iMind

Newsletter of the Faculty of General Adult Psychiatry

Autumn 2018

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General Adult Psychiatry

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Summary of GAP Faculty executive meeting in October 2018

by

Dr Lenny Cornwall
Chair, GAP Executive

@lennycornwall

We've just had the budget and the promise from the government to increase funding for mental health services: an extra £20bn for NHS England by 2023-24 with at least £2bn for mental health services. Is this good news or bad news or maybe a bit of both? Highlighting the need for extra funding for mental health services has to be a good thing. But given that mental health services get 11% of NHS funding when we deal with 23% of the disease, getting 10% of the "new money" actually takes us further away from parity of funding. In the run up to the announcement of the new NHS Long Term Plan, we have made a strong case for new investment in core adult mental health services: in our community, crisis, and inpatient teams. Much of our understanding here comes from our survey of members conducted last year – the final report will be published on the faculty web pages very soon. If you want to know what we have said, then read Andy Moore's editorial in BJPsych Bulletin, entitled "The forgotten foundations: in core mental health services, no one can hear you scream".

We had an impact in the publication of a report from the All Party Parliamentary Group on Mental Health, which boldly stated: "Core services are the 'backbone' of secondary mental health care, supporting adults whose needs fall outside services targeted at specific conditions. We urgently need to invest in core mental health services, such as community mental health teams, for adults severely affected by mental illness and reform thresholds for getting help so that everyone gets timely and effective support regardless of diagnosis. It should be a priority to reduce the number of people reaching crisis point and prevent disparities in accessing services." You can download the full report here.

The report was picked up by the Guardian which ran this story, quoting Andy Moore.

If you want to know if the government's announcements will make a real difference, compare them to this plan to achieve parity of funding recently published by the Institute for Public Policy Research here.

We will continue to focus relentlessly on improving funding for core adult mental health services. At our recent executive meeting, we looked at what we can do to make better funding work: developing a demand and capacity model for CMHTs, understanding what the key ingredients of effective models of care are, improving our own data literacy, highlighting the evidence base that co-production and continuity of care improves outcomes. These topics will be picked up at our 2019 conferences. As well as our annual conference in Manchester in October, we will run a spring one-day conference at the College, jointly organised with the Informatics Committee and the Leadership and Management Committee, so please keep an eye out for further details.

Finally, I can announce that Billy Boland has been elected to take over from me as faculty chair next summer. He has been an excellent vice-chair so I am sure he will do a great job. And another energetic member of the executive, Asif Bachlani, has been elected as the faculty finance officer. There will be an election at the end of the year for the vacancies on the faculty executive committee and I very much hope you will use your vote.

Acute Care survey

by

Dr Jonathan Scott

@JonathanCScott

As many members will be aware from previous news articles, attending our conference and Andrew Moore's recent article in the BJPsych Bulletin (1), we conducted a major survey on Acute Care last year. The final report has been accepted for publication by the College and should be published very soon. The key message is that 'core' services (what used to be commonly called community mental health teams) are under great pressure and indeed deteriorating. This issue has been noted in the press recently and the College is lobbying very hard to ensure the problem is addressed. We hope the report will contribute to this discussion, especially if there really is new money for mental health going forward.

There were over 600 responses to the survey with nearly 20% of the adult consultant workforce in the UK participating. The results are a mix of both quantitative and qualitative analysis, although much of the richness of the data comes from the latter. As expected, a great deal of service reconfiguration was reported but the overwhelming consensus was that the quality of care is declining. A very strong theme that emerged was concern regarding continuity of care. In particular, patients have to move between many teams and barriers to these pathways are being reinforced, not reduced.

Similarly, the availability of inpatient beds is widely regarded to be inadequate. This concerned acute care but also rehabilitation services, another area that has received little attention recently. Substance misuse services were also highlighted as having very limited resource. 57% reported that their organisation never or rarely met the proposed recommendation of the Commission on Acute Adult Psychiatric Care for a 4-hour waiting target, 49% noting a decline in the situation since that report was published in February 2016.

