RQIA & RCPsych in NI
Part II and Part IV Psychiatrist Meeting

Working towards improvement

Friday 19 January 2018

RQIA & RCPsych in NI
Part II and Part IV Psychiatrist Meeting

Opening remarks

Ms Olive Macleod
Chief Executive, RQIA

RQIA & RCPsych in NI
Part II and Part IV Psychiatrist Meeting

Risk in modern practice

Dr Philip McGarry

Risk in Modern Psychiatry

Dr Philip McGarry FRCPsych
Consultant Psychiatrist

“IT’S ALL ABOUT RISK, RISK, RISK”

Louise
Nursing Student

"PREDICTION IS VERY DIFFICULT, ESPECIALLY ABOUT THE FUTURE"

Niels Bohr
Nobel Physicist

PREDICTION OF DANGEROUSNESS

967 patients released from US maximum security hospital in 1966. Only 3% were returned to maximum security by 1973.

Steadman, Cocozza 1994

TEXT

“THERE IS AN INCREASING CONCERN FOR DOING THE THING RIGHT, VERSUS DOING THE RIGHT THING”

Eileen Munro
Professor of Social Policy, LSE

WHO'S KILLING WHOM?

"SUICIDES OFTEN SPLIT OFF THEIR BODY AS A SEPARATE OBJECT, WITH THEIR ESSENTIAL SPIRIT LIVING ON".

Rob Hale FRCPsych
Psychoanalyst

Is suicide always preventable or is it part of the human condition?

- 7 suicides in Bible-Samson, Saul, Judas
- Graeco-Roman society – ‘noble death’
- Suicide bombing (Tamils and Islamists)
- Hunger strikes – Terence MacSwiney (1920)
- Sean McCaughey 1946
- IRA/INLA (1981)
- Guantanamo Bay

Many suicides are NOT mainly due to the effects of mental illness

Slobodan Praljak suicide 'could not have been prevented'

31 December 2017 Share

Slobodan Praljak drank a small vial of liquid after his prison sentence was upheld

The UN court in the Hague says it could not have prevented a war criminal from taking poison and killing himself

Top Stories

Extra £44m for Calais border security
The UK government money will be spent on fencing, CCTV and infrared detection technology.
37 minutes ago

Emily Maitlis fears stalker won't stop
1 hour ago

Travel disruption as high winds hit UK
1 hour ago

Features

Why I took my wife's last name

‘A Government that wants to take away its citizens’ rights will first try to frighten them and then get them to agree to hand them over'

Paddy Ashdown
Former Lib Dem Leader

MI5

UK facing most severe terror threat ever, warns MI5 chief

Head of intelligence service says more attacks are inevitable as Britain sees 'dramatic upshift' in Islamist terrorism

Vikram Dodd *Police and crime correspondent*

Tue 17 Oct 2017 19.11 BST

Britain is facing its most severe ever terrorist threat and fresh attacks in the country are inevitable, according to the head of Britain's normally secretive domestic intelligence service in a rare public speech.

Andrew Parker, the director general of MI5, said the UK had seen "a dramatic upshift in the threat" from Islamist terrorism this year, reflecting attacks that

most popular


Donald Trump faces backlash as he reveals 'Fake News Awards' winners


UK gales fell trees, disrupt travel and close schools


Man convicted of theft in 1976 cleared after Googling his

Margaret Thatcher: Seconds from death at the hands of an IRA bomber
It was probably the most chilling political sound bite of its era.


Pa
1364931
PA

Risk Prediction

The public embrace readily the counter factual

In reality, human behaviour is unpredictable due to low base rates of suicide and homicide. Individual prediction of violence in the mentally ill is not possible.

Complexity science notes ‘unrealistic faith in plans', where claims of predictability are ‘hostage to fortune’

In a German study (Zukaschek 2014, BJ Psych) of suicides on railways by psychiatric in-patients, the most salient risk factor (a 20 times increase) was a change of therapist in the previous week.

“Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm, to determine who should and should not be offered treatment or who should be discharged”.

NICE, Self-Harm; Longer Term Management (CG 133) 2011

TEXT

CR 150: Risk to Others (2008)

- **Government and media pressures; culture of blame and risk**
- **Accurate prediction for individual patients ‘never possible’**
- **Routine risk assessment instruments of limited value and should be phased out.**
- **Risk assessment and management a core function of all clinicians and must be core training competency.**
- **Care planning should involve patients and families.**

VIEWS OF PSYCHIATRISTS (CR158)

"Separate Risk assessment tools can be dangerous"

"Practice becoming increasingly defensive"

"vast amounts of paperwork, which reduces time spent with patients"

"tick box mentality; instead staff need to have time to carry out a proper assessment"

TEXT

CR 158 Self-harm, Suicide and Risk 2010

Locally developed risk assessment tools should be abandoned

People attending hospital after self harm should receive a biopsychosocial assessment by a clinician with adequate skill and expertise

Psychiatrists assessing people who have self harmed should undertake a comprehensive psychiatric history and mental state examination, together with an assessment of risk; thus risk and needs assessment should be more closely tethered

CR 158 (2)

Regular Reflective Practice can be of real benefit to staff

Commissioners should ensure evidence based psychological therapies are available for those who need them

Research needs to be funded into relevant therapies and models of care, including those who repeatedly self-harm

Mental health professionals should collaborate with the voluntary sector and explore partnership working

Risk and Clinical Practice

- **Detentions rose in England by 50% between 2005 and 2015.**
- **Paradoxically, ASWs and GPs seem increasingly likely to detain people without any evidence of mental illness (on the basis of risk), but not detain patients with self evident severe mental illness**
- **This is in the context of a chronic lack of acute beds**

Risk and Clinical Practice

‘There is a grave danger that the natural instinct of the majority of psychiatrists to move away from a paternalistic and risk - averse model of care is being compromised by paying too much heed to the often confused and fear-based concerns of policy makers and the media, who want us to ‘move into the community’ while simultaneously guaranteeing that ‘adverse outcomes will not occur’

McGarry P, O’Hare A, McNally C

B J Psych Bulletin 2011

Risk and Clinical Practice

Community Treatment Orders …. no evidence of effectiveness and dramatically more patients on them than anticipated (Octet, 2013)

Calling in the police ….
(a) viewing pornography
(b) Adult safeguarding
(c) people who are drunk

Shall we ‘shop’ women who have taken Mifepristone?

TEXT

“Risk assessment tools don’t improve the assessment, they may make it worse“

"..... pressure to use them comes from non-clinicians .... defensiveness is part, but also a genuine misunderstanding of what risk assessment can achieve ... it adds little to good clinical assessment but could falsely suggest some people are low risk"

Professor Louis Appleby
1st December 2015

Pokorny's complaint that the overwhelming number of false positives renders suicide risk assessment unfeasible is just as valid in 2016 as it was in 1983.
We recommend abandoning attempts to design interventions based on risk stratification and instead aim to provide an adequate standard of care to all of our patients.

Nielssen, Wallace, Large
B.J. Psych Bulletin 2017

POKORNY'S COMPLAINT

In 1983 Pokorny found 96.3% of high risk suicide predictions (in US veterans) were false positives, and over 50% false negatives. ALL subsequent studies reported similar results including STARR (2015), with 98.7% false positives

TEXT

Risk and Clinicians

Professor Sir Robin Murray and Professor Tim Kendall have both spoken in Belfast about the 'risk industry' and the 'risk culture'.

Clinicians are increasingly feeling bullied and frightened about professional consequences of adverse outcomes. This results in less time to listen to, talk with and actually care for the patients.

TEXT

CR 201: RETHINKING RISK TO OTHERS (2016)

- Risk management is core role of psychiatrists, but is also a multidisciplinary and political matter.
- There is tension between psychiatrists' primary duty to treat patients, while protecting the public.
- A Good Practice Guide as an aide memoire to the assessment and management of risk is provided as an appendix

TEXT

CR 201 (2)

- Risk Management is core function of all doctors
- Adverse outcomes cannot be eliminated, but some can be avoided or reduced in frequency
- Risk assessment is integral to and not separate from the wider clinical assessment.
- Patients should be actively involved in risk management.
- Unvalidated risk assessment tools can skew good clinical practice.

TEXT

CR 201 (3)

- There is an annual average of 75 homicides in UK committed by the mentally ill . Most have alcohol and/or drug dependence/misuse, and many have personality disorder.
- 12% have a diagnosis of Schizophrenia.
- Substance misuse significantly increases the risk of violence in the mentally ill.

TEXT

CR 201 (4)

While improved risk assessment has a real but limited part to play, some (Munn and Rungay, Petch; Taylor & Bunn) argue that more deaths could be prevented by improved mental healthcare, irrespective of the risk of violence.

Instruments such as the HCR 20 can have value in the range of settings in which they have been validated.

TEXT

Redraft of CR 158 (Risk to Self)

Patient Safety Committee still working on it

Section on the internet/social media and stigma

Briefer and more clinically based than CR158

Section on effects of suicide on families and on staff

Section on ‘Zero Suicide’ (!)

WHAT TO DO

Comprehensive, good quality care for all patients

Good history, examination, biopsychosocial formulation and treatment plan; easily accessible.

Risk in Modern Psychiatry

Dr Philip McGarry FRCPsych

Consultant Psychiatrist

RQIA & RCPsych in NI
Part II and Part IV Psychiatrist Meeting

Overview of RAID

Dr Uzma Huda, Divisional Medical Director, NHSCT

Northern Health and Social Care Trust

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REFORM AND MODERNISATION PROGRAMME

Northern Trust RAID

Integrated Mental Health Liaison Service

Dr Uzma Huda, Consultant Psychiatrist

To deliver excellent integrated services in partnership with our community

Rapid **A**ssessment **I**nterface **D**ischarge

RAID is a :

- A specialist multidisciplinary mental health team.
- It is based and assimilated into Acute General hospital setting
- It provides rapid , timely high quality mental health interventions to those who present or admitted to General Hospitals.
- It supports recovery, promotes the well-being of patients through screening and health promotion activities.

Origins of RAID concept

- Model developed in Birmingham; evaluation published by Dr G Tadros(Tadros et al; Psy Bulletin (2013) 37:4-10)
- Draws on work of Dr P Aitken (Developing models of liaison psychiatry services- guidance for commissioning support: NHS England, Strategic clinical networks Sept 2013)
- Economic evaluation published (Parsonage & Fossey, (2011) *Economic evaluation of a liaison psychiatry service*. London: Centre for Mental Health.

The need for Mental Health services in Acute Hospitals

- the prevalence of co-morbid mental health problems among patients in general and acute hospitals is extremely high;
- many of these problems typically go undiagnosed and untreated;
- in the absence of effective intervention, mental health co-morbidities lead to poorer health outcomes and significantly increased costs of care
- improvements in the identification, management and treatment of mental health conditions in hospital can significantly reduce the scale and cost of these problems.

ref: Liaison Psychiatry in the modern NHS; Parsonage, Fossey & Tutty, Centre for Mental Health (2011)

Liaison services pre- RAID

- Mental health liaison provided by consultant psychotherapist AAH and sector psychiatrist Causeway (working hours only)
- Psychiatry of old age liaison since 2012 – 1 consultant & 2 band 7 practitioners (working hours only)
- DSH service – provided by CRHTT (24/7)
- Alcohol liaison service – 1 WTE band 7 (AAH working hours only)

Different pathways into each service

NHSCT RAID

- The Northern Trust RAID service is based on the Birmingham Model but with adjustments to meet local needs.
- It is created by reengineering existing services with additional resources to provide the additional functions of the service.
- Based in the acute hospitals
- Age inclusive with appropriate pathways for 16-18 and LD referrals

RAID Team

- 7 band 7 practitioners
- 7 band 6 practitioners
- 2 wte Consultant Psychiatrists
- 2 Speciality Doctors
- 1 Consultant Clinical Psychologist- 8C grade
- Administration support
- Project Manager/Service Manager

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Rapid Assessment Interface Discharge

- Integrated model of liaison psychiatry
- Age- inclusive- any patient over age 16
- Comprehensive- all specialisms
- Rapid response – 24/7
- Multi-professional team
- Clinical involvement alongside training and supervision for gen hospital staff

To deliver excellent integrated services in partnership with our community

Development of the service

Single point of entry for all mental health assessments at the Mental Health Hub

Processes established to support referral and evaluation of the service.

Recruitment of staff, training and induction

Respond to Emergency Department within 2hours/ Wards within 24hours

Establish Night duty.

