How to improve psychiatric services: a perspective from critical psychiatry

ABSTRACT

Concern has been expressed from both within and outwith psychiatry about the relative lack of improvement of mental health services. Critical psychiatry is an emerging school of thought, mainly the product of practicing clinicians, which could be useful in remedying this situation. This article outlines, for psychiatrists and doctors of other specialities, practices which could be improved, and the competencies required to achieve this, in terms of knowledge, skills and attitudes.

Similar to other medical specialities, psychiatry is undergoing a process of self-examination, in the context of persistent stigma towards practitioners and patients alike, reduced trainee interest in the speciality and the advent of new technology. With this in mind, the Royal College of Psychiatrists is planning to rewrite the trainee curriculum to bring it up to date, and make it relevant to the proposed hybrid community consultant post, requiring competencies in general medicine, primary care and psychiatry.

The Care Quality Commission (2017) has highlighted specific inadequacies of psychiatric practice as reasons why a grading of 'outstanding' is rarely achieved. These include inadequate joined-up care with primary and acute services, poor physical treatment of psychiatric patients and polypharmacy in managing challenging behaviour by learning disability and old age sub-specialities, typically involving off-label prescribing of antipsychotic and anti-epileptic drugs.

The Care Quality Commission has also commented on the lack of shared decision making ('co-production') between patients, carers and clinicians on treatment and on remediation of risks associated with mental illness. Perhaps this finding is consistent with increasing detentions under the Mental Health Act 2007 in England over the last 5 years (Health and Social Care Information Centre, 2015). It is hoped that the emerging strand of critical thinking by psychiatrists themselves could help improve services. Some of the insights could also help non-psychiatrists in their work.

What is critical psychiatry?

Critical psychiatry can be described as a process whereby psychiatrists critically examine how they think, act and reflect. Thinking in psychiatry involves making judgements on aspects such as diagnosis, insight and risks. Action includes how psychiatrists consult, communicate and decide between treatments. Reflection entails looking at patient and peer feedback, clinical outcomes and the ethics underpinning psychiatry. This approach is distinct from 'anti-psychiatry' which is essentially a belief system, supported by historical findings. The core belief of anti-psychiatry, as elucidated by Thomas Szasz (Szasz, 1960), is that psychiatric illnesses and associated diagnostic classifications are myths which are progressively dismantled as neuroscience finds underlying biological deficits and devises curative treatments (as opposed to the palliative symptom relief and containment offered by psychiatrists). The evidence for anti-psychiatry rests on the management of epilepsy moving from psychiatry to neurology (Reynolds and Trimble, 2009).

How psychiatrists think

Psychiatric conditions rarely have specific and sensitive biomarkers. Even for patients with dementia, the sensitivity of modern scanning is only around 80% (Wollman and Prohovnik, 2003). The best failsafe for over-diagnosis is research-based operational criteria, but practicing psychiatrists rarely use these because of limitations of time (Datta, 2013). Psychiatrists are considered to have expertise in predicting another's motivations, desires and behaviour; the so-called 'theory of mind' competency (Premack and Woodruff, 1978). This ability appears to be related to 'self-insight' – the gift of 'seeing ourselves as others see us'. In general, these tools appear to be more accurate when predictions are made using an abstract rather than an emotional mind set (Eyal and Epley, 2010); relevant for example in risk assessment and prognostication.

All humans have thinking errors, both in individual and group settings. These can result in incorrect assumptions unless due diligence is practiced. For example, doctors tend to look for evidence to support a diagnosis, rather than evidence which would contradict it. This is called 'confirmation bias' (Mendel et al, 2011). Furthermore, 'misuse of heuristics' (Bukow, 2013) occurs when a doctor applies treatment guidelines to patients who do not fit the inclusion criteria of the trials which were used to formulate these guidelines. This bias is compounded by the doctor not disclosing this limitation of evidence to the patient because of concerns about losing face – which is known as affective bias (Poland and Caplan, 2004). National

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guidelines on treatment are often arrived at by comparing effect sizes between different trials which were performed under differing conditions including control groups. This leads to a bias called 'overconfidence' (Dobelli, 2013). Slavishly following such guidelines because of the fear of peer disapproval leads once again to affective bias.

Group biases can originate in established multidisciplinary teams and in ad hoc groups. The best known of these biases is 'groupthink' (Janis, 1972) when there is unquestioned agreement on a judgement or decision as a result of various motives and influences. The other main group bias is 'escalation of commitment' (Staw, 1981), where a process is continued despite evidence of ineffectiveness because of a fear of consequences if the direction is changed or reversed.

How psychiatrists act

Communication involves a wide range of activities, including telephone communication with other staff, discussions with service users and formal reports or letters. The common theme based on GP (Blakey et al, 1997) and hospital doctor (Leonard et al, 1990) feedback is that written communication by psychiatrists tends to be disorganized, unnecessarily lengthy and inadequately headlined with 'key items' such as diagnosis, treatment and follow up.

