

Newsletter

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From the editor

Mental health services in the NHS are going through a period of changes unprecedented in magnitude. There are major challenges to sectorised services, boundary issues between specialist services, changes in commissioning, issues of working out a payment by results system, and the massive changes in the training structures. It is difficult to predict the outcome of these changes and the way in we work is set to change (again!). Amidst all these changes adult psychiatrists need to ensure seamless and effective care for their patients. Although the pace of these changes and the uncertainties surrounding several key areas may leave many of us confused, we need to look at them as a way of discussing the roles and responsibilities of the specialist psychiatrist caring for working age adults.

At this year's annual meeting we discussed some of these developments shared the impact of these changes on the way we work. As the largest faculty of the college, we do have the responsibility as well as the opportunity to approach these changes with a view to influencing the process in such a way as to improve the services for our patients. However, unlike other specialties, general psychiatry has not been too territorial or cohesive. The Faculty's initiatives in the recent years have been geared towards improving the sense of cohesion.

The Executive members of the Faculty would like to extend a warm invitation to all the members to our residential meeting in October. There will be range of workshops and interesting discussions and presentations. Also, we would request all members to ensure that they register with the online membership of the Royal College of Psychiatrists, and give consent for electronic communication. This will become the main means of communication from the College as well as the Faculty regarding the new developments in our profession.

Our Faculty had its strategy day in June, and we recognized some of the key achievements and accomplishments in the past year. We do need your help and suggestions on key issues as well as your views and contributions to the Faculty's work and this newsletter. We look forward to seeing many of you at the Faculty residential meeting in October.

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**From the chair
Michele Hampson.**

As I begin my term of office as Chair of the Faculty, I see that role as akin to the conductor of the orchestra. I can't be an expert on all the issues that we need to address but must identify the key themes and enable each member of the Executive to play their instrument well.

The special quality of a live performance comes from the interaction with the audience, in this case the Faculty's membership. The best live performance, a chance to meet with us, to network, share and learn, is at the Residential Meeting, which this year offers the added attraction of the renovated Tyne quayside. A growing number make this an annual event and I hope you will join us. Details of the meeting can be found on page 16 of this newsletter.

I would like to express my gratitude to Jed Boardman, the previous Chair, for holding the conductor's baton with such authority. He ensured the completion of the interface documents with the other Faculties as part of the Roles and Responsibilities of the Consultant in General Adult Psychiatry document, spoke powerfully on our behalf within and outside the College and strengthened links with the membership and Divisions by inviting the regional representatives to our Faculty Executive meetings.

I should also like to express my gratitude to all the Faculty Executive members who have completed their term of office, for all their contributions to the work of the Faculty. I would like to give particular thanks to Suresh Joseph, our former Secretary, for agreeing to stay on as Chair of the Faculty Education Committee. The curriculum is being rewritten and we need to identify competencies, assessment tools and prescribed experience, especially for ST3-6. So if you have an interest in education and would like to assist this work, please contact Charlotte Cox (ccox@repsych.ac.uk). If you would like to assist as an evaluator for Article 14 applications (see page 17), that would be invaluable, as we need to ensure that applications are quickly assessed. So there are many ways in which you too can get involved with the Faculty!

So what is the music? I would like to hope it could be the last movement of a symphony, the original tune, the importance of the adult psychiatrist role, not simply within the multi-disciplinary team but also as a bridge with primary care and the other psychiatric services and a leader in service development, being confidently reasserted. The Faculty Executive Strategy Day highlighted the need to identify the values and principles of General and Community Psychiatry. That means we need to ensure that New Ways of Working has been effectively implemented, so let us know of your experience, both positive and negative so we can represent those views. This is now a concern of the College with a group reviewing the implementation of New Ways of Working and a meeting looking at professionalism and psychiatry arranged for the Autumn.

We need to hope that with a new Minister of Health we can put behind us a time when the medical voice went unheeded, leading most recently to the terrible anguish caused to our trainees by MTAS. We need to develop the curriculum for their future training and address issues of revalidation. Two of the four tasks of the NHS Review initiated by Alan Johnson are about improving patient care specifically mentioning those with long term conditions and ensuring accessibility of services. We need to use this to ensure adequate resources for effective Mental Health Services. This means responding to the Payment by Results agenda, agreeing measures of outcome so that we are not simply controlled or manipulated by activity targets and determining the best balance from a patient perspective of integrated versus specialised services. We need to be encouraged by the changes that have been agreed in the Mental Health Bill, which has demonstrated the effectiveness of working with fellow professionals and organisations. We now should offer to help in drafting the Code of Practice.

As a Faculty we plan to work with the Vice President on issues around the primary/secondary care interface, with Linda Gask leading on this for our Faculty.

So it is still all change, with for English colleagues a new Mental Capacity Act this year and a new Mental Health Act to follow. So the tempo is definitely allegro and my hope is *ma non troppo!*

Are we being deprofessionalised?

Dinesh Bhugra

It is relevant to ask this question now, especially in the aftermath of the MTAS fiasco. And what a fiasco it was! With everyone blaming everyone else, the people who conceived of it and 'tried' to deliver it got away with £6m as the news goes. However, one positive to come out of it is for us to pause and think about all the changes and so-called reforms that are being thrown at us endlessly. Is it simply a cock-up or a conspiracy to undermine the medical profession?