The data collected for this report will be over a year old at the time of publication. It could be argued that the conclusions do not reflect the current situation. In response to this, we note that the area that has received perhaps the greatest attention during the period of data collection and writing is Out of Area Placements (OAPs) of psychiatric patients, a direct consequence of bed shortages. Despite the collective effort, there has been limited improvement in the situation with overall numbers showing no significant change (2). Similarly, crisis services have been a focus of attention from 2014. It is highly unlikely there has been significant change to the situation in the period of a year, particularly when front line funding has not increased (3).

Not all responses were negative. 27% felt crisis services had improved over the previous two years and there was evidence of a good deal of innovation. However, these developments seemed to be taking place in isolation, even within Trusts. It was not possible to find any association between perceptions of good quality care and reported service improvements.

The overall recommendation is that, going forward, there should be a focus on core services and the 'whole system' of care, not isolated services. Within this framework, greater attention needs to be given to continuity of care. The Faculty is currently undertaking a review of services models, led by Russell Razzaque, which will further inform this debate. We would encourage all members to respond to requests for involvement in this task.

1. Moore A. The forgotten foundations: in core mental health services, no one can hear you scream. In: BJPsych Bulletin: 1-4. Cambridge University Press, 2018.

2. Campbell D. Mental health patients still sent hundreds of miles for treatment: Despite government promises to end practice, figures show almost no change since 2016. In: The Observer: 2018.

3. Iacobucci G. Many CCGs are failing to boost mental health funding, BMA warns. British Medical Journal. 2018; 360.

GAP annual meeting reflections

By

Dr Andrea Malizia

@andreamalizia1

I am of course biased!

All the sessions of the Annual Meeting I was at delivered high quality content and the initial feedback has been positive. A couple of the most significant comments so far have been "When I got back I applied a piece of advice regarding transitioning to adult services for a person with ADHD in that situation", "I was delighted to finally hear an explanation of the subsyndromes in schizophrenia from the person who has done a lot of work on it"; "I got something from all the sessions in spite of the fact that it was not obvious that I would have chosen to go to them a priori".

I hope that having a mix of experts, expert clinicians and researchers has served our community well - please give us as much feedback as possible. We no longer try to have a theme for the conference as it can become restrictive. However the nexus that linked many of the sessions was a focus on understanding context, not being trapped by boundaries and being cognisant of different points of view. Hence we are grateful that service users, managers, child psychiatrists, psychologists, social scientists and people who work in organisations that advocate better care and better resourcing for our target population were able to contribute; thank you for talking to an audience which may not be your usual one.

I do not want to name anybody in particular because it would be unfair to the people who have not been named. However a particular debt of gratitude to Mr Stuart Bell who stepped up and delivered an excellent plenary at the last minute when The Right Honourable Norman Lamb MP had to withdraw. Everyone I talked with, enjoyed his talk and was encouraged by it. The recent discussion on funding of General Adult services is causing ripples and I suspect that this will be a topic that merits further attention in the months to come. The bottom line however is that we need to redress inequalities of funding compared with physical health – not rob Peter to pay Paul.

Apart from the plenaries the session on ASD was the fullest. There were no seats left in spite of being in the largest room available and people were standing at the back. This speaks to the fact that General Adult psychiatrists deal with both ASD and ADHD but our 'traditional' training does not make us well equipped to do so. Something that those who develop higher training curricula should be mindful of for the future. Psychiatric co-morbidity and lack of learning disability are the norm so we need to recognise them and ensure that they are part of a recognised treatment strategy.

My only negative: attendance in the last session on Friday was low. This can be disheartening for people who present. If anyone has ideas on how to prevent the haemorrhage without locking the doors please let us know.

We now look forward to 2019 and Alessandro and I have started working on it. If you have any suggestions for sessions send to Emma George by 30th November and they will be considered. Please include the title theme and three or four speakers who would complement each other. Also we would like to promote QI project reporting as we aim to make the GAP annual conference a prime showcase for QI posters –

you have about 6-8 months to do something if you have not started it and I would expect that there are a number of people out there who are itching to communicate their work. Please encourage everyone around you to do so – QI is important and doable.

