

## Correspondence

### NHS morality and care based on compassionate values

It is difficult to disagree with the main thread of Cox & Gray's argument that the National Health Service (NHS) as a whole has lost its grip on being person-centred in any genuine way, amidst the industrialisation and authoritarian managerialism of the modern NHS.<sup>1</sup> However, I would take issue that the College Centre for Quality Improvement (CCQI) is being idle about the matter.

For over 12 years, I have worked with CCQI staff to set up and develop three projects to promote exactly what Cox and Gray are asking for: robust systems of quality assurance and quality maintenance which focus on the emotional experience of the patients in their particular treatment environments. The Community of Communities quality network for therapeutic communities<sup>2</sup> started in 2002; the Enabling Environments Award<sup>3</sup> (which is suitable for any setting) was established in 2009; and the National Enabling Environments in Prisons project began to improve relational-based practice in participating British prisons in 2009. All three projects continue to flourish, and more are planned.

The Enabling Environments Award is based on a set of ten value statements which define 'relational excellence' in work environments. These value statements have been processed to form ten standards, each with several criteria for demonstrating that they have been met. Naturally, compassion and the quality of relationships are at the centre of the expectations. The standards are measured by submission of a portfolio, for which we have designed a flexible and hopefully enjoyable process, rather than a persecutory inspection. Rather than being part of the regulatory burden that many units nowadays feel, our experience to date is that participants take great pride in the process and receiving the resultant award. It is important to note that the award was prominently mentioned in the Royal College of Psychiatrists' report Cox & Gray are commenting on, OP92: 'The Enabling Environments Award recognises that good relationships promote well-being, but that many organisations and groups fail to address this aspect of people's lives'.<sup>4</sup> It therefore already forms part of the College's response to the Francis report.

Unfortunately, the response from NHS organisations (mental health and others) has not been encouraging and the award is much better used and recognised in the prison service and all sorts of different third-sector units. I believe this may be caused by a deeper malaise in the NHS, very much in line with what Cox and Gray are arguing in their paper. In short, the NHS is being run with a competitive business model to such an extreme and aggressive extent that 'soft' values such as empathy, emotional intelligence and kindness are given no force.

Related to this, it is worth mentioning that the Institute of Group Analysis, alongside other organisations including the Royal College of Psychiatrists, are running a 6-month listening exercise to gather information from staff across the range of NHS professions and specialties.<sup>5</sup> When the information is collected and collated, it will be used to negotiate with politicians of all parties in advance of next year's general

election. As Cox & Gray argue, this is a moral question – and a profoundly important one for all of us who want the NHS to survive in a form that we can once again be proud of.

**Declaration of interest:** R.H. is Enabling Environments Lead, Royal College of Psychiatrists' Centre for Quality Improvement.

- 1 Cox J, Gray A. The College reply to Francis misses the big question: a commentary on OP92. *Psychiatr Bull* 2014; **38**: 152–3.
- 2 Haigh R, Tucker S. Democratic development of standards: the community of communities – a quality network of therapeutic communities. *Psychiatr Quart* 2004; **75**: 263–77.
- 3 Johnson R, Haigh R. Social psychiatry and social policy for the 21st century: new concepts for new needs – the 'Enabling Environments' initiative. *Ment Health Soc Inclusion* 2011; **15**: 17–23.
- 4 Royal College of Psychiatrists. *Driving Quality Implementation in the Context of the Francis Report (OP92)*. Royal College of Psychiatrists, 2013.
- 5 Moberly T. Doctors are invited to help improve NHS staff culture. *BMJ Careers* 2014; 14 Aug.

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In December 2013, the Royal College of Psychiatrists published an occasional paper responding to the Francis report, OP92.<sup>1</sup> In an editorial, John Cox and Alison Gray stridently criticise the document.<sup>2</sup> By contrast, I believe that OP92 strikes exactly the right tone and that the actions it sets out should be strongly supported. All members of the College should read it (it is available at the College website: [www.rcpsych.ac.uk/files/pdfversion/OP92.pdf](http://www.rcpsych.ac.uk/files/pdfversion/OP92.pdf)). It succinctly relates principles to the actions that the College is taking.