The main activity of trainee psychiatrists – consultation with service users – has been scrutinized (Rimondini et al, 2006). Service users often describe 'passive listening' by trainees, who ignore repeated questions. In some instances, trainees appear to respond to direct questions with a further question. This might be the result of an overriding focus on achieving a diagnosis or estimating the degree of insight. Similar findings have been elicited with qualified psychiatrists (McCabe et al, 2002) with younger and female doctors performing better in handling patient questions.

Multidisciplinary team ward rounds and care programming meetings have also had mixed feedback from service users (Lawrence et al, 2009), with concerns about being interrogated, not having specific questions addressed, not knowing the staff in attendance, not seeing the consultant beforehand, and being expected to wait without a set appointment.

Full disclosure of benefits and side effects of treatments leading to shared decision making is stipulated in national guidance for major psychoses (National Institute for Clinical Excellence, 2002). Evidence of this actually taking place consistently is lacking (Shepherd et al, 2014). Particular concern has been expressed about psychiatrists not discussing metabolic, cognitive and cardiovascular side effects of antipsychotic medication (Mitchell et al, 2012). Furthermore, shared decision making respecting a patient's right to take risks in order to maintain his/her privacy and family life (article 8 of the European Convention of Human Rights) is recommended (Faulkner, 2012), but not always achieved.

A specific example of where co-production could be helpful is in the field of risk assessment and remediation. There is no evidence that the usual clinician-generated risk assessment (including the use of structured risk scales) is effective in predicting actual suicidal behaviour (Carter et al, 2017). Alternatives involving co-production have emerged (Cole-King et al, 2013), such as use of a suicide safety plan for all service users in receipt of mental health services. This includes documenting emotional resilience factors, harm reduction based on previous thinking or actions and clear points of contact if suicidal thoughts arise.

How psychiatrists reflect

Outcome data are often difficult to collect because 'new ways of working' lead to earlier discharge (Brown and Bhugra, 2007) thereby preventing longer follow up. Furthermore, publication of outcomes of consultant-led teams is often lacking, so analysis of outliers cannot take place. This is despite all provider organizations collecting such information – for example, time to be diagnosed, medication errors, complaints, ratio of new assessments to discharges, and friends and family test results.

The usual method of reflection, the case-based discussion, is a snapshot of process rather than outcome, with no feedback from patients (Williamson and Osborne, 2012). However, it provides a framework to review the logic leading to a diagnosis, and the rationale for treatment selection and follow-up arrangements. Defensibility of documentation can be examined although checking validity of contents – by examining documentation of other professionals – is not always done. The process of selecting cases for a case-based discussion varies, but often a case is selected by the psychiatrist rather than a random selection by another person.

All doctors are subject to 360-degree feedback on personal qualities, involving anonymised input from colleagues, patients and managers. However, feedback provided can simply reflect an isolated contact, and might not reflect a longer term experience of the doctor, as provided in a reference. There is also the potential for false assessments by respondents associated with affective bias (Sullivan, 2012).

Reflection on effectiveness of various treatments rests on one's awareness of relevant research findings. There is also limited understanding of publication bias (Mathew and Charney, 2009) – especially awareness that publication rests on financial and academic interests of the authors, journal editors and pharmaceutical companies. Trainees might not appreciate the constraints of discussion in educational meetings sponsored by pharmaceutical companies as a result of 'commercially sensitive' issues.

Reflecting on history and ethics of psychiatric practice is rare, largely because of its neglect in the curriculum. Issues such as eugenics and social Darwinism are not considered by most psychiatric trainees (Strous, 2007). Ethics of enforced treatment is taught mainly on the basis of legal requirements – i.e. how restriction can be carried out –rather than if restriction is in the best interest of the person with respect to human rights legislation. Furthermore, the social and governmental expectations of psychiatrists are rarely discussed because of the fear of appearing overtly political.

General competencies informed by critical psychiatry

Perhaps the overall competency is the ability to be aware of the various influences restricting independent thought, including requirements of the training curricula and peer expectations. Furthermore, being able to balance powers afforded by mental health with the human rights of individual patients, including the right to take risks in order to return home, needs to be considered and documented carefully. Independent thinking requires support; perhaps group reflection – the equivalent of Balint groups in general practice (Fitzgerald and Hunter, 2003) – could also be helpful.

One of the key insights offered by critical psychiatry is thinking differently about psychotropics; moving away from seeing these drugs as treatment for diseases, towards seeing them as methods of temporarily relieving symptoms. This is similar to palliative treatment of chronic neurological conditions such as Parkinson's disease. Moncrieff and Cohen (2005) have described psychotropics as legal mind-altering chemicals, capable of changing a person's mental state for the better or worse. Impartially summarizing the effects of a drug to service users using layman's language is a key competency.

Competencies in knowledge

Knowledge of the history of psychiatry as well as understanding legislation relevant to human rights and equality should be a key trainee competency. Furthermore, awareness of commonly held creeds and faiths should be maintained, thereby improving understanding of the whole patient. Understanding bias should also be a core competency, with the trainee reflecting on potential biases during case-based discussions.

