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Kent Journal of Psychiatry

Dedicated to Psychiatry trainees and trainers

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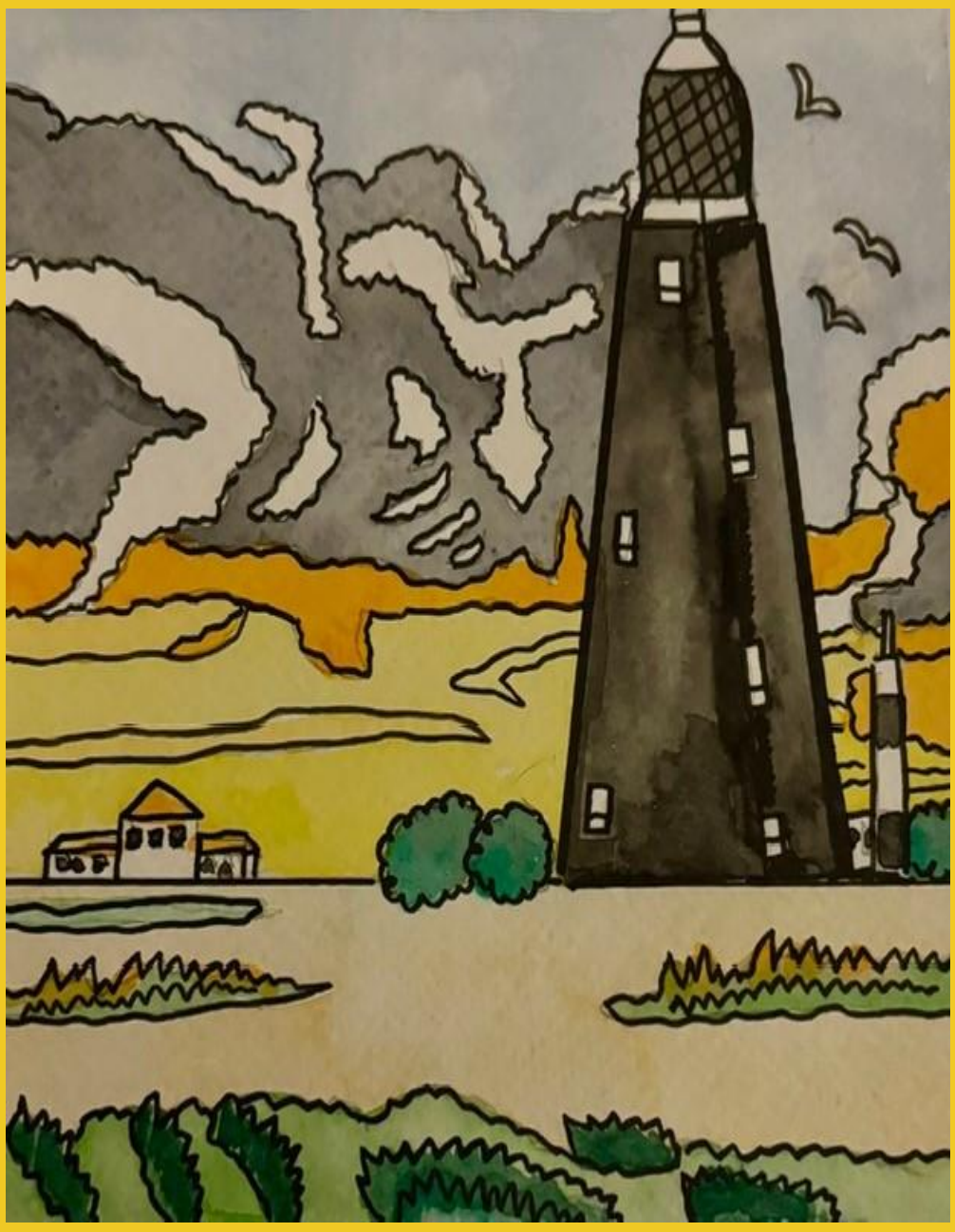

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Editorial

The final issue of 2025 is here, featuring articles on medical student education, community treatment orders, managing aggression, and opinion pieces on institutional awards and misaligned incentives in psychiatry.

Across mental health services, unease is growing as the long-promised 10-year health plan drifts without clarity, raising concerns it may become another aspirational document without the investment or reform needed to deliver real change. The introduction of the Community Integrated Virtual Hospital model adds further uncertainty, with ongoing questions about digital readiness, staffing, and the safe scaling of virtual care. At the same time, the new Mental Health Act demands major cultural and operational shifts from organisations already struggling to maintain core services.

All of this is set against worsening financial pressures that threaten to derail even well-intentioned reforms. Tightening budgets and rising demand are forcing services into short-term crisis management rather than long-term strategy. The current anxiety in mental health services is not a resistance to progress; it is a call for sustainable, credible, and properly resourced reform.

Medical Student Participation in the OpenMinds Project: Motivations, Experiences, and Impact on Knowledge, Skills, and Attitudes Toward Adolescent Mental Health

Femi Balogun

Abstract

Background

Recruitment to psychiatry remains low, and stigma towards mental illness persists among medical students. The OpenMinds project, a student-led adolescent mental health initiative, provides early, experiential exposure to psychiatry through teaching-based interventions.

Objective

To explore why medical students chose to participate in OpenMinds and how participation influenced their knowledge, skills, and attitudes toward mental health.

Methods

Twelve medical students participated in three focus groups. Sessions were audio- and video-recorded, transcribed verbatim (~35,000 words), and analysed using qualitative content analysis with an inductive approach. Themes were generated from the manifest and latent content.

Results

Key motivators for participation included teaching opportunities, project attributes (interactive, hands-on, small group), youth work experience, and desire to help the community. Impacts included improved teaching and reflective skills, increased awareness of adolescent mental health, positive affective changes, and enhanced understanding of stigma. Participation also reinforced interest in psychiatry or public mental health involvement.

Conclusions

The OpenMinds project offers a promising model for early, experiential psychiatry education. Integrating teaching, community engagement, and autonomy can foster positive attitudes, skills, and interest in mental health among medical students.

Keywords

medical education, psychiatry, mental health, adolescent, qualitative research, teaching

Introduction

The public health problem

Adolescent mental ill-health represents a growing public health crisis in the United Kingdom. Recent reports suggest that over one in five 14-year-old girls have engaged in self-harming behaviour [1], while child and adolescent mental health service (CAMHS) referrals reached almost 400,000 in April 2018 alone, the highest figure on record [2]. Yet service provision remains insufficient, with an estimated 0.7 million children nationwide experiencing clinically significant mental illness but only a quarter receiving treatment [3]. Suicide remains a tragic outcome; between 2014 and 2015, 150 probable suicides

occurred among young people in England, with 43% having had no prior contact with public services such as healthcare, social care, or mental health support agencies [4].

This rising demand is not matched by workforce capacity. Consultant numbers in child and adolescent psychiatry have fallen [5], waiting times frequently exceed 12–18 months [6], and inpatient provision is limited to around 2.5 beds per 100,000 population [7]. Meanwhile, mental health disorders constitute the largest single cause of disability in the UK, with an estimated annual economic cost of £105 billion [8].

A school-based approach

In response, increasing attention has focused on preventive, school-based interventions. The UK government's 2018 Green Paper proposed placing new mental health practitioners in schools, aiming to reduce waiting times and improve early intervention. School-based programmes have demonstrated cost-effectiveness, with resilience-building interventions costing approximately £5 per pupil compared with £2,400 for CAMHS referral and £61,000 per inpatient admission [9, 10].

The OpenMinds programme

OpenMinds UK is a school-based public mental health initiative designed to improve mental health literacy, reduce stigma, and promote positive attitudes towards help-seeking. Delivered by medical students to secondary school pupils, the programme is now embedded across six UK medical schools, including King's College London, as an elective credited component of the curriculum. The model combines psychiatrist-led training for medical students with classroom delivery of mental health education, adopting a near-peer approach due to the relative age proximity between medical students and adolescents. Since its launch, OpenMinds has involved over 300 medical students and reached more than 4,000 pupils.

Quantitative evaluation has demonstrated improvements in knowledge and attitudes among both school and medical student participants [11]. However, limited qualitative research has explored the experiences of medical students themselves, particularly their motivations for participation and the personal impact of involvement.

Why this project?

