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Service innovation in a heated environment: CATS on a hot tin roof

Over the past few years, numerous articles have highlighted the strain on (and drain of staff from) our specialty. Many general adult psychiatrists are developing bleak views of themselves, the world and the future. Encouragingly, consultants such as Hampson (2003) are structuring their roles with some success. However, we are going through a major overhaul of the model of delivery of care and need to adapt our roles accordingly. Although tuning a Triumph Spitfire might make it run more smoothly for a while, it is still an inferior beast compared with a modern car and might be better on the scrap heap. A more radical approach is needed, which we outline in this article. One of the authors (G.I.) has experience of working as a consultant psychiatrist in Australia, where the state of Victoria changed the model of delivery of general adult psychiatric services to adopt a superior American model, leading to improved patient and carer satisfaction (Joy *et al*, 2001). The same model has been adopted by the UK government (Department of Health, 2001) through the creation of crisis assessment and treatment services (CATS), assertive outreach teams, and specialist community and in-patient services. Consultant psychiatrists are challenged to adapt their practice accordingly. The Royal College of Psychiatrists has recently set up a Working Group to address this issue (Royal College of Psychiatrists, 2004).

What is a consultant psychiatrist?

The ambiguity of our role in the modern National Health Service (NHS) has been outlined by Timms (2003). Although current resources call for a more consultative role, expectations from the government are of a more ubiquitous presence. The NHS Executive (2001) suggested that consultants be at the forefront of service delivery, maintaining a high degree of patient contact and the greatest burden of high-intensity working patterns. Are we expected to manage the mine *and* work at the coal face? The burden for many staff has become difficult to bear, with the ever-increasing pressure to improve quality and standards in the absence of adequate resources – not least the shortage of general adult consultant psychiatrists. Our identity and function seem to be becoming increasingly muddled, with conflicting expectations from the government, patients and other health care staff. Patients may want to see a consultant; however, quality of care may suffer rather than be improved as a consequence, owing to excessive expectations and the spreading of our presence too thinly, instead of targeting situations where a high level of knowledge and skill is needed. With so much confusion as to our future role, it is unsurprising to find stress and disillusionment among our colleagues (Rathod *et al*, 2000). The burden of care cannot be seen as the consultant's sole responsibility, but lies with all staff. Many health care staff, such as nurses, are happy to take on more responsibility, and this is being encouraged.

The image of general psychiatry is tarnished by perceived long hours, unlimited demands, endless risks and little time to practise the 'art of psychiatry' (Colgan, 2002). This perception appears to be reflected in poor recruitment. Cope (2003) reported an alarming shortfall of both specialist registrar and senior house officer recruitment, with almost a quarter of specialist registrar posts unfilled in 2001. The 14% of unfilled consultant general adult posts is unlikely to shrink in the short to medium term. How do we make the work more appealing?

New roles

The changing role of general adult psychiatrists is outlined by Kennedy & Griffiths (2001); traditional and adapted consultant roles are contrasted with new roles. This is a good starting point; however, we feel that the roles should be more specialised, and those that are defined look suspiciously like the Spitfire with a respray. Emergency work is seen as a source of stress due to its unpredictability. In Newcastle, the bulk of emergency work is managed by the CATS, which provide rapid assessment of community-based patients in crisis from any source. Any patient deemed to be in crisis will be assessed and appropriate management (including home-based treatment as an alternative to hospital admission) rapidly instigated. This has significantly reduced the number of emergencies dealt with by the sector

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consultant, allowing the planning of routine work and reduction of perceived stress.

The next progression of specialisation in the general adult services is to create separate consultant posts for in-patient and community care, as is the case in many areas of the USA and Australia. In this way, consultants can be dedicated to one particular aspect of patient care without being distracted by other issues or by having too many areas to cover, which is a major complaint of consultants working in the traditional role. The reliable presence of a consultant – whether in a community care team or an in-patient unit – allows increased efficiency in decision-making, more support for staff and more effective team-building. We believe that the reported disillusionment among staff in these specialist areas can be improved by this model, and this was certainly the experience of one of the authors (G.I.) in Australia. The ultimate beneficiaries of this new structuring will be the patients, who will receive better care.

Distribution

The new role for consultants entails distribution of tasks to other experienced mental health clinicians, with the provision of supervision as necessary. Distribution is different to delegation, in that it implies the transfer of responsibility as well as the task. Consultants in this model cannot be fully responsible for cases in which they have provided little or no input. The keys to the success of such a model are clarity of role and function, adequate training, supervision and robust communication networks. For some, this change of culture appears daunting; however, in our experience non-medical clinicians welcome such developments, and describe an increased sense of autonomy and utilisation of skills. Rather than splitting the team, this model has led to greater coherence and collective decision-making, which has had a beneficial effect on patients.

In their traditional role, consultants delegate tasks to others but retain responsibility. The limits of responsibility (Kennedy & Griffiths, 2002) are worrying in a specialty increasingly involved in the community, where risks are perceived to be higher compared with the containment of an in-patient unit. The 'blame culture', which has grown in recent years, is a large contributor towards the increasing stress complained about by many consultants. Some mistakenly believe that responsibility for all patients under their care, whether they have been consulted about a case or not, ultimately lies with themselves. This is unrealistic in that contacts frequently occur with other health care staff on a regular basis without the consultant ever being involved. The solution is for experienced staff to have responsibility for discussing worrying cases in the supportive environment of a multidisciplinary team. This can only occur if all involved are familiar and comfortable with the dynamics of the team.