Increasingly, I am becoming convinced that the agenda here is to deprofessionalise doctors in general. The reasons for this lie in the creation of layers of 'reforms' which have been implemented without any piloting. The services are fragmented on the basis of function with teams feeling stressed and threatened and drawing their drawbridges. With the European Working Time Directive in place, training is becoming fragmented. With the introduction of MMC and 4-month rotations in Foundation Year 2, the face-to-face contact between the trainee and the patient is becoming reduced further. The changes in the structure, delivery and assessment of training, the creation of yet another body (PMETB) with wide-ranging power has led to another tier of management. The underlying message is that rather than the professionals, we know best – 'we' being the politicians. Yet when it comes to trust, the general public trusts doctors much more than they trust these very same politicians. Also, when asked, one-third of parents would like their children to be doctors, indicating that the profession is still held in high esteem. The reasons for this shift to deprofessionalise doctors are about control. It is easier to control non-professionals using multiple layers and messages. The issues in psychiatry are further complicated by the pressure to create a new Mental Health Act in England, and also with New Ways of Working. With the best will in the world, New Ways of Working was designed to share responsibility within the multidisciplinary team

and to leave the consultant to deal with complex cases. However, a question that urgently needs to be addressed is - how do we train trainees to deal with complex cases when they may have limited time and opportunity to do so? Furthermore, in many Trusts, New Ways of Working is being used to take the roles away from psychiatrists.

The professional is defined as someone who works from a large and broad knowledge base and provides a service to those who benefit from it, and this relationship is honest, fair, legal and ethical. Such an individual is expected to be the spokesperson for the public policy, independent of the state, and is self regulated. Caring is the core business of doctoring and part of the deal to be a professional is essential in maintaining and delivering good quality care. The core functions of medicine are under serious threat from this group of politicians and mandarins.

The questions that we need to ask are:

- Is psychiatry really under threat?
- If so, where from? What is the nature of the threat?
- What should we be doing as a profession?
- Who are our allies?

The answers lie in the relationship with our patients and their carers. We need to move with patients, their carers, NGOs and the independent sector to define who we are, what we stand for and where we go from here.

The Royal College of Psychiatrists is planning to host a series of meetings later this year to discuss these issues. The profession needs to stand together as a body and then as a body within the medical profession to ensure that divide and rule does not work.

If you wish to make a comment or respond to this article email us at adultpsychiatry@yahoo.co.uk

The idea of a Special Interest Group for Early Intervention in Psychosis Mark Agius

There is a growing volume of evidence that the present DoH Policy, to implement Early Intervention Services across the United Kingdom by December 2006, is a wise one. Recent studies show that in first psychotic episodes, outcomes from Early Intervention (EI) in Psychosis services are better than those from standard Community Mental Health Teams.

However, much needs to be done in order for this policy to come to fruition. At the Conference, organised by the Faculty of General and Community Psychiatry, in Liverpool last October, I proposed the formation of a College Special Interest Group (SIG) for Doctors working in Early Intervention services. The reasons for the urgency that this should happen are as follows:

1. It is necessary to define the paradigm of Early Psychosis, which these services must apply in diagnosis and treatment. This will inevitably be different from the standard view of Psychotic illness as defined by ICD10 or DSM 4. It will be a much more dynamic model, taking into account how symptoms develop over time and taking into account the different dimensions or syndromes which comprise a psychotic illness, and which may vary in prominence as the illness progresses, [contributing to the diagnostic instability in the early phase of this illness]. The paradigm must also take into account recent research on the genetics of psychosis, as well as modern psychological models of psychosis, and how various social factors [deprivation, stress, ethnicity, urban life etc] interplay with biological factors to bring about the development of psychotic illness. The involvement of all of these factors within the diagnostic and therapeutic process will have profound effects on diagnostic process and treatment outcome. It is necessary that those doctors who work in EI services should hold a consensus, a balanced view regarding this paradigm, and be willing to apply it in practice.

2. It follows from the above that Senior Doctors or Consultants who work within EI services should have some experience of working within such a paradigm. Therefore, it is wise that doctors should be appointed to EI services who have a proven track record of working with Patients who are in the early phases of a psychotic illness, either as a result of having worked in such a service before or of having carried out research in the area. A SIG should have the function of setting standards in order that effective appointments should be made.

3. Whereas it is clear that EI services will function as a multidisciplinary team, the position of the Consultant Psychiatrist within the team requires further clarification, in particular regarding diagnostic procedures and the imparting of 'Bad News' to patients

and maintaining the paradigm of EI services. Members of other professions have much to contribute to the diagnostic process, however psychotic illness, despite the improvement in prognosis, remains a diagnosis with serious, potentially life-changing implications, and it is therefore essential that the Consultant Psychiatrist be fully involved in the diagnostic and treatment process, fully utilising the Doctor-Patient relationship in providing guidance and support to their patients. It is to be hoped that a SIG will enable consensus guidelines to be developed to ensure that this happens.

4. The existence of a specific paradigm of EI, and the need to have continuity of care for vulnerable patients, will also mean having specific guidelines as to how EI services should interact with other services. At present, in many parts of the country, these services function totally separately from EI services with different consultants being responsible for care, with no agreed philosophy of care. While in other areas, these services form part of a seamless, multi-modular service for young Psychotic Patients with the same consultant working with the patient throughout [such as in the LEO Services of Lambeth and the EPPIC service of Melbourne, Australia]. A SIG would allow collective dialogue with our consultant colleagues and our managers in order that the most appropriate solution is found to these issues and that the patient receives the most appropriate care in the least restrictive environment, as intended by the IRIS Guidelines [IRIS 1999].

5. With the development of EI services across England by the end of 2006, it is essential that sufficient resources be made available by commissioners and managers in order that all patients with a first psychotic illness should receive three years of treatment in an EI Service. There should be no circumstance in which Community Mental Health Teams should treat patients with first episodes of psychosis after December 2006, particularly given the improved outcomes now attributed to EI services. This will entail resource reallocation, drawing up of auditable consensus standards as well as negotiations with managers and commissioners, which the SIG should play a major role.

6. Finally, the implementation of EI services across England must lead to the disappearance of patients with a first psychotic episode from CMHT care. This will have major training implications for Junior Doctors at all levels, who unless attached to EI services, will not have the opportunity to experience managing EI patients and learning the EI paradigm. It is therefore essential that the SIG influences the deployment of junior doctors to EI services, both to work in the

services and to do research, in order to establish a new cadre of doctors to work in EI services in the future.