Finally a big thanks to all the staff at RCPsych that make the conference possible and in particular to Emma George who keeps a lot of threads together throughout the year. Also a big thank you to my partner in crime - Alessandro Colasanti whose energy and enthusiasm are infectious.

Resurrection of Mental Health Treatment Requirement

By

Dr Imran Malik

@mimisbaba

Community Orders (CO) were introduced as a sentencing option in April 2005, as one of the provisions of the Criminal Justice Act 2003. These replaced the earlier community sentence for adult offenders.

The Act provides for 13 possible requirements to be made part of a CO or Suspended Sentence Order (SSO). The Mental Health Treatment Requirement (MHTR) is one of three treatment based requirements along with the Drug Rehabilitation Requirement (DRR) and Alcohol Treatment Requirement (ATR). These treatment requirements are collectively referred to as Community Sentence Treatment Requirements (CSTR), although it is not a recognised legal term in the Act.

Ministry of Justice (MoJ) figures show that approximately 29% of people serving community orders self-reported having a mental health condition, and of those who were formally assessed 32% were identified as having a drug misuse issue and 38% were identified as having an alcohol misuse issue.

Despite the high numbers of Offenders with mental health and substance misuse issues, in 2016 treatment requirements were the least used of all community requirements: MHTR 0.3%, DRR 5% and ATR 3%.

MoJ has driven the need to increase the uptake of treatment requirements sentenced within community orders with a view to reducing short term custodial sentences for those with multiple vulnerabilities that could be managed within a community setting, with the aim to reduce reoffending by improving health and social outcomes.

The college, in consultation with its faculties, has produced a paper outlining the scope of MHTR for its members. The document also has the support of MOJ, Public Health England, Department of Health and NHS England.

On 10 August 2018, Justice Secretary David Gauke formally launched the programme with a press release.

The story was also covered by The Times, Independent and ITV News.

Currently operating framework for CSTR is being drafted to incorporate pathways into secondary mental health services as thus far the pilots only included MHTRs at a primary care level addressing the needs of the patients who do not meet the criteria of secondary services.

In relation to accessing the secondary mental health services there have been concerns expressed by clinicians particularly in relation to pressure it may put the already stretched services under. Some of the frequently asked questions are answered below;

Can CSTR be imposed?

Consistent with the general principle that engagement in treatment is voluntary, a court can only impose an MHTR, DRR or ATR where the offender has expressed a willingness to comply with the requirement.

Can two treatment requirements run concurrently?

These can be either standalone requirements as in MHTR on its own or one of a number of requirements as in MHTR with either DRR or ATR or for that matter in any combination as part of a CO or SSO.

Who is suitable for CSTR?

CSTRs can be used for adult offenders requiring treatment related to mental health and/or substance misuse and convicted of an offence which falls within the CO or SSO sentencing threshold.

Even if there is no link between offending and mental disorder, could CSTR still be applicable?

Yes. The type of offence will determine whether the offender is eligible for CO or SSO. Once it is established that the court disposal is going to be CO or SSO only then it is explored whether the individual will benefit from a treatment requirement regardless of there being a causal link with offending or not.

When is MHTR suitable?

The Criminal Justice Act 2003 states that a MHTR can be given where the court is satisfied that an offender has a mental health condition that is treatable either in a community setting or as an outpatient in a non-secure setting, but one that does not warrant making a hospital or guardianship order within the meaning of the Mental Health Act 1983.

An MHTR can only be given when arrangements have been or can be made for the treatment which will be delivered under the requirement (including arrangements for any residential care) and the offender consents.

Can MHTR be put in place for personality disorders?

The MHTR can be used in relation to any mental health issue, including personality disorders.

Can MHTR be put in place for people with Learning Disability?

A learning difficulty or disability is not a mental health condition. Just like any other offender, an individual with a learning disability or difficulty would not be appropriate for a CSTR unless their primary problem was with drugs, alcohol or mental health.

How long can a CSTR be ordered for?