This study sought to address this gap by examining the experiences of medical students at King's College London who participated in OpenMinds. Specifically, the research asked: (1) why medical students chose OpenMinds from among other elective programmes; and (2) how participation influenced their knowledge, attitudes, and skills. By answering these questions, the study aims to provide qualitative evidence of programme impact, to identify components that appeal to medical students, and to inform medical educators and curriculum developers on strategies to promote psychiatry and reduce stigma within the profession.

Methods

Study aim

This qualitative study explored why medical students chose to participate in the OpenMinds public mental health program and how their involvement influenced their knowledge, skills, and attitudes. Three objectives guided the study: identifying factors influencing elective selection, evaluating the impact on participants' skills and attitudes, and exploring stigma-related experiences.

Design

Data were collected via three focus group interviews with medical students at King's College London who had participated in OpenMinds. Focus groups were selected to capture rich, interactive discussion, allowing participants to share experiences, build on each other's insights, and reveal both verbal and non-verbal communication [12]. Interviews were audio- and video-recorded, transcribed verbatim, and analysed using qualitative content analysis [13, 14]. An inductive approach was used, allowing themes to emerge

from the data rather than imposing predefined categories.

Participants

Twelve medical students (four male, eight female) volunteered from a pool of forty-four eligible participants. Focus group composition was determined by availability, resulting in three groups of four to five students. Minimal demographic data (age, year of study, prior teaching experience) were collected. All participants provided written informed consent.

Procedure

Focus groups were conducted in quiet rooms on campus, with participants seated in a horseshoe arrangement. Open-ended questions addressed reasons for participating, perceived impact on knowledge and skills, attitudes towards mental health and psychiatry, experiences of stigma, and intentions for future public mental health involvement. Sessions lasted 49–90 minutes each, totalling 3 hours and 25 minutes.

Analysis

Transcripts were read repeatedly to gain an overview, and "meaning units" were extracted, condensed, coded, and grouped into categories and themes. This process focused on both manifest and latent content while maintaining fidelity to participants' original statements. Efforts to enhance reliability included transparent documentation of coding decisions and reflective consideration of researcher bias.

Ethics

The study adhered to ethical principles, with no reported distress among participants. All data were securely stored in accordance with the Data Protection Act [15], and the researcher declares no conflicts of interest.

Results

Motivations for Participation

Opportunity to Teach: All students cited the teaching component as a key motivator. Many valued developing teaching skills as essential for their future medical careers. Peer-focused teaching ("students-teaching-students") was appealing.

Project Attributes: Students preferred small group sessions, interactive and hands-on learning, autonomy in lesson design, and relaxed assessments.

Youth Work and Community Engagement: Previous experience with youth work, desire to help adolescents, and addressing mental health stigma were important motivators.

Table 1: Motivations for Participation

Theme	Subthemes
Teaching Opportunity	Acquire teaching skills, students-teaching-students model, previous experience
Project Attributes	Small group sessions, interactive, hands-on, autonomy, relaxed assessments
Youth Work	Previous youth work experience, interest in working with adolescents
Helping in the Community	Apply medical knowledge, fight stigma, improve mental health literacy

Impact for Participation

Improved Skills: Students reported enhanced teaching, reflective, organisational, and project management skills, as well as engagement with adolescents.

Increased Awareness: Participation improved general mental health knowledge, awareness of holistic care, and understanding of public health challenges.

Affective Change: Students reported positive attitude changes toward mental health, early intervention, and preventative work.

Stigma Awareness: Students recognised the complexity of stigma, reflected on personal biases, and observed generational improvements in attitudes.

Theme	Subthemes
Improved Skills	Teaching, reflective, organisational, engagement skills
Increased Awareness	Mental health knowledge, holistic care, professional attitudes
Affective Change	Interest in psychiatry/psychology, positive attitude change
Stigma	Recognition, generational trends, anti-stigma engagement

Future Public Mental Health Involvement: Students expressed intent to continue mental health work in clinical or community contexts, with some pursuing psychiatry careers.

Theme	Subthemes
Likely Participation	Already involved, keen but no specific plans, known area
Personal Use Only	Enhance professional interactions, maintain knowledge
Career in Psychiatry	Decided, undecided, considering psychiatry

Discussion

This study underscores the importance of early and experiential exposure to mental health and psychiatry within undergraduate medical education. The OpenMinds programme, with its teaching-focused, hands-on, and community-based model, provided participants with valuable opportunities to develop practical teaching skills, enhance mental health literacy, and engage directly with adolescents in a preventive public health context. Such experiential learning not only deepened students' understanding of mental health but also fostered empathy and a sense of social responsibility, key attributes for future clinicians. Importantly, the programme's emphasis on peer-led education and autonomy appeared to strengthen participants' confidence and reinforce positive attitudes toward psychiatry and public mental health practice.

These findings align with existing literature highlighting the benefits of early and enriched exposure to psychiatry in medical education. Brown et al [15] and Mortlock et al [16] both emphasise that structured, positive learning experiences can help to counteract the negative stereotypes and stigmatising attitudes sometimes transmitted by senior clinicians. The experiential, student-led nature of OpenMinds mirrors these recommendations by providing authentic teaching and community engagement experiences that promote active learning and reflection. Consistent with adult learning theory, the programme's design encouraged autonomy, relevance, and self-direction—elements known to enhance motivation and retention of learning.

Nevertheless, several limitations should be acknowledged. Participation in this study was limited to students who voluntarily selected the OpenMinds elective, which may have introduced self-selection bias and resulted in an overrepresentation of individuals already interested in psychiatry or mental health advocacy. Consequently, the findings may not reflect the perspectives of students less inclined toward these topics. Moreover, as the study relied on short-term qualitative feedback, the long-term sustainability and practical impact of the programme on clinical practice and career choices remain uncertain. Future research employing longitudinal designs could help determine whether these positive attitudinal and skill-based changes persist over time and translate into improved patient care or increased recruitment into psychiatry.

Overall, the results suggest that experiential, community-oriented approaches such as OpenMinds can meaningfully enrich medical education by integrating public mental health principles with teaching and professional development. Embedding similar initiatives within medical curricula may strengthen students' preparedness to address mental health needs

across diverse clinical settings and contribute to reducing stigma within the healthcare profession.

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Evaluating the Effectiveness of Community Treatment Orders (CTOs) Across Two London Boroughs: A Service-Based Analysis

Zohreh Madani & Hamid Rahmanian

Abstract

This paper examines the clinical effectiveness of Community Treatment Orders (CTOs) in two London mental health service areas: Carshalton & Wallington (C&W) and Sutton & Cheam (S&C). Using patient data from May 2025, it evaluates the impact of CTOs on medication adherence, crisis readmission, and risk management. Findings indicate that CTOs contribute to greater stability, reduced hospitalisation, and improved engagement, though outcomes differ by population complexity. In C&W, CTOs supported adherence and relapse prevention among a stable psychosis cohort, while in S&C they were crucial for managing dual-diagnosis and forensic patients, underscoring their context-dependent value in community psychiatry.

Introduction

Community Treatment Orders (CTOs), introduced under Section 17A of the Mental Health Act 1983 (amended 2007), were designed to provide supervised treatment for individuals with severe mental illness in the community rather than under hospital detention. They aim to improve adherence, reduce relapse and readmission, and sustain continuity of care in less restrictive settings [1]. CTOs represent a key policy instrument within the UK's recovery-oriented, risk-managed approach to deinstitutionalised care [2].

Despite their widespread use, CTOs remain controversial. Proponents argue that they promote treatment stability and reduce the "revolving-door" pattern of admissions [3], while critics highlight mixed empirical results and ethical concerns regarding coercion and autonomy. The landmark OCTET trial found no significant differences in readmission rates between CTO and non-CTO groups [4], prompting debate over whether perceived benefits arise from enhanced follow-up rather than legal compulsion. Qualitative research further reveals that clinicians often regard CTOs as pragmatic tools for engagement, whereas patients frequently experience them as coercive and stigmatising [8,9].

This study evaluates CTO outcomes across two contrasting NHS service areas, C&W and S&C, to explore how demographic, legal, and organisational contexts shape effectiveness. By integrating quantitative and qualitative indicators, it seeks to clarify the conditions under which CTOs are most clinically beneficial and ethically defensible within community mental health care.

Methods

A retrospective observational analysis examined CTO outcomes using routinely collected NHS data from May 2025. Patient records and CTO referral logs from C&W and S&C provided information on clinical progress, medication adherence, legal status, and multidisciplinary reviews. Supplementary demographic and diagnostic data were extracted from team databases to account for case-mix variation.