I believe that all the above reasons make the establishment of the Special Interest Group a matter of urgency. Immediately after the workshop in October, doctors working in Early Intervention services made over thirty expressions of interest for the formation of such a group. Subsequently, the numbers have grown to sixty-five. I am anxious to increase this number further

before beginning the process of asking for official College approval. Meanwhile, we are functioning as an e-mail support group, to provide support, and solve problems for our nascent services as they arise. I welcome any comments on the views which are expressed above, which are purely my own. I would ask anyone who is interested in joining the SIG when it is formed to contact me at mark.aguis@blpt.nhs.uk

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Work Work Work! Chris Simpson

At 14 it became clear that if he really wanted to be a doctor then he would have to get very high grades at 'A' Level. The first step was to work hard to get good GCSEs so that he could get the right choices for 'A' Level. Two years in 6th Form doing 'A' Levels, which appeared to have no resemblance to clinical medicine, ended with total exhaustion but he scraped through the exams. Meanwhile his friends had not worked so hard and got on to their university courses.

At medical school, he discovered that university was not what it was cracked up to be. There was a lot of work to do in medicine. Most evenings his colleagues doing other degrees were going out and experiencing the university nightlife. He had to stay in and confine his entertainment to the weekend. The course went on longer than his colleagues. So intensity and length of work were increased for the medical student compared to other students.

At last he qualified and worked as a House Officer. A year of working hard with the exhilaration of having achieved his ambitions – a doctor at last! Then it's SHO and Registrar posts; normal working days plus on call nights with revision for membership in-between but he got there at the end.

At last he is a Consultant. He is expected to work 40 hours a week but he works far more and spends his time complaining about it.

Why? We are conditioned to link long working hours to how we value ourselves as doctors. This is our own doing. In fact, we are valued by our patients, our employers and our teams for our skills and knowledge and not for the amount of hours we work. The problem of excessive working hours comes from within.

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What do SpRs and their trainers think of special interest sessions? Kudlur Swamy & Sanju George

Background

Higher specialist training (HST) in psychiatry is different from other medical specialities in that it allows 20% of training time (2 sessions per week) for 'special interest'. The HST handbook (Royal College of Psychiatrists, 1998) recommends that special interest sessions (SIS) be used "for special clinical interests" but does not provide detailed guidance. However, the format of HST is currently in a state of flux and uncertainty as it is being re-shaped by the recent implementation of initiatives in postgraduate medical education, such as Modernising Medical Careers (www.mmc.co.uk), and Postgraduate Medical Education and Training Board (www.pmetb.co.uk). In this context, we set out to answer the following key question: 'what do specialist registrars (SpRs) and their

trainers think of SIS?' by conducting a survey of SpRs and their trainers.

Methods

We conducted a postal questionnaire survey of all SpRs (n=45) and SpR trainers (n=55) in general adult psychiatry in the West Midlands region. Separate questionnaires were designed for trainees and trainers to elicit their views on the usefulness and utilisation of SIS.

Some questions had to be answered in a yes/no choice format, and some in the format of choosing from the set of options: definitely not, probably not, no opinion, probably and definitely. There was also space provided

for comments and suggestions. Responses were tabulated (numbers and percentages) and are presented in the results section.

Key findings

Thirty-four of the forty-five SpRs (75.6%) and 42 of the 55 (76.4%) trainers returned completed questionnaires.

Trainees' responses

The majority of the trainees (31/34, 91.2%) reported having 'protected' regular SIS. Trainees were also asked 'how they had found out about the various SI options available locally?' 19/34 (55.8%) said that they received no guidance at all and 11/34 received information from fellow trainees. The most common factors trainees identified (from a list of options) as important in choosing a SI were future career goals (21/34, 61.7%), gaining further clinical experience in areas not covered during SHO training (7/34, 20.6%) and academic interests (6/34, 17.6%). More trainees than not had no regular support (22/34, 64.7%) or regular supervision (26/34, 76.5%).

Responses regarding the usefulness of SIS were as follows: very effective (17/34, 50%), effective (12/34, 35.3%), and no opinion (5/34, 14.7%). Trainees also identified some difficulties faced in utilising SIS effectively: lack of information regarding the available SIS options (19/34, 55.9%), lack of guidance from supervising consultant (4/34, 11.8%) and lack of time due to regular job commitments (4/34).

Trainers' responses

The responses to the question 'what factors should a trainee consider in choosing a SIS?' included future career goals (20/42, 47.6%), academic interests (2/42), to gain further clinical experience (9/42), while the remainder were combinations of one or more of the above three options. 32/42 (76.1%) of trainers felt that SIS were a good use of training time. Although 30/42 trainers reported guiding trainees in their choice of SIS, 27/42 admitted to not supervising their trainee's SIS.

Interpretation and implications

It was reassuring to note that 31/34 (91.2%) of the SpRs were having regular 'protected' SIS, and that a large majority (>85%) found them to be useful. Most of the trainees (>85%) viewed the current provision of time for SIS (2 sessions per week) as optimal, and desired no change in either direction. Factors that influenced the choice of SIS included future career goals (61.7%) and for further clinical experience (20.6%) – and were very

much in keeping with the guidance issued by the Royal College of Psychiatrists. Overall, these findings would indicate that SpRs carefully plan and appropriately utilise their SIS. Our findings are similar to those of Stephenson and Puffett (2000) who found that 78% of SpRs were satisfied with their use of SIS time.

However, some of the findings are concerning: 56% of trainees reported receiving no guidance in finding out about or choosing a SIS, and 76% had no regular supervision for their SIS activities. In most HST schemes in the UK, there is no clear guidance on how best to utilise SIS, and there is a sense of diffusion of responsibility as to who supervises a trainee's SIS. Some feasible suggestions made by trainees included making available a list of SIS options available locally; ensuring provision of 'protected' SIS; and regular support and supervision from the supervising consultant.

