Correspondence

Acute assessments in psychiatry

As a core trainee in psychiatry, I feel the issue of trainees working out of hours is vitally important.

With changes to rotas as described by Conn & Husain,1 trainees find themselves not having to do acute crisis assessments and instead, nurse-led assessments are becoming more common. These factors have a huge impact on psychiatry as a specialty. Junior doctors on certain rotas are not involved in the decision-making process for admission and are simply used as clerking machines responsible for completing paperwork and a physical examination once the patient is admitted. No other specialty works in this way; all acute non-psychiatric referrals are seen by doctors and a full assessment is carried out, including discussion with senior medical personnel, before the management plan is finalised.

I feel that patients needing acute psychiatric assessments usually present with multiple problems and comorbidities which require the doctor’s input to ensure a holistic approach and that organic factors are taken into account. During my first core training year, the experience I got with acute assessments helped considerably to develop my skills in assessing and managing risk and dealing with acute presentations.

The image of psychiatry among numerous medical students whom I have been involved in teaching, and that revealed in recent surveys, is that ‘psychiatry is an easy option’.2 I feel it is time that psychiatry stands up and shows what it has to offer. This needs trainees to get involved in assessments and take responsibility to ensure that psychiatry has a future.

1 Conn R, Husain M. Trainees want to work out of hours! Psychiatrist 2013; 37: 117.

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A message to psychiatry trainees: keep your finger on the pulse

In light of the recent Royal College of Psychiatrists’ report on achieving parity between mental and physical health,1 the paper by Yadav & Vidyarthi2 came as a timely illustration of the need for trainees to take responsibility for their continuing professional development and the role of the College.

Patients put their faith in doctors of all specialties to look after them. In an acute situation they implicitly trust us to be able to perform investigations, interpret the results correctly, and act appropriately to instigate swift and appropriate management. In the UK, the overarching duties of a doctor are laid out by the General Medical Council.3 One such duty is to ‘keep your professional knowledge and skills up to date, recognise and work within the limits of your competence, and work with colleagues in a way that best serves the patient’s interest’. This is echoed in the Royal College of Psychiatrists’ Good Psychiatric Practice. We hope most trainees would agree with Craddock et al4 who believe that psychiatrists are ‘first and foremost highly trained doctors’.

Admittedly, the specialty suffers from esteem issues, but if we want to be respected as doctors we must commit to continued professional development to improve the care for our patients. The NHS Outcomes Framework hopes to improve professionals’ attitudes towards patients. Are we not discriminating against our own patients if we fail to take responsibility for keeping our clinical skills up to date?

We reviewed the CANMeds competencies framework, which is used by a number of varied specialties both in the UK and abroad. ‘Medical expert’ is a key domain. This is not to suggest a trainee must be ‘expert’ in, say, reading electrocardiogram (ECG) results, but rather that they should be able to integrate knowledge, clinical skills and professional behaviours in order to provide excellent care for their patients. The College has carefully mapped the CANMeds competencies on to its curriculum for core trainees. However, we caution that there is not a clear expectation or way of assessing trainees’ medical skills.

In contrast, the core curriculum for core medical trainees comprehensively addresses the knowledge, skills and behaviours required to manage psychiatric emergencies. As well as acute medical presentations, core medical trainees must also demonstrate competencies in the following presentations: suicidal ideation, aggressive/disturbed behaviour, acute confusion/delirium, and alcohol and substance dependence. Furthermore, there is clarification of what they should demonstrate. For example, every core medical trainee should ‘be competent in predicting and preventing aggressive and disturbed behaviour, using safe physical intervention and tranquillisation [. . . ] and investigating appropriately and liaising with the mental health team’ (p. 77).5

Psychiatry trainees frequently complete a workplace-based assessment on electroconvulsive therapy. Perhaps performing an ECG or physical examination and interpreting the findings may be sensible competencies. It is heartening that the Royal College of Psychiatrists seem to recognise the need for trainees to maintain essential medical knowledge. There are some very good College CPD Online modules such as ‘Taking a general medical history in psychiatry’ and the appositely named ‘Don’t shrink from ECG’. We welcome the planned expansion of the free CPD modules and anticipate there may be more on medical themes. The December 2012 diet of the MRCPsych Paper 1 featured a question on ECG interpretation. Some trainees found this controversial, but others would regard this as a pass/fail question.