Effectiveness indicators included medication adherence (percentage of prescribed doses received three months before and after CTO), crisis readmission (psychiatric admissions six months pre- and post-CTO), documented high-risk incidents (as a proxy for risk management), and service engagement (attendance at community reviews and multidisciplinary meetings). Quantitative outcomes were expressed as relative percentage changes, while qualitative themes, such as engagement, stability, and risk containment, were derived from clinical notes.

Results

Across both sites, CTOs were associated with improved adherence, engagement, and safety outcomes. In Carshalton & Wallington (C&W), three patients (all under Section 17A) demonstrated increased medication adherence from approximately 60% to over 90%, a 67% reduction in hospital readmissions, and no recorded forensic incidents. Patients maintained stable trajectories and strong community engagement, suggesting that CTOs were effective in consolidating recovery among low-risk service users.

In Sutton & Cheam (S&C), eight patients, four under Section 42 and four under Section 17A, presented with more complex forensic and dual-diagnosis profiles. Medication compliance rose by around 40%, while recorded violent incidents fell by half. CTOs were central to stabilising high-risk individuals, preventing acute relapse, and sustaining structured engagement under Ministry of Justice restrictions. While both sites showed positive clinical effects, outcomes reflected contextual differences: CTOs in C&W primarily reinforced stability in compliant patients, whereas in S&C, they functioned as essential mechanisms for risk management and containment.

Discussion

The findings align with existing evidence suggesting that CTO effectiveness is shaped by patient characteristics and service context [2,4]. In C&W, success appeared linked to consistent staffing and a stable clinical population, while in S&C, outcomes were driven by more intensive risk management structures and consultant continuity. These contextual variables complicate direct comparisons and suggest that CTOs may serve distinct functions across service models, from adherence reinforcement to forensic risk control [2].

Clinician reflections and prior research reveal the persistent ethical tension underpinning CTO use: while they can enhance safety and stability, they risk undermining autonomy and therapeutic trust [1,9]. As such, CTOs occupy an ethically ambiguous space, protective yet paternalistic, requiring continuous scrutiny of proportionality and necessity.

This study's limitations include a small sample size, retrospective design, and reliance on clinical documentation, which restricts causal inference and generalisability. Nonetheless, it highlights the importance of contextual analysis and suggests that CTOs' value lies in structured continuity and relational engagement rather than compulsion alone.

Conclusion

CTOs remain a valuable but context-dependent component of community psychiatry. Their effectiveness depends on patient complexity, service resources, and the strength of multidisciplinary collaboration. To ensure ethical legitimacy and clinical justification, CTO continuation should be regularly reviewed through multidisciplinary panels. Enhancing access to independent advocacy and patient education may reduce perceived coercion, while standardising outcome metrics, such as adherence and relapse rates, across NHS Trusts would improve national evaluation and accountability. Future research should adopt mixed-methods, longitudinal designs to capture both measurable outcomes and lived experiences of CTO use in diverse service settings.

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Pharmacological management of aggression in patients with traumatic brain injury: a systematic review

H. Smith, E. Collison-Ani, A. Isola, G. Burrah

Abstract

Background

Aggression is a common sequela following TBI. Aggressive behaviour includes agitation, irritability, anger, verbal outbursts, physical aggression against objects, self or other persons, and violent, hostile or assaultive behaviour. Prescribing practice usually derives from management in other patient populations and personal experience of the clinician. This review aims to analyse research in pharmacological intervention following TBI. Given the sparsity of available evidence, an expansive definition of aggression is used to review the evidence for all emotional and behavioural issues subsequent to TBI.

Methods

PubMed, ProQuest, PsychInfo, Ovid Medline, Web of Science and Google Scholar were searched for clinical trials of aggression management in TBI. Inclusion criteria was: participants over 16 with confirmed TBI diagnosis; primary outcome assessing aggression using objective rating scale; trial of single medication. Exclusion criteria was: participants 16 or younger; presence of other neurodegenerative disorder, primary psychiatric diagnosis, or other acquired brain injury e.g. stroke.

Results

10 studies were identified. Of 6 medications used in these studies, only amantadine had level II evidence in support of treatment. Amantadine demonstrated Neuropsychiatric Inventory - Irritability scale reduction of 4.3 compared to 2.6 in placebo ($p = 0.0085$). Later trials failed to confirm this benefit.

Conclusions

Carbamazepine, methylphenidate, quetiapine, risperidone, and sertraline do not have evidenced benefit in post-TBI aggression management, although are well tolerated. Amantadine demonstrates mixed evidence in support. Larger studies with consistent outcome measures and uniform inclusion criteria should be conducted.

Introduction

Traumatic Brain Injury (TBI) is a major cause of health, social and economic problems. TBI disrupts the normal function of the brain, caused by a bump, blow or jolt to the head or a penetrating head injury. Aggression is the most common sequela post-TBI. The spectrum of aggressive behaviour includes agitation and irritability, anger, verbal outbursts, physical aggression against objects, self or other persons, severe irritability, and violent, hostile, or assaultive behaviour. Aggression affects an individual's access to rehabilitation, employment and community activities. More effective support and treatment will, therefore, help to improve the quality of life for individuals with aggression post-TBI and their families [1,2].

Post-TBI aggression can be managed with pharmacological and non-pharmacological approaches. There are no Food and Drug Administration (FDA) approved medications for aggression related to TBI. Clinicians rely on

experience treating similar conditions and extrapolation of management from non-TBI populations. Resultantly, there is wide variation in prescribing practices; equally efficacious medications, variability of clinical presentation, severity of neurobehavioral symptoms, and lack of clinical practice guidelines contribute to this [3]. Antipsychotics remain the most prescribed medication to manage post-TBI aggression. This contrasts with available evidence and recommendations from systematic reviews [4,5,6].

Methods

Ovid Medline, ProQuest, PubMed, Web of Science, PsychINFO, and Google Scholar were searched between January 1975 and November 2024. The following search terms were used:

(pharmaco* OR drug* OR treatment OR therap* OR management OR beta blocker* OR antipsychotic* OR typical antipsychotic* OR atypical antipsychotic* OR anticonvulsant* OR antiepileptic OR dopamine agonist* OR amantadine OR psychostimulant* OR antidepressant* OR sertraline OR trazodone OR TCAs OR alpha agonist* OR hypnotic* OR anxiolytic* OR benzodiazepine* OR lithium OR methylphenidate OR amphetamine OR propranolol OR pindolol OR buspirone OR carbamazepine) AND (irritability OR hostility OR aggress* OR agitation OR challenging behavior OR violen* OR assault*) AND (traumatic brain injur* OR head injur* OR TBI OR brain trauma)

Clinical trials, both controlled and uncontrolled, were eligible. One author (GB) identified which studies met inclusion criteria, screened each report, and conducted the bias assessment using the Cochrane RobB2 tool. Several papers had some concerning features relating to randomisation, missing data, outcome measures and selection bias. Full assessment is given in the appendix. For each paper, a summary of these features is given in the results section. Two authors (GB, HS), independently collected and reviewed data from each report. Where discrepancies in study screening and data extraction were identified, these authors jointly discussed whether the study met predefined inclusion criteria and verified outcomes. No included paper required further verification steps. Outcomes sought were any change in aggression as identified by a validated, standardised outcome measure (Table 2). A broad definition of aggression, inclusive of all behavioural and emotional changes was included in the search strategy to identify all possible reports given the limited data available.