The length of the requirement would be recommended at the Pre-Sentence Report (PSR) stage and would depend on the assessed treatment need of the offender, provided the overall restriction on liberty imposed by the CO or SSO in its totality is commensurate with the seriousness of the offence(s).

A CSTR can last for a maximum of three years as part of a CO and two years as part of a SSO. There is no longer a minimum length in law.

In practice, however, CSTRs are usually much shorter as individuals won't need to spend two to three years in treatment. Where necessary, other punitive requirements can be imposed alongside the CSTR as part of a CO or SSO to reflect offence seriousness.

For MHTR purpose who is Responsible Clinician (RC) / Registered Practitioner (RP)?

This is the healthcare professional who oversees the treatment requirement. This person has to be either a consultant psychiatrist or qualified registered psychologist. The term Responsible Clinician was initially proposed but given that it lends itself to confusion with the meaning it carries under the mental health act hence for MHTRs the term is being replaced by Registered Practitioner.

Does RC/RP have to provide treatment himself/herself?

No.

Intervention can be provided by any member of their team as long as they are overseeing the intervention in supervisory capacity.

Does MHTR need to be supported by a medical or psychiatric report?

No.

However, the suitability of an offender for an MHTR has to be assessed by a suitably qualified medical practitioner. This no longer has to be a Section 12 registered medical practitioner (under the Mental Health Act 1983), but could include alternatives from the broader mental health community, such as a psychologist, or a forensic psychologist, qualified Community Mental Health Team workers or community psychiatric nurses.

If the practitioner is not the RC/RP, the RC/RP will need to agree to and oversee the proposed treatment.

How long does RC/RP have, to make a decision on whether to agree or disagree with MHTR?

Court is expected to sentence offenders on the first hearing however if further information is required, which would be the case in MHTRs, expectation is that a decision is made by RC/RP within 7 days so sentencing can be

carried out in a timely fashion. RC/RP doesn't have to see the patient themselves, one of their qualified team members can carry out the assessment or this could be done on their behalf by liaison & diversion team.

Does agreeing to MHTR come with any statutory paperwork?

None for healthcare professionals. For the RC/RP it would be providing treatment as usual as they would provide to any other patient with similar mental health needs.

Is it similar to CTOs?

Largely speaking no but it has some similarities.

Unlike CTO in case of MHTR the patient is consenting. Someone from external agency, probation officer, is involved to monitor their engagement with MHTR. You would be expected to liaise with them should you have any concerns. If they fail to engage with MHTR or you are of the view that the treatment is no longer required, probation officer will take them back to court for revising the sentence if appropriate.

There are no reports to do or tribunals to attend.

MHTR like CTO offers a framework for patients who would otherwise not engage with services.

If use of MHTR increases is this going to increase workload for secondary mental health services in particular community teams?

It is unlikely that there would be any substantial increase in workload.

Most of these patients would usually be already open to community services but is likely to have had a poor track record of engagement. Some may have been discharged

due to disengagement. A very small number may not be known at all nonetheless would meet the criteria of secondary mental health services. Therefore, by MHTR providing a framework of engagement there may be a slight increase in the numbers as the non-engagers may start engaging. To put these numbers in perspective, during the one year pilot in Northamptonshire just under 100 offenders were given MHTRs and only 5 of them required MHTR intervention through secondary care and all of them were already known to the services.

Are Clinical Commissioning Groups (CCGs) responsible for the treatment of offenders and MHTRs?

Yes. CCGs are responsible for the healthcare needs of offenders in the community (including mental health). The

only exception to this is drug and alcohol services, which are commissioned by Local Authorities.

Offenders sentenced to CO or SSO are members of the local community and have the same rights and opportunities as any member of the general public.

Should offenders be given the same or faster access to treatment than the general population?

As members of the general population, offenders in the community should access treatment in the same way as anyone else, via mental health services commissioned by CCGs, and drug and alcohol treatment services commissioned via local authorities.

However, when vulnerabilities become the reason for the offending, this needs to be addressed with some urgency as one would for patients in crisis who are presenting with risks to themselves and or others.