The majority of the trainers (76%) said that SIS were a good use of training time. 70% of the trainers were opposed to scrapping SIS from the training curriculum, although 31% felt that there probably was a case for a reduction in the time allocated for SIS. These findings demonstrate that trainers, as well as trainees, regard SIS as useful and important. Almost two-thirds of the trainers reported that they did not supervise their trainee's SIS. Better guidance on who (supervising consultant or the consultant with whom the trainee does SIS) should provide supervision for the trainee's SIS is required. Such supervisory arrangements need to be in place prior to trainees starting their SIS. Trainers identified some of the potential pitfalls of the current system of organising SIS and recommended the following solutions: First, trainees need to think and plan carefully before choosing a SIS, both in terms of how it meets their training requirements and the supervision available. Second, there needs to be better monitoring of the trainee's SIS activities. Finally, trainees need to be accountable for how they utilise this time and how it contributes to their overall training.

To our knowledge, this is the first survey in the UK to have elicited trainees' and trainers' views on SIS. It is hoped that the findings of this survey will inform and guide those involved in shaping the future of HST in psychiatry. In conclusion, SpRs and their trainers view SIS as a useful and integral component of HST. Hence, any decision to alter this should only be arrived at after extensive consultation with the key stakeholders in this debate-i.e. higher specialist trainees and trainers.

If you wish to make a comment or respond to this article email us at adultpsychiatry@yahoo.co.uk

**From Our Intrepid Reporter:
A Personal Experience of the New and Reformed Mental Health Farm
Zsarina Sciocco**

It wasn't too long before our intrepid reporter Zsarina arrived at the much heralded mental health farm. She knew that this was the place where her batteries could be recharged, her backbone strengthened and her cynicism excised. The mission statement in the reception area clearly indicated that the place had recently been totally reformed. The welcome from the staff was delightful – they had a specialist team for every condition and after a good nights sleep in her single sex room she was assured she would receive the treatment she urgently needed.

In the morning, the receptionist gave her a welcome pack and instructions. But first, Zsarina had to choose and book her stay. A little inconvenient of course but a short trip to the local village and a phone call back to the same receptionist confirmed that her intentions were serious. She was so pleased to see her name appear on the waiting list; now she could start her quest for treatment in earnest!

But where to start? Luckily the induction pack had it all. Each expert was clearly described in detail and all had a separate team and outbuildings on the farm (some bigger than others). Zsarina knew her stress was serious and acute. Surely the Crisis expert was the best bet. She scrutinised the ordinance survey map (vide infra), which she found at the bottom of the pack and headed off to the CHRT. Zsarina was only too pleased to tell the crisis worker her story while he busily wrote it all down on his forms. His face suddenly changed when he came to the section on Substances. Zsarina had to admit the truth and confess to drinking a little more than is wise for a woman of her age. He murmured something about 'units' and scolded her for her behaviour. Furthermore, even if she thought she was in a crisis, this was not the type of Crisis that the Crisis Team dealt with. Didn't she know that they weren't even PIG compliant and her unwarranted arrival at his door would spark a deviancy report! Off to the substance team immediately!

The understanding reader can easily imagine Zsarina's relief when she arrived at the said building and retold her story to a young lady (albeit adorned with a great deal of ironmongery) who seemed very keen to help. The young girl even made her a nice cup of tea and offered Zsarina one of her own especially relaxing cigarettes while she spoke with her supervisor. On her return, Zsarina knew immediately that the news was bad. The supervisor was alarmed that Zsarina's mental health was clearly affected by her cumulative work related stress and the primary care counselling team was the only place for her. But this was on another farm which was miles away! The best thing was for her to go back to the Crisis Man and say all this nonsense was

making her suicidal. He would surely help then. Alternatively, she could ask for a care coordinator from the Recovery Team but would have to get admitted to the ward first (on reflection the Substance Worker thought this wasn't a good idea because you had to get past the Crisis Man before you can get admitted to the ward and everyone knew by now that she didn't meet his Criteria).

Although the relaxing cigarette helped, the afternoon proved very tiring and stressful. The Recovery Team man, although eccentrically dressed, was sympathetic but pointed out that her eating patterns amounted to a serious disorder which needed attention first. No CeePeeAA for her. The Eating Disorders Team unfortunately only provided an Anorexia service ('not enough resources you understand') and suggested her rather interesting combination of problems pointed to a personality malfunction. Having completed the 250 item personality questionnaire in the Non-Exclusion Building, Zsarina was pleased to learn that she wasn't wholly pathological – just accentuated. However, the good news was tempered by a certain despondency when she discovered this meant she wasn't suitable for the service as everyone she met there seemed just as stressed as she was (it was only later that she discovered the people she met were service employees). The PD woman kindly suggested the assertive outreach team. Zsarina wasn't hopeful but it didn't matter anyway as there was no one at the team base and there was a clear message on the door stating *their* Criteria. Continuing Care were a total disappointment and Zsarina was bold enough to refuse to assist in the completion of their out dated forms. After tea, she tried the forensic people but the three person assessment team told her quite firmly that a traffic violation was a misdemeanour and anyway they only looked backwards (she was too tired to ask!). There followed a wonderful if completely un-productive chat with the early intervention girl. The jolly Maternal and Perinatal woman was no help unless she was pregnant or had just delivered; although she had to warn Zsarina that she better be quick as there was a 7 month waiting list. Finally she arrived at the door marked Psychotherapy, completed a very colourful array of forms (Zsarina managed this in double quick time as she had seen them a week earlier in Cosmo) but left in disgust when she saw they were dated for the following year.

Weary and heavy in heart, Zsarina made her way back to her room. She was completely stressed out. The mini bar offered an unhealthy blend of spirits and chocolate. What could she do but succumb? In the morning she awoke with a pounding headache. She recalled the previous day's events hazily and presumed they must be

'false memories'. No sane Health Farm Manager could organise a service like this deliberately. But on the bed was the Ordinance Survey Map of the Farm she had tried to negotiate with such little success and such great frustration in search of her cure. It was only then that it dawned on her that her nightmare was in reality part of her misguided spouse's dreams. The reader can

understand why she got back on the motorway as quick as a flash and vowed never to return – alternative therapy for her!