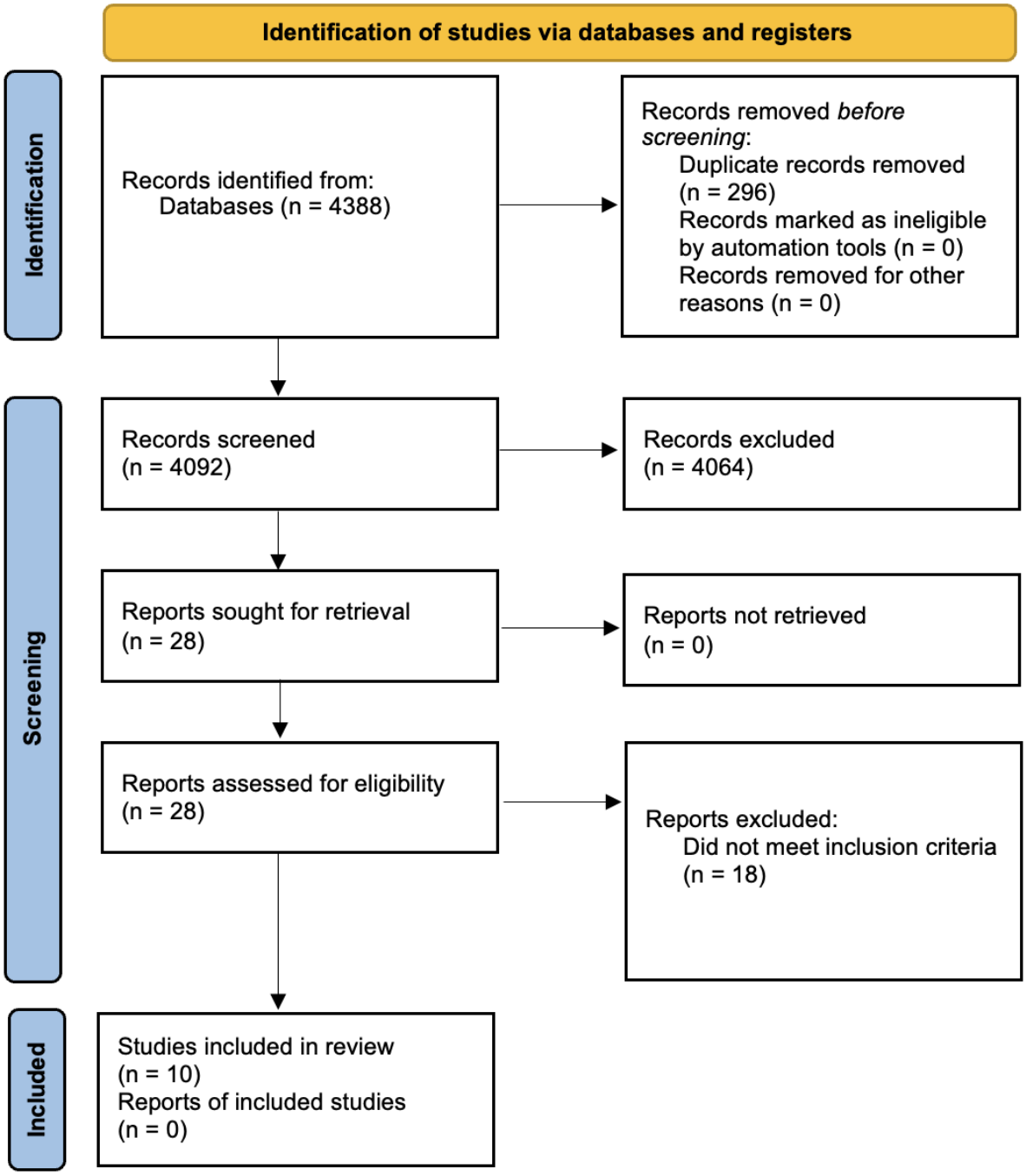
Any trials utilising children under 16 were excluded to remove confounding due to aggression relating to developmental conditions such as ADHD. Any trials where participants had neurodegenerative disorders (e.g. dementia), acquired brain injury (e.g. stroke) or primary psychiatric diagnosis (e.g. schizophrenia) were excluded to remove confounding due to aggression related to these diagnoses. Any trials including participants with a history of behavioural disturbance prior to TBI or those in the acute or posttraumatic amnesic phase were excluded to remove possible confounding with prior data.

Given the limited data available, no data synthesis or meta-analysis was conducted. Results are presented descriptively for each study. The review was not registered in advance with PRISMA.

Results

The PRISMA flow chart (Figure 1) shows the results of the literature search. Ten studies were included in the final review. Seven were RCTs. Three were open trials, one of which was not blinded. A summary of the full-text articles excluded with reasons is given in the appendix. Reasons for exclusion included unspecified time since injury, inconsistent diagnosis, focus on cognitive recovery, and description of case series. Of note, all studies investigating the use of beta blockers were excluded for reasons including participants in the acute-TBI phase, and unspecified outcome measures.

Figure 1: PRISMA summary of identified studies



TBI diagnosis and inclusion criteria

There was significant variability in confirmation of TBI diagnosis (Table 2). For several studies, no thresholds for TBI severity for inclusion were used; therefore, the diagnosis of TBI was equivalent to the inclusion criteria. Some estimation of severity can be made based on the manner in way participants were recruited.

Table 1: Methods of diagnosis and TBI inclusion criteria.

Other inclusion criteria the same as the literature search strategy, such as recruiting only adults, have not been repeated in the table.

Study	Method of TBI diagnosis	Inclusion criteria relating to TBI severity or chronicity
Azouvi et al, 1999 [7]	Referral diagnosis of severe closed head injury	
Deb et al, 2020 [8]	GCS score < 8 at time of injury	Minimum 6 months post-injury
Hammond et al, 2015 [9]	Reported behavioural changes affecting care and/or family reintegration	Minimum 6 months post-injury
Hammond et al, 2017 [10]	Mayo Clinic criteria	Score of > 6 on observer-rated NPI-I Most Problematic questionnaire
Hammond et al, 2014 [11]	GCS < 13, motor score < 6	
Hammond et al, 2021 [12]	Loss of consciousness	As above
Kant et al, 1998 [13]	Post-traumatic amnesia > 24 hours	Minimum 6 months post-injury
Kim & Bijlani, 2006 [14]	Positive neuroimaging	Score of > 2 on NPI-I questionnaire
Mooney & Haas, 1993 [15]	Focal neurological signs	As in Hammond et al, 2015

Outcome measures

Each paper employed one or more of a battery of available assessments of post-TBI aggression, either specifically or as part of broader mood and behaviour analysis. A summary is given in Table 2. Each yields a quantitative outcome measure.

Table 2: Measures of post-TBI aggression used in the selected papers

Outcome measure	Subtype	Measure of	Rated by
ABS (Agitated Behaviour Scale)		Post-traumatic agitation during acute recovery phase	Observer (objective)
KAS (Katz Adjustment Scale)		Social personality and behavioural characteristics of inpatient psychiatric patients returning to the community	Observer
NPI (Neuropsychiatry Inventory)	Most aberrant; Observer NPI-Problematic; NPI-A; NPI-I; NPI-I Distress; Participant problematic	12 domains, including irritability, agitation/aggression	Participant or observer
NRS (Neurobehavioral rating scale)	NRS-R	Changes in neurobehavioral functioning post-TBI	Observer
OAS (Overt Aggression Scale)	MOAS; OAS-M	Post-TBI aggression	Observer
POMS (Profile of Mood States)		Mood-assessment	Participant
STAS (State-Trait Anger Scale)		Fluctuating states of anger, irritability, annoyance	Participant
STAXI-2 (State-Trait Anger Expression Inventory)		Experience and expression of anger	Participant or observer

High variability in outcome measure and trial structure, as well as limited study number and sample sizes necessitate a descriptive summary of individual results rather than data synthesis. Results are reported in positive reduction values, i.e., a larger number indicates greater reduction in test score. A summary of the relevant outcomes is given in Table 3 and Figure 1.

The predominant population in this review are male. The incidence of TBI in the general population is over twice as high in men as in women [17]. The gender distribution in this review is reflective of the TBI population. The time since injury for 3 studies was at least 6 months, and the remainder had an average of 38 months. This suggests the cohort of participants were likely in the chronic phase and representative of the chronic TBI population. All participants were recruited from community settings. Participants in four studies [7,8,13,15] were recruited from rehabilitation centres and neurology or neuropsychiatry clinics. Another four studies [9,10,11,12] recruited participants from physician referrals, local brain injury support groups, and newsletters. This suggests that our review identifies mild to moderate levels of aggression. Additionally, individuals who are self-motivated to volunteer for studies may be more motivated to adhere to trial conditions than the general population.

Amantadine

Results from amantadine trials are inconsistent, which is in keeping with additional systematic reviews [4] and a Cochrane review [6]. Worsening of agitation has been noted in studies outside the scope of this paper [18]. Where significant effects are found, there is focused benefit on the outcome measure subtypes associated with aggression. Hammond et al conducted three amantadine trials. Participants taking neuroleptic medication or MAOIs were excluded but those on a stable psychoactive stimulant dosage were not.

Hammond et al [11] conducted a 28-day RCT (n = 76) which demonstrated an NPI-I reduction of 4.3 in the treatment group compared to 2.6 in the placebo (p = 0.0085) with 100mg BD amantadine or matched placebo. Exclusion of individuals with minimal to no baseline aggression increased this to 4.56 in treatment versus 2.46 in placebo (p = 0.046). 80% of the treatment group improved by 3 points compared to 44% in the placebo (p = 0.0016). Mean change in NPI-A was not significant compared to placebo for the whole cohort. After exclusion of participants with minimal to no baseline aggression, there was a mean reduction of 4.65 compared to 2.46 in placebo (p = 0.046).

