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Guest Editorial

General psychiatry, still in no-man's land after all these years

Martin Deahl

Summary

Mental health services have changed beyond recognition in my 38-year career. In this editorial I reflect on those changes and highlight the issues that undermine patient care and damage staff morale. In particular, modern mental health services have undermined the therapeutic relationship, the bedrock underpinning all psychiatric treatment.

Keywords

Mental health services; staff morale; therapeutic relationship; functionalisation; the role of the psychiatrist.

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In 1997 Trevor Turner and I published an editorial in this journal that we titled 'General psychiatry in no-man's land', outlining the trials and tribulations of our work at that time.[1] More than 25 years on I thought it timely to write an update to the sad state of affairs at that time. On the cusp of retirement, I had hoped to report improvement, or at least see light at the end of what has been a very dark tunnel. I reflect on my 38 years in National Health Service (NHS) psychiatry and make a plea to the Royal College of Psychiatrists, the NHS and the government to seize these issues and improve the *status quo*.

Postgraduate training then and now

In 1985 I commenced postgraduate training in psychiatry at the Maudsley Hospital, London. In addition to my workaday routine, the highlight of my first job on an adult general ward was being allocated one particular patient by my consultant trainer. 18-year-old Elizabeth had been referred with a first episode of a psychotic illness. My remit was to get to know her, her family and her life story better than anyone else, corroborating her history with third-party informants, including school reports and interviews with significant others in her life. Medication free, she remained in hospital for nearly 2 months while my painstaking detective work proceeded. Finally, I had the opportunity of presenting her to my consultant and multidisciplinary team – a 3-h interrogation exploring her psychopathology from multiple perspectives in what was a thorough biopsychosocial formulation. The conclusion – diagnosis and treatment: first episode of a schizophrenic illness, antipsychotic medication, education of patient and an appropriate care-plan and follow-up. Ostensibly, the same result could have been achieved after a routine 1-h assessment. The point of the exercise was to teach me a holistic biopsychosocial approach. However, what it also achieved was trust, empathy and familiarity, creating a degree of concordance that would otherwise not have been possible, a consensual, rather than coercive, therapeutic relationship that became the bedrock of her subsequent care. Elizabeth and her family actually appreciated the experience, the care, the thoroughness and assiduous attention to detail which, they felt, more than justified her lengthy in-patient stay.

Some 35 years later my patients' average length of stay was a paltry 72 h – detained patients, discharged the following day, unassessed, simply to create a bed for someone who was perceived as more unwell and needy. If my trainee was fortunate enough to have the time to perform a thorough psychiatric examination (a rather rare occurrence), they seldom saw the patient again as a consequence of rapid patient turnover and the trainee's shift pattern. Both patient and trainee suffered, the patient inappropriately discharged to a family and domestic situation often ill-equipped to cope, no matter how much the (usually desultory) input from the crisis team. The trainee, no matter how book-wise, lacking the apprenticeship experience and continuity that I found so valuable. The tradecraft of psychiatry is best learned on the ward, not the lecture theatre. In no other specialty are the adverse consequences of bed shortages more evident and more damaging to patients and staff alike. Moreover, patients are now routinely transferred to the independent sector, often many miles from home, where visits from family and friends as well as adequate discharge planning are difficult, if not impossible.

'Functionalisation' and electronic patient records: joint destroyers

In 1990 I became a consultant adult psychiatrist in the London borough of Hackney, responsible for all adult psychiatry in a geographical 'patch' of approximately 50 000 people. I looked after them through thick and thin, at home, in the out-patient clinic and day hospital, on the ward and, when necessary, on the psychiatric intensive care unit (PICU). The job was as varied as it was interesting. Accompanying vulnerable individuals throughout their patient journey, caring for them in good times and bad, providing continuity and consistency again bred mutual trust, respect and job satisfaction.

