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Newsletter of the Faculty of General Adult Psychiatry

July 2019

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General Adult Psychiatry

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The challenge of continuity - Chair's blog

Dr Lenny Cornwall

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Early in June I chaired my final meeting of the faculty executive. After International Congress, I will hand over to Billy Boland and rest assured, the faculty is in good hands.

I first joined the executive as a newly elected member in 2007 in the wake of 'New Ways of Working'. Looking back, New Ways of Working arose as a response to the increasing workload in community teams which made the traditional sector psychiatrist job for a 30-50,000 population impossible to manage. As ever, things go full circle and the new 'Framework for Community Mental Health Support, Care and Treatment' from NCCMH and NHS England is in part an answer to the increasing inability of community teams to cope with the demands placed upon them. In my own service, referrals have increased by 60% in two years and I don't think we are unusual in that regard. How we implement the framework and the NHS Long Term Plan was the main focus at our strategy meeting and will be the main work of the faculty in the coming years.

What's not clear in what I've seen so far is the role of the psychiatrist in the new model of a 'core community mental health network'. We certainly do not have sufficient psychiatrists to provide one for every network covering a 30-50,000 population. Ultimately that would be desirable and a target that we will campaign for. Otherwise, the risk is that the psychiatrist will become disconnected from the team delivering the service. Meanwhile we need to define our role and the position of emerging roles such as non-medical approved clinicians, physician associates and advanced clinical practitioners.

The new model is explicit about delivering greater integration across the delivery of mental care. For most of us, that means improving continuity of care, and this was the key issue we discussed at the recent faculty executive meeting. One question I would like us to consider is who is continuity of care for – the patient or the clinician? That may seem a stupid question on the face of it. Of course, it is for the patient and recent research has shown that declining continuity has led to worse outcomes (McDonald A. et al. Continuity of care and clinical outcomes in the community for people with severe mental illness. BJPsych 2019: 214; 273-78). This study used a continuity of care measure designed for use in primary care where the average patient had 5 contacts over 2 years. But mental health care is inevitably more complicated with many more contacts (>30 in 2 years on average, according to the NCCMH framework document).

Reading this paper has highlighted for me the difficulty in conceptualising and defining continuity of care. Anecdotally we know that patients value continuity of care, so why not create a measure that asks them about their own experience of continuity.

My challenge to colleagues is this. What can you do to enhance continuity within your current model of service, perhaps using a QI approach? What can you do to redesign your service to enhance continuity? And, what can our research colleagues do to study the issue further?

But back to my earlier question: who is continuity for? I think we need to consider this as an

important element of our own well-being at work. One of the most satisfying aspects of my job is the continuity of support I have been able provide to some patients over 18 years, demonstrating the difference that you can make over time. For many colleagues this has been damaged in recent years because of service fragmentation.

So let's rethink how we can enhance continuity of care, but not just within our teams and between the different teams in the specialist mental health services. Let's consider how we can best provide continuity across the lifespan and between all our partners: acute care, social care, primary care and the voluntary sector.

The minutes for the GAF executive committee meeting held on 4th June 2019 are here.

Dr Cornwall is consultant psychiatrist and Deputy Medical Director at Tees, Esk & Wear Valleys NHS Foundation Trust, and GAF Chair.

GAP Annual Conference on 10-11 October 2019

By

Dr Alessandro Colasanti, Dr Andrea Malizia

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October is that time of year. The summer is definitely over, the clocks are going backwards; it is too early to taste the new vintage and jingles linked to seasonal shopping make their way onto the media earlier and earlier every year. So, it must be time to nurture the brain, keep up to date with developments in your chosen profession and meet up with your specialty colleagues from all over the UK. May be even present some data and get some feedback. We are of course talking about the GAF annual meeting which will take place on 10-11 October 2019 in Manchester.

Three plenaries, 12 symposia and ten seminars/masterclasses as well as the AGM, poster presentations and other informal activities (culinary excursions, morning runs, coffee with long lost friends and other delegates) are the essence of the annual meeting.