Hammond et al [9] demonstrated no significant effect when p-values were adjusted to account for multiple comparisons. Raw data showed NPI-I Most Aberrant Observer score reduction of 3.74 in the treatment group compared to 3.68 in placebo (p = 0.025), which is a minimal effect. Day 60 reduction in NPI-I Most Problematic Observer score was 4.68 in treatment versus 3.8 in placebo (p = 0.025), and 3.47 in treatment versus 2.29 in placebo for Most Problematic Participant score. Day 60 NPI-I Distress Participant score showed a reduction of 1.87 in treatment versus 1.35 in placebo (p = 0.025). Day 60 reduction in NPI-I Most Aberrant Observer score was 4.39 in treatment versus 3.9 in placebo (p = 0.025) and Most Aberrant Participant score was 3.7 in treatment versus 2.77 in placebo (p = 0.025). Of note, recruitment partially from brain injury support groups, as well as no recording of utilisation of psychosocial support such as rehabilitation therapies and counselling may have increased the apparent placebo response rate.

Hammond et al [10] demonstrated NPI-A Most Problematic Participant score reduction of 5.27 in the treatment group compared to 2.89 in the placebo (p = 0.0118). Significant effects were also reported in NPI-A Distress Participant score with distress > 2. However, all other NPI and STAXI categories demonstrated no significant effect.

Carbamazepine

Our review finds no favourable evidence for the use of carbamazepine in chronic TBI aggression. Some reviews [19] use evidence from case studies to demonstrate improvement; however, they include participants in the acute phases of TBI.

Azouvi et al [7] conducted an open trial (n = 10) demonstrating a NSR-R reduction of 2.3 (p = 0.02) and ABS of 2.2 (p = 0.02) at 2 weeks after treatment initiation. At the end of the trial NSR-R reduced overall by 3.9 (p = 0.01). Participants did not continue to improve and at 8 weeks post-treatment the only significant decreases from pretrial baseline were in NSR-R subgroups irritability (2.4, p = 0.01) and disinhibition (2.04, p < 0.05). Only 5 participants showed a 50% or more decrease in NSR-R scores, 3 of whom were in the subacute post-injury stage. ABS also reduced from 32.7 to 24.4 (p = 0.02); however, any value above 21 is considered as still demonstrating agitated behaviour. Carbamazepine was started at 200mg OD, titrated to a maximum of 600-1200mg OD, although treatment response was independent of dosage. Sedative effects were noted, which limited dose increases. One significant cutaneous allergic reaction occurred.

Hammond et al [12] conducted a 42-day RCT which did not identify significant treatment effect, but also did not note any adverse treatment events. Carbamazepine was titrated to a maximum of 800mg. A history of carbamazepine hypersensitivity, contraindication, or drug interactions were exclusion criteria. Participants taking neuroleptic medication or MAOIs were excluded but those on a stable psychoactive stimulant dosage were not.

Methylphenidate

Data in support of methylphenidate is poor. Mooney & Haas [15] conducted a 6-week RCT which identified a reduction of 2.37 in STAS trait anger (p < 0.000) and minor improvements of 0.26 in KAS belligerence (p = 0.005) and 0.22 in POMS

anger-hostility (p = 0.001). Methylphenidate was titrated up to 30mg OD. As a small (n = 12) single-blinded study with recognised subject randomisation bias, including only male participants, the validity of these results may be questioned.

Speech et al [16] conducted a double-blind, placebo controlled RCT (n = 12) in which participants received 1 week of methylphenidate followed by 1 week of placebo, or vice versa. No information on participant recruitment, concurrent medication use, or randomisation protocol was given. Patients, family members, and assessors were blinded. Dose was determined by weight. No significant difference was identified using the KAS scale. However, all 12 patients correctly determined the order of administration at the end of the trial and 11 reported improvement in personality functioning and cognition, as agreed by 8 of 11 observers.

Quetiapine

Our review finds scope for exploring the use of quetiapine in a further RCT. Kim & Bijlani [14] conducted a 6-week open trial (n = 7), which identified a reduction in OAS-M score of 84.5% (p = 0.002) with quetiapine titrated to a maximum of 800mg OD. Participants using neuroleptics, lithium, or psychoactive drugs were excluded but those taking antidepressants, benzodiazepines, or anticonvulsants were not. However, there was no blinding, no control group, and no compliance or sociodemographic data. Sedation was reported in 43% of participants.

Risperidone

There is minimal data in support of risperidone use. Deb et al [8] conducted a 12-week RCT (n=14) of risperidone vs placebo and identified a MOAS reduction for both placebo (9.5) and risperidone (2.8) to approximately the same level, accounted for by the placebo group having a higher starting MOAS score. No p-values were reported, and the authors stated this was not a significant effect. Aggression was defined as any form of behaviour directed towards the goal of harming or injuring another living being, divided into verbal and physical aggression. Antipsychotic use was an exclusion criterion. Other reviews [6,19] did not identify any further evidence aside from case studies.

Sertraline

Our review finds there is evidence for exploring the efficacy of sertraline in an RCT. Kant et al [13] conducted an 8-week open-label study (n = 13), which demonstrated a reduction in OAS-M aggression score of 226.79 (p < 0.01) and OAS-M irritability of 0.85 (p < 0.01) at 8 weeks with sertraline titrated to 200mg OD. However, this was an open trial with lack of blinding, small size, and lack of a control group. A systematic review [19] did not find that sertraline had significant effect in acute TBI.

Table 3: Summary of results from identified studies with main identified significant treatment effect and relevant study details.

Treatment	Study	Result	Conclusion	Salient study details
Amantadine	Hammond et al, 2014 [11]	NPI-I reduction of 4.3 (treatment) vs 2.6 (placebo) p = 0.0085	Positive treatment effect	RCT n = 76
	Hammond et al, 2015 [9]	No significant effect when accounting for multiple comparison	No treatment effect	RCT n = 168
	Hammond et al, 2017 [10]	NPI-A Most Problematic (participant rating) reduction of 5.27 (treatment) vs 2.89 (placebo) p = 0.0118	Positive treatment effect	RCT n = 118
Carbamazepine	Azouvi et al, 1999 [7]	NSR-R reduction of 3.9 p = 0.01	Limited positive treatment effect	Open trial; no placebo n = 10
	Hammond et al, 2021 [12]	No significant effect	No treatment effect	RCT n = 70
Methylphenidate	Mooney & Haas, 1993 [15]	STAS Anger reduction of 2.37 p < 0.000	Positive treatment effect	RCT n = 12 Randomisation bias
	Speech et al, 1993 [16]	No significant effect	No treatment effect	RCT n = 12
Quetiapine	Kim & Bijlani, 2006 [14]	OAS-M reduction of 84.5% p = 0.002	Positive treatment effect	Open trial; no placebo n = 7
Risperidone	Deb et al, 2020 [8]	No significant effect	No treatment effect	RCT n = 14
Sertraline	Kant et al, 1998 [13]	OAS-M raw score reduction of 226.79 p < 0.01	Positive treatment effect	Open trial; no placebo n = 13

Conclusions

Significant results were found for amantadine, carbamazepine, sertraline, and quetiapine. A trial using amantadine conducted by Hammond et al [11] was the only RCT (n = 76) and is therefore the best evidenced; however, follow-up trials failed to replicate these results. The variability in effect size of amantadine may be due to off-target effects, as well as differences in the cognitive profile of included participants relating to severity and time since injury, that may differentially influence the concentration or distribution of drug targets. The studies for carbamazepine, sertraline, and quetiapine that identified significant treatment effect were small open trials. Therefore, amantadine was the only treatment with level 2 evidence of benefit for aggression and irritability in this patient population in our review. Although this is not conclusive evidence, clinicians should consider amantadine for managing aggression in the TBI population, particularly those > 6 months after sustaining a closed head injury. This is supported by other reviews [20,21].

These studies indicate amantadine, sertraline, quetiapine, methylphenidate and risperidone are tolerated well in this patient population. Only one patient had a severe allergic reaction to carbamazepine. Methylphenidate was not noted to have increased or worsened aggressive behaviours.