Next Issue: Zsarina Confronts her Demons

The Care Programme Approach Views of consultant psychiatrists 15 years on Dr Michele Hampson

Introduction.

Since the Care Programme Approach, (CPA) was introduced in 1991 it has attracted three main criticisms: it is seen as unnecessarily bureaucratic, can hinder the doctor patient relationship and there is no research evidence to justify its use. CPA has not only remained but has become more complex with new targets such as electronic CPA and increased stipulations with regards to the care plan for enhanced CPA. Chief Executives were made responsible for CPA judged on data from case note audit and user survey and it was a factor affecting the Trust's star rating. The need to be increasingly prescriptive both in the process and its monitoring might indicate a problem in securing grass roots support for the process.

Since CPA was introduced multi-disciplinary community teams have developed and the work has been targeted on those with severe mental illness, with more patients having a community team member as their care co-ordinator.

The Faculty Executive Committee thought it was timely to survey their members' views regarding CPA, which had not previously been attempted. Did CPA's survival and indeed development depend solely on the policy of the Department of Health or had the professions' view changed?

A questionnaire was drawn up, agreed by the Committee and distributed through the Faculty newsletter. Only consultants from England and Wales were invited to respond as CPA does not apply in Scotland. The questionnaire was also available for completion at the Faculty's annual meeting in 2003.

Results.

There were 200 replies, giving a response rate of only 8%.

1. CPA in principle.

There was 90-95% % agreement for the key principles; namely a comprehensive assessment, care plan, named care co-ordinator, regular review and user and carer involvement.

2. Effectiveness of CPA in practice.

The respondents felt that CPA ensured a comprehensive assessment (90%) and care package, (74%), prioritisation of care co-ordinators for those with severe mental illness, (61%) and prevented loss of contact with the service, (61%). The therapeutic relationship with the doctor was not improved, (77%) and the process was problem and not patient-centred, (58 %). It was felt by only 36% to help patients access help in a crisis.

Consultants were asked to comment on the 2 levels of CPA, enhanced and standard care, separately with regard to reviews and care plans (see table 1).

3. CPA tiers.

It was unclear which tier was most appropriate for a given patient, (54%) and 68% wanted the abolition of standard CPA with the retention of enhanced CPA. The paperwork was justified by the increased user and carer involvement, (25%) and the extra time required for CPA was justified (22% and 55%) for standard and enhanced CPA respectively.

4. HoNOS.

The Health of the Nation Outcome Scale was found to be useful neither as part of the assessment process, (79%) nor for the reviews both for standard and enhanced care, (84%).

Table 1. Usefulness of CPA reviews and care plans for standard and enhanced CPA.

CPA Reviews	Enhanced CPA %	Standard CPA %
Extra time justified	46	19
Promotes user involvement	64	31
Promotes carer involvement	72	50
Improves care co-ordination	66	
Improves liaison Primary Care	13	16
Improves liaison other agencies	73	31
Improves Dr-patient relationship	39	24
Care Plans		
Better communication with users	59	36
Better communication with carers	60	29
Helps implementation of care package	58	29
Useful after first assessment		32
Useful at review		34

Discussion.

The response rate was low perhaps due to the length of the questionnaire. With such a low response rate the findings must be interpreted with caution.

The most interesting finding is the distinction between the strong support for the principles of CPA in contrast to the reservations regarding its effectiveness in practice. About 40% felt that CPA did not achieve its intended aim; namely to improve the care of the severely mentally ill and to prevent them losing contact with services.

The concerns were greatest for standard CPA, where by definition care co-ordination is less relevant and the care plan can become out of date quickly with recovery. In many areas no use is made of the HONOS ratings collected. Perhaps the College Research Unit, which trained clinicians in its use, might wish to evaluate its effectiveness in practice in determine whether it assists

in monitoring the health of those with severe mental illness, as was intended.

How could CPA be made to work better? As a result of the questionnaire it has come to light that the Department of Health has commissioned a review of CPA which the author has been invited to attend. There is therefore an opportunity for your ideas to inform this process.

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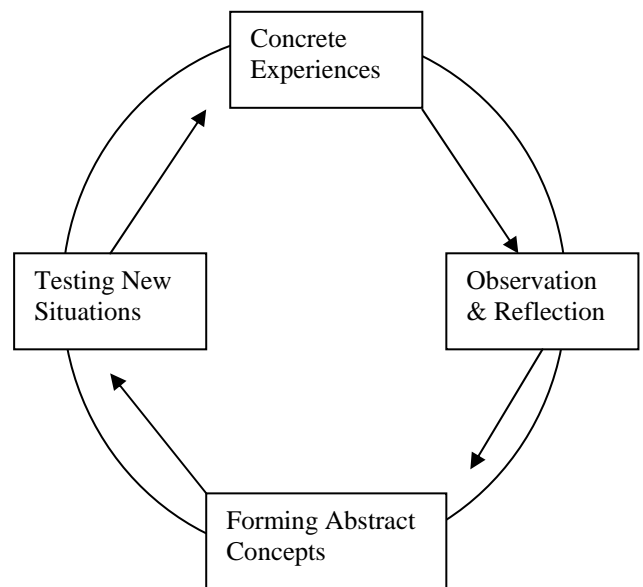
Acknowledgements

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Portfolio in Specialist Psychiatry Training
Ipsita Mitra

A portfolio is a compilation of a person's work and skills acquired over a period of time. It is useful in providing evidence of progress in training, acquisition of knowledge, skills, and achievements and overall professional development. It can also be used as a reflective, learning tool for self-improvement by helping to identify areas of weakness that need further training and experience, and how these needs may be met.