I suspect that that the source of dissatisfaction for Cox & Gray lies in the following passages in the document: 'Responses to inadequate or abusive practice tend to emphasise the practical, ethical or moral failings of individuals. These are relevant, but, alone, statements of the importance of compassion, patient-centred care and the duty of candour are unlikely to prevent further scandals. Inadequate and abusive care arises in response to situational forces and a variety of behavioural cues. [ . . . ] We need to take on board the lessons of the Milligram (1974) and Zimbardo (Haney et al, 1973) experiments [ . . . ] namely that ordinary, decent people will behave badly in environments that are not designed to help them to behave well'.<sup>1</sup>(pp. 4–5)

This touches on a systemic and empirical understanding of the problems in British healthcare delivery, which is exactly the appropriate approach for applied scientists to take. However, Cox & Gray seem to prefer a model of moral decay, which they want addressed through urgent dialogue between the College and the medical profession in general on the one hand, and religious leaders and thinkers on the other. They introduce this suggestion through the rhetorical device of an allegation that OP92 fails to address the inadequacies of the 'business model' in healthcare. This criticism is in any case

inaccurate; OP92 includes an implicit critique of the entire system and the clinical environments it creates, as can be seen in the passages I have quoted.

It is disappointing that Cox & Gray declare no conflict of interest in their editorial. Four years ago, in a letter to this journal,<sup>3</sup> they supported a call by Robert Higgo and myself<sup>4</sup> for the College to establish a working party on psychiatry and religion. Their declaration of interest in that letter was as follows: 'John Cox is a Christian from the Methodist Tradition. Alison Gray was recently ordained Deacon in the Church of England', and their affiliation was stated as 'Centre for Faith Science and Values in Healthcare, University of Gloucestershire'.

Cox & Gray's religious faith may well help them to adhere to their own moral standards. They have every right to understand things that go wrong in the world in terms of morality and religious faith. These are personal matters. The suggestion that the Royal College of Psychiatrists should take such a position is wholly inappropriate and wrong. The College has important institutional roles concerning ethics and proper professional behaviour, which are part of its overall *raison d'être*: to maintain and improve standards of care for patients. These roles would be utterly compromised by dabbling in morality and religion. If the College were to take a position on individual morality informed by religious thinking, we would enter a morass of schism and conflict. This would do nothing to protect patients.

Three years ago, concern was raised that the ostensibly anodyne College position paper *Recommendations for Psychiatrists on Spirituality and Religion* would be taken as permission to breach professional boundaries with respect to religion.<sup>5</sup> The vast majority of psychiatrists successfully avoid inappropriate interdigitation of faith, belief and professional practice. It will not be just the atheists who will find Cox & Gray's editorial worrying.

**Declaration of interest:** I am an atheist.

- 1 Royal College of Psychiatrists. *Driving Quality Implementation in the Context of the Francis Report* (OP92). Royal College of Psychiatrists, 2013.
- 2 Cox J, Gray A. The College reply to Francis misses the big question: a commentary on OP92. *Psychiatr Bull* 2014; **38**:152–3.
- 3 Cox J, Gray A. Proposed College working party on psychiatry and religion. *Psychiatrist* 2011; **35**: 118.
- 4 Poole R, Higgo R. Psychiatry, religion and spirituality: a way forward. *Psychiatrist* 2010; **34**: 452–3.
- 5 Poole R. Praying with patients: belief, faith and boundary conditions. Author's reply. *Br J Psychiatry* 2011; **199**: 518.

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**Authors' reply:** We welcome the opportunity to reply to Professor Poole's stimulating and challenging commentary on our editorial which, even if misunderstood, has clearly succeeded in alerting the readership to the pressing managerial and moral challenges for the NHS in the aftermath of the Francis report.

The College, in its 6-month update of its report, has a further chance to unravel the complex contributing circumstances in Mid Staffordshire, and to consider not confining its recommendations to mental health services alone. The failure to put patients first and the neglect of basic quality of care standards could be replicated elsewhere.<sup>1</sup> The task is

not confined to applied scientists, but involves values as well as the personal ethics of members. Therefore, in appearing to belittle the contribution of moral philosophers, comparative religion experts and even patient groups to the consideration of the roots of compassion and to the conceptual underpinning of patient-centred care, Prof. Poole is out of kilter with much local and international work in this field.<sup>2</sup>

We would wish also to counter his suspicion that the source of our dissatisfaction with OP92 was linked to a secret Christian plot to impose our religious values on others of a different faith or none. That was far from our intent – as a detailed, unblinkered reading of the editorial would confirm. Moreover, our earlier disclosures of interest were as cited, but have been repeated without first checking neither their current accuracy, nor the precise context in which those declarations were appropriate. For the interest of readers, J.C. remains a lay member of a Methodist Church in Cheltenham, A.G. is now an associate priest in the Church of England, and the Centre for the study of Faith, Science and Values at the University of Gloucestershire closed last year.