Service incrementally introduced but fully functional on 01/09/15

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5 Domains of RAID

- Frail elderly - (delirium, dementia and depression)
- Deliberate self harm
- Medical liaison
- Psychological interventions
- Substance Misuse Liaison

Evidence - Tadros et al; Psy Bulletin (2013) 37:4-10

- Increase in detection and diagnosis of mental illness
- Reduced LoS compared to pre- RAID: estimated savings over 12 months13,935 bed days – equating to 38 beds per day
- Reduction in readmissions- equates to 1800 saved admissions over 12 months
- ED referrals- 91% seen within 1 hour
- Bed days savings seen in the elderly population

How does RAID makes its efficiencies

- Early detection and treatment of dementia, depression and delirium.
- Increased efficiency in ED by 2 hour response time
- Introduction of screening for the frail elderly and substance misuse liaison both in ED and wards.
- Support to wards in the psychological management of patients in the ward.
- Assist in discharge planning.
- Support to ICB

Expected outcomes-performance measurements

- 90% of patients in ED referred for MH assessment will have that assessment begun within 2 hours
- 5% month on month decrease of patients leaving ED without a specialist MH assessment
- 10% reduction in percentage of patients with DSH who re-present within 30 days of assessment
- Admission avoidance- (reduced LoS, reduced number of admissions/readmissions)

Outcomes data

Number of Referrals to RAID Service by Age and Gender							
	Age Band	Jul-17		Aug-17		Sep-17	
		M	F	M	F	M	F
	<18	9	13	6	12	4	12
	18 - 65	185	137	179	151	162	130
	>65	59	71	90	64	76	101
Total		253	221	275	227	242	243
		474		502		485	

Outcomes data

4.2 Source of Referral	(Data Source: Epex)					
Source of Referral Groups	Jul-17		Aug-17		Sep-17	
Antrim ED	139		166		177	
Antrim-Obs Ward	21		21		15	
Antrim Wards	184		191		179	
Causeway ED	60		61		38	
Causeway Wards	64		57		66	
Other Sources	6		6		9	
Totals	474		502		484	

Outcomes data

% of patients who received a mental health assessment in the Emergency Department within 2 hours of being referred				
.4 to the RAID service - (Target 90%)				
Hospital	Baseline (Mar 15)	Jul-17	Aug-17	Sep-17
Antrim ED	N/A	87%	88%	89%
Causeway ED	N/A	98%	98%	100%

Outcomes data

Number of Patients Discharged from ED with a Diagnosis of Mental Health without a referral to RAID				
(Target – show a % decrease month on month)				
Hospital	Age Band	Jul-17	Aug-17	Sep-17
Antrim ED	<18	13	7	7
	18 - 65	57	45	44
	>65	5	11	6
Causeway ED	<18	4	7	1
	18 - 65	54	35	35
	>65	2	3	5
Total		135	108	98

Activity data

Admissions to medical and surgical wards with Primary or Secondary Diagnosis of Mental Health -						
(Target – show a reduction month on month)						
Hospital on Admission	Ave Mthly Adms - 14/15	Diagnosis	Jul-17	Aug-17	Sept - 17	Ave Mthly Adms (Tax Year)- 16/17
Antrim Wards	43	Primary	60	63	62	48
	488	Secondary	538	560	482	499
Causeway Wards	10	Primary	19	7	14	10
	193	Secondary	211	174	160	188
Total	734		828	804	**718**	**744**

Activity data

Length of stay / bed days in medical hospital beds - (Target – show a reduction month on month)					
Hospital on Admission	Average Monthly Bed days- 14/15 **(Tax Year)**	Average Monthly Bed days- 16/17 **(Tax year)**	Jul-17 (Total Monthly)	Aug-17 (Total Monthly)	Sept 17 (Total Monthly)
Antrim Wards	3102	3286	3438	3561	2961
Causeway Wards	1032	1245	1104	1098	1142
Total	4134	**4531**	**4542**	**4659**	**4103**

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Re-attender project

Measure		Benchmark - position at April 2017	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
	Reduce the numbers of people with a MH diagnosis representing within 30 days to ED.	38 Individuals	38	29	24	22	30	24
		52 Total Reattendances	52	40	28	32	40	33

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Delirium Project

Measure	Benchmark - position at March 2016	Apr-17	May-17	Jun-17	Jul-17	Aug-17
An increase in the ns of people screened for delirium in the Direct Assessment Unit.	Baseline to be established.	188	150	149	113	190
Reduce the number of people admitted to hospital with a delirium from the Direct Assessment Unit (DAU).	2	1	0	4	1	5
Reduced length of stay for people with a diagnosis of delirium who have been admitted to a ward via the Direct Assessment Unit (Total for All Clients)	37	16	0	40	10	37
Increase the number of staff who have attended Delirium Mgt Training (Cummulative Total number of People Trained to Date)	0	20			40	80

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Medically Unexplained Symptoms

- Exploring ways to ensure detection of people who re-present to ED with medically unexplained systems.
- Development of stepped intervention pathways and outward referral pathways.
- In progress.

Alcohol Screening and Intervention

- Model established to screen for hazardous drinking for all ED presenters
- Referral pathway based on screening outcomes for brief advice and in more significant cases, brief intervention – provided by RAID as follow up.

RAID Embedding through Training

- Development of a mental health training team – collaboration between RAID and Acute
- Development of a modular training system covering core domains addressing needs of ‘Treat as One’-NICEPOD
- In progress

The way forward - developments

- Delirium care pathway in Direct Assessment Unit
- Initiative to reduce re-attendances to the ED
- Detection and intervention pathways for medically unexplained systems.
- Embedding of alcohol screening in the acute environment and establishment of brief intervention pathway

Longer term

- Impact of improved detection on mental health services
- Further development of MH liaison e.g.primary care
- Better services for ARBI
- Embedding of Alcohol Disorder Care Pathway

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Thank You

- Questions?

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Part II and Part IV Psychiatrist Meeting

Findings from survey on Part II Training & Regulation

Dr Gerry Lynch & Dr Niall Corrigan

Overview

- **Background**
- **Rationale for respective surveys**
- **Results of survey:**
  1. **Trainees' response to use of MHO and possible Part II status**
  2. **Consultants' views on RMO induction, training and their use of MHO**
- **Issues arising and panel discussion and next steps**

Current Situation

- **RQIA has power to appoint Part II medical practitioners - article 25 of the Health and Social care reform act 2009)**

- **Medical practitioners at consultant psychiatrist level who have specialist experience in the diagnosis or treatment of mental disorder and who meet criteria set out by RQIA are eligible to apply**

- **Approval is not automatic**

RQIA Criteria

- **Award of CCT**
- **Appointment to post of Consultant Psychiatrist**
- **Full Registration with GMC**
- **Current CPD Certificate**
- **Signed Reference**
- **Have completed GAIN modules**

Background

NI Psychiatric Training Committee concerns about Training in Psycho-legal issues during Specialty Training

1. Experience in utilising NI MHO
2. Tribunal experience
3. Capacity assessments
4. Fitness to be interviewed assessments
5. Court Experience

Was there a discrepancy in NI Trainees' ability to meet Psycho-legal competencies compared to rest of UK?

Background

- **<u>April 2016</u>: Survey commissioned via NIMDTA and RCPsych aiming to gauge Specialty Trainees view on Psycho-legal Training and extension of Part Two Status**
- **<u>Autumn 2016/17</u>: Survey results presented to NI PTC, NIMDTA and RCPsych Executive**
- **Trainee Survey raised broader questions about RMO training and renewal of competencies for Part II Status**
- **<u>Oct 2017:</u> subsequent Consultant survey on MHO use and regulation of Part Two Status**

Trainees' Survey on Psycho-legal Competencies and Part II Status

Part Two Approval

- **RQIA's requirement for a psychiatrist to be in receipt of CCT for appointment to the Part II Register**
- ***'A specialist in the diagnosis and treatment of mental disorder'***
- This definition for Part II approval is the same as that for **Section 12 Approval** [England and Wales] and **Section 22 Approval** [Scotland]

Roles and Responsibilities of Part II Doctors

1. Detention for assessment for greater than 48 hours – **Form 8 and 9**
2. Primary assessor in prison to hospital transfer – **Transfer Direction Order**
3. Criminal court requires verbal evidence from one Part 2 Approved doctor in the following situations– **fitness to be tried and an insanity plea**

- In addition, Northern Irish Trainees ***cannot act up*** in their last 6 months of training in the **full capacity** of being a consultant, as a Registered Medical Officer [RMO].
- An RMO's additional roles and responsibilities are:
- Detention for treatment - **Form 10, 11 and 12** and Independent **MHRT** report writing and live testimony

RCPsych Curricula

General Adult Psychiatry Curriculum 2016

Forensic Psychiatry Curriculum 2016

4c Mental health legislation
Knowledge
Demonstrate practical knowledge of the relevant mental health legislation. Including the use of emergency powers and compulsory treatment aspects.
Skills
Demonstrate the competent assessment of a patient using relevant mental health legislation both in emergency and routine practice
Be able to give testimony at an appropriately convened tribunal to review the detention of a compulsory patient
Be able to manage a detained patient within the relevant mental health legislation
Attitudes demonstrated through behaviours
Always work within appropriate practice guidelines for the use of mental health legislation
Be prepared to give advice to others on the use of mental health and allied legislation

emonstrate skills in riting formal reports ddressing simple edico-legal issues cluding medical sposal at court, dvice on Restriction rders. (CBD, upervisor's reports)	demonstrate the ability to write formal reports to 3rd parties including to courts legal representatives, judicial bodies covering complex issues especially fitness to plead, mental condition defenses, dangerousness and sentencing. (CBD, supervisor's reports)
ive evidence to courts n simple medico legal sues e.g. restriction rder disposal (mini CE, ACE, CBD, upervisors report)	Give evidence to courts on more complex medico legal issues e.g. fitness to plead, defences, dangerousness (mini ACE, ACE, CBD, supervisors report)

NI Training Pathway

Specialist: 'Part 2 Approved'

Northern Ireland

- **3%**

CT1-3	ST4-8	CONS
36 Months Competent Training MRCPSYCH		CCT GAIN Modules

Rest of UK Training Pathway

Specialist:
'Section 12/22 Approved'

England
Scotland
Wales

CT1-3 → **ST4-8** → **CONS**

CCT

•97%

36 Months Competent Training MRCPSYCH Section 12/22 Course

Case for creating a Part II Light Status

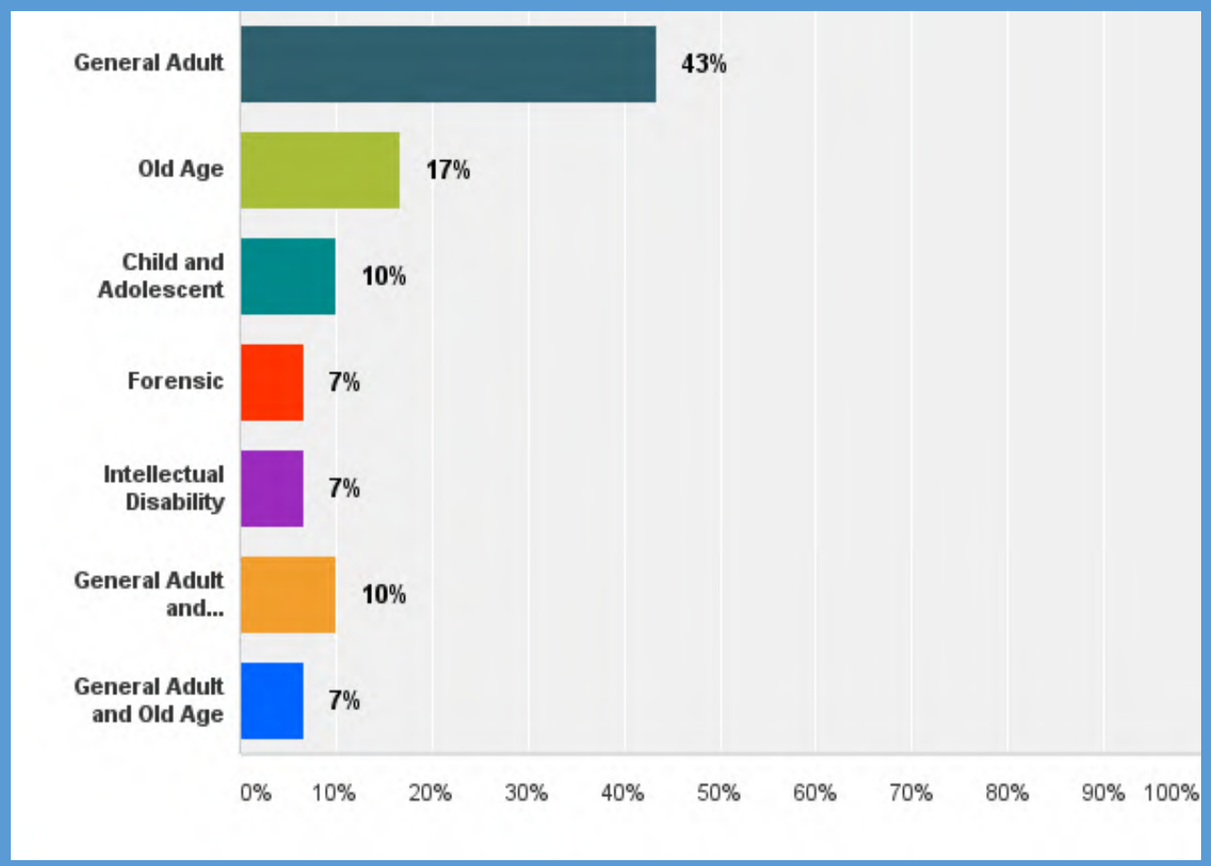
1. **Disparity in training with rest of UK**
2. **Model of Medical Training – decreasing level of supervision until competent**
3. **Serious responsibility to detain – up to 48hrs**
4. **Not Proportionate under MHO that ST4-ST8 = FY2**
5. **Barrier for Trainees to carry out capacity legislation**
6. **Trainee could be Section 12 approved in England and move to NI then not Part II approved**