Portfolio based learning draws on experiential learning based on Kolb's learning theory with reflection as a key element. Kolb's theory sets out a four stage learning cycle in which immediate or concrete experiences are observed or reflected upon by an individual. These are then assimilated into concepts which are then used for future experimental actions (See Fig 1). A similar theory was cited by John Dewey, philosopher and psychologist, who said that experience plus reflection equals education and learning.



Kolb's Four Stage Learning theory

Why a Portfolio?

Training in the Specialist Registrar grade requires steady progress through planned programmes designed to meet the curricular requirements of the Royal Colleges and Faculties and delivered to standards set by them. The Record of In-Training Assessment (RITA) provides a record of the Specialist Registrar's progress through the training programme and an annual review of the trainee's progress is usually carried out by a speciality-based panel. (A Guide to Specialist Registrar Training, February 1998).

The Specialist Registrar Training Handbook published by the Department of Health suggests that documentation which may be evidence of satisfactory progress can include portfolio or a log-book. Some Royal Colleges have outlined the direction that a portfolio should take and the nature of documentation that is required of trainees. The Royal College of Psychiatrists, however, does not have any specific guidance regarding this (personal communication from Postgraduate Education Department, Royal College of Psychiatrists). A search of the Royal College website came up with a template for maintaining a portfolio for trainees undertaking their training abroad but not for trainees in England.

As the Higher Specialist Training in Psychiatry offers considerable flexibility to suit individual needs with some emphasis on self-directed, heuristic learning, it is possible to lose focus in the absence of a set and rigid programme. Maintaining a portfolio can help to direct towards an objective focussed learning and development without being prescriptive. Also, time and effort invested in maintaining a portfolio on a regular basis helps to alleviate the last-minute rush and anxiety of collecting and collating documentary evidence in preparing for the RITA.

What goes into the Portfolio?

Essentially, the Portfolio is an expanded version of Curriculum Vitae. Sometimes, it may be difficult to decide what should be included in a portfolio. This will, to some extent, depend on the training needs and vary between trainees. The portfolio should be a document embodying personal learning objectives and evidence of learning and personal development. The learning objectives should be specific, measurable, attainable, resourced, relevant and time-limited. (SMART). They should also be challenging, interesting and valuable (Holloway, 2000). The need to keep the portfolio manageable means that any material not relevant should be edited (Brigden, 1999).

A matter of some difficulty with trainees is whether any negative experience should be included and there may be a temptation to omit them. However, all of us are not perfect and the portfolio does not have to be all good. In fact, it may be used as a reflective tool for self-learning and how to do things differently next time.

Suggested Framework

A framework for maintaining a portfolio during higher specialist training in Psychiatry is suggested below. Although the authors have tried to draw up the framework to reflect the spirit of the multi-faceted SpR training in Psychiatry, the list is intended as guidance only; is not all-inclusive or exhaustive and should be adapted to suit individual training requirements to make it relevant to the individual. Decisions on what is chosen to be included in a portfolio can be made in discussions with the educational supervisor. This will also facilitate the learning process by identification of knowledge gaps and learning needs by active engagement of the supervisor in this process.

Framework for Portfolio during Higher Specialist Training in Psychiatry

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Section 1: An updated CV

Section 2: Details of current placement (Name of supervisor, a brief description of the post, period of time in the post, weekly timetable, agreed objectives and plans and timescales of achieving these)

Section 3: Clinical work

- Anonymised list of patients with a brief description of the type of case (new patients, in-patients, domiciliary visits)
- Any interesting cases
- Any cases involving medico-legal issues
- Any cases involving child care issues
- On-call work experience
- Representation of RMO at managers/ Tribunal hearings
- Report writing for Courts/ Managers or Tribunal hearings
- Any other report writing e.g. for Driving license, Power of Attorney and Capacity issues (adequately anonymised reports may be included in the portfolio)
- Mental Health Act assessments
-

Section 4: Experience of Special Interest Sessions

- Placement, Name of supervisor, Number of sessions per week
- Learning objectives
- Experience gained
- Areas for further knowledge / experience required and action plan to achieve this
- Feedback from supervisor

Section 5: Audit and Research

- Any completed work
- Any ongoing projects (Title, stage of the project, date expected for completion. Details of any ongoing course that you are enrolled in towards achieving a qualification should also be included).
- Presentations (to include details of presentation - date, location, topic, audience, whether local, regional, national or international level, oral or poster presentation, what was learnt from the experience)
- Publications (a copy of the publication will help to impress! If an article has been submitted for publication, consider filling in details of this.)
- Any Awards (will always impress!)
- A Reading list

Section 6: Teaching Experience

- Dates of teaching
- Topics covered
- Whom did you teach - Medical students, Junior colleagues, colleagues from other professions, carers/service-users
- Feedback received
- What has been learnt

Section 7: Management Experience

- Nature of experience gained
- Training Courses attended
- Learning Objectives
- Areas for further development

Section 8: Conferences / Courses Attended

- Date and Location
- Name of Conference
- Organising body

- What was learnt from attending

Section 9: Supervision Record

- Topics discussed
- Any comments

Section 10: Appraisal

- Any documentation (RITA forms)

Section 11: Miscellaneous

Extra-curricular activities - you may wish to include an achievement of which you are proud (any voluntary activities or community services).

Any not-so-good experiences or events. These may become positive experiences if one can reflect critically and provide evidence of learning from the process.

Anything else that is felt to be relevant

Section 12: Future Plans

- Plans to rectify any gaps in knowledge or experience
- Career intentions

Section 13: Appendix

- GMC Certificate
- Any relevant certificates (Certificates received for obtaining Membership, other qualifications, Prizes, attending conferences etc).
- Any Thank-you letters/ cards
- Record of study leaves taken and planned for the future

Conclusion

A good portfolio shows a balance between reflection and evidence (Brigden, 1999). In addition to providing evidence of learning, knowledge and skills, it is a tool which, when used wisely, can enhance one's personal and professional development through a process of self-reflection and rectification. Although, this article has focussed on the portfolio in the context of higher specialist training in Psychiatry, the format may be tailored to fit basic trainees in Psychiatry as well. It may also be a handy companion for Consultants aspiring to continual professional development and lifelong learning.