There was significant variability in patient inclusion criteria in these studies. Study protocols tended to include subjects stabilised on concurrent

medication; however, delayed or additive effects from these treatments cannot be discounted. Further studies should focus on the application of uniform inclusion criteria to increase the likelihood of producing reliable and reproducible results. They could also consider withdrawing medications with a washout period to remove the additive effect of concurrent medication.

There was significant variability in aggression scales. Each scale attempts to characterise a broad variety of behaviours. To allow data synthesis, utilisation of a variety of aggression scales, each focused on a sub-group of behaviour (e.g. verbal vs physical) verified in the post-TBI community would allow flexibility of selection for the specific study population as well as inter-publication comparison. However, the authors accept this would require further consensus in the research community that may not yet be present.

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Rest of the references and appendices are available on request.

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Perils of Institutional Awards for Psychiatrists: A Critical Examination

M Aamer Sarfraz & Mary Aston

Abstract

Institutional awards are prevalent features of contemporary professional life, widely presumed to incentivise excellence and raise standards. This paper argues that within the specific context of psychiatry, such recognitions are ethically corrosive, epistemologically reductive, and institutionally counterproductive. Drawing on theoretical frameworks from Pierre Bourdieu, Michel Foucault, and the self-determination theory of Deci and Ryan, we contend that awards fundamentally misrepresent the ethos of psychiatric care. They transfigure intrinsic ethical commitments into extrinsic competitions for symbolic capital, reinforce existing power hierarchies, promote epistemic conformity, and undermine the collaborative nature of mental health work. By commodifying compassion and virtue, awards create a moral hazard, shifting focus from patient-centred outcomes to institutional performance metrics. This paper examines these risks across four interconnected domains - the ethical, epistemic, professional, and political-economic, and concludes by proposing alternative, collective models of recognition that align with the foundational principles of the psychiatric profession.

Introduction

Awards and formal recognitions are deeply embedded in the cultural fabric of professions, serving as seemingly benign mechanisms to celebrate achievement, motivate performance, and signal institutional values. In fields like sales or engineering, where output is readily quantifiable, such incentives may align with organisational goals. However, this paper argues that the uncritical import of this competitive, meritocratic model into psychiatry, a discipline whose core value resides in the nuanced, relational, and often unquantifiable therapeutic alliance, generates profound and perverse consequences.

The moral foundations of psychiatric work, anchored in empathy, ethical integrity, and a humble engagement with human suffering, are fundamentally at odds with the logics of ranking, competition, and the so called prestige. Psychiatry's ethos of care resists quantification; it depends upon relational depth, moral seriousness, and the recognition of human vulnerability rather than comparative achievement. Yet, contemporary institutional cultures increasingly valorise forms of recognition that translate the moral labour of care into measurable prestige. Following Bourdieu [1], such awards operate as performative acts that generate "symbolic capital," converting the qualitative dimensions of compassion and ethical commitment into a hierarchical economy of distinction. This process subtly reshapes the profession's moral terrain, where acknowledgement becomes entangled with the pursuit of institutional legitimacy rather than the sustenance of genuine therapeutic engagement.

This paper contends that the conferral of awards upon psychiatrists, within hospitals, universities, and mental health organisations alike, undermines the very moral and epistemic foundations upon which psychiatric care depends. Far from encouraging excellence, these recognitions risk consolidating hierarchies, producing epistemic closure, and commodifying virtue as a marketable credential. By transforming ethical care into a form of exchangeable capital, awards obscure systemic failures, depoliticise moral inquiry, and perpetuate the illusion of institutional meritocracy. Ultimately, the paper contends that for psychiatry to preserve its ethical seriousness and social credibility, it must resist the seductions of prestige culture and critically

interrogate the institutional mechanisms that reward individual distinction at the expense of collective moral purpose.

The Ethical Erosion

The primary objection to awards in psychiatry is ethical. The moral foundation of the profession is built upon patient-centred care, confidentiality, and profound humility in the face of complex biopsychosocial distress. This foundation is sustained by intrinsic motivation - the psychiatrist's authentic commitment to healing and alleviating suffering for its own sake. A substantial body of psychological research, notably Self-Determination Theory [2,3], demonstrates that the introduction of salient extrinsic rewards can systematically undermine intrinsic motivation. When an activity is undertaken for its inherent satisfaction, the imposition of a contingent reward can shift the perceived locus of causality from internal to external, thereby "crowding out" the original, authentic drive [2].

In organisational psychiatry, awards endorse precisely this shift. The psychiatrist's orientation subtly transmutes from care for the patient to care for prestige. Success becomes defined not by therapeutic presence or empathic understanding, but by visible, measurable outputs: publication counts, grant income, number of patients seen, or institutional visibility. The most decorated psychiatrists may, therefore, be those who excel at institutional performance and self-promotion rather than the quiet, demanding labour of therapeutic excellence. This dynamic represents a profound category error, as articulated by Ivan Illich [4] in his critique of the industrialisation of medical care: it commodifies compassion, transforming a moral relation into a transactional one. The award does not recognise the quality of care; it redefines it, trivialising its moral gravity by reducing it to a trophy.

Epistemic Closure

Psychiatry is a branch of medicine characterised by fundamental epistemological tensions; it navigates between biological reductionism, psychodynamic interpretation, social constructivist models, and trauma-informed approaches. This pluralism is a source of vitality and critical self-reflection. However, institutional awards implicitly codify and valorise a specific epistemic stance, thereby fostering conformity and stifling dissent.

When an organisation confers an "Excellence in Research" award for neuroimaging studies or an "Innovation in Treatment" award for psychopharmacological protocols, it is not making a neutral judgment of merit. It is making a political statement about what constitutes valid knowledge and valuable intervention. This process aligns with Foucault's [5] concept of disciplinary power, which operates not through overt coercion but through the normalisation of certain truths and practices. A psychiatrist whose work aligns with the organisational orthodoxy, for instance, by prioritising quick-turnover of patients via discharge-based solutions, is more likely to be rewarded than one who challenges institutional norms by questioning quality of care, advocating for resource-intensive therapies, or criticising intimidation culture.

Consequently, the award system produces a form of epistemic closure. It creates a "cognitive monopoly" [6] that punishes ideological dissent and rewards alignment. The pursuit of recognition becomes a powerful incentive to adhere to the dominant paradigm, marginalising alternative perspectives and critical voices. Such critique might equally apply to other branches of medicine, but is particularly dangerous in psychiatry, where diagnostic categories and treatment modalities are constantly evolving and are subject to cultural and economic influences.

The Reinforcement of Hierarchy and the Dynamics of Symbolic Violence

Awards are rarely distributed equitably; they tend to flow upward, consolidating the status of those already occupying senior, administratively powerful, or well-networked positions. This process perpetuates and naturalises symbolic inequality

within medical organisations. The junior clinician, the community-based psychiatrist, or the professional dedicated to complex, "unpublishable" clinical work becomes further alienated, witnessing the conflation of moral and professional worth with bureaucratic rank.

The very definition of a psychiatrist hinges on their role as a physician dedicated to the clinical care of individuals with mental health disorders. It is therefore, deeply awkward that a trend has emerged within, for example, the Royal College of Psychiatrists to confer its honours not upon exemplary clinicians, but upon medical managers who are often entirely removed from direct patient care. This trick in recognition criteria mirrors the now discredited historical pattern of “Excellence Awards” where awards were exchanged within a closed network, devoid of transparent assessment. The resulting system had created a perverse double reward: these managers are already remunerated via their salaried job plans for their administrative duties, yet they received additional, ostensibly merit-based accolades for the same work. The current trend not only devalues the work of frontline psychiatrists but also risks steering the entire profession away from its clinical roots and towards a purely bureaucratic model.

Drawing on Bourdieu’s [1] sociology, institutional awards operate as instruments of "symbolic violence" - a gentle, often misrecognised form of violence that imposes hierarchies of value as natural and legitimate. The ceremony, the plaque, and the title "Psychiatrist of the Year" consecrate the dominance of the elite, validating their authority through a ritual of celebration. This dynamic is especially pernicious in psychiatry because it mirrors and reinforces the very power asymmetries that the therapeutic relationship seeks to navigate ethically and that critical psychiatry seeks to deconstruct [7]. Such awards, often based on committees or peer-recognition, do not democratise recognition; they consolidate the power of an established in-group, creating a feedback loop where symbolic capital begets more symbolic capital.

