have been significant and, in some cases, far-reaching changes in out-of-hours hospital work, there has been little discussion of the implications for out-of-hours work in the community and whether the principles of the Hospital at Night programme apply equally to the community at night.

This paper sets out the response by a medium-sized specialist mental health and learning disability trust in Dorset to the challenges of providing safe and appropriate out-of-hours care in the community, balancing the need to have satisfactory working hours, not only for training grade doctors but also for career grade doctors. In meeting this challenge the trust was influenced by the Royal College of Psychiatrists' *Good Psychiatric Practice* (Royal College of Psychiatrists, 2004). This states that all psychiatrists should be equipped to deal with emergencies across sub-specialties. In the section on competencies, *Good Psychiatric Practice* states that 'All psychiatrists will have a common basic understanding of the following specialties: child and adolescent psychiatry, forensic

psychiatry, general adult psychiatry, psychiatry of learning disability, liaison psychiatry, psychiatry of old age, psychotherapy and psychiatry of substance misuse. Knowledge and skills in these areas will need to be maintained and updated. All psychiatrists should be competent to assess and undertake the immediate management of patients for whom they have responsibility when on-call over the weekends and in emergencies.' The document goes on to state that 'All psychiatrists should have skills in the assessment of psychiatric disorder complicated by or associated with substance misuse and of psychiatric problems in young people, older people and people with learning disability and skills in the immediate (short-term) management of these conditions, together with sufficient knowledge of management strategies and local services to suggest appropriate care for these conditions and knowledge of the differing ethical and legal frameworks to ensure appropriate emergency care'.

The trust was also influenced by the emerging proposals from the now published *New Ways of Working for Psychiatrists* (Department of Health, 2005b) and the White Paper *Valuing People* (Department of Health, 2001). *New Ways of Working for Psychiatrists* gives clear guidance about the need for trusts to devise job plans for consultant psychiatrists that will prevent them from becoming burnt out and demoralised through excessive workloads. *Valuing People* is clear that 'a person with learning disability who has a mental illness should therefore expect to be able to access services and be treated in the same way as everyone else'.

Historical on-call arrangements in East Dorset

In 1993 there were two separate consultant on-call rotas for general adult and old age services within East Dorset, with consultants on call 1 in 5. In 1996 these rotas merged into one so that there was a single rota covering patients in learning disability, general adult and old age psychiatry. Child and adolescent services were covered by a separate rota. The frequency of on call at this time was 1 in 11 for consultants in general adult, old age and learning disability psychiatry and 1 in 3 for consultants in



child and adolescent psychiatry. The senior doctor on call was supported by a resident junior doctor in the main hospital base and a non-resident junior doctor/staff grade in other peripheral units.

In 2001 an out-of-hours nursing service was established to run alongside and in parallel with the medical on-call rota, to provide additional support for existing patients but not to provide assessment of new patients. In 2003 the out-of-hours nursing service was strengthened by the appointment of nurse practitioners to undertake first-line assessments from the accident and emergency departments of the two local general hospitals and to take all hospital calls at night in place of junior doctors who became non-resident.

In 2003 the trust also appointed 1.5 additional consultant psychiatrists in child and adolescent mental health services (CAMHS). These new consultants did not wish to participate in a 1 in 4.5 on-call rota or even a 1 in 6 on-call rota, which was the projected development for CAMHS within the trust. A discussion was held with the consultant body as to whether the CAMHS consultants should join the well-established combined learning disability, general adult and old age psychiatry on-call rota. It was agreed to trial a combined senior on-call rota for a period of 6 months.

Preparation for combined rotas

Training was given by the child and adolescent consultants to their consultant colleagues in the management of psychiatric emergencies in children; in particular, the use of the Children Act 2004, the issues of capacity and consent in children and the links with social services. Arrangements were clarified with the paediatric services that all children under 16 who had taken overdoses would be admitted to a paediatric ward overnight and reviewed by CAMHS the next day. At weekends, the paediatrician would make a decision about whether the child needed to be kept in hospital until the next working day. This decision could be made in conjunction with the on-call psychiatrist. Arrangements were made for emergency assessments by the CAMHS team of all children who had been discharged from the general hospital on the next working day.

Child and adolescent consultants and general adult consultants, in psychiatry were both anxious about their extended on-call roles. However, the training reassured anxious colleagues in both adult and child and adolescent services. All consultants indicated that they would be happy to be contacted by other colleagues, even if not on call, to provide advice during the trial period.

At the end of a 6-month trial there was unanimous agreement by consultants within the trust that the on-call system had been a success and it was therefore agreed to continue.

Training grade doctors

It was discussed initially whether the specialist registrars in general adult/old age psychiatry and CAMHS should remain on separate rotas. It was decided not to do this,

both because of the College recommendations about training in the emergency management of other sub-specialties (Royal College of Psychiatrists, 2004) and because specialist registrars were being trained to be consultants, and the on-call rota, although innovative, might well be adopted elsewhere. Those specialist registrars obtaining consultant posts in Dorset would be helped by the experience of on call across the sub-specialties.

Safeguards were incorporated into the system for specialist registrars.