A Personal Guide to Guidelines

Paul Blenkiron

Guidelines are evidence filtered through opinion – but whose opinion should that be? The days of GOBSATS (good old boys sat around tables) have now been replaced with expert multidisciplinary teams (including service users and carers) who appraise research evidence from systematic reviews. Yet has this sophistication changed the outcome? The quality of the mental health evidence base remains variable: of 109 recommendations within the 2002 NICE Schizophrenia Guidelines, 75 rely on expert consensus alone (the lowest grade of evidence in the hierarchy of the Guidelines Development Group). An expert consensus committee meeting in the 13th century would probably have concluded that a flat earth lay at the centre of the universe, depression resulted from an imbalance of black bile, and that blood letting was an effective treatment for many physical ailments.

And yet the case for using guidelines is building. We live in the age of the information paradox: surrounded by so much information and yet it appears increasingly harder to access just when we need it. The Cochrane trials register currently contains over 375,000 entries. As Mark Twain commented “It ain’t what people don’t know that hurts them – it’s what they know that ain’t so.” There is a danger that as clinicians we will place our knowledge into only two subjective categories: evidence that we believe in and evidence that we do not. Surely we can improve upon this?

The National Health Service probably has the largest guideline development programme of any health care system in the world. The National Institute for Health and Clinical Excellence (NICE) was set up in 1999 to give guidance on the “effectiveness and cost effectiveness” of treatments to professionals and service users. Recommendations based solely on clinical judgement and experience are susceptible to self interest, so NICE uses multidisciplinary teams which include service users and carers. As most guidelines are out of date within 3 to 5 years, a regular review date for revising the content is to be welcomed.

Yet any unbridled enthusiasm and expectations for guidelines should be countered by their limitations and potential abuses. One concern that psychiatrists have about mushrooming guidelines is that they reduce clinical care to “cookbook medicine”. Plato (in the 4th century BC) was the first to argue that guidelines “presupposed standardised treatments for average patients rather than customised treatments for particular patients”. This view is particularly relevant to psychiatric practice. A surgeon’s skill in approaching the unique anatomical field of a patient during an operation is akin to a mental health professional

working with a person’s specific psychological characteristics. Using guidelines only doubtfully relevant to a particular individual is like using evidence in the manner of the fabled drunkard: he searched under the street lamp for his door key because that was where the light was, even though he had dropped the key somewhere else.

NICE has at least two service user or carer members on every guideline development group. Service users have equal status to other members, sometimes forcing professionals to face issues about the limitations of the treatments they have to offer. The danger is to overly rely upon service user opinion in place of objective evidence (or the lack of it). Despite submissions from the Royal College of Psychiatrists, NICE did not recommend the use of electroconvulsive therapy for conditions such as treatment-resistant depression of moderate severity. It is encouraging that the call from NICE for more user based research has been heard and a recent study reported that 71% of service users had found the experience of a course of ECT to be better or no worse than a visit to the dentist (Benbow & Crentsil, 2004).

The General Medical Council advises clinicians “normally to use recommended guidelines”. However, published guidelines have an uncertain legal status in the United Kingdom. Some deviation from general recommendations is inevitable and the chairman of NICE Sir Michael Rawlins has accepted that it is then “up to the health professional to decide ... what to do in (their) place”. At the moment, not adhering to guidelines continues to be defensible in negligence claims by relying upon the Bolam Test: acting in accordance with a responsible body of medical practitioners, not necessarily the majority opinion. NICE has tried to reassure doctors that they only have to have “considered the guidelines, not to follow them in every case”. However, it seems that “the future ain’t what it used to be”. The legal consequences of failure to follow “guideline X” are building: in the USA, guidelines are cited as proof of negligence in 7% of malpractice actions. But while ignorance of clinical guidelines is a poor legal defence, the Medical Defence Union does advise that a reasoned decision to deviate from them in an individual case, backed up by good clinical record keeping, may be acceptable (Colbrook, 2005). The Royal College of Psychiatrists and the British Geriatric Society may have gone further than this. Upon hearing that NICE did not recommend the use of acetylcholinesterase inhibitors for early dementia (NICE, 2006), these bodies reminded doctors that GMC regulations state they should make the care of their patient their first concern – implying that clinicians

should continue to prescribe anti-dementia drugs where it appears clinically appropriate.

Can educational dissemination of guidelines make a difference at the front line of clinical care? Indicators from the primary care management of depression are not encouraging. The Hampshire Depression Project (Thompson et al, 2000) demonstrated that comprehensive educational interventions aimed at general practitioners are ineffective in improving patient care when used alone. Fortunately, implementing them alongside case management has been shown to improve the clinical outcome. Evidence based examples include using a nurse to provide support and monitoring, and involving the GP, psychologist and psychiatrist in shared collaborative care (Whitty & Eccles, 2004). But influencing professionals to actually use guidelines remains a significant challenge (Blenkiron, 1998).

If clinicians are feeling uncomfortable at the breadth of the guidelines now being produced, they may be tempted to follow the advice of George Bernard Shaw (1903): "The reasonable man adapts himself to the world: the unreasonable one persists in trying to adapt the world to himself. Therefore all progress depends on the unreasonable man". Mental health professionals are much more likely to use guidelines that they feel they own. This could be achieved by adapting national recommendations for local use. Better still, guidelines may be developed "bottom up" rather than "top down" from the start.

So what can we conclude about clinical guidelines? First, "I cannot say whether things will get better if they change: what I can say is that they must change if they are to get better" (GC Lichtenberg, 1742-99). Second, more research on the effectiveness of implementing guidelines is urgently needed. Third, professionals need to walk the tight rope of pragmatism and cost-effectiveness. By all means, continue to embrace the collective wisdom of others. But equally, we should not lose sight of individual patient care as our central priority.