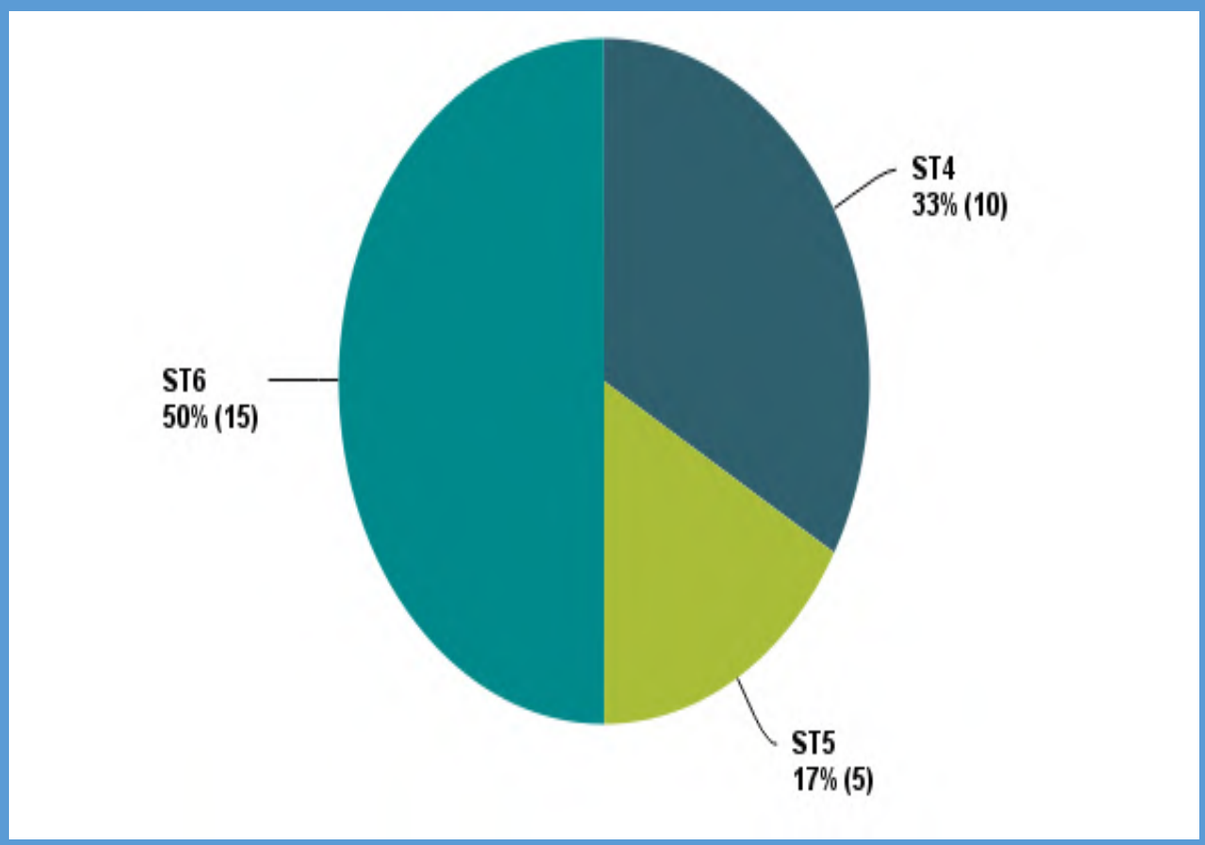
Case against any change in Part II Status

1. The requirement for CCT Approval has been in place for 30 years and this has not been reported to be an issue so far
2. Serious Responsibility to detain beyond 48 hrs.
3. RQIA is the legal agency to decide who is appointed to the Part 2 Register and they have previously not found there to be need to change the current requirements.
4. Stakeholders including constituent Trusts may be unhappy over potential exposure if Trainees are to undertake Form 8/9.
5. Potential for Tribunal to be sought in the assessment period

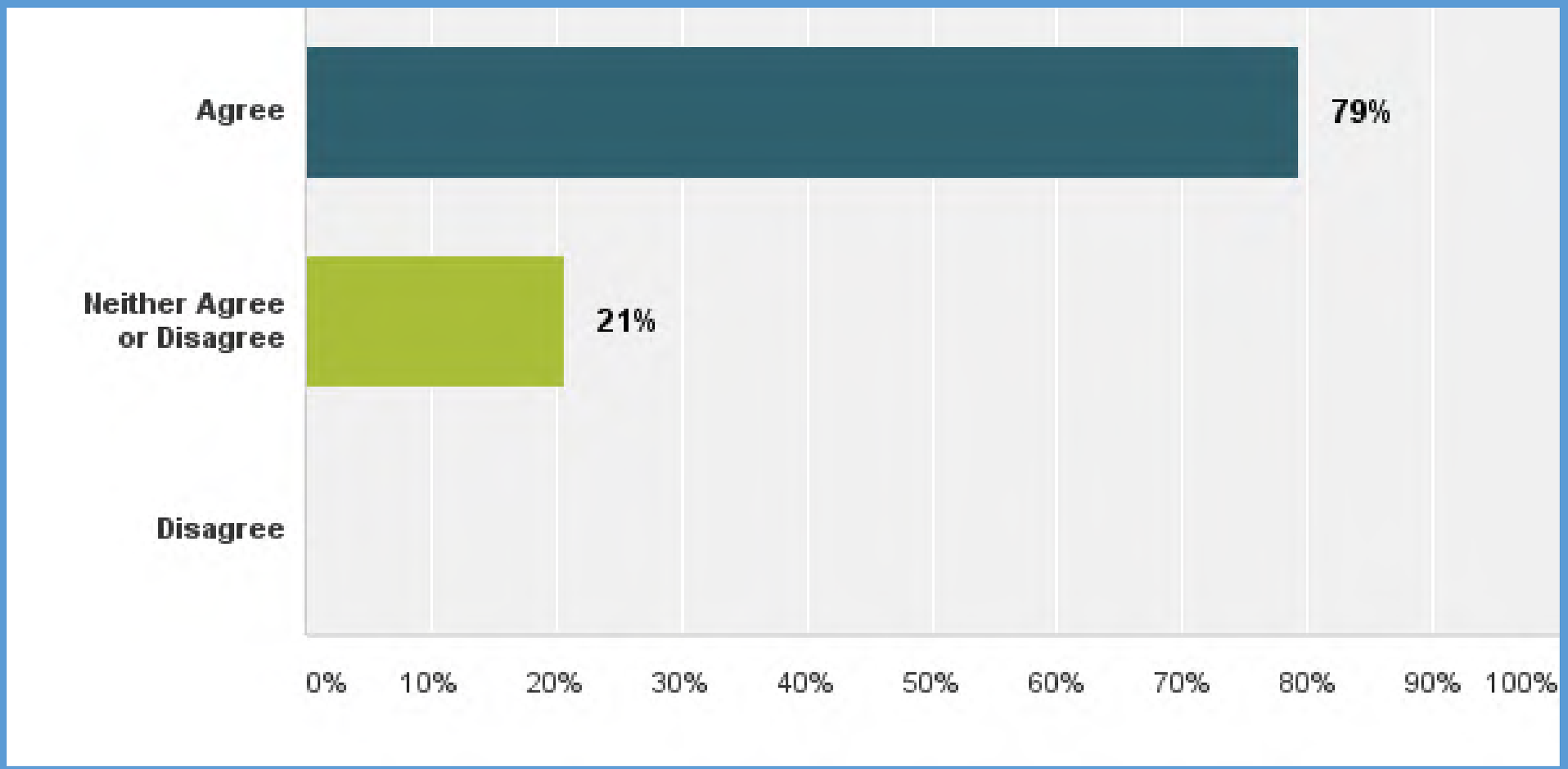
Trainees' Psycho-legal Questionnaire

- **>80% (29/35)Higher Specialty Trainees surveyed**
- **Electronic Survey undertaken in 2016**





Q: The requirements for Part 2 Approval [NI], Section 12 Approval [England and Wales] and Section 22 Approval [Scotland] should be broadly equivalent?



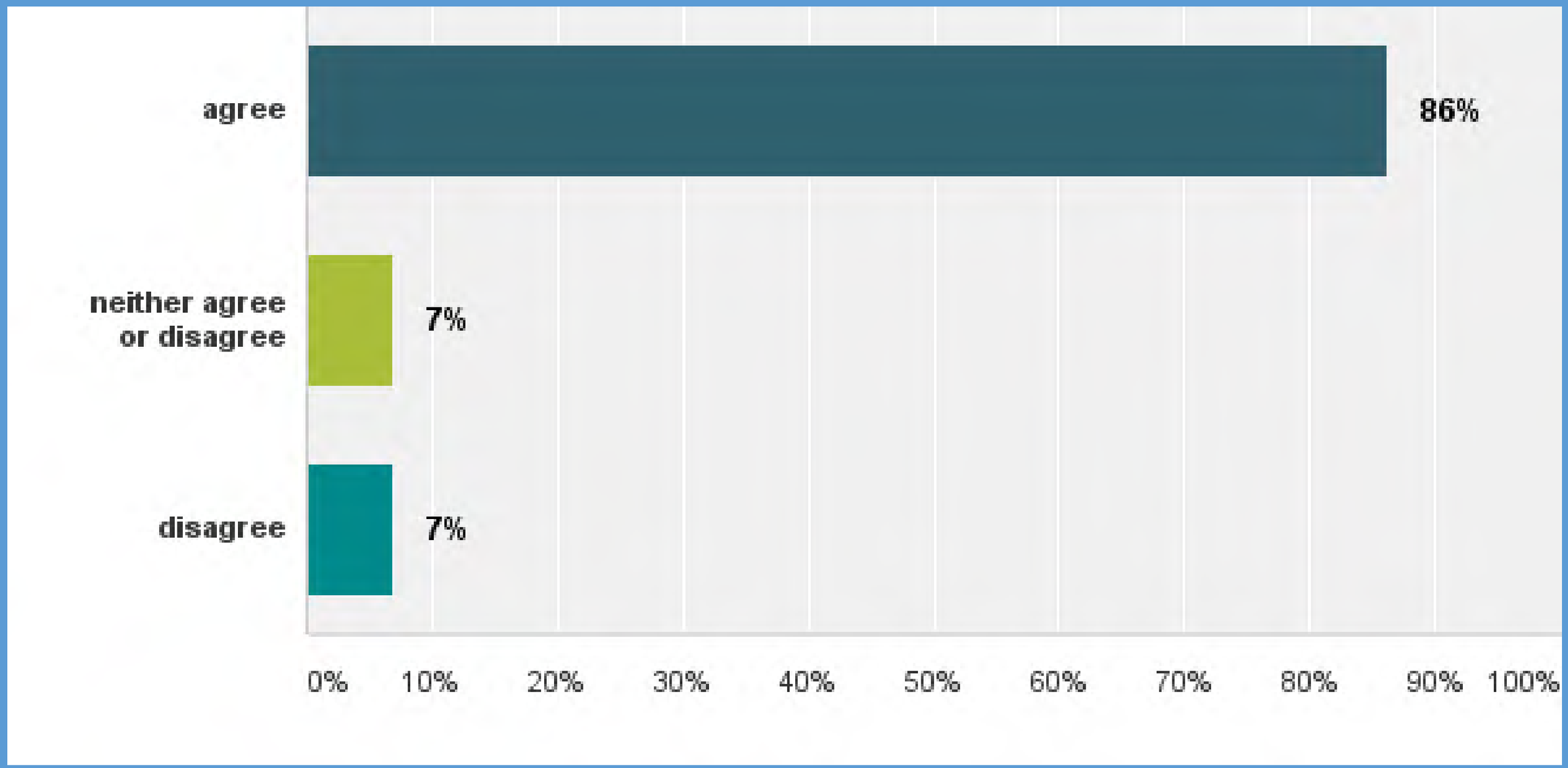
Q: The roles and responsibilities of Part 2 Approval are well understood by NI ST4-8 psychiatry trainees?