The Commodification of Virtue and the Performance of Care

Awards transform the intrinsic virtues essential to psychiatry (empathy, patience, discretion, and integrity) into performative commodities. The worth of a psychiatrist becomes mediated not by their private, unwavering commitment to patients, but by their public, measurable outputs and institutional visibility. A clinician who spends hours with traumatised patients, achieving fragile therapeutic breakthroughs, generates no "impact factor." In contrast, a colleague who publishes a high-profile paper, secures a large grant or creates a “new service”, activities more aligned with organisational branding, becomes the award-worthy subject.

This shift, from high-value to high-profile work, engenders what Erving Goffman [8] might describe as a heightened performativity in the professional front stage. It creates environments where virtue is signalled rather than practiced, encouraging psychiatrists to tailor their work to appear award-worthy. This may involve crafting compelling but simplistic research narratives, engaging in selective data presentation, or forming politically expedient collaborations rather than scientifically or clinically rigorous ones. The award ceremony thus becomes a Baudrillardian simulacrum; a spectacle of virtue and achievement that is increasingly detached from the complex, messy, and often unsuccessful reality of clinical work. The authentic moral substance of care is corroded by the pressure to perform a sanitised, institutionally palatable version of success.

The Erosion of Collegiality and the Collective Ecology of Care

Modern mental healthcare is fundamentally and irreducibly collaborative. Effective treatment plans emerge from interdisciplinary teams comprising of psychologists, social workers, psychiatric nurses, occupational therapists, and support workers. Awards directed at individual psychiatrists fundamentally

misrecognise this reality by individualising credit for what is inherently a communal achievement.

This misrecognition has corrosive psychological and social consequences within teams. It fragments interdisciplinary cooperation, replacing collegial solidarity with competition for scarce symbolic resources. The result is often resentment, demoralisation, and the perception of favouritism. Team members may justifiably feel that their contributions are rendered invisible when the psychiatrist alone is celebrated for a successful outcome that was contingent upon the collective effort. This award-induced individualism undermines the very teamwork that constitutes best practice in mental health, creating a hidden curriculum that teaches professionals to prioritise individual acclaim over collective patient welfare.

The Political-Economy of Awards

From a political-economic perspective, institutional awards function as a sophisticated form of organisational control and a low-cost substitute for meaningful structural reform. In an era of systemic strain, characterised by underfunding, staff shortages, and bureaucratic overload, awards offer a cheap solution to the problem of morale. Instead of investing in better working conditions, higher salaries, smaller caseloads, or robust ethical oversight, institutions can offer a ritual of symbolic recognition.

This phenomenon aligns with what David Graeber [9] might critique as the rise of "bullshit jobs" and their accompanying empty accolades. The award transforms the psychiatrist into a brand ambassador for the institution, generating public legitimacy and attracting funding, students or trainees; all while masking underlying systemic failures. The celebrated "excellence" of a few individuals becomes a smokescreen for institutional mediocrity or neglect. In this light, the awarded psychiatrist is both product and advertisement, a figure whose shining public image serves to distract from the realities of overwork, burnout, and the rationing of care that define the daily experience of many in the system [10].

Conclusion: Towards an Ethics of Uncelebrated Care

The argument against institutional awards in psychiatry is not an argument against excellence, rigor, or dedication. It is, rather, a plea for a form of recognition that aligns with the moral and epistemological foundations of the profession. It is a request to focus more on colleagues who are in busy jobs, working in rural settings or carry out non-traditional research. If psychiatry is to retain its integrity and fulfil its mission of alleviating human suffering, it must consciously reject the logic of awards that commodify compassion, entrench power, and foster competition.

Alternative models of recognition must be collective, ethical, and silent. This could include:

Team-based acknowledgements: celebrating the success of entire units or multidisciplinary teams based on patients' feedback
Investment in professional development: rewarding excellence with opportunities for further training, sabbaticals, or resources to improve clinical services.
Creating spaces for reflective practice: institutional support for Balint groups or other forums where the intrinsic challenges and rewards of clinical work can be shared and processed collectively.

The best psychiatrists are often those who work quietly and unseen; their devotion is resistant to the metrics of performative success. The profession's core values - humility, reflection, and solidarity - are antithetical to the culture of trophies and ceremonial acclaim. To reclaim its ethical centre, psychiatry must have the courage to embrace the dignity of uncelebrated care, recognising that the deepest forms of excellence often shun the spotlight.

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Misaligned Incentives in Psychiatry – The Principal-Agent Problem

Musa Sami

"Primum non nocere" (First, do no harm)

Most of us enter medicine for the beneficence of our patients and greater society. There is an altruistic purpose to our pursuits and clinical care. The four pillars of medical ethics (non-maleficence, beneficence, justice, and autonomy) are the conventional criteria by which we are taught to aspire to make decisions about clinical care, the services we run and commission, and the research that we undertake [1]. However, during clinical and research training, and certainly in consultant practice, most clinicians will come across misalignments of care and outcomes in contradistinction to ethical values. This can lead to psychological distress and internal dissonance – a phenomenon known as moral injury [2].

Moral injury has been described as widespread in clinical practice [3] and psychiatry [4]. This can be associated with complex phenomena in clinicians, including despair, anger, burnout, and clinical cynicism.

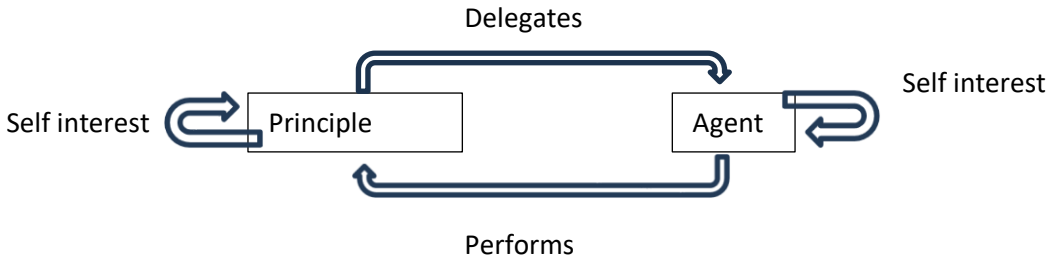
I will argue that the ethical frameworks we are taught are incomplete for understanding how decisions are arrived at. Our failure to understand, as clinicians, the models relevant to decision-making can exacerbate these tensions. Conventional medical ethics teaches us altruistic models, whereas the models we often need to apply are those of self-interest. I will focus on two different models to understand this issue: the principal-agent problem (described in this paper) and game theory approaches (described in a future paper).

By describing these relations, I am not advocating that psychiatrists should turn into self-interested, capricious individuals. I am simply advocating for the use of this lens to understand how relations work in the complex teams and dynamics we see around us.

The Principal-Agent Problem

This describes situations where the interests of a principal, who delegates authority to an agent to perform a task, become misaligned. The issues to consider are the payoffs (the outcomes) accruing to each party depending on their decisions.

Figure 1: Principal-Agent relations:



Let us first consider situations outside of medicine and healthcare to understand this in detail. For example, an employer who runs a restaurant delegates responsibility to employees, i.e., a manager, chef, and waiting staff. In this simple scenario, the employer is the principal and the employees are the agents. Let us assume, for the sake of simplicity, that all costs are fixed except for the wage bill. The employer hires the employees for a wage *w*. If the employer chooses a high wage (wH), there is an increased likelihood of retention and higher quality staff; if they choose to pay a low wage (wL), there will be less retention and lower quality staff. Whereas wH and wL denote the payoff to the highly paid and lowly paid worker respectively, the payoff (i.e., profit) to the employer is:

Profit = Total Revenue - wage bill - other fixed costs.

This can be expanded to:

Profit = (Price of meals x Number of meals sold) – (wage set (wH or wL) x Number of workers) – other fixed costs.

It may be that paying a higher wage bill leads to a higher quality restaurant and more total revenue, and hence it may be in the employer's interests to pay at the higher rate. Alternatively, it may be that lower quality staff pretend to be higher quality staff to obtain the higher wage (by, for example, exaggerating their experience and resume during the selection process – this is a problem of information asymmetry). Or it may be that once the higher wage has been agreed, staff shirk their responsibilities since they have a contract for higher pay in their hands (this is a problem of moral hazard). Although these are examples of misaligned incentives (the workers are not working for the profit of the employer but for their own self-interest), it does not have to be fatal.