Rex Haigh, on the other hand, is correct to have identified our implicit awareness that the values of the therapeutic community, the understandings of the need for healthy environments respectful of the person – and the grasp of group processes – have each conditioned our search for solutions to the current NHS impasse. The excellent work undertaken by the College's Centre for Quality Improvement (CCQI) was referred to in our editorial and in the College response. It is much to be hoped that the CCQI will increasingly be more integrated with the other College structures, so that its impact on routine medical work in acute hospital care (such as intensive care, a gastrointestinal cancer service or a primary care community unit) can be facilitated. The lack of uptake of the CCQI's projects in the NHS (other than the Quality Network for Perinatal Mental Health Services, which is conspicuously successful)<sup>3</sup> is, in the context of the Francis recommendations, a cause for much concern and may be symptomatic of the current malaise.

We thank both correspondents for prolonging this timely and important debate. We conclude by declaring an interest in the hope that the College, in tandem with other national organisations, will seek for a majority opinion about the nature of these key structural issues in the NHS – including the fitness for purpose of the competitive business model – and also facilitate a greater understanding of the conceptual (biological, philosophical, ethical, humanistic and religious) underpinning of the nature of health, the process of healing and the primacy of the person.

**Declaration of interest:** A.G. is a Non-Stipendiary Associate Priest in the Church of England.

- 1 Dewhurst NG, Jones MC, Wilson JA. Time to refocus the NHS on quality and dignity of patient care: RCPE response to Mid Staffordshire. *J R Coll Physicians Edinb* 2013; **43**: 3–6.
- 2 Miles A, Mezzich JK. Person-centered medicine: advancing methods, promoting implementation. *Int J Pers Centered Med* 2011; **3**: 423–5.
- 3 Solomon S, Thomson P. *The Quality Network for Perinatal Mental Health Services*. College Centre for Quality Improvement, 2010.

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### False positive phencyclidine result on urine drug testing: a little known cause

Phencyclidine (PCP) is a hallucinogenic drug, often referred to as 'angel dust'. Its short-term effects are seen for approximately 1 h after ingestion and may include hallucinations, disinhibition, euphoria and agitation. Long-term use can lead to symptoms resembling psychotic disorders such as schizophrenia. Its detection time in urine is approximately 8 days.<sup>1</sup> We would like to highlight two cases of false positive results for PCP on urine drug screening at a community mental health rehabilitation centre.

Patient A was a 25-year-old male with paranoid schizophrenia, admitted to an acute psychiatric ward under Section 2 of the Mental Health Act 1983 because of deterioration in mental state following medication non-adherence and a history of illicit drug use. He was transferred to the rehabilitation centre under Section 3 of the Act 5 months later, exhibiting mainly negative symptoms of schizophrenia. He was receiving treatment with venlafaxine 150 mg twice daily, lithium carbonate 800 mg once daily and clozapine 400 mg in the evening; he also had lactulose 10 ml twice daily. A urine drug screen was performed after staff found cannabis in his room. The result was positive for both PCP and THC (marijuana), although the patient denied taking any PCP. The test was repeated and results were positive for PCP only.

Patient B was a 38-year-old male with paranoid schizophrenia admitted under Section 2 of the Mental Health Act after being arrested for wielding knives in public. He was transferred to the rehabilitation centre under Section 3 of the Act 8 months later with ongoing psychotic symptoms including 'electric shock sensations' which he attributed to possible chemical warfare. He was receiving treatment with risperdal consta 50 mg IM twice weekly, venlafaxine 75 mg twice daily, clonazepam 0.5 mg twice daily and procyclidine 5 mg twice daily. A urine drug screen was performed since he had become increasingly guarded and irritable, despite good adherence to medication. The result was positive for PCP and benzodiazepines. The benzodiazepines could be explained by clonazepam but the patient again denied taking any PCP. The same results were obtained when the test was repeated.