- The specialist registrar should contact the consultant on call for discussion of the management of all patients aged 15 and under
- The specialist registrar was encouraged to contact the child and adolescent psychiatrist the next working day for supervision and advice about all patients under the age of 16 seen out of hours
- Any concerns and difficulties would be discussed in the already established monthly on-call supervision group between specialist registrars and consultant psychiatrists.

The system was approved by the Specialist Training Committee in Psychiatry of the Wessex Deanery. Subsequently inspectors from the Royal College of Psychiatrists General Adult and Old Age Higher Specialist Training Scheme expressed concern about such trainees working with children and adolescents and those with learning disability out of hours. They have recommended that this aspect of the rota for these trainees ceases.

Functioning of the new rota

The new rota has now been running successfully for over 2 years. The consultant body continue to be supportive of the rota and feel that they have the necessary skills to manage emergencies as they arise. All new consultants appointed to the rota in all sub-specialties are given appropriate training and induction to ensure that they feel equipped to undertake the role of senior on-call consultant. Feedback from specialist registrars has indicated that they receive appropriate support and supervision in fulfilling their on-call duties.

Discussion

The change from traditional ways of working always has the potential to raise anxieties, and in medicine concerns about reduction in standards. We believe that we have developed an on-call system which both maintains high standards of psychiatric practice and provides an appropriate work–life balance for consultant psychiatrists. The system is in line with all relevant government directives and facilitates achievement of the objectives set out in *Good Psychiatric Practice*. Feedback from consultant psychiatrists has been uniformly positive. Feedback from specialist registrars has indicated that the on call has been a useful training experience and has been appropriately supported by training and supervision. There have been no concerns about clinical practice out of hours. We



hope that this system of on call, which we believe is not replicated elsewhere in the country, provokes discussion about best practice in out-of-hours psychiatric provision. This could be a model as to how high standards can be maintained while ensuring that career grade doctors have satisfactory and enjoyable working lives. Recruitment and retention of consultant psychiatrists remains an ongoing problem and improving the quality of a consultant's working life both in and out of hours will help address this issue.

Declaration of interest

L.M.-W. is the Medical Director of Dorset HealthCare NHS Trust and a general adult psychiatrist. D.C. is Associate Medical Director of Dorset HealthCare NHS Trust and a consultant in old age psychiatry.

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Therapeutic use of soap operas in autistic-spectrum disorders

'Soap opera' is a popular television genre that 'invites the audience to . . . identify with characters' (Livingstone, 1990). Storylines tend to be shaped by national and local culture, although they may feature a disproportionate number of unstable relationships and tragedies (Liebes & Livingstone, 1998). Narratives evolve continually, allowing scriptwriters to incite viewer debate on myriad topical social issues, including mental illness (Reveley, 1997).

Social change attributable to television drama programmes has already been documented (Singhal & Obregon, 1999). In 1975, the first pro-social soap opera 'Ven Conmigo' was credited with a 63% rise in literacy rates in Mexico (Brown *et al*, 1989). Following the screening of a Tanzanian soap opera on family planning methods, a large field study demonstrated an impressive increase in the uptake of contraception (Rogers *et al*, 1999). This capacity for community change implies potential for individual change, a concept which might support the therapeutic use of soap opera material. Moreover, the enduring emphasis on inter-character relationships in soap operas might provide a resource for exploring emotions and relationships in a clinical setting. Their rich audio-visual medium and established public popularity might also motivate potential clients (Creswell, 2001).

Current evidence supporting the therapeutic use of soap operas is limited but they have been used effectively to encourage discussion, problem-solving and self-awareness in therapeutic groups (Falk-Kessler & Froschauer, 1978). Qualitative research supports the use of soap opera material in identity work with Asian adolescents (Barker, 1997). Dutch adolescent girls who watched a soap opera in which family conflicts were a

central theme could relate the narratives to their own lives, discuss 'primordial life values' and reflect how they might have behaved in similar situations (De Bruin, 2001). Soap opera material has also been used effectively in cognitive skills training with an adolescent with learning disability (Creswell, 2001). A 'soap therapy' approach might be useful in children, including those with autistic-spectrum disorders, where descriptions of adapted cognitive therapy are currently relatively uncommon. Since family discussion of favourite television programmes has already been suggested to enhance social learning in autistic-spectrum disorders (Williams & Wright, 2004), therapeutic application of soap opera material might be similarly useful.

There is an ongoing need for evidence-based methods of teaching emotional recognition and social skills to individuals with autistic-spectrum disorders. A key feature of autistic cognition is delayed development of 'theory of mind', the concept that these individuals struggle to understand the thoughts, emotions and plans of others (Baron-Cohen *et al*, 1985). Since they fail to grasp that others think differently, people with autistic-spectrum disorders tend to encounter difficulties in relating to and anticipating the actions of others. Consequently, they may appear to be eccentric or self-centred, which further compounds their potential social isolation. One method used to facilitate social awareness is the 'social story', whereby hypothetical scenarios focus discussion on perspectives and cognitions of the self and others (Gray, 1993). Specially commissioned film clips have also been used effectively, but this is expensive and time-consuming, particularly for individualised therapies. More current tools include interactive computer programs