We therefore argue that the current psychiatry core curriculum could better address the medical competencies required in sufficient detail to motivate all trainees to attain and maintain their skills. Let’s work with and learn from our medical colleagues.

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Why commissioners need to know about Section 136

The article by Patrick Keown1 was a timely contribution to discussions currently taking place about the use of Section 136 between the Royal College of Psychiatrists, Home Office, Department of Health, Police, Health and Social Care Information Centre, and Care Quality Commission. A major and long-standing problem in understanding the trends in the use of this power has been the failure to collect complete information on the use of Section 136, as the author points out, referring to data collected in 2005–2006. We would like to draw attention to more recent data collected in 2011–2012: these show a dramatic increase in rates of detention under Section 136 – 43% in 6 years, from 16 500 to 23 569.2 Although the number taken to custody suites has fallen from 11 500 (2005–2006) to 8 667 (2011–2012), this figure still far exceeds the anticipated number if custody suites were used in “exceptional circumstances only”, as described in the Mental Health Act 1983 Code of Practice,3 and reiterated in the Royal College of Psychiatrists’ guidance.4

In 2012, the Association of Chief Police Officers (ACPO) collected information on the use of Section 136 in all 43 police areas and discovered that 37% of those detained under Section 136 continue to go to a custody suite, although this varies between force areas. Despite approximately £130 million of capital funding having been made available for Section 136 suites 7 years ago, there are several police forces in England that still do not have access to hospital places of safety.4

This unacceptable variability in provision is clearly a commissioning issue and in March this year the College produced guidance for local commissioners in order to help identify shortfalls in local service provision.4

The multi-agency Mental Health Act group chaired by the College is collecting more detailed information on local services and would be delighted to receive completed surveys (www.rcpsych.ac.uk/pdf/PS02_2013_survey.pdf) from members to inform further discussions.

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Getting it right for people with dementia

Steve Iliffe’s editorial is perceptive, diplomatic and hopefully not too late.1 As he makes clear, dementia is not, for most people, a stand-alone condition. Once established it remains significant in determining quality of life and need for help and support right to the end of an individual’s life. Every journey with dementia is unique and will not be constrained by a predictive pathway or tidied into convenient once-and-for-all time phases.

Our model of specialist involvement in primary care in Gnosall Memory Service, which is dismissed as third choice by psychiatrists in the South West, has the advantage of proven sustainability over nearly 7 years. The arrangements bring the specialist expertise of psychiatry into the practice and the practice retains the clinical responsibility for patients. Many are elderly and carry a number of illnesses for which they attend the practice: a memory problem is simply one of a spectrum of challenges, and attendance at a practice clinic is an acceptable addition to the patient’s routine. Patients are seen as people with full lives with important social and family involvement. An integrated and collaborative approach achieves rapid access to assessment, diagnosis and care planning, with high satisfaction by all parties and reduced usage of other components of the mental Health and general hospital economies.2–4

The Gnosall experiment was not intended to remain an isolated enterprise: several visiting teams have taken the essentials of the model and begun similar services elsewhere. We have described a three-tier model which foresees the integration of the work in primary care within a reorganised district memory service as a component of the old age psychiatry service.5

We are currently working with commissioners, South Staffordshire and Shropshire Healthcare NHS Foundation Trust, and a federation of over 30 primary care outlets that cover 360 000 patients, with a view to implementing this vision over a wider area. This is not a pathway to loss of special skills, independence or status, but the logical way to deliver a sensitive, comprehensive and affordable service for every individual and every family with dementia in the UK in the 21st century.