**G&C Faculty
Annual Residential Meeting, October 2007**

In October of last year, the Faculty organised a very successful Annual Residential Meeting in Southampton jointly with the Faculty of Rehabilitation and Social Psychiatry. Around 250 delegates were present on each of the two days of the conference, well up on previous years and a testament to the quality of the programme.

This year, the Faculty is re-visiting Newcastle, which previously hosted an extremely successful meeting in 2002. The meeting this year will take place in the Hilton Hotel based on the Gateshead side of the River Tyne with magnificent views over the river and Tyne and Millennium Bridges. There will be two themes running in parallel throughout the meeting: vulnerability and service delivery.

On the theme of vulnerability there will be a range of symposia including: "Vulnerable populations: Psychotropic Medication and Childbirth"; "Biological, psychological and environmental risks for depression"; and "Applied pharmacogenetics – Can we pre-select treatment responders". There will also be a debate titled "Antecedents of psychosis: Clinical relevance?". A plenary lecture will be given by Dr Paul Makin from Newcastle University on "Vulnerable to, and service provision for, metabolic disease in severe mental illness".

On the service delivery theme Dr Hugh Griffiths from NIMHE will be giving a talk titled "Challenges in Service delivery for general and community psychiatry". There will also be symposia on "The management of dual diagnosis patients: The specialist or the generalist?" and "Clinician / User interactions" and a debate regarding "Functional models of service delivery".

As usual there will be a range of workshops occurring on both days of the meeting ranging from "Industry funded services: Should you look a gift horse in the mouth?" and "The new MRCPsych exams – Not like they were in my day!" to "Reducing vulnerability to relapse: Improving adherence" and "Dual diagnosis – creating a seamless service".

A trainee / new consultant research session will give an opportunity for oral presentations from the authors of short listed poster abstracts. This session will be judged and the best presentation will be awarded a prize. This will be in addition to posters that will be displayed throughout the meeting.

The Faculty Executive and the Local Organising Committee look forward to welcoming you to Newcastle in October.

Hamish McAllister-Williams
Academic Secretary and Chair, Local Organising Committee

(Note the provisional programme is posted on the Faculty website.)

Article 14 Evaluators required

The Royal College of Psychiatrists is in the process of setting up a large forum of psychiatrists from all specialties to assist with the assessment of Article 14 applications.

The College's role is to assess individual applications for Specialist Registration in Psychiatry according to the conditions set out under Article 14 of The General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003. The College works closely with the Postgraduate Medical Education and Training Board to ensure that a robust system of assessment is established for all applicants who apply for specialist registration under this route.

The evaluator's role is to assess applicants' qualifications, training and experience under all 6 Good Medical Practice headings and to determine whether the applicant meets the criteria specified by the PMETB and the College, and to further determine whether their competences are equivalent both in clinical and theoretical content to those of a UK holder of the Certificate of Completion of Training (CCT) in psychiatry.

Specific Responsibilities

- To review individual applications for Article 14, and apply the agreed standards according to the evaluator's assessment notes
- To recommend further training, experience, examinations, assessments or other tests of competence necessary to demonstrate the applicant's equivalency to a UK qualified specialist

Each application is normally scrutinised by 3 College evaluators and the time allocated to complete the assessment is 3 weeks. We particularly need evaluators in General Adult Psychiatry.

Although the College has already appointed a large number of evaluators, this has proved insufficient to cope with the high number of applications we regularly receive from the PMETB. The PMETB have set strict deadlines which the College is obliged to meet under the current arrangements with the Board.

We therefore need evaluators, who are reliable, IT competent, comfortable to work with complex documents on screen and be able to devote 4 to 5 hours (or more) per application. All applications are sent to evaluators on a CD-Rom.

If you would be interested in offering your services to assist the College please contact Miss Lena Hartley at the details below for an evaluator remit and further information.

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Faculty of General and Community Psychiatry: The Executive

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Dr Michele Hampson	(Elected: 2007)
Honorary secretary	
Dr Leon Rozewicz	(Elected: 2007)
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Dr Frances Burnett	(Acting - 2007)
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Dr Pradeep Arya	(Co-opted 2003 - SpR rep)
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Professor Kam Bhui	(Elected 2007)
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Dr Lisetta Lovett	(Elected 2005)
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Dr Mark Salter	(Elected 2005)
Dr Mary Jane Tacchi	(Elected 2005)
Dr Tony Zigmond	(Co-opted 2005)

List of Current Faculty Regional Representatives

Region	Representative
East Anglia	Ashok Patel
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Northwest Thames (London, Northwest)	Lester Sireling (Division Rep)
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Yorkshire	Dympna Ryan

Letters

We welcome your letters, and will hope to feature them in our next edition. Please write to the Editor at the address below

NCAS recruitment request

The National Clinical Assessment Service is seeking to recruit two consultants in general adult psychiatry to be part of the NCAS assessor panel. Assessors are required to be available for up to 15 days a year (for assessment and training days) to ensure provision of a service to England, Wales, and Northern Ireland.

Members work as part of a small assessment team to conduct clinical performance assessments. The purpose of an assessment is to: provide an independent view on the performance of the practitioner, within the wider context of their practice; identify satisfactory practice and any areas of concern; identify factors that may be contributing to these concerns; make recommendations for addressing any difficulties identified.

It is essential that you are in good standing with the GMC and your specialty, and have a minimum of five years' experience as a general adult psychiatrist. You will be familiar with the principles of assessment, audit and review with at least two years' experience as an assessor as well as having proven report writing skills. You will currently be working in NHS practice environment and intend to do so for the next two years.

For an application pack and further information please visit www.ncas.npsa.nhs.uk

Closing date 14 December 2007

If you have any queries, please contact Harpreet Diocee on 020 7084 3963 or email ncas.education@ncas.npsa.nhs.uk

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Don't forget to mail or email us with your responses and articles for publication