21%
Agreed

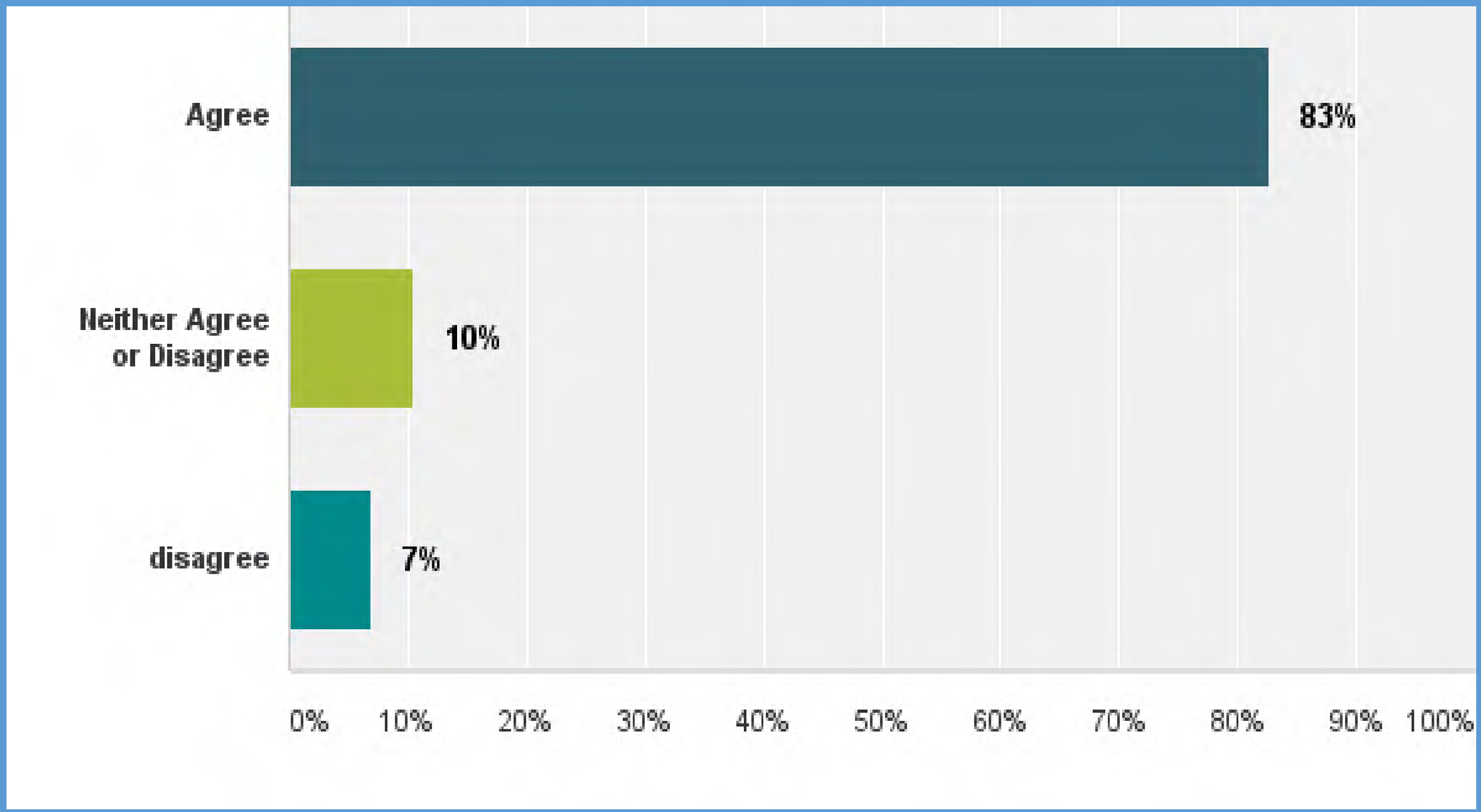
14%
Unsure

66%
Disagreed

Q: NI ST4-8 psychiatry trainees are clinically capable of assessing patients for detention under a Form 8?



Q: NI ST4-8 psychiatry trainees are clinically capable of assessing patients for detention under a Form 9?



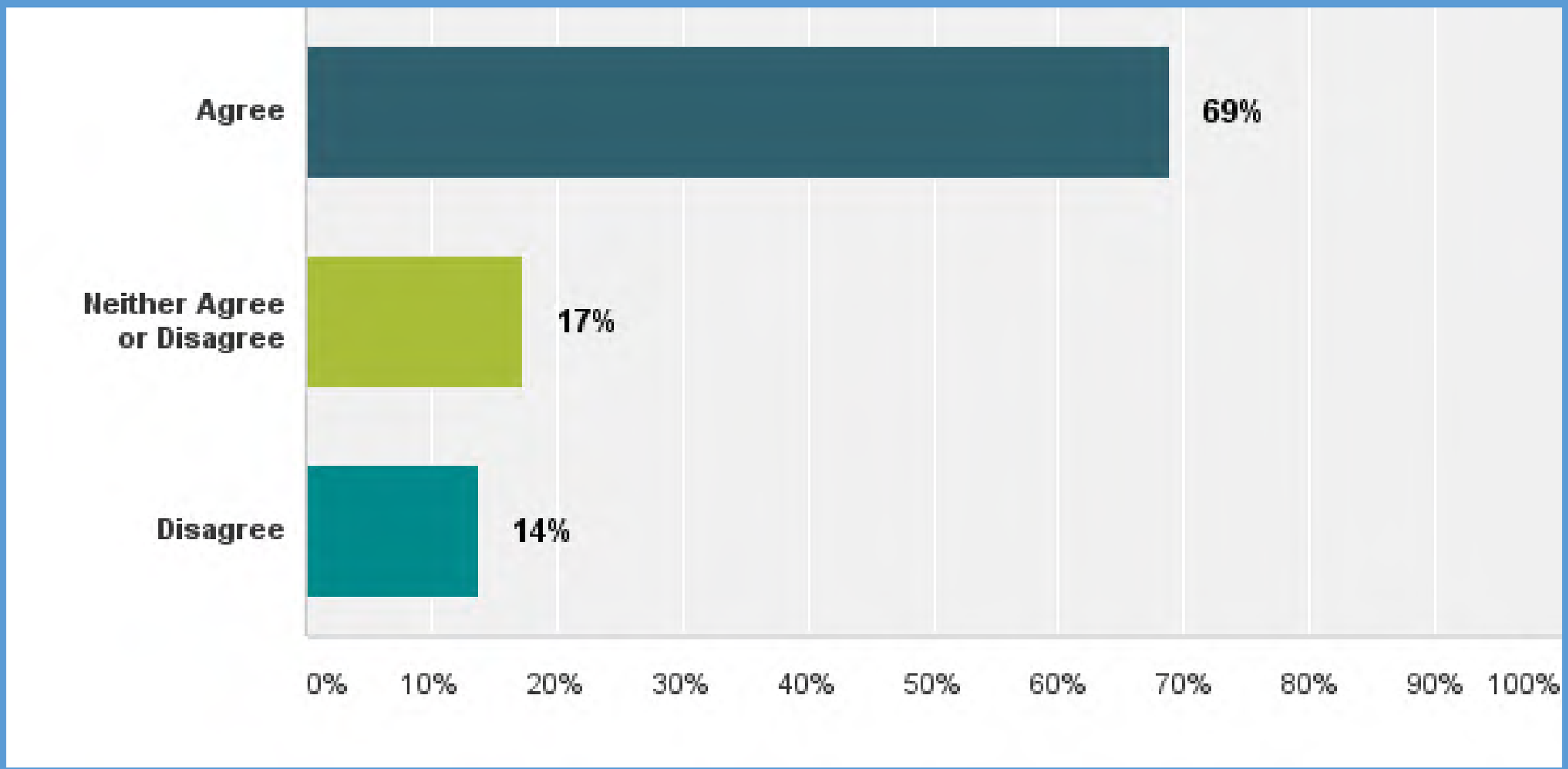
Q: NI ST4-8 psychiatry trainees are clinically capable of acting up in the full capacity of consultant work, as a Registered Medical Officer [RMO], in the last 6/12 of training?

79% Agreed

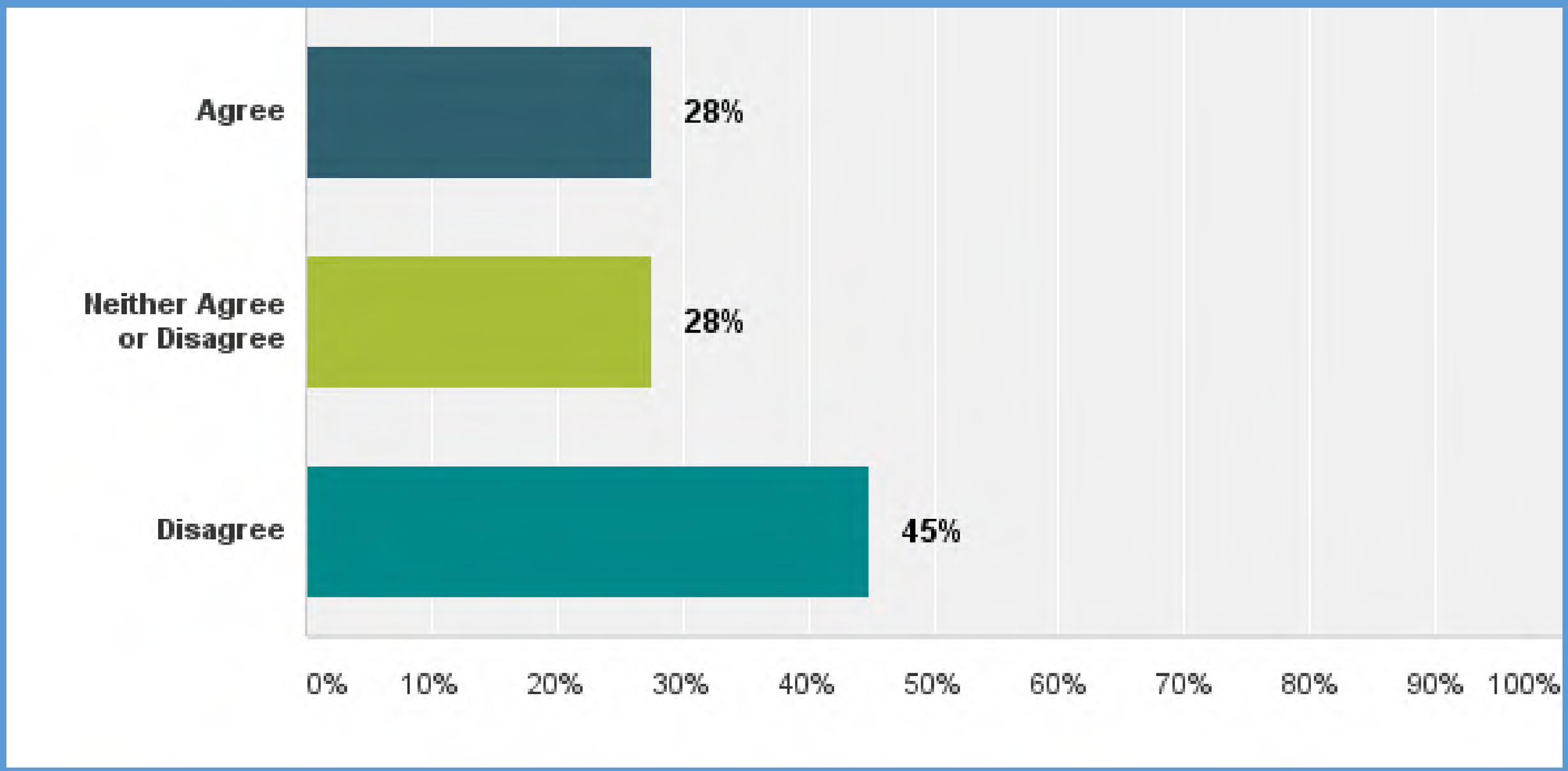
14% Unsure

7% Disagreed

Q: The RQIA requirement of CCT for Part II Approval is a barrier to higher psychiatry training?