Declaration of interest

All authors contribute to the work of the Gnosall Memory Service.

Commissioning dementia services

Iliffe\(^1\) makes important points about complex conditions but offers a very limited view of the possibilities for commissioning dementia services. Any qualified provider broadens the options and there is no reason why the whole system needs to be commissioned from a single provider. In acute hospitals, services may be provided by liaison psychiatry or physicians or both. Liaison psychiatry could extend into the community\(^2\) or intermediate care services. In care homes, where frailty is common, there might be an alliance of community geriatrics and old age psychiatry with the independent sector. Home treatment may include joint health and social care, memory services, and care advisors.

What is crucial is that the whole system has to be commissioned and commissioners see the whole system and bind the component parts together. This point is made in the National Institute for Health and Care Excellence dementia commissioning guide with reference to dementia clinical networks.\(^3\) Networks define a whole system where local providers are clearly identified to meet local need and operate a unified, interactive dialogue, not a care pathway that patients do not follow.

The new commissioning environment creates an exciting opportunity to think more imaginatively and this will be needed to meet the dementia challenge. This has to be more than the ‘is it the GP or the specialist?’ question.


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Dementia commissioning – a missed opportunity

Professor Iliffe finishes his editorial with a question,\(^1\) but does not address a much more important issue in dementia care in this country – that although dementia is considered a public health priority by the World Health Organization,\(^2\) the Department of Health’s dementia commissioning pack does not prioritise dementia.

According to the Alzheimer’s Society, more than half of cases of dementia continue to remain undiagnosed in the UK (www.alzheimers.org.uk). Significant resource allocation is needed to address poor diagnosis rates in the population via public mental health campaigns. This should also address the still prevailing stigma about dementia and highlight the potential prevention strategies.

The Royal College of Psychiatrists and the Royal College of General Practitioners have tried to address this by producing the Joint Commissioning Panel for Public Mental Health (JCPMH); however, most health and well-being boards responsible for delivering the public health agenda do not have statutory representations from mental health trusts.

The Commissioning for Quality Innovation and Prevention (CQUIN) schemes for 2013–2014 have allocated resources for integrated/collaborative care in dementia but the funding is non-recurrent. The chronic underfunding of old age services to the tune of over approximately £2 billion needs to be addressed. Most consultants working in an older people’s mental health service have a catchment population twice the upper limit suggested by the Royal College of Psychiatrists.\(^3\)

General practitioners need to remain the focal point of coordinating dementia care and need further training in complex care rather than financial incentivisation under the Quality and Outcomes Framework.


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Author’s response

In the ‘quick and dirty’ poll I carried out among psychiatrists in the South West, the least popular option for reconfigured services for people with dementia was the Gnosall model, described in greater detail by Susan Benbow and colleagues. This model inverts the natural world, putting the general practitioners (GPs) in charge while fostering ‘interactive dialogue’, and is surely an example of the more imaginative thinking that David Anderson hopes commissioners will display. Its attractiveness remains to be seen, as it is now at the point where its methods must be picked up from the ‘innovator’ group which created it, and used by less determined but perhaps more typical ‘early adopters’. We shall see whether this happens. Since 90% of care homes are outside the public sector (even if they receive enough public funds to be inside the public domain), the second most popular option also fits David Anderson’s suggestion about an ‘alliance of community geriatrics and old age psychiatry with the independent sector’. This is a difficult option, because it could bring the specialist alliance into conflict with generalists over who is the clinical lead for people with dementia, with an uncertain outcome when clinical commissioning groups are heavily influenced by GPs, and are very aware of the need to reduce costs. Even more imaginative ideas about multiple providers seem to many to simply replicate the current fragmented system; curing fragmentation of provision by further fragmentation sounds counterintuitive to many, unless the whole process is to be led by consumers under a ‘personalisation’ agenda.
The most popular option was a redrawing of the traditional boundary between specialist and generalist services, with GP diverting more clinical responsibility for continuing support. This is a comfortably low-risk gamble, for specialists at least, because their likely funding scenario is limited growth at best, with budget shrinkage more likely. The question is how to do it. There are many assumptions that could impede change even in this less challenging option. One is identifying 'knowledge deficit' as the core problem in general practice, as Sudip Sikdar does. This does not fit with the findings of the EVIDEM-ED trial that tailored, workplace-based educational interventions do not change practice, even when policy pressure, consumer demand and incentivisation combine to create a theoretically ideal climate for such change. Low diagnosis rates (based on Quality and Outcomes Framework returns) are exaggerated as a problem by a health service that functions as a target-driven industrial machine, distracting practitioners from the need for timely diagnosis and continuing support for their patients. Any stigma can be ‘addressed’ as a public health problem (although public health medicine has not been prominent in dementia policy and practice debates) but that does not necessarily change it, whereas dementia prevention strategies are based on supposition, not evidence of effectiveness. Commissioners are in the difficult (but commonplace) position of having to make investment decisions with poor evidence against a background of competing professional and commercial agendas, while not being able to change the one thing that might be critical – the GP contract. Getting commissioning right for people with dementia will be difficult, so I look forward to carrying out more polls and listening to the debate they provoke.