This cultural shift towards non-medical disciplines taking more active roles in areas traditionally managed by doctors has been harder to accept in some specialties, one of which is psychiatry. Taking advice from a suitably experienced non-medical clinician is something traditionalist doctors find hard to accept, owing to an unhealthy perception of superior status and lack of experience of team work. Everyone – patient or general practitioner – would like to have direct contact with the most experienced clinician. In some cases, this is appropriate. However, in order to better use this scarce resource, direct consultation with the consultant should mainly occur when difficult diagnostic or management issues remain to be resolved.

Crisis assessment and treatment services are truly multidisciplinary, with each profession respecting and valuing each other's opinion, rather than simply being a group of professionals who meet and exchange information. Work is distributed rather than delegated (as discussed above), but the sense of collective responsibility is strong. Experienced clinicians (G grade nurses, approved social workers, senior occupational therapists) undertake initial assessments of patients in crisis and provide interventions for those receiving home-based treatment. The team meets twice a day for allocation of work and clinical supervision. Consultants offer advice at these meetings and undertake individual patient assessments whenever required. They also become involved with more complicated cases, to assist with diagnosis, prescribe medication and advise on risk management. Junior medical staff provide medical input, but their main task is to learn from more experienced colleagues. The consultants work exclusively for the service and are therefore readily available, and do not have the feeling of being pulled in too many directions. This allows the consultant to become a more fully integrated member of the team and to specialise in the management of acute cases. After hours, the consultants revert to the on-call rota. Some psychiatrists may fear loss of power and control in such a service, but there is a clear role for the consultant psychiatrist that is valued and respected and unlikely to be eroded. It represents a form of leadership that allows other disciplines to develop and gain expertise.

Effects of the new service

Both authors work with Newcastle and North Tyneside CATS; M.J.T. has been involved with the development of the service over the past 4 years. The achievements of the service include lower rates of in-patient bed occupancy and reduced use of the Mental Health Act 1983 for formal admission (further information available from the author upon request). Bed occupancy has been reduced in the Newcastle area to the extent that one hospital ward is due to be closed, facilitating the redistribution of resources. An acute day service is being provided for those whose needs are intermediate between an in-patient stay and home-based treatment. This increases the scope and choice for the provision of acute care. The community mental health teams are expanding, and will concentrate on providing specialist packages of care for those with serious mental illness; their services include education, psychosocial interventions, encouragement of

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Table 1. Traditional *v.* new consultant roles

Traditional consultant role	Crisis Assessment and Treatment Service consultant
Member of many teams (in-patient, CMHT, etc.)	Member of one team only
Multiple foci for expertise	One focus for expertise
'Jack of all trades', trying to do everything	Expert, developing expertise
Weekly supervision of a number of teams	Twice-daily supervision of one team
Risk of burnout, unmanageable workload; job unattractive to trainees	Improved morale, greater job satisfaction
Delegation of work	Distribution of work
Burden of responsibility	Collective responsibility
Professionals who meet infrequently	True multidisciplinary working
Style: controlling	Style: enabling

CMHT, community mental health team.

medication adherence and relapse prevention. Early intervention services are now available for specialist intervention in first-episode psychosis. The whole mental health service has become more responsive to the need for change, and a major reorganisation of primary and secondary care is in progress to improve the quality of care provided.

The provision of the CATS has largely been welcomed by patients, carers and referers. There is often a strong desire among patients and carers for the patient to be treated at home; before this was an option, patients who rejected hospital treatment sometimes had to be subjected to compulsory admission under the Mental Health Act 1983. Now the wards are no longer over-occupied, allowing the staff to provide improved care, and beds are available when needed, which reduces the time taken in desperate searches for beds. In-patient work is becoming increasingly specialised, in that staff are dealing with more acutely unwell and difficult to manage patients who cannot be treated at home. In this changed environment, the staff skill requirements will inevitably shift and become more refined. In Australia, G.I. found that the psychiatric wards provided a much more intensive therapeutic environment than in the UK, with daily meetings involving the consultant rather than the traditional weekly ward rounds. More intensive treatment leads to shorter duration of in-patient stay, which not only benefits the patients but is also a more efficient use of beds. The in-patient service is adopting this model, with dedicated consultants to reap these benefits.

Conclusion

The initiatives for redefining roles and responsibility yearned for by psychiatrists such as Colgan are now happening. The general adult psychiatrists' role is evolving, and the service innovations discussed above provide a positive way forward (Table 1). Resistance to change is institutionally inherent and is possibly our greatest challenge. A more antipodean approach to change is required, with greater willingness to try something new to improve services. The Newcastle and North Tyneside Crisis Assessment and Treatment Service demonstrates that change is possible to the advantage of all concerned, whether doctors or patients. The consultant role in the new service has been defined, but can be tailored to the preference of the individual consultant involved. Patient care must always come first; however, thinking about ourselves and using our initiative to create satisfying work environments is a worthwhile goal. Traditionally we have had to mould ourselves to a defined job description, with the presumption that this is the only way to work. Adaptability must include the whole organisation and starts at the top, with managers and consultants leading the way. Let us stop feeling sorry for ourselves, and make general adult psychiatry the flagship of future psychiatric services.

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