It is a legal requirement that a CSTR ordered to address an offender's mental health, and/or substance misuse issues has to be provided within the period of time specified within the court order.

Person-centred care in psychiatric practice

Royal College of Psychiatrists Report CR215 Person-centred care: implications for training in psychiatry

By

Dr Subodh Dave
@subodhdave1

Dr Jed Boardman

Advances in precision medicine and genomics are enabling a vision of care that is personalized and targeted to individual needs and physiology. Parallel to this technological advance has been another notable change in the practice of medicine - a move away from the traditional deference of the patient to medical authority towards a more active role for the patient - a move from "patient" to "person".

Patient v/s person – an academic distinction?

Patient-centred care involves treating the patient with respect and dignity and paying attention to their values and their individual psychosocial context but ultimately all of these are in the service of decisions about the person's diagnosis and treatment.

In a subtle but significant shift, person-centred care focuses on the patient's history, strengths, values, beliefs etc, not merely to inform decisions about diagnosis and treatment but to help them live the life they wish to lead to. This centrality to 'personhood' is not merely a theoretical construct but has clinical implications

So what is person-centred care?

The Health Foundation's definition provides a composite, more comprehensive definition and is the one that has been most useful in translating the idea of person-centred to action in routine medical practice.

"Person-centred care:
(1) Affording people dignity compassion and respect;
(2) Offering coordinated care, support or treatment;
(3) Offering personalised care, support or treatment;
(4) Supporting people to recognise and develop their own strengths and abilities to enable them to live an independent and fulfilling life".

Aren't we already practicing in a person-centred way?

Psychiatry, with its strong biopsychosocial ethos and whole-person focus, should be a natural leader in providing person-centred care. In practice, CQC reports suggest that only 60% of patients report definitely being involved in decisions pertaining to their own care. Moreover, there is significant variation in practice with some clinicians working far more collaboratively with their patients than others. Psychiatrists tend to overestimate their person-centredness though admittedly with a significant number of patients detained against their will, there is additional dimension to this challenge in psychiatric practice. Finally, chronic underfunding of mental health services, significant rise in referrals and increased regulatory pressures have all contributed to clinician burnout and compassion fatigue.

How can I become more person-centred?

It is helpful to have a clear and explicit rationale for embedding person-centred approaches in one's practice. The case for person-focused care is compelling and self-evident when the definition of person-centred care is flipped to ask if it is acceptable to offer patients care that is lacking in dignity, compassion and

respect or to treat patients as a collection of symptoms without taking into account their wider individual/social context.

Some practice tools that may help:

1) Shared decision-making.

Clinical decisions should be based on best available evidence, expert clinical advice and the patient's personal beliefs, value systems and preferences. Enabling full patient participation in the clinical decision making process respects patient autonomy but also has benefits in terms of better patient ownership of the care plan, improved adherence and improved outcomes. Co-authoring care plans, writing letters addressed to patients and providing open access to medical records are ways of improving such collaborative working.

2) Self-management

Supporting people in taking ownership of the management of their long-term health conditions to help them achieve their broader life goals.

3) Co-production

Going beyond patient involvement in clinical decision making, this approach is focused on breaking down power barriers between patient and professionals, recognizing and valuing the strengths of each.

4) Rights-based approach

Clearly, psychiatric practice requires specialist knowledge of mental health and capacity legislation. It is also important to ensure adequate knowledge and application of human rights and disability discrimination legislation. Skills pertaining to advocacy are also relevant in this context.

5) Social inclusion and recovery

The evidence for social determinants of mental illness such as poverty, unemployment and loneliness is overwhelming and yet social treatments are underutilized and social causations not adequately studied. Knowing the assets/strengths of the community in one's area of practice can help improve clinical outcomes.

6) Spiritual History

Spiritual beliefs whether religious or otherwise are concerned with human experiences of relatedness, meaning and purpose in life. Assessment of these should be part of routine clinical practice.

7) Formulation Skills

Developing a shared understanding of a person's problems; developing the personal narrative based not only on predisposing, precipitating and perpetuating biological, is not only respectful but also clinically crucial.