Two international leaders in psychiatric research are delivering plenary lectures: one from the USA and one from Denmark to share their considerable knowledge and experience. **John Augustus Rush** needs little introduction for anyone who has been following developments of treatments in affective disorders including time limited psychotherapies, antidepressants and neuromodulation/ stimulation. **Gitte Moos Knusden**'s early research activity included understanding how the blood brain barrier operates in man; she is one of a small number of clinical neuroscientists in the world who has a firm grip on understanding human in vivo molecular psychopharmacology in health and disease. Their plenaries are complemented by **Louise Howard** exploring the implications of the Domestic Violence and Abuse Bill and of the NICE Domestic Homicide reviews for general adult psychiatry.

Symposia focus on the aspects of delivery of good care, clinical problems and new research. Seminars and masterclasses provide an opportunity to interact with the speakers on key topics. Picking a few names

in the highlights seems unfair, so for this purpose you will have to trust that Alessandro, Andrea and members of the executive who have all worked at putting together the programme have picked knowledgeable and interesting speakers.

Themes include complex PTSD; the foundation of psychological growth in peer support relationships; managing difficult issues in bipolar affective disorder (measurement in primary care, lithium in pregnancy and treating comorbid ADHD); borderline personality disorders and how to manage them in the community; sleep disorders; ensuring that GAP services get an appropriate proportion of funding; barriers to clozapine treatment implementation; treatment refractory affective disorders; poverty, social inequalities and mental health; cannabinoids in psychiatry; inpatient services; withdrawal from and the importance of sexual side effects of antidepressants; NCCMH pathways and treatments in the community; data literacy in psychiatry; developing a lifetime understanding of affective disorders (genes, lifetime suicide risk and transitions from adolescence). At this stage a couple of sessions need confirmation, so the above is not a complete list.

Speakers' provenance encompasses virtually the whole of the UK from Glasgow to Cardiff, from Exeter to London and from Oxford to Newcastle. Notably absent are our colleagues from Northern Ireland and Eire and you will discover why at the meeting.

The chair and vice chair are going to surprise us with another topical symposium and from the current discussions we can say that it will be very interesting, thus hopefully establishing a tradition for this symposium (started last year) in years to come.

Finally, we have a session on Arts and Psychiatry with three entertaining and thoughtful speakers covering literature, personal experience of creativity and figurative arts. We all hope that this will tickle everyone who values what art has to offer in being a well-rounded clinician.

Please look out for the twitter feed, come to the meeting, participate actively giving us inputs for next year and reflections on this year. Importantly talk with the colleagues and keep general adult psychiatry great☺.

Dr Alessandro Colasanti is senior lecturer in Psychiatry at University of Sussex and GAF academic secretary.

Dr Andrea Malizia is consultant psychiatrist at North Bristol NHS Trust and GAF academic secretary.

The essence of co-production

By

Jacquie Jamieson

@ https://en.wikipedia.org/wiki/Jock_Tamson%27s_Bairns

Where does co-production begin; does it start out on an equal footing; are there hidden/acknowledged rules as to who chooses what/when/where/how to co-produce?

If we are to co-produce authentically, do we perhaps need to co-sense, co-initiate, co-create, co-deliver and co-evaluate also?

Does co-production begin with the same pattern; reviewing/updating system change; are we leading the system; making the system sense and see itself - or

does the system/hidden power dynamics/hierarchy actually lead/guide/parent this process?

Are we chosen/do we choose to co-produce with people more likely to conform, collude (perhaps unwittingly), and comply, or are we willing to learn/change/shift through contemplative dialogue?

Perhaps we might begin with co-sensing what it is we wish to co-produce, why this particular subject, who with and why this particular person. During co-sensing are we prepared to unravel the hidden layers of systemic conditioning, to stay aware that what we are hearing and saying comes from how we know what we know?