Given that both patients denied taking PCP our suspicion was aroused. None of the other patients on the unit who had urine drug screens tested positive for PCP. Venlafaxine was the only medication taken by both patient A and B. A review of the literature revealed several case reports of false positive urine immunoassay results for PCP in patients taking venlafaxine of various doses. In one case series, three patients in an emergency department in Danbury Hospital, Connecticut, USA, were found to have false positive urine assay results for PCP due to venlafaxine.<sup>2</sup> Another case reported a false positive result for PCP in a patient with an intellectual disability who received 75 mg/d of venlafaxine extended-release (XR)<sup>3</sup> and another that resulted from venlafaxine overdose.<sup>4</sup>

This effect is thought to be due to cross-reactivity between venlafaxine and the active metabolite O-desmethyl-venlafaxine with the PCP assay reagent, although they are not structurally related.<sup>2</sup> The US Food and Drug Administration warns that false positive test results may be expected for several days following discontinuation of venlafaxine.<sup>5</sup>

Confirmatory tests, such as gas chromatography/mass spectrometry can be used to distinguish between the two.

Based on this information, the urine assay results showing PCP for patients A and B were determined to be false positives due to cross-reactivity with venlafaxine. Patient A's leave was reinstated as it had been cancelled until drug testing was negative. For patient B, we were able to exclude illicit drug use as a cause for his altered mental state. Increased awareness of the cross-reactivity between PCP and venlafaxine is important for all healthcare professionals to avoid inappropriate suspicion of illicit drug use.

- 1 Moeller KE, Lee KC, Kissack JC. Urine drug screening: practical guide for clinicians. *Mayo Clin Proc* 2008; **83**: 66–76.
- 2 Sena SF, Kazimi S, Wu AH. False-positive phencyclidine immunoassay results caused by venlafaxine and O-desmethylvenlafaxine. *Clin Chem* 2002; **48**: 676–7.
- 3 Brahm NC, Brown RC. Venlafaxine usage resulted in a false positive immunoassay for phencyclidine. *J Coll Psychiatr Neurol Pharm* ([http://cpnp.org/\\_docs/resource/jcpnp/venlafaxine.pdf](http://cpnp.org/_docs/resource/jcpnp/venlafaxine.pdf)).
- 4 Bond GR, Steele PE, Uges DR. Massive venlafaxine overdose resulted in a false positive Abott AxSYM urine immunoassay for phencyclidine. *J Toxicol Clin Toxicol* 2003; **41**: 999–1002.
- 5 U.S. Food and Drug Administration. Effexor (venlafaxine HCl) tablets and Effexor XR (venlafaxine HCl) extended-release capsule. FDA (<http://www.fda.gov/Safety/MedWatch/SafetyInformation/ucm201064.htm>).

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### No beds for young people – also in Scotland

I read Myers *et al's* correspondence<sup>1</sup> with great interest. I am a consultant child and adolescent psychiatrist working in the forensic child and adolescent mental health services and I am simply dumbfounded by the difficulties that frequently present when trying to coordinate in-patient admissions for young people in Scotland for those who have mental health problems and concurrent risk to others.

Like the authors of the letter, I see the deterioration and the stigma that young people face when admissions are being coordinated. At present, there are no secure mental health beds in Scotland who accept under-18-year-olds. Our only option is to beg for intensive psychiatric care unit beds from colleagues in adult services. I also echo concerns that there is no joined-up bed management system within the service I work for, which means that should I wish to admit a young person, it is up to me to call each unit individually.

Often my only option is to send young people to England, where there are private-sector adolescent medium secure beds. This comes with significant cost, both financial and emotional. I have seen how hard it is for families to agree to send their loved ones so far away, knowing they will struggle to visit or sometimes even telephone. In addition, if a young person is on remand or pre-trial, they cannot be sent across the border.

I thank the authors for making me realise that I am not isolated in this demoralising and stigmatising situation. But this is a bittersweet pill as it only serves to highlight that services need to be made more available for young people across the country.

- 1 Myers G, Coyle D, Kowalski C, Srinivasan R. How can a young person wait over 90 hours in an emergency department for a bed? *Psychiatr Bull* 2014; **38**: 250.