Admittedly, in the good times psychiatry's role may seem little more than 'hand-holding' and appear an unnecessary and unaffordable luxury to budget holders. However, non-clinicians fail to appreciate how 'hand-holding' bolsters the therapeutic relationship and makes any intervention that much more effective when times are bad. That all went by the board in 2006 when a policy of 'functionalisation' was introduced, starting initially with dedicated PICU consultants and steadily expanding to completely silo out-patient care, early intervention, crisis and home treatment, and of course the in-patient unit, each with its own consultant and team. Although this clearly helps managers quantify clinical activity, continuity of care is no more, with a merry-go-round of patient 'pass the parcel' between several teams, often never seeing the same consultant twice; communication between teams can be limited and, from my perspective, when I refer to another team, my patient effectively disappears into a veritable black hole. My work as an out-patient consultant became monotonous and repetitive and job satisfaction and morale deteriorated as a consequence. In addition to the breadth of my role

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shrinking, so too, its depth suffered. In 1990, I had time to talk to my patients, engage them psychotherapeutically where appropriate and, despite the time pressure, attempted at least to maintain a holistic, biopsychosocial approach. Now I feel my job has been reduced to little more than a prescribing machine. Sufficient time to 'talk' to patients has become an unaffordable luxury and, if a patient needs 'talking to', nurse practitioners, care coordinators, psychology assistants and support workers are there to do it for me. Whither continuity of care and job satisfaction?

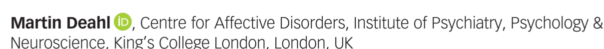
To add insult to injury, all this has been compounded by a loss of respect and a serious loss of personal support: in 1990, I had a secretary – far more than an audio-typist, the secretary was the first port of call for patients, general practitioners (GPs) and colleagues trying to contact me. She (and it usually was she) knew the patients, triaged them, organised me when it felt I was being pulled in several directions and often became a friend (I still keep in touch with most of the many secretaries over the years who were pivotal to my practice). In 2016, following the introduction of an electronic records system, secretaries became surplus to requirements and we were expected to write our own correspondence to GPs and colleagues. The quality of correspondence rapidly deteriorated (often little more than a perfunctory progress note) and what with typing letters and entering patient data required by managers, I soon found myself spending more time typing than in face-to-face contact with the patient. To think, 15 years' training to become a consultant only to spend the majority of my time tapping away at a keyboard. Moreover, patients knew the medical secretary (and *vice versa*) and a familiar, friendly voice on the other end of the phone can, to a distressed patient, mean everything. Now sadly, patients' phone calls are diverted to a call centre where, if they are lucky enough to get past the electronic reception (press 6 if you are suicidal, etc.), they speak to a junior administrative assistant who, more often than not, will simply tell them to go to their GP. The shift in care from the personal to the very impersonal has conspired to turn the patient from a human being into a psychiatric 'case', and throughout, the pressure from managers to remain 'on message' with their NHS trust and its veneer of quality and improvement while at the same time witnessing services unravelling has been both stressful and heart-breaking, so-called moral stress.[2]

The need for action

This is not meant to be a personal whinge, rather, a *cri du coeur*. These issues are important on a number of levels: recruiting into NHS psychiatry has reached crisis levels, retention too is problematic, with many vacant posts stretching remaining staff ever more thinly – even the most prestigious institutions routinely have unfilled consultant vacancies. Juniors lack a proper training with the demise of apprenticeship, and patients lack the therapeutic relationship they once enjoyed, undermining the effectiveness of any treatment. Many are unhappy in today's medical workplace.[3] There have been positive changes during my career. In particular, the stigma that bedevils mental illness has, without doubt, diminished, although this probably owes more to celebrities speaking out about their own problems in the media than any policy or campaign. Furthermore, the NHS still enjoys moderate to high respect from much of the rest of the world, as the NHS has managed its brand of socialised medicine and has controlled expenses quite effectively; these are enviable achievements. The qualities of engagement, patient-centred care, sense of continuity and good staff morale could be achieved in a multitude of ways. International comparisons are informative. In the USA, for example, public sector psychiatry has encountered similar dissatisfaction, and the field has, with some success, since advocated for diversification of professionally rewarding tasks, such as administrative leadership, research, teaching and a collaborative team approach in overall care. Focusing on patients' quality of life and recovery are the real goals.[4] What is astonishing is the paucity of research as to how psychiatry got into this mess in the first place. Perhaps the consultant psychiatrist is perceived as an expensive dinosaur – after all, with the advent of nurse prescribers, is there anything left we can do that cannot be done by someone else? Even our unique responsibilities under the Mental Health Act have become eroded as the privileges of the psychiatrist are gradually devolved to other mental health professionals. This analysis may be attractive to some budget holders and managers but what price experience and the wisdom gained from the 15 years of training and clinical grind? Our contribution to clinical care and common sense is unique and unequalled. Some would argue that we, as psychiatrists, as well as those who purport to represent us, have let psychiatry down by adopting a supine, passive approach and allowing a professional 'race to the bottom'. Why is it, after all, that Wilde's dictum that a cynic knows the price of everything and the value of nothing somehow rings uncomfortably true? Surely, psychiatrists, with our longer, richer training in medicine, which itself provides a boot camp of exposure to human suffering, are best placed to take a lead in answering this question.