Co-sensing is intentional. We come into the relationship with a specific purpose in mind. A specific intention. This intention is to purposefully communicate in ways that help all parties to step outside their current story. Sharing wisdom, recognising ego, being present in our humanness, finding the best in all of us. Co-sensing is about putting energy into mutual learning relationships as opposed to service relationships.

When we are present in contemplative dialogue, we are able to step back from our truth and be authentically open to the truth of others whilst holding our own. We are able to co-sense the impact of culture/worldview at every stage of the process.

Co-production is highlighted in the General Adult Faculty Four Year Strategic Plan (2019 – 2023). Let's begin with co-sensing what this might feel like for each of us; what/when/where/how might we work together to effect deep and meaningful change?

Every act of communication is an act of tremendous courage in which we give ourselves over to two parallel possibilities: the possibility of planting into another mind a seed sprouted in ours and watching it blossom into a breath-taking flower of mutual understanding; and the possibility of being wholly misunderstood, reduced to a withering weed. Candour and clarity go a long way in fertilizing the soil, but in the end, there is always a degree of unpredictability in the climate of communication — even the warmest intention can be met with frost. Yet something impels us to hold these possibilities in both hands and go on surrendering to the beauty and terror of conversation, that ancient and abiding human gift. And the most magical thing, the most sacred thing, is that whichever the outcome, we end up having transformed one another in this vulnerable-making process of speaking and listening.

Recommended reading:

Ursula K.Le Guin: 'Telling is listening'.

Ms Jamieson is a RCPsych user/carer representative.

Putting "community" at the heart of community psychiatry: the new community mental health pathway

By

Dr Subodh Dave

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Winter of austerity

A community of spirit

Hope fills my heart

Do we need a *new* framework for "Community Mental Health Support, Care and Treatment"?

Over the last decade, I have seen a doubling in the number of patients under my care (in the community)

without any additional resource. If anything, with cuts in social care budgets and difficulties in recruitment and retention of psychiatrists, CPNs and other healthcare staff, the pressure on the Community Mental Health Team (CMHT) seems relentless. I am aware that my experience mirrors that of my colleagues across the country.

While specialist services such as Liaison, Perinatal along with the more established teams such as Crisis Resolution and Early Intervention Teams, have attracted funding and helped parts of the community mental health pathway, they have done little to either reduce fragmentation or to improve the flow across the entire community care pathway. Waiting lists have become longer and caseloads often exceed national norms. National NHS Benchmarking data suggests that the number of assessments in CMHTs has been increasing though there has been a fall in the number of people being assessed. Add the data that only less than half of the referrals to CMHTs come from primary care (the rest are from other teams or agencies), and one can see that the community care pathway is far from seamless or efficient. This picture becomes even more vivid when we consider that it is not unusual for people to have multiple assessments from CMHTs, Crisis teams, Liaison teams, Police Triage teams etc. in the few hours before an admission.

Public education programmes including ones led by the RCPsych have been effective in raising mental health awareness but successful campaigns such as 1in4 can obscure the fact that mental illness does indeed discriminate with those facing social and economic adversity disproportionately likely to experience mental illness. The recent Mental Health Act (MHA) Review has also demonstrated that BAME communities are more likely to be treated under compulsory powers of MHA whether in in-patient or community settings.

Despite awareness of these social determinants of mental health, CMHTs tend not to focus on mental health inequalities. The focus of care may have shifted from in-patient settings to the community but this has not resulted in active engagement with and utilization of community assets. Social determinants when addresses are often through the statutory route than through a genuine involvement of local communities. In my personal experience, awareness of local community assets is often absent in CMHTs.

The current framework of care – Care Programme Approach (CPA) is partly to blame. Originally intended to be based on care needs, it has instead been largely driven by risk. Moreover, there is a significant variation in its implementation with a CQC report showing a range of 3-73% patients on CPA across mental health Trusts.

In sum, community mental health provision in general is not readily accessible, is at times of poor quality and does not make the best use of community-based resources. Also pertinently, it currently lacks a framework that explicitly addresses these concerns.