Competencies in knowledge include understanding cardiovascular protection via medication, exercise and nutrition, so an informed discussion on health promotion can take place with patients, for example using QRISK. Understanding sleep disorders (Stores, 2003) should perhaps be mandatory for psychiatric trainees, as it is for trainee neurologists. Regarding medical topics, understanding movement disorders, metabolic syndromes (diabetes and thyroid disorders), as well as autoimmune conditions such as systemic lupus erythematosus could be helpful; a potential source of examination questions for the MRCPsych exam.

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Both trainees and clinicians need to build awareness of new technology for managing psychiatric symptoms such as computerised cognitive behaviour therapy for depression (National Institute for Health and Care Excellence, 2013), avatar therapy for auditory hallucinations (Leff et al, 2013), and assistive technology in dementia care (Bharucha et al, 2009).

Skills

The key skill suggested by critical psychiatry is the ability to appraise the scientific literature, looking for bias in study design, publication bias and deciding if the conclusions are consistent with the strength of the findings. Joining the Cochrane Collaboration to review a treatment could help a trainee to develop the skill of critical appraisal more so than attending journal clubs. For example, there has been a Cochrane analysis of methylphenidate in childhood and adolescent attention deficit hyperactivity disorder (Storebø et al, 2015).

Demonstrating flexibility when taking a history or giving information is a valuable competency. There is a role for 'experts by experience' (patient and carers) to teach and assess consultation skills (Livingston and Cooper, 2003). Furthermore, the adoption of 'open dialogue' (Seikkula et al, 2003) in intensive home treatment and early intervention in psychosis provides trainees with consultation skills aimed at helping patients and families to formulate their understanding of the current mental health problem, leading to their own solutions. Associated with this co-production with patients and carers, for example in devising a safety plan in the context of suicide risk, is an essential skill for both psychiatrists and other doctors seeing patients.

On communicating saliently, perhaps the SBAR system – as recommended by the NHS Innovation Agency – could help. SBAR stands for situation, background, assessment and recommendations, and is a format to communicate salient information succinctly. It is commonly used in acute specialities including intensive care, paediatrics and obstetrics, and has been adapted to psychiatric practice to describe multi-morbidity (de Silva, 2013), and used for telephone discussions, handovers, ward rounds and multidisciplinary meetings. SBAR can also be a useful brief consultation framework, understandable to patients. A further competency is 'brief motivational interviewing' (Borrelli et al, 2007), used to limit harmful behaviour as well as to assist treatment adherence.

The General Medical Council (2012) have described clinical leadership as a core role of doctors. Consistent with this, it might be better if psychiatrists wrote a succinct care plan jointly with service users on one side of A4 paper, including three sub-sections:

KEY POINTS

- Critical psychiatry needs to be seen as separate from 'anti-psychiatry' which is a belief system which is unhelpful in development of mental health services.
- Thinking errors or biases are often seen in psychiatry and in other medical specialities, both in individual and team settings, which can be remedied by prior awareness and reflection.
- Consultation and information giving skills could be helped by training and assessment by 'expert' patients and carers.
- Psychiatrists and other doctors need to be careful in discussing potential harms and risks when prescribing psychotropics, especially in using antipsychotic medication.
- Neuroscience topics such as sleep disorders, and history of psychiatry, for example eugenics, should be part of the curriculum for psychiatric trainees.

1. A treatment plan
2. A risk management plan
3. A recovery/discharge plan.

These subsections should inform each other and should form a unified document, which is carried by the service user and reviewed at each ward round, care programme approach meeting and GP consultation. The other side of the sheet of paper could include an up-to-date list of medications, hypersensitivities, advance directives or wishes and an up-to-date list of contact names and numbers.

Attitudes

The main attitude associated with critical psychiatry is not necessarily conforming to peer expectations about the necessity to detain under the Mental Health Act 2007 and/or medicate without patient consent. Furthermore, being respectful of patient wishes (possibly unwise decisions) on treatment is a key attitude. Humility about how much psychiatry does not know, including our relative ignorance about how to apply non-drug technologies to alleviate symptoms, would be helpful. Having the courage to learn from mistakes is essential.

Attitudes could be made more patient-centric by volunteering for mental health charities or getting involved in patient-centred therapies such as horticulture (Haigh, 2012) which is increasingly being used to help service users who have head injury or personality disorders. Furthermore, willingness to learn from personal clinical outcomes could be helped by technological innovations associated with electronic notes. A patient's notes could be 'tagged' for learning needs, so that a trainee could be alerted if a further contact or activity takes place. This could also help supervision.

Finally, psychiatrists should take a lead in publishing outcomes of individual consultant-led teams to be benchmarked against other teams, to achieve general improvement of standards. This has been used to measure joint surgery teams, with significant improvements in safety and quality (Holt et al, 2008).

Conclusions

Critical psychiatry often elicits a combination of fear and irritation among some psychiatrists; hopefully this article will dispel some of the accompanying myths about the approach, and encourage critical thinking by all psychiatrists. In particular, recommendations on competencies in knowledge, skills and attitudes should focus doctors minds on a constructive dialogue to improve services. **BJHM**

Conflict of interest: Dr P de Silva has worked for the Care Quality Commission as a specialist advisor and is a Cochrane Collaborator. He is also part of the UK Critical Psychiatry Network.

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