Conclusion

Person-centred care can occasionally be portrayed as a version of customer service. This would be a disservice to the humane, compassionate, relation-focused approach that places the individual and their unique environment at the heart of the clinical interaction. The co-produced College report CR-215 Person-centred care: implications for training in psychiatry offers more details.

Acknowledgements to:

Person-Centred Training and Curriculum (PCTC) Scoping Group

GAP 2018 Prize winners

By

Dr Oliver Dale

@oliverdale10

Each year the General Adult Faculty runs a series of competitions, with prizes ranging in size from £50 to £250. It is a great pleasure to organise these competitions as well as quite a learning experience as the entries cover a vast array of topics.

The quality of the entries is typically very good indeed and this year was no exception at all. With over 70 posters and 10 essay entrants, our team of markers had their work cut out to decide on who should be awarded.

It should also be noted that these activities are quite a good way to engage with the public. The essay title this year did cause a bit of debate on twitter, as did some of the posters which reached a far wider audience than the conference alone.

Before listing the winners, it is worth thanking all the entrants as the efforts they made were well worth it and the comments from delegates were uniformly positive. I also want to thank the markers who took the time to score and debate the winners. It involves a lot of work and is greatly appreciated and brings real vigour to the process.

For those interested in the prize essays, when the new website is up and running we will publish the winner and runners up.

Best oral presentation

James Bailey

Acute alcohol and drug use in violent suicidal acts: A five year post-mortem study (Authors: Dr James Bailey; Dr Nicola Kalk; Dr Rebecca Andrews; Dr Mike Kelleher and Dr Susan Paterson)

Best poster

Laurence Astill Wright

Understanding public opinion to the introduction of minimum unit pricing in Scotland: a qualitative study using Twitter (Authors: Dr Laurence Astill Wright; Dr Su Golder and Prof Jim McCambridge)

Best medical student poster

Danish Hafeez

Persistence of psychotic-Like experiences in a community sample of adolescents (Authors: Mr Danish Hafeez and Prof Alison Yung)

Best poster from psychiatric trainee

Andrew Howe

Audit of changes in clinical outcome measures and incidents of suicidal acts in a therapeutic community for those with personality disorders in south London (Authors: Dr Andrew Howe and Ms Merryn Jones)

Best poster from a foundation year doctor

Yuki Takao

Early treatment response audit (Authors: Dr Yuki Takao; Dr Andrew Kissane and Dr Richard Trante)

QI trainee prize for the poster

Nina Baurch

The effect of a quality improvement project to improve sleep on an acute psychiatric ward (Authors: Nina Baruch; Daniel Casey; Ela Powezka; Alvaro Barrera and Gail Critchlow)

Bonus poster

Nick Kosky

The Horse Course ReStart programme - examination of an initial data set (Authors: Dr Nick Korsky and Prof Anne Hemingway)

Anne Pang

Addressing psychiatric clinic letters to patients: a pilot Study

Authors: Dr Anne Pang

Jessica McGinty

The influence of depressive symptoms during first episode psychosis on long-term functional outcome: a systematic review and meta-analysis (Authors: Jessica McGinty and Dr Rachel Upthegrove)

Medical student essay prize

Essay title: Is diagnosis dead?

Josh Breedon - winner

George Mundy-Bird – runner-up

Rayhan Ghanchi - highly commended

James Pilcher - highly commended

The Medical Student Essay Prize in General Adult Psychiatry 2019

By

Dr Oliver Dale

The General Adult Faculty would like to invite interested medical students to apply for the Medical Student Essay Prize. The title for 2019 is:

"Courage is a key quality for the general adult psychiatrist"

The winner will receive £250 plus two days' free registration at the Faculty conference, one night at the conference hotel, and standard advance rail travel within the UK (receipts required).

Two runners-up (awarded at the judges' discretion) will receive two days' free registration, one night at the conference hotel, and standard advance rail travel. The conference prize package is for the year in which the prize is awarded and cannot be carried over.