Psychiatry faces a dilemma reflecting a culture that is increasingly beset by the difficulty of balancing the advantages of the generalist and the expert, the needs of the individual against those of the many and a worrying drift from holistic humanism to abstracted mechanism. We must strive to resist the insidious creep of modernism, the possibly harmful banality of our nosological taxonomies, the self-defensive nature of service, our cultural obsession with risk, and the demise of the therapeutic relationship that should be at the heart of psychiatric practice.[5,6]

This must change. Medicine, and especially psychiatry, should be led by professionals who put the patient, not the bottom line, first. Psychiatry's *raison d'être* is to protect the interests of some of society's most vulnerable individuals, and attempt to recreate a working environment that allows for the return of a fulfilled, rewarding, professional career. Failing to protect our interests and restore some of our professional esteem ultimately lets our patients, as well as ourselves down, and may well be signalling the end of psychiatry as we know it.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Psychiatry in music

Psychopathology in *Shine On You Crazy Diamond*

Alonso E. Garrido-Pinzás

It has already been said that Syd Barrett, founding member of the legendary band Pink Floyd, was one of the most relevant rock musicians to be affected by a psychosis. After the release of their debut album, Barrett's deteriorating mental health led him to leave the band at the young age of 22. Although his specific diagnosis was never disclosed, it is believed to be either schizophrenia or a psychosis resulting from his misuse of substances such as LSD and marijuana. His bandmates suffered his decline and blamed it on drug use and industry pressures.

Pink Floyd's discography is sparkled with references to mental illness. *Brain Damage*, the penultimate track of 1973's *The Dark Side of the Moon*, and 1979's album *The Wall* both refer to and describe mental struggles. Furthermore, *Wish You Were Here,* the band's ninth album, addresses themes of alienation and a greedy music business, and explicitly comments on their loss of Syd and their bereavement. *Shine On You Crazy Diamond* is an epic 26-minute-long progressive rock track written about and dedicated to Barrett; the song is split into parts – as if nodding to the etymological origin of the word 'schizophrenia' and the fractured self, nuclear to this disorder – and serves as bookends to the album. Roger Waters' lyrics describe Barrett with certain psychopathologic prowess.

Different themes are intertwined among the verses: stardom and its effect on young musicians; a romanticisation of addiction and drug misuse as a means to find truth; and the narrator's observations on Barrett's psychotic symptoms. These are soaked in nostalgia and interspersed with cries of encouragement sung by a gospel-like choir ('Shine on, you crazy diamond!'). Several lines describe possible symptoms. The song's opening verse, 'Remember when you were young/You shone like the sun (…) Now there's a look in your eyes/Like black holes in the sky' could be interpreted as a description of the vital change and the flat affect found in schizophrenia and other chronic psychoses. 'Nobody knows where you are/How near or how far' allude to both spatial and affective isolation, and this alienation is further emphasised by calling him a 'stranger'. Other lines convey descriptions of hallucinatory phenomena describing Barrett as a 'target for faraway laughter' and a 'seer of visions'. His behavioural change and disorganisation are outlined with terms like 'raver' and 'random precision'. Finally, addressing him as a 'prisoner' summarises the condition he is confined to live in.

Despite the fact that none of the composers had any formal training on the subject *Shine On You Crazy Diamond* artfully depicts Syd Barrett's psychopathology, providing valuable insight into his mental struggles. It also serves as a heartfelt reflection of the profound loss felt by Barrett's long-time friends and bandmates, and explores the interplay between art and mental health.

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