Q12: NI ST4-8 psychiatry trainees have adequate training towards becoming a Part II approved doctor?



Q: NI ST4-8 psychiatry trainees should be Part 2 approved?

69% Agreed

24% Unsure

7% Disagreed

Q: I am on course to achieve the psycho-legal competencies as detailed in my RCPSYCH subspeciality higher curriculum by the end of training?

10% Agreed

41% Unsure

48% Disagreed

Trainees' Comments

"I feel that there is a need for a more structured teaching programme as part of higher specialist training with involvement of RQIA; so that these processes can be experienced and understood while under the supervision of an RMO rather than as a new consultant."

"The degree to which a trainee is exposed to Part 2 MHO work depends very much on the mix of training posts they have in higher training- with no standardization of MHO training….If there were a requirement for all trainees to have carried out an assessment for Form 8, 9 or 10 under supervision then this would work towards improved opportunities for all trainees in this area."

"There are several significant deficits in medico-legal training highlighted in this survey. It is in the interests of patients and trainees for this to be addressed."

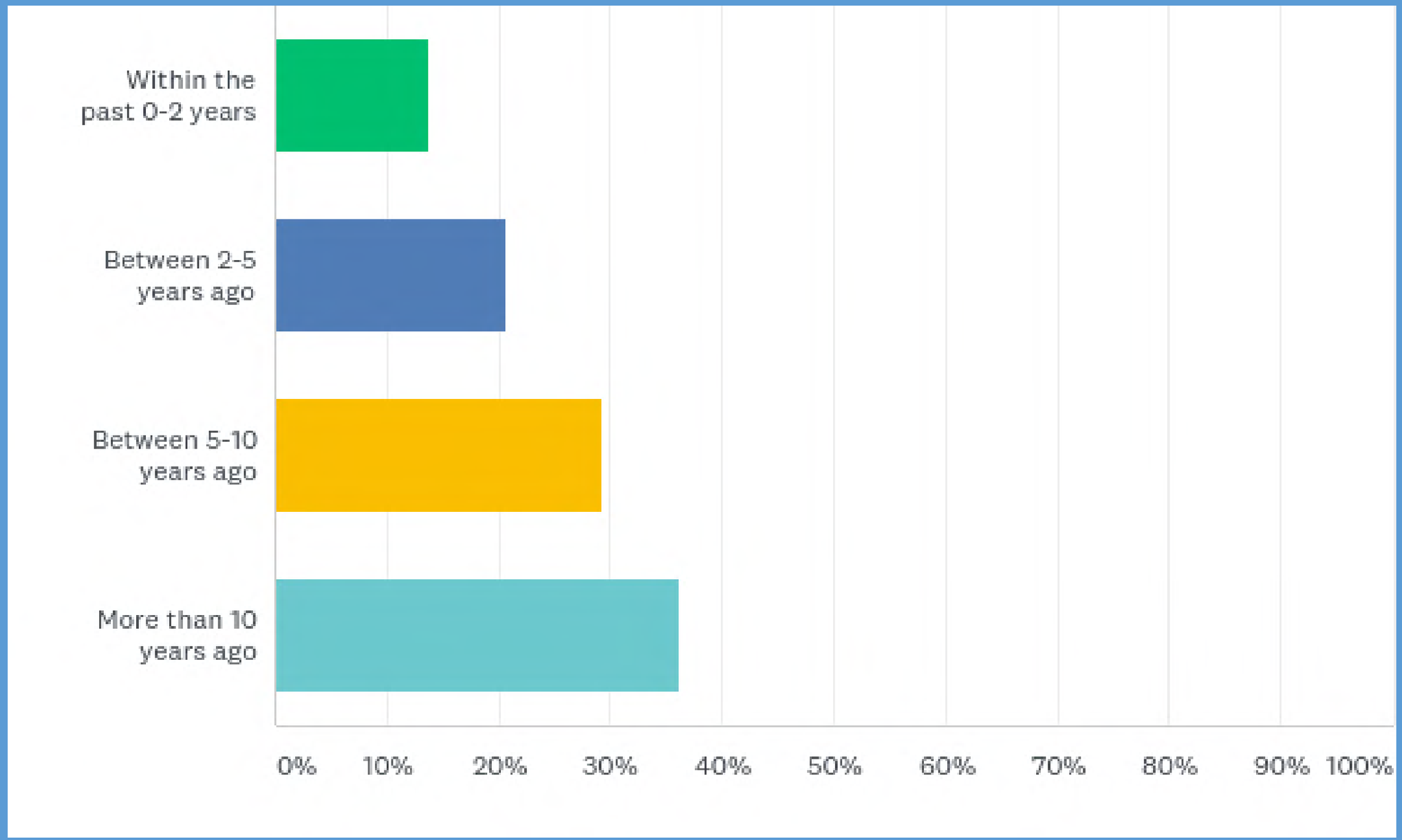
Consultants' Survey

- **October to November 2017**
- **198 Questionnaires Sent – 58 Replies (30% response)**

Views sought on:

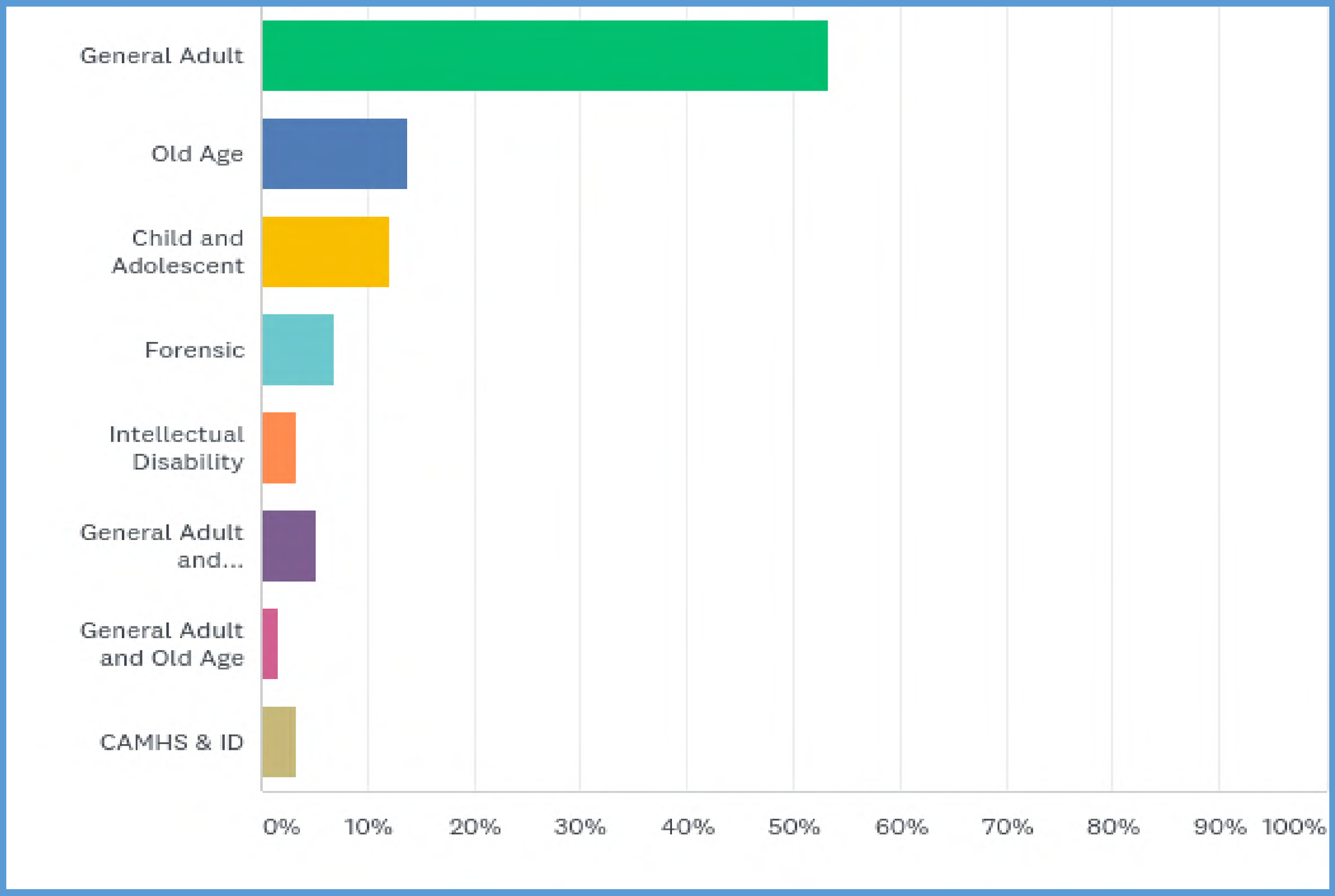
1. **Acceptability of application process and criteria**
2. **Their own competencies and training**
3. **Needs of doctors in training**

Q1: When did you receive Part II Approval?



8	
12	
17	
21	

Q2: In which specialty do you mainly practice?



31

8

7

4

2

3

1

2

Acceptability of the Application Process

48 comments received

19 - straightforward with no issues

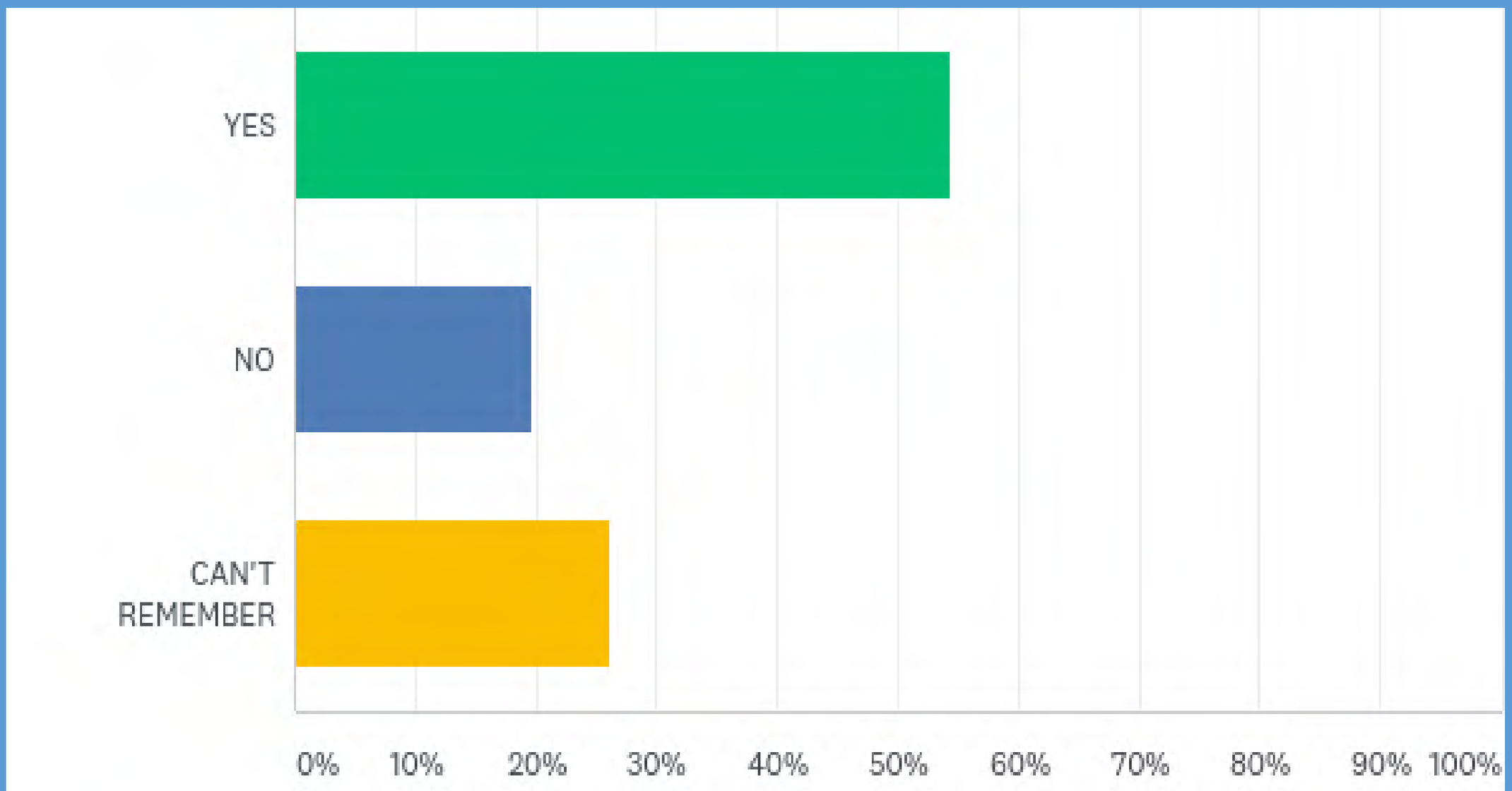
15 - cumbersome/complex/time consuming

Particular issues:

- ❑ **confusion over documentation required (Access NI)**
- ❑ **Meeting deadlines for panels**
- ❑ **More streamlined than on previous occasions**

Q4: Was the application form user friendly? (Part II Application Form)

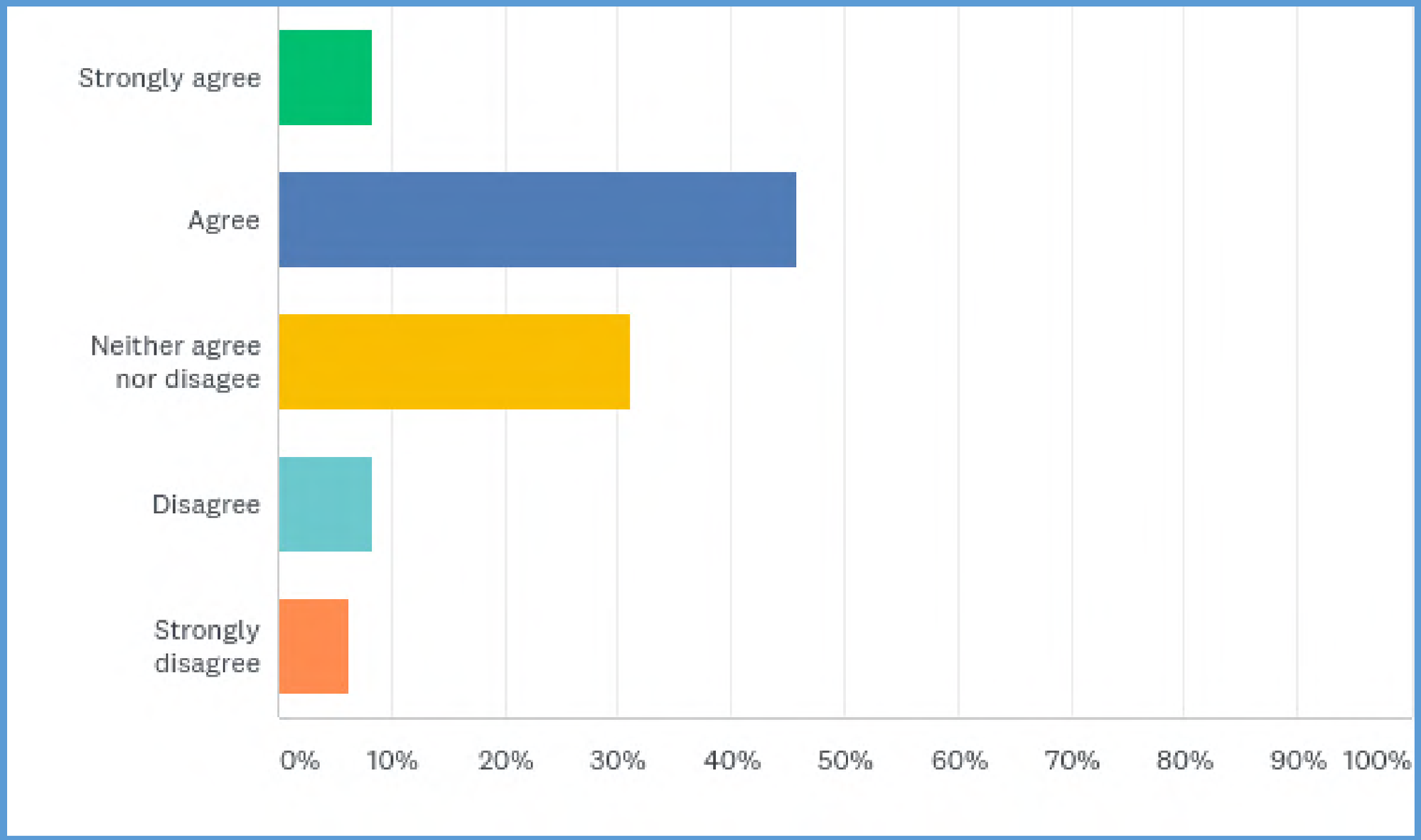
- Answered: 46 Skipped: 12



25	
9	
12	

Q5: The criteria set by RQIA for Part II Status are fair?

- Answered: 48 Skipped: 10



4

22

15

4

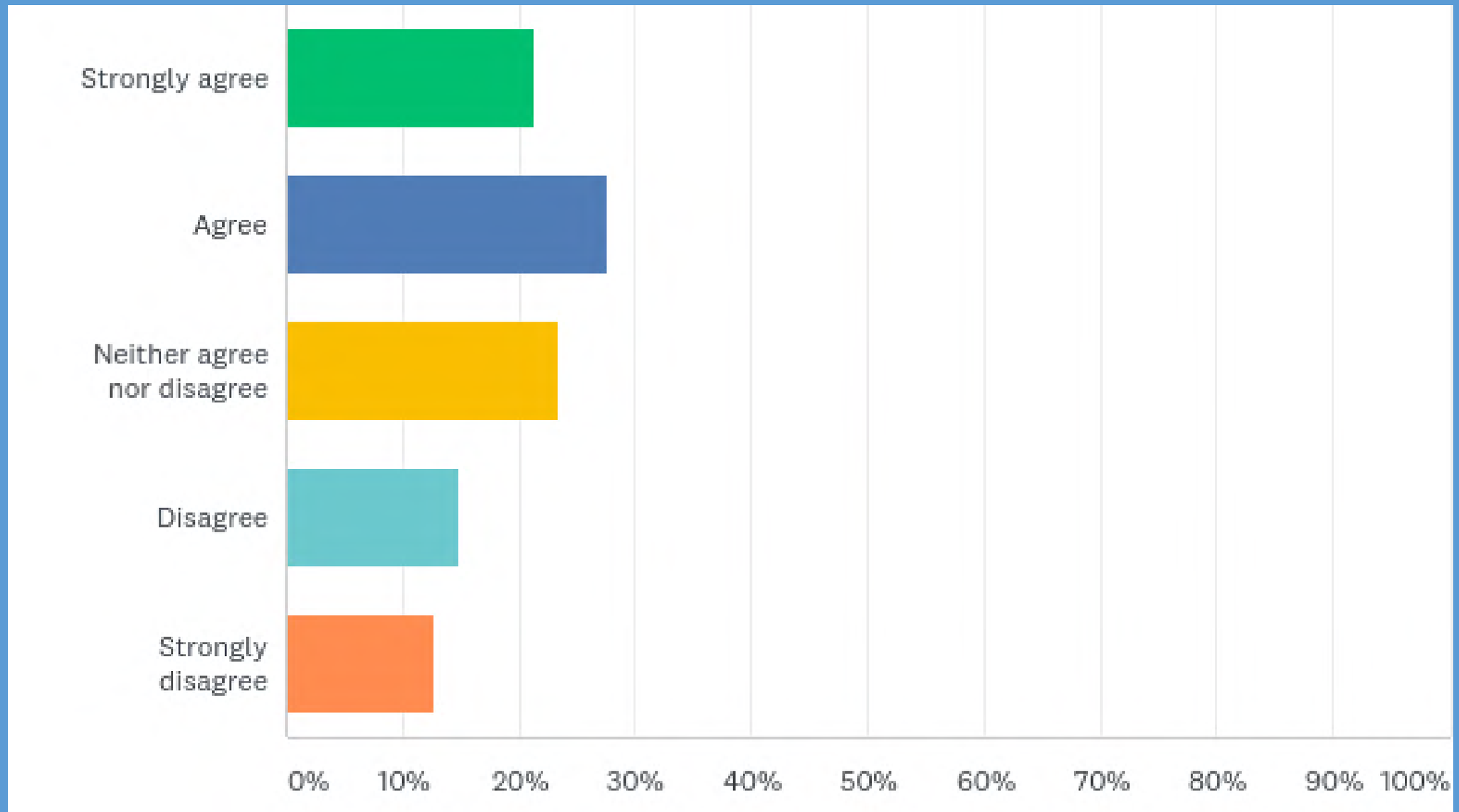
3

Are the criteria fair?

- **Overly-restrictive**
- **Unfair to trainees**
- **Assumption that CCT holders are competent**
- **Should dovetail with other processes**

Q9: One criterion set by RQIA is that Part II Status is only awarded to those who have obtained a CCT. This is in contrast to other UK jurisdictions where a trainee can be Section 12/22 approved after three years' training and obtaining the MRCPsych. It has been stated that the RQIA requirement for CCT for Part II Approval is a barrier to Higher Psychiatry Training. Do you agree with this statement?

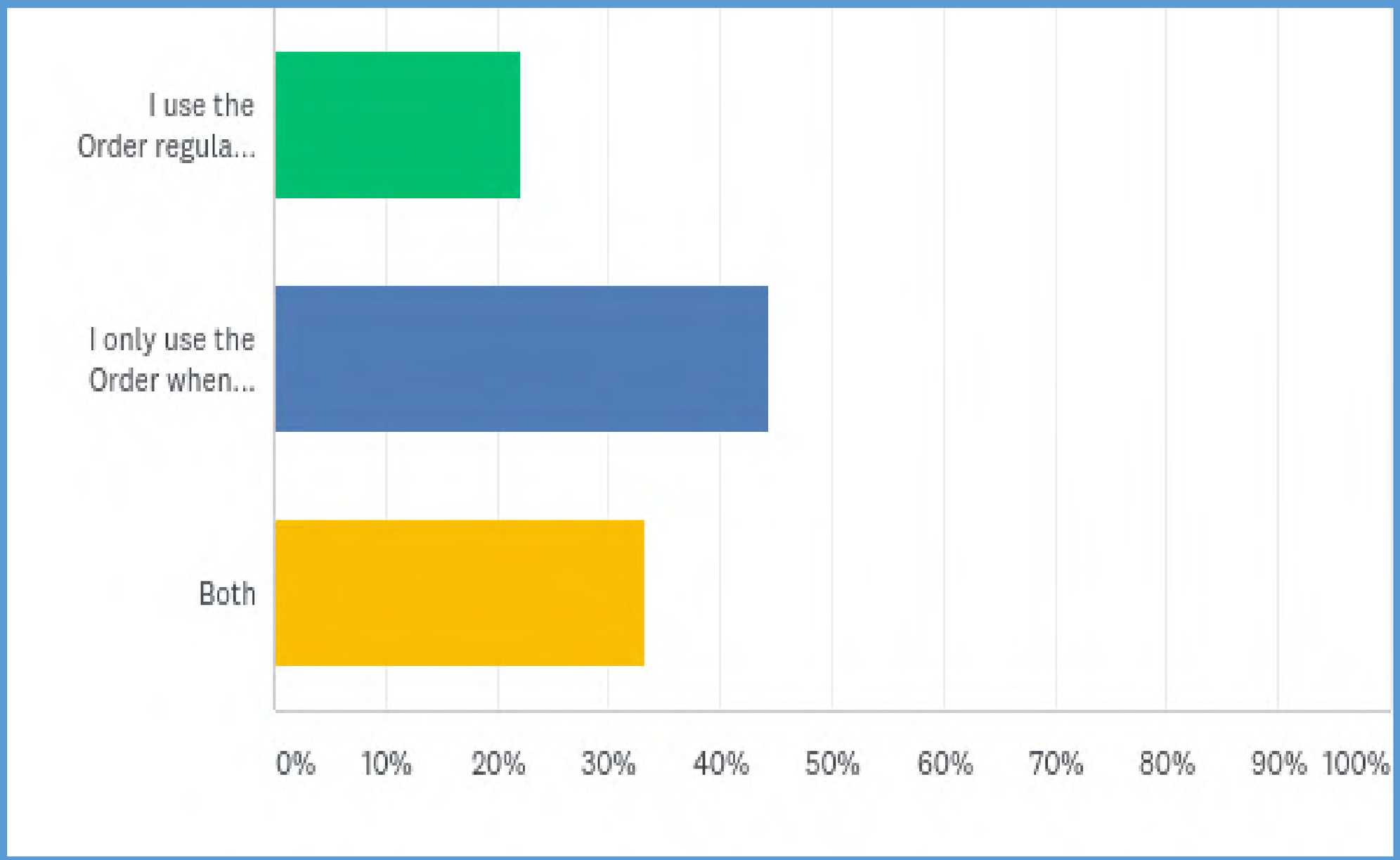
Answered: 47 Skipped: 11



Strongly agree	10
Agree	13
Neither agree nor disagree	11
Disagree	7
Strongly disagree	6