Marking will be based on content, presentation and scientific merit. Criteria for judging will include clarity of expression, understanding of the literature and evidence, cogency of argument and overall ability to convey enthusiasm and originality within a 3000-word limit.

Submissions to Faculty Administrator Stephanie Whitehead.

Closing date: Thursday 28 February 2019.

Curriculum Review

By

Dr Indira Vinjamuri

@IVinjamuri

All Medical Specialty Curricula need to be re-mapped onto the GMC's Generic Professional Capabilities Framework by 2020. We are working with Dr John Russell (Chair of the Curriculum committee) on a review project. We are keeping in mind the key challenges of ageing population, chronic illnesses with multiple co-morbidities, recruitment and retention and increased regulation and patient/public expectation. Surveys have been conducted and feedback obtained from college members (780 responses!) and all views are being taken into account. The aim is to prepare our trainees to be successful consultants and offer sufficient flexibility.

The work is ongoing, so please feel free to write to us with ideas, however big or small - curricula@rcpsych.ac.uk.

General adult consultants are also welcome to join the Specialist Advisory Committee, please write to Tony.Roche@rcpsych.ac.uk as we are biggest faculty and our curriculum needs your input.

Members Small Project Grants Scheme A funding opportunity to kick start your project!

By

Dr Safi Afghan

@safiafghan1

The Faculty is keen to recognise and promote the work of its Members that may relate to quality improvement, service innovation, education & training, improving mental health literacy/public engagement, recruitment etc. The Faculty is able to support up to 12 projects for up to £2,000 each for 2019. These would include 2 to 3 projects that clearly relate to promoting the recruitment, retention and development of the psychiatric workforce.

If you would like to apply for the 2019 funding round, please contact the Faculty administrator Stephanie Whitehead for an application form or visit the Faculty webpage for more information.

The successful applicants will be expected to complete their work within the identified time frame and submit a poster or a written report ahead of the GAP Annual Conference (2019).

The deadline for submission is Sunday 27 January 2019.

GAP Clinician and Data Conference – Friday 22 February 2019

By

Dr Asif Bachlani

@Asifmbachlani

One of the Faculty's key objectives for 2019 is to increase data literacy for psychiatrists working in General Adult Psychiatry. You may ask - why is this important?

Answer:

Although the Mental Health FYFV increased funding for mental health services, what most of us are acutely aware of is that this was not for 'core' adult mental health services such as CMHTs, HTTs and Inpatient Services. One of the many reasons for this was lack of data and meaningful outcomes that objectively demonstrate patients that we treat get better.

In order to support psychiatrists working in GAP to advocate and fight for their service we are keen to support trainees, SAS doctors and consultants in the skills necessary to engage, analyse and understand data in order to develop and improve their services and advocate for more funding.

This conference is being organised with the RCPsych Informatics Committee and RCPsych Leadership and Management Committee. We have expert speakers on importance of data and outcomes to improve services for patients.

Speakers confirmed so far:

Stephen Watkins
Director of the NHS Benchmarking Network

Geraldine Strathdee
National Professional Adviser CQC Mental Health Team

Billy Boland
Deputy Medical Director, Hertfordshire Partnership University NHS Foundation Trust

Prof Martin Pitt
Associate Professor of Healthcare Modelling and Simulation, University of Exeter

David Somerfield
Chief Operating Officer, Consultant Psychiatrist

Registration and Booking will shortly be open for the event – look out for details on twitter or the RCPsych GAP webpage.

Hope to see you there!

Online survey - Prescribing ECT for clozapine-refractory schizophrenia

Dr Simon Chu

Have you prescribed ECT for schizophrenia? Would you consider prescribing ECT? If not, why not?

Despite encouraging evidence of effectiveness, ECT is rarely prescribed in the treatment of schizophrenia. Researchers at Mersey Care NHS Foundation Trust are surveying consultants' views on the barriers to prescribing ECT in clozapine-refractory schizophrenia.

The online survey takes just 3 minutes to complete and is submitted anonymously.

Your views will inform an on-going research programme examining the use of ECT in schizophrenia treatment. Please consider completing the survey