Since all parties act in their own self-interest, an equilibrium (point of balance) will be reached when (i) the profits of the employer are greater than the profits the restaurateur can make by employing his capital anywhere else (i.e., profit – employer's opportunity cost >= £0) and (ii) the employees can make a wage which compensates them for their time worked and is higher than what they can receive elsewhere (i.e., wage – utility of hours worked – opportunity cost of employee's labour > £0). These conditions are called constraints. If this equilibrium can be reached, the restaurant will run; if it cannot, the restaurant will shut down.

Note the essential aspects of this scenario are that:

1. All parties need to be properly compensated for the restaurant to run.
2. All parties work in their own self-interest.
3. Whether the restaurant can turn a profit or not is not the only determination of success – the constraints need to be satisfied for equilibrium to be reached.

Although this scenario may be slightly removed from a psychiatry setting, I have used it deliberately. When we consider how a restaurant should be run and whether it should continue to be run, we do not consider the ethics of serving food to the customer or the ethics of supplying higher or lower quality food; we simply consider the self-interest of all parties involved.

How This Is Relevant to Psychiatry

Such a model can be directly transposed into a psychiatry setting. I once attended a Medical Advisory Committee where consultants were complaining about the understaffing of nurses to the Director of Transformational Change. Caseloads were high and morale was low. Community Mental Health nurses are banded, with a Band 6 Nurse who can expect to earn £38,638 to £46,581 [5]. The consultants were complaining that nurses were being employed who would not stay and that they were being paid too little. Vacancies were not being filled. The Director was arguing that by paying the lowest rate in the band, the Trust could afford to hire more nurses. In this situation, by setting a low wage (wL), one could hire six Band 6 Nurses compared to five at the higher wage (wH).

Let us consider commissioners as the principals in this scenario (although they are

themselves the agents of politicians). Nurses undertake the psychiatry caseload that needs to be done and hence act as the ultimate agent.

Let us consider the pay-offs for the nurses. This is self-evidently the wages they are receiving. Yet the opportunity cost represents the wage they could have received doing something else – an Uber driver in an in-demand area or a qualified plumber can earn in excess of £40,000, and an electrical engineer £38,025-£52,000. In the immediate context, the nurse may decide to locum rather than take a substantive role for the Trust and attain a salary in excess of £50,000. Hence, one can see that the base rate of Band 6 nurses is not attractive and may explain why a strategy to pay wL was not effective.

What are the pay-offs that the commissioners are looking for? Since bonuses are not available in the NHS, the main mechanism for maximising payoff is promotion and career advancement. Commissioning is a complex process; some commissioners may have limited mental health training and a poor understanding of mental health needs. Many will not be around for long and will move on after a few years. Their immediate drive is to avoid scrutiny, which may involve delivering good quality services, but also includes financial scrutiny and ensuring efficiency savings. As long as they can make such savings and maintain a minimal clinical standard, they can move on to the next job and apply for career progression. Hence, the under-recruitment of nurses may even form a perverse incentive, as it helps financial standards to be met. This is not necessarily deliberate but is the way the system works.

Hence, we can see how the CMHTs were being essentially set up to fail by the misalignment of incentives between commissioners and nurses. It was no use for the consultants throwing their hands in the air, arguing on moral or ethical grounds that nurses needed to be paid better. Similarly, the commissioners who would argue the service was not delivering using moral judgments ('no one should receive this poor quality of care') were missing the point. To correct the system, one needed to identify and correct the misalignments.

Of course, ultimately in state-commissioned services, there is a system of principal-agent relations: the ultimate principal is the voting public, who delegate authority to politicians to provide mental health services, who delegate responsibilities to commissioners to run mental health services. In fact, if we extend the principal-agent problem in this way, we can see that different pay-offs are present from the politicians to the commissioners - whereby politicians are not concerned about mental health until there are scandals that can affect their vote bank; and from voters to politicians - whereby the voting public has other priorities until there is a mental health crisis. Hence, there are misaligned incentives and a loss of information at every level of the system. If we talk simply in moral terms, we miss the essential misalignments by which such a situation is perpetuated.

The Principal-Agent Problem in Psychiatric Research

Let us consider why not all psychiatric research that is of benefit to the public will get published, and why, conversely, much of the published clinical research leads nowhere. There has been a stagnation of effective therapies, as discussed by Professor Nutt in his recent opinion piece in The Lancet Psychiatry [6]:

"As a research and clinical psychiatrist, I have found the past 50 years to be very disappointing from the perspective of developing novel treatments for mental illness. Although understanding of the brain has massively advanced, most of the medicines used in psychiatry today are functionally the same as the drugs discovered by serendipity in the 1950s, and almost no mechanistically new treatments have been discovered."

Let us consider the system of publicly funded research in the West, where only that research can progress which is properly funded and supported by an academic organisation such as a university department. A grant body will only fund research that meets a quality criteria or threshold,

since, ostensibly, funds are limited, psychiatric research is important, and high-quality research needs to be undertaken for public benefit. The grant body's stated aims are often altruistic and can often be found in their statement of purpose. The grant body hence invites submissions for research, excludes the low-quality research, and funds high-quality research. At least, this is the theory.

Let us consider that Researcher A is undertaking research into a novel intervention X. Such an intervention could be a promising compound, the repurposing of a drug, a psycho-social intervention, or a new modality such as a neuromodulatory therapy.

Intervention X is seen as a new and promising panacea, and great claims are made about it in both the academic and general press. In fact, there may be more promising and under-appreciated interventions, such as Intervention Y and Z; however, 'X' is very much the flavour of the month. Applications to work on Y and Z by Researchers B and C tend to be excluded to the benefit of the academic team working on X.

In this case, the grant body is the contracting principal for two agents. One agent is evidently Researchers A, B and C, who submits an application for funding. But the grant body cannot assess the quality of the research by itself; this requires expertise and scientific competence in the given field. Hence, the grant body also contracts another agent – the panel to discuss the application and solicit peer reviewers for the application (Researchers D and E). Because of the limitations of resource in the grant body, it will often ask the applicants for a list of peer reviewers it can use and those to be excluded. Grant applications will often be single rather than double-blinded (where the reviewers are aware of who the applicants are). Some instructions from the grant body are self-defeating. Novelty is prioritised over reproducibility, and excellence 'on paper' is prioritised over sound fundamentals. Researchers D and E do not have positive views of, or know, Researchers B and C and discount their work immediately. Hence the system embeds within itself a bias towards established names and fashionable topics.

Even though the grant body may be set up in the public interest, the agents' pay-offs are invariably self-interested. Petty jealousies, friendships, and network effects are riven in the small worlds where researchers review each other's work. Learning how to 'game the system' is the essential skill for getting the grant – achieved by getting papers published in key journals (where the same issues exist), denigrating competitors' work, and selectively presenting results. 'Pay-offs' in academia tend to be promotion, recognition, attending key conferences, and being seen as a thought leader. These pay-offs can be in contradistinction to the goal of research for public benefit. Researcher A is successful, and Intervention X is studied.

By the time it is recognised that Intervention X is of no public benefit, the researchers will have moved on. Researcher (now Professor) A will have received their grant funding and will have embedded themselves within the system as an indispensable academic who can 'get grants' (i.e., the meaningful payoff to Prof A's employer, the University). Hence, Professor A has been throughout in a position of moral hazard (lacking incentive to guard against the risk of failure by being protected from its consequences). Interventions Y and Z will have lost grant funding opportunities, and Researchers B and C will have quit the field (a process of adverse selection, where the lack of information led to Y and Z not even being properly considered). We end up in a position where there is a reproducibility crisis in psychology and the neurosciences [8] indicating the system is failing to produce high-quality research. Clinicians disengage from researchers and see them as existing in ivory towers in an alternate universe.

A tongue-in-cheek overview of such behaviours was penned by Professor Irina Dumitrescu [7] in "Ten rules for succeeding in academia through upward toxicity", which readers are advised to consult.

Conclusion

In this paper, I have tried to argue that misalignments in incentives between contracting parties (the agent and the principal) can explain many of the fault lines we come across. Our failure as psychiatrists to understand this in its appropriate context can lead to moral injury. This paper is an introductory explanatory primer to how we can see examples of the principal-agent problem around us. The methodology proposed is to define the situation in terms of who is the principal, who is the agent, what the pay-offs are, and how this may lead to misalignment in incentives and perverse behaviours. Sometimes several principal-agent relations co-exist. Further detailed examples can be considered where there is information asymmetry (where both parties have unequal information), and whether there are situations of adverse selection (where the undisclosed information leads to an imbalance between parties and disrupts alignment) or moral hazard (where parties are protected from the adverse consequences of risky decisions).

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