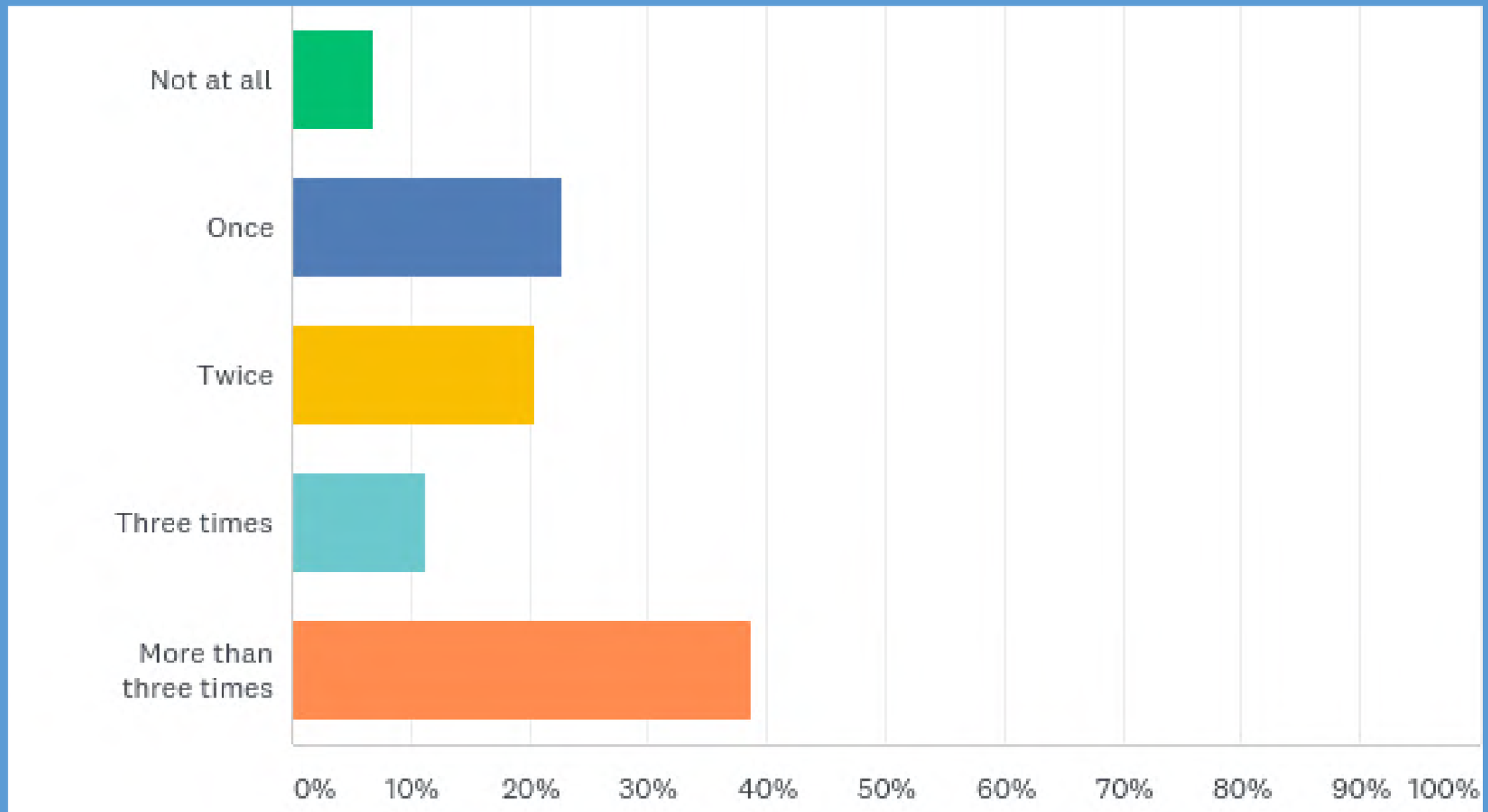
Q10: In what situations do you use the Mental Health Order (NI) 1986?

- Answered: 45 Skipped: 13



Q11: While "on-call" how many times approximately in the last 6 months have you used the MHO?

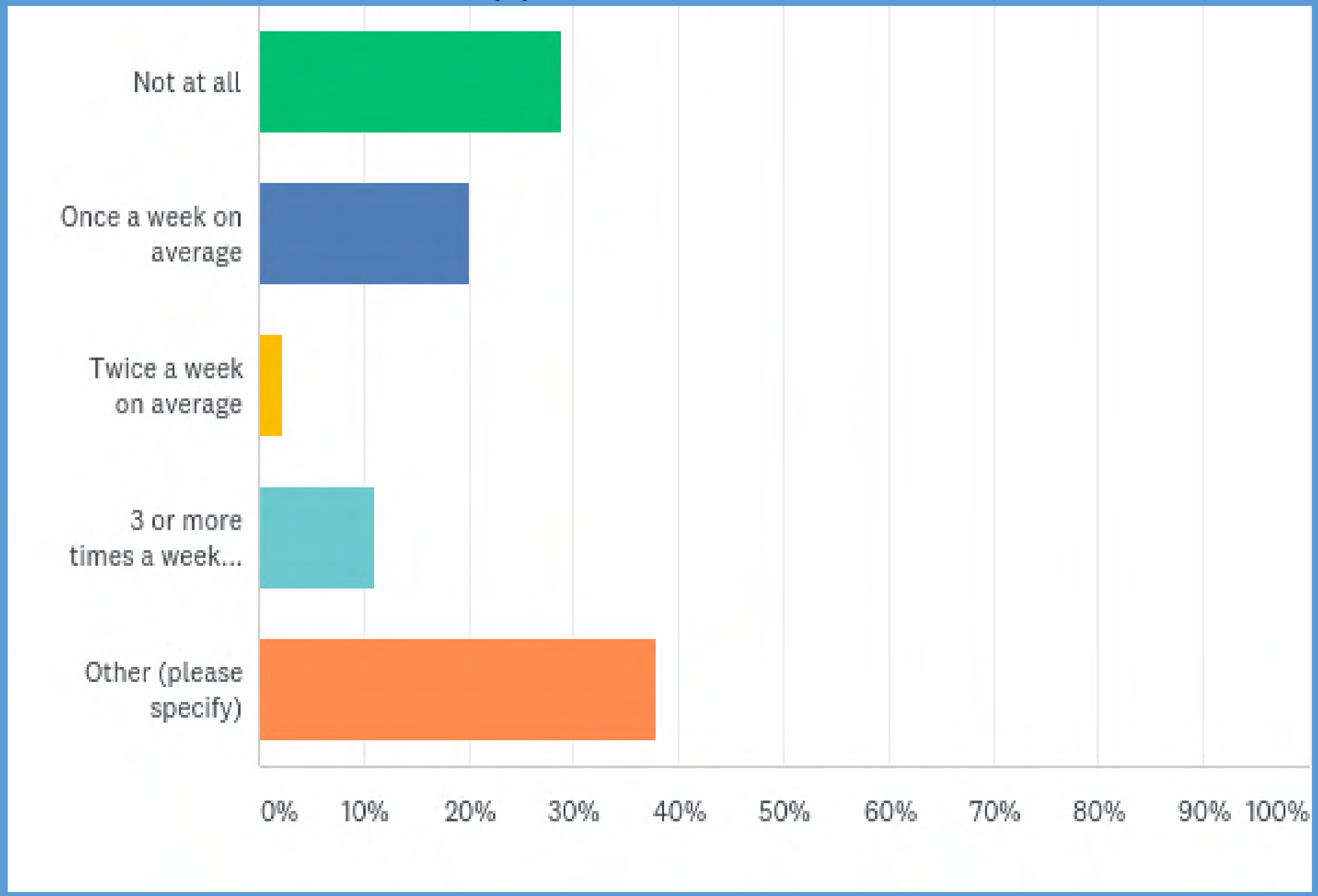
- Answered: 44 Skipped: 14



3
10
9
5
17

Q12: While 'in your daily work', how many times approximately in the past 6 months have you used the MHO?

- Answered: 45 Skipped: 13



13

9

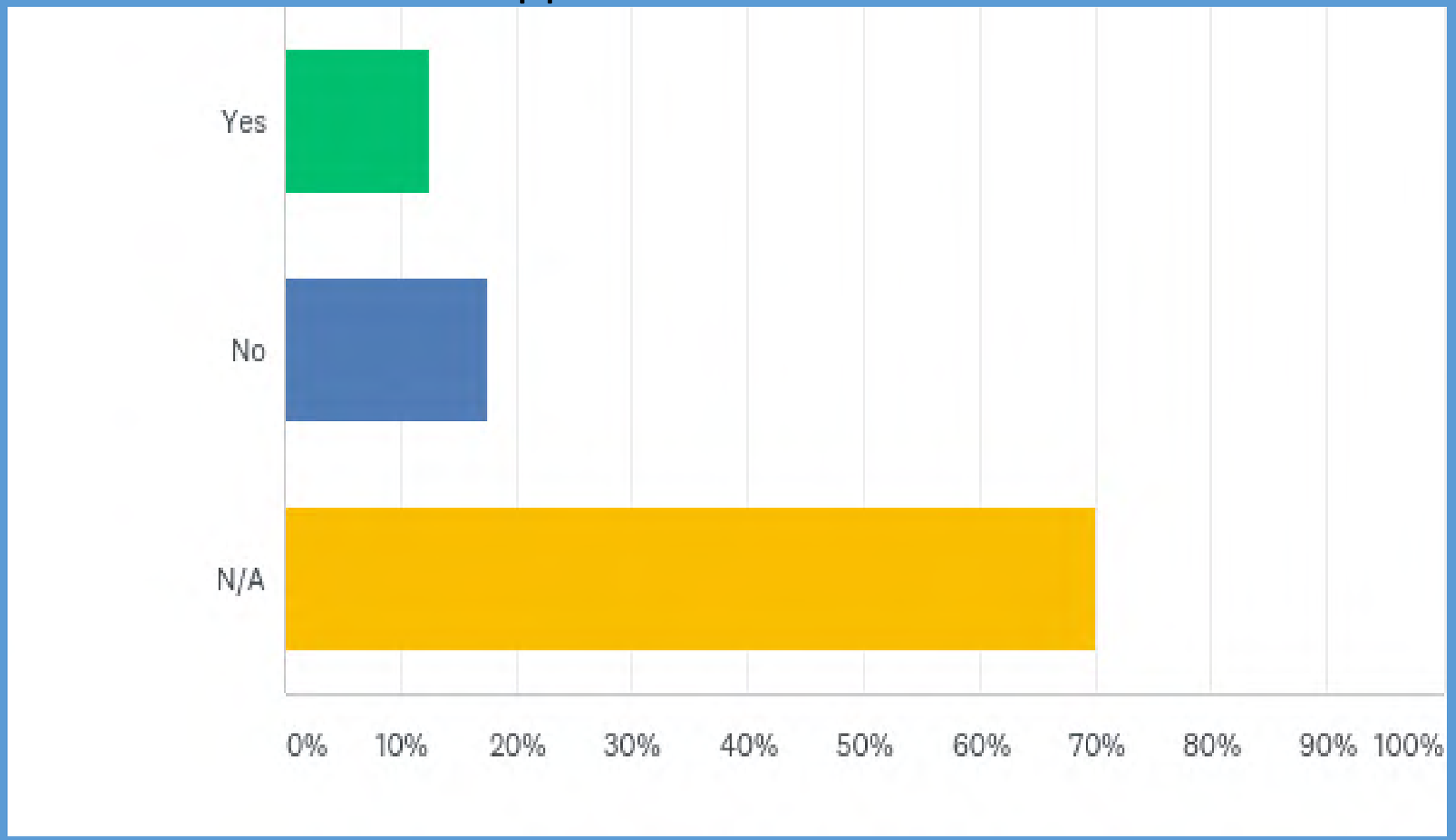
1

5

17

Q13: If recently appointed as a Consultant, (within last 5 years), do you think your training and CCT Award adequately equipped you to be appointed as a Part II Doctor?