So what's new about this framework?

Community and integration are at the heart of The NHS Long Term Plan. The framework offers a blueprint to realize the key objective of the Long Term Plan viz. to develop "new and integrated models of primary and community mental health care (which) will support adults and older adults with severe mental illnesses".

The new framework was co-produced with active involvement of patients and carers working along with a range of clinicians including GPs, Consultant

Psychiatrists, nurses, social workers, psychologists and NHS England policy makers.

Keeping with the integration theme, the framework provides a template to healthcare providers (and that includes us as members of the General Adult Faculty), commissioners, STPs (Sustainability Transformation Programmes), ICSs (Integrated Care Systems) and PCNs (Primary Care Networks) to deliver a model that focuses on closer integration of mental and physical healthcare on the one hand and between community and voluntary sector resources and statutory health/social care resources on the other.

The new framework retains the clear focus on the diagnosis and management of complex and severe mental illnesses with longer-term needs delivered by specialists at a wider community level (about 250,000 people). PCNs on the other hand with a population of about 50,000 would have a care model focused on primary prevention of mental illness, promotion of mental health and well-being and improved quality of life.

The key change will be the integration of or at the very least a blurring of the boundaries between primary and secondary care. It is envisaged that expanding community teams in mental health Trusts aligned to PCNs will lead the way in providing support to patients and to the workforce in primary care. Co-locating IAPT workers in primary care has been successful in several areas in the country and the proposed framework will build on this approach to bring about an expansion in the co-location of CMHT staff in primary care.

It is worth remembering that primary care does not refer to GPs alone but also includes other primary care agents such as pharmacists, podiatrists, physiotherapists, health visitors, district nurses etc. One can see the potential transformation in the mental health landscape if the wider healthcare workforce is able to perform non-specialist primary assessment, intervention and signposting as needed. This will require a significant investment in appropriate training for primary care staff aided by creation of new roles such as care navigators or social prescribers.

This coupled with the "No Wrong Door" approach will mean that traditional community hubs such as libraries, parks, social clubs, sports groups, cultural organisations, faith groups will not only be places where people with mental illness can be referred to for rehabilitation and social integration but will also be integral parts of the wider community mental health and well being service.

Person-centred care/Co-production/Health Inequalities focus

A critical element of the new framework is the emphasis on care planning personalized to the individual taking into account both their needs and strengths. 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. This involves treating people with dignity, respect and compassion and paying attention to their values and individual psychosocial context.

At a population level, a focus on health inequalities will help local commissioners and providers in ensuring that services afford equitable access and endeavour to deliver equitable mental health outcomes for various groups with increased vulnerability to mental illness.

Final Thoughts

Change is the only constant is an oft-heard phrase in

the NHS. Given this view, there is an understandable skepticism of new initiatives. However, a project that puts community at the heart of the community mental health pathway deserves to succeed. The NHS Long Term Plan should be injecting new moneys for mental health services. Whether this will translate the vision outlined above to action will depend on two key factors a) culture change in services and b) governance and accountability structures within integrated health systems.

Dr Dave is consultant psychiatrist at Derbyshire Healthcare Foundation Trust, associate dean of RCPsych, honorary associate professor at University of Nottingham, clinical adviser for the National Collaborating Centre of Mental Health and RCPsych Trainer of the Year 2017.

Curriculum Review Update

By

Dr Indira Vinjamuri

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From the SAC, we have great news to share! The GMC has accepted our COG submission for the core psychiatry curriculum with some suggestions. All the hard work put in from the curriculum review group has seen results. Veryan Richards, our lay rep says, 'It is a significant achievement to be able to shape the foundation of the new Curricula to reflect a balance in the psychosocial and biomedical strands of clinical practice, and in the prioritising of some key elements eg., person-centred care, core values, sustainability and advanced communication skills necessary for strong therapeutic relationships and shared decision-making.'