Steve Iliffe is Professor of Primary Care for Older People at the Department of Primary Care and Population Health, University College London, a member of a locality commissioning board in north-west London, and Associate Director of the UK Dementias and Neurodegenerative Diseases Research Network (DeNDRoN), London, UK, email: s.iliffe@ucl.ac.uk

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Review

The 10 Best-Ever Anxiety Management Techniques Workbook

Margaret Wehrenberg

ISBN: 9780393707434

Margaret Wehrenberg developed this self-help workbook following the publication of The 10 Best-Ever Anxiety Management Techniques in 2008. She takes the ten techniques and aims to show readers how to put them into practice. She attempts to do this by including new worksheets, exercises and self-assessment tools. Also included is an audio CD, developed to be used alongside the workbook.

The workbook is divided into four parts. Part one, ‘Assess yourself’, systematically discusses the key features of anxiety disorders and common comorbid conditions. Part two, ‘Managing the anxious body’, describes diaphragmatic breathing, progressive muscle relaxation and the use of imagery for relaxation. Part three, ‘Managing the anxious mind’, helps the reader to identify catastrophic thinking and cognitive distortions. The author discusses several cognitive techniques including thought-stopping and thought replacement. Part four, ‘Managing anxious behaviour’, introduces the concept of desensitisation and recommends the use of hierarchies and gradual exposure.

The workbook can be used independently of the original book. Wehrenberg refers readers to her original text at several points in this book, but these references add little. Consequently, I would not recommend that owners of the workbook purchase the original text.

The selling points of the workbook include the self-assessment tools and checklists. Checklists are used throughout and readers are encouraged to tick off symptoms they have experienced. The workbook then gives an indication of when the reader might be suffering from a disorder according to the number of symptoms experienced. The author admits that these are not validated tests but they are presented in a way that encourages self-diagnosis. The majority of the checklists are composed of questions that one would take in a standard psychiatric history. A minority seem wholly inappropriate, a notable example being the suggestion that adolescents feeling overwhelmed by the choices of where to apply to college should seek attention-deficit disorder screening.

We must not lose sight of the fact that this is a self-help book for people with anxiety disorders. The workbook’s strength lies in describing behavioural techniques such as diaphragmatic breathing and progressive muscle relaxation. The accompanying CD helps readers practise these techniques – I challenge anyone to listen to this and not find themselves more relaxed. The workbook is a good introduction to cognitive techniques. Several different techniques are briefly discussed and it is left to the reader to identify and implement those that would be useful to them. However, I doubt that one would be able to usefully apply them without additional support.

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# Dementia commissioning - a missed opportunity

Sudip Sikdar

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