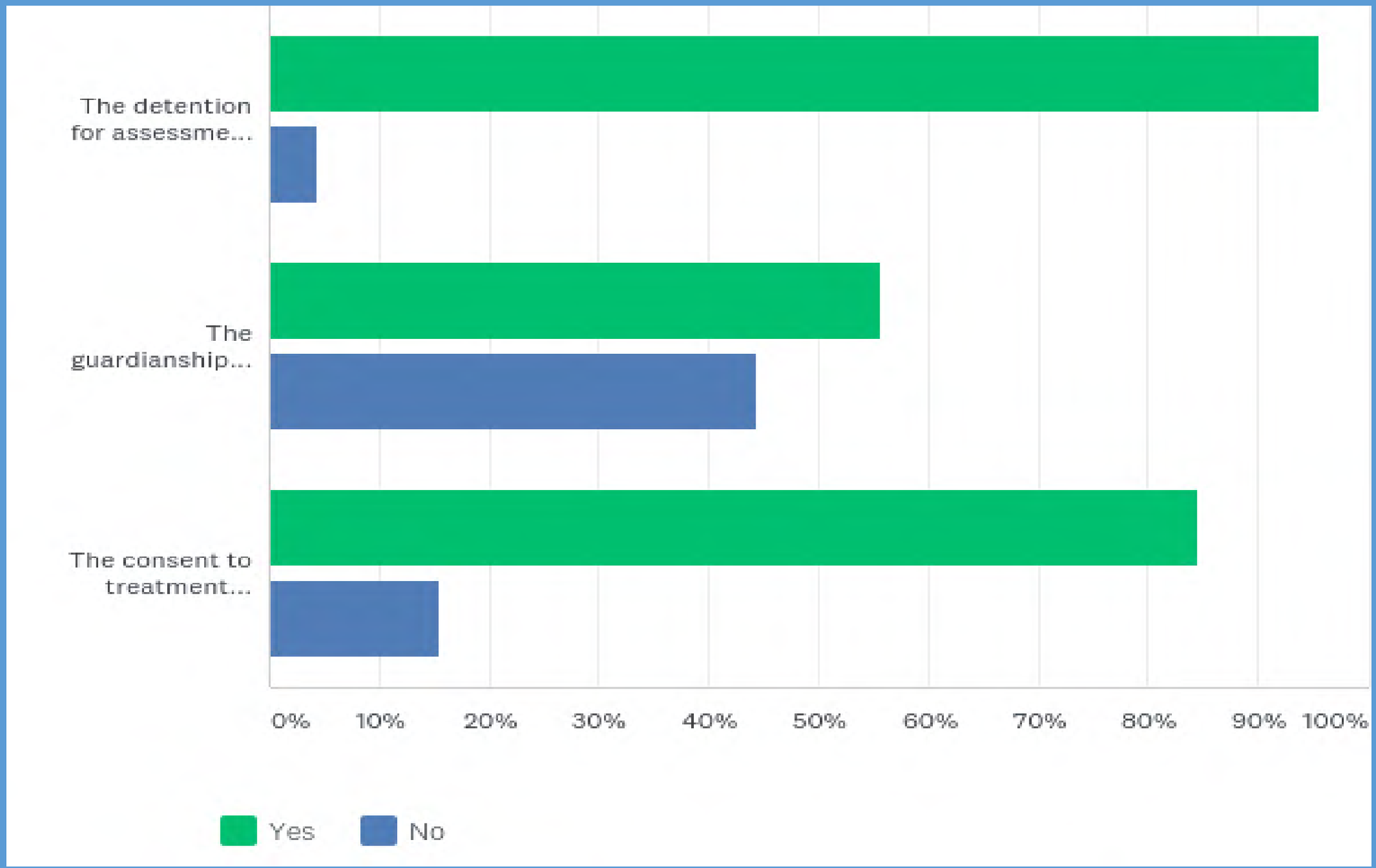
- Answered: 40 Skipped: 18



5	
7	
28	

Q15: I think I have adequate experience and competencies in all aspects of the Mental Health Order:-

- Answered: 45 Skipped: 13



Yes/No
43/2
25/20
38/7

Suggestions for improvement in the process

- **Align with other processes (appraisal/revalidation)**
- **Update original forms rather than re-apply**
- **Provide adequate notice/reminders**

How could training be improved?

- **Formal mandatory training courses (including simulation/case-based discussions)**
- **Awarding trainees Part II 'light' status**
- **More frontline exposure – especially in inpatient settings**
- **Shadowing consultants**
- **Primary care/forensic issues**

Best means of maintaining competencies

- **Regular use (less functionalisation of jobs)**
- **Training events - 6 months - 3 years**
- **Newsletters/ regular updates/feedback**

Summary of findings

- **49% agreed that part 2 status was requirement was a barrier to training**
- **44% only use the MHO when on call**
- **When on call, 30% used the MHO not at all or only once (in 6 months)**
- **In their daily work, 29% did not use the MHO at all (6 months)**
- **Half of those who qualified in the last 5 years did not think their training equipped them adequately to use the MHO**

Summary of findings (cont.)

- ***>80% of respondents did think they had adequate experience and competencies for use of the MHO in terms of the detention and treatment powers, but only 55% thought this was the case for the Guardianship powers…***

Proposed Pathway for Trainees

CT1-CT3

- Expectation of attendance at one MHRT
- Completion of MRCPsych
- Completion of 36 months core training
- **Part 2 and RMO Approval Training course can be taken after completing MRCPSYCH but a trainee can only become Part 2 Light Approved after 36 months core training is completed**

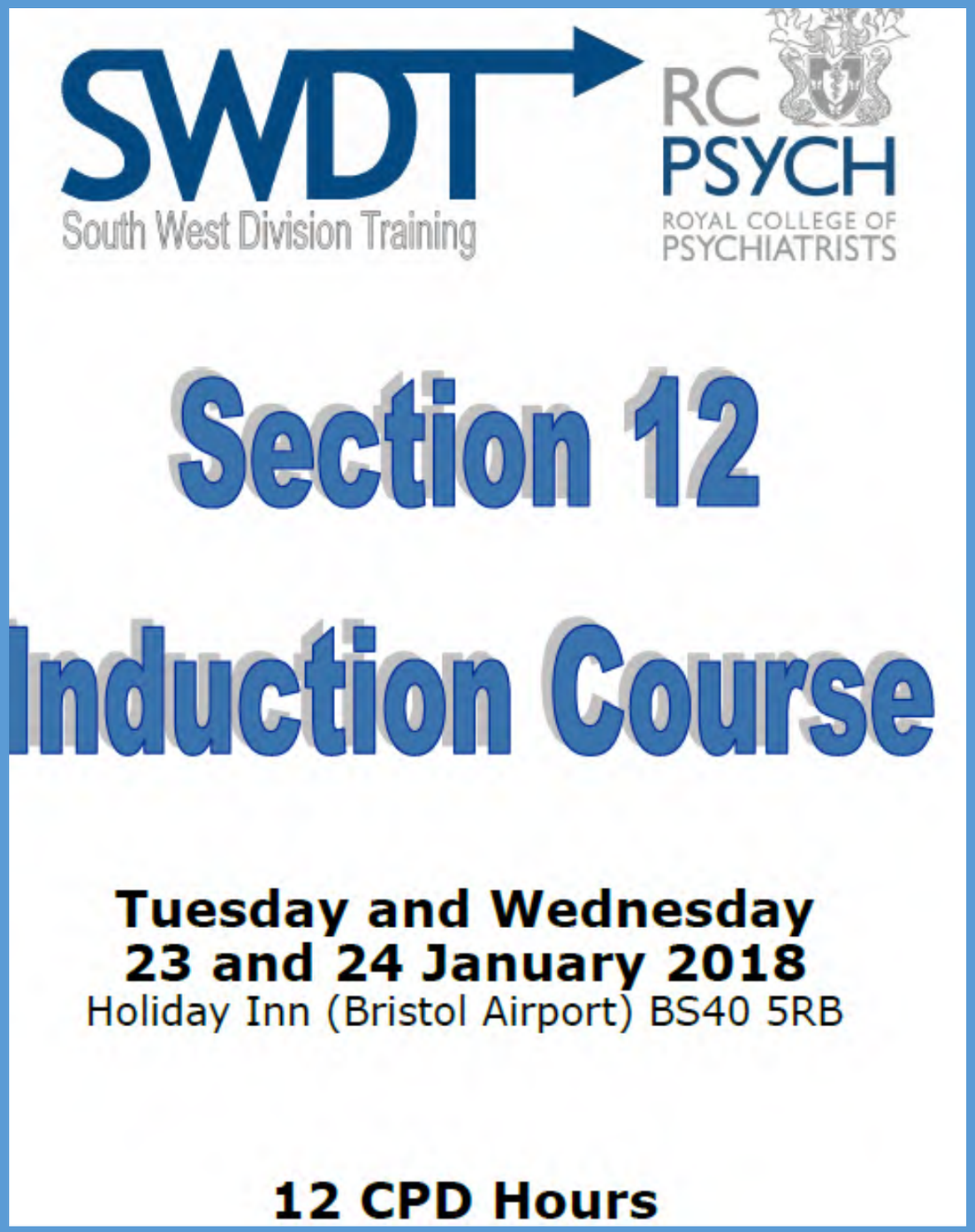
ST4 - ST5

- **ST4-6 are able to assess and detain patients under a Form 8/Form 9 but cannot act as RMO**
- **Expectation that a trainee will competently completed MHRT Report/Provided oral evidence by ST6**

ST6

- **In last year of training trainees can apply for RMO approval. Will require evidence of competently completing an MHRT report/oral evidence and support of NIMDTA to apply for approval**
- Final year trainees can only become RMO approved in last 6 months of training, which according to NIMDTA rules can only be for a maximum period of 3 months in the last 6 months of training.

S12 Training in England and Wales



- Two day induction course;
- Lectures, case studies and group work;
- Focusses on Legal Framework and clinical case studies;

- S12 Refresher Course – 1 day course for S12 approved clinicians;
- Case studies and new legal precedents in working of the MH Act;

Discussion Points

- **How do Trainees achieve competency in use of NI MHO?**
- **How do Consultants demonstrate competencies in use of NI MHO?**
- **Should Part Two status be aligned to revalidation?**
- **Does there need to be a regular mandated course for Part II doctors?**

Stakeholders

Patients/ clients

RQIA

Trusts

NIMDTA

NIJAC

RCPsych

Public

Consultants

DLS

ASWs/Nursing

GPs

RQIA & RCPsych in NI
Part II and Part IV Psychiatrist Meeting

Panel Discussion

Dr Gerry Lynch, Dr Niall Corrigan,
Dr John Simpson & Patrick Convery

The Matthew Elvidge Trust

Sharing Information to save lives
- a personal perspective

Hamish Elvidge

Sharing Information to save lives

Three topics for today

- The Trust
- **Matthew's experience and what we have learnt**
- A different approach to consent and confidentiality

Sharing Information to save lives

The Matthew Elvidge Trust

- **Wellbeing and good mental health**
- **Schools and Universities**
- **Government Advice**
- **Support after Suicide Partnership**

Sharing Information to save lives

Matthew's Story

Sharing Information to save lives

Three opportunities

- Risk Assessment
- **Post Assessment Support**
- Confidentiality

Sharing Information to save lives

Risk Assessment

‘Relaxed, calm, laughed at the right time, well dressed…. good job, nice home, supportive family……’

Sharing Information to save lives

Risk Assessment

‘They just ticked the boxes…… and didn’t look into Matthew’s eyes…’

Sharing Information to save lives

Post Assessment Support

- **Monitoring**
- **Trusted family/friend involvement**
- **Information**

Sharing Information to save lives

Confidentiality

‘Insufficient evidence had been collected… from useful sources before Matthew’s assessment.’

Sharing Information to save lives

Confidentiality

‘We strongly support working closely with families. …listening to the concerns of families is a key factor in determining risk.’ Consensus Statement

‘We need to engender a shift away from the current presumption that patients will not want their families or friends to be involved in recovery.’ Select Committee

Sharing Information to save lives

Confidentiality

‘In our experience, it’s always much better to involve a trusted, family member, friend or colleague in your assessment, treatment and recovery. This will result in you recovering much quicker.

Would you like us to make contact with someone… and would you like us to do this together…?

Sharing Information to save lives

Summary

Review how you involve trusted family members or friends in your patient assessment and care.

Review how you ask for consent.

Implement all the principles of the Consensus Statement.

RQIA & RCPsych in NI
Part II and Part IV Psychiatrist Meeting

Closing remarks

Dr Gerry Lynch
Chair – RCPsych in NI