The COG application for Adult Psychiatry (ST) was submitted to the GMC on 9 May 2019. They met on 13 June 2019 to scrutinise our work and will report back to us by 11 July 2019. Many thanks to all the consultants and trainees who gave this their time and skills. Rehab, liaison and addictions working groups have been working on their purpose statements for submission by September 2019. Curriculum committee work is ongoing and our next project will be a CAG application to the GMC.

As always, anyone willing to give us a helping hand is welcome. Tony Roche, the curricula and quality manager at RCPsych is sadly leaving us for new ventures. He will be greatly missed but we wish him the best and hope there will be an equally enthusiastic successor to help us carry on the work.

Dr Vinjamuri is consultant psychiatrist and Director of Medical Education at Mersey Care NHS Foundation Trust, and RCPsych GA-SAC Chair.

General Adult Faculty Prizes

By

Dr Oliver Dale

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Once again we had really strong entries for the Medical Student Essay. Taking a lead from the College who recently described the key values underpinning our College's work, we asked the entrants to answer "Courage is a key quality for a general adult psychiatrist'. We had 9 entries, all of a very high calibre. Our 4 judges ranked them through two

rounds of marking and as with tradition we will be announcing the winner at the General Adult Faculty conference in October.

At the recent faculty executive meeting, we have also agreed though that from hereon, we will be increasing the number of free conference places from the top 2 prize essay entrants to the top 3. This includes free travel and accommodation. It is quite a significant prize, but we think it is worthy of the efforts that the entrants demonstrated yet again. We also hope it will encourage other students to take up the challenge.

Medical Student Essay Prize

Winner: £250

GAP Annual Conference Presentations Prize

Oral prize: £250

Best Overall Poster prize: £150

Medical Student Poster Winner: £50

Foundation Year Doctor Poster Winner: £50

Psychiatric Trainee Doctor Poster Winner: £50

SAS/Consultant Poster Winner: £50

QI Prize: £50

Dr Dale is consultant psychiatrist and clinical lead for Cassel Hospital & Personality Disorder Pathway at West London Mental Health Trust, Chair of Cassel Hospital Charitable Trust and GAF executive committee member.

RCPsych Data Conference 2020

By

Dr Asif Bachlani

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Following the success of the GAPData19 conference in February 2019, we are delighted to announce that there will be a follow up conference in 2020 on the theme of Data, Outcomes and Digital. The aim of the conference is to support clinicians having access to clinically relevant data to improve the service they provide to their patients.

The 2020 conference will build on the success of the GAP Data Conference and focus on how to move from data to improved outcomes for patients and how digital technology will support improved decision-making and patient outcomes. Due to popularity of the GAP Data conference, the 2020 Data conference will now be pan-faculty with the morning being seminars relevant to all and then afternoon workshops that are tailored to each of the faculties involved - CAMHS, Eating Disorder, General Adult, Intellectual Disabilities, Liaison, Older Adult and Perinatal.

We are once again delighted to confirm Stephen Watkins, Director of NHS Benchmarking Network as one of the keynote speakers who told us in February 2019 that the NHS has the best quality data on mental health in the world.

The conference will once again be open to all our MDT colleagues – OT, CPNs, social workers, psychologists, Informatics and CCIOs as well as Trainees and SAS doctors.

So what's the date you ask so you can put it in your diary? RCPsych Data Conference 2020 will be on Monday 1 June 2020.

The twitter hashtag for the event is **#RCPsychData20**.

Dr Bachlani is consultant psychiatrist and chief clinical information office at SWSLTG, co-lead of NHS London Mental Health, NHS London clinical lead for Mental Health Outcomes and GAF Finance Officer.

New Higher Trainee Rep – Dr Tom Stockmann

We welcome Tom Stockmann as the new representative of Higher Trainees on the faculty executive committee. Dr Stockmann is a general psychiatry ST6 in East London. He has completed fellowships in medical education and psychiatric research, and his interests include evaluation of psychiatric medication and Open Dialogue.