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### It is more than just beds

We read with interest the correspondence by Myers *et al*<sup>1</sup> and echo their concern. In our region, child and adolescent psychiatrists are increasingly dealing with similar situations and are concerned for young people and their experience of services out of hours. We agree that there is no current system to find out bed availability and no external support to make this process efficient.

Fortunately, in our region we have an out-of-hours process whereby referrals can be made and we have agreement for two tier 4 providers to accept emergency admissions. Since this process was initiated, the referrals for out-of-hours beds have steadily increased and in the past 6 months 30 referrals were made, two-thirds of which were for people aged 17+. However, despite this process, only five young people were able to access these emergency beds in that period. The majority of young people had to wait until NHS England was available to manage the referral the next working day. Hence, there have also been calls in our region for daily bed state availability and for NHS England to be accessible out of hours.

Ensuring the best use of a scarce resource and the prioritisation of available beds requires high-quality and skilled clinical assessment. We also provide a gateway service/access assessment during working hours. This has averted the need for in-patient admission for a third of patients referred. It has been valued by referrers and ensures that the right patient accesses the right type of service. However, this service is not available out of hours.

We agree that increased bed provision is not the only solution. The divide in commissioning arrangements for tier 3 and tier 4 services means the development of alternatives to in-patient admission; outreach and crisis services and day-patient services have been patchy, too. In Birmingham we have developed a child and adolescent mental health home treatment service that has demonstrated a reduction in need for admission and cut length of stay by 50%. Birmingham has also set up daytime and out-of-hours community emergency response and assessment teams that respond to emergency referrals from all the local general hospitals.

The report published by the Health Select Committee on 5 November 2014 highlights this major problem with access to in-patient services, as well as problems with commissioning and the lack of services which bridge the gap between in-patient and out-patient services.<sup>2</sup> It takes a whole-systems view and recognises that the problem is about more than just beds.

- 1 Myers G, Coyle D, Kowalski C, Srinivasan R. How can a young person wait over 90 hours in an emergency department for a bed? *Psychiatr Bull* 2014; **38**: 250.

- 2 House of Commons Health Committee. *Children's and Adolescents' Mental Health and CAMHS. Third Report of Session 2014–15*. TSO (The Stationery Office) (<http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhealth/342/342.pdf>).

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### Self-diagnosing bipolar disorder: questions for clinicians

It is not uncommon in psychiatry to receive referrals for patients who believe they have bipolar affective disorder. This has been explained partly by a trend of celebrities openly talking about having bipolar disorder along with an explosion of information about bipolar illness on the internet.<sup>1</sup>

We analysed the records of 46 patients who over a 3-year period requested referral to a community mental health team seeking a diagnosis of bipolar illness. The patients were predominantly young women (mean age 32 years, female:male ratio 31:15). Clinically, they presented with problems of anxiety and low mood with a history of mood swings (90%), racing thoughts (70%), impulsivity (100%) and overactivity (60%). All patients had visited a website offering self-assessment for bipolar illness and reported scores being highly suggestive of a bipolar illness – this had influenced their decision to seek referral. Around 25% of patients reported seeing a TV programme featuring a celebrity talking about their bipolar illness. Five patients, of their own accord, had joined their local Bipolar UK support group before the assessment.

None of the patients were given the diagnosis of bipolar illness at initial assessment. All were given formulations about their problems in terms of mood swings, coping and lifestyle issues. The ICD-10 diagnostic categories were mixed anxiety depression/adjustment disorder/dysthymia (20 patients); emotionally unstable personality disorder (10); alcoholism/alcohol misuse (5); no psychiatric diagnosis (11). About a third of patients, after having their history taken, readily agreed at the end of the first meeting that they were not suffering from a bipolar illness. Five patients asked for a second opinion; all were experiencing relationship problems.

Our experience highlights the issues that may be encountered while assessing patients who actively seek diagnosis of a bipolar illness. There is merit in taking the patient into confidence about the confusion surrounding diagnosing bipolar illness and the risks associated with medical treatment. Also, while trying to arrive at a diagnosis, it may be best to look for classical or severe bipolar illness and if the evidence is not strongly suggestive then the diagnosis should be avoided or deferred until conclusive evidence is obtained.

- 1 Chan D, Sireling L. 'I want to be bipolar' . . . a new phenomenon. *Psychiatrist* 2010; **34**:103–5.

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