COLUMNS

Correspondence

Encouraging dialogue for better collaboration and service improvement†

I am writing in response to the editorial by Dr Sami Timimi published in April 2015.[1]

First of all, I must declare my allegiances. I am the Clinical Lead for the London and South East Children and Young People's Improving Access to Psychological Therapies (CYP-IAPT) Learning Collaborative and a founder member of the Child Outcomes Research Consortium (CORC), so from the point of view of the original article I am doubly damned.

I feel moved to write, not to defend either CORC or CYP-IAPT specifically – there will be independent evaluations of the programme in time – but because I feel that what was portrayed in the original article does not fit with my lived experience of either CORC or CYP-IAPT and I want to give my perspective. My view will, of course, be as partial as Sami's; we all speak from a position and a certain point of understanding shaped by our past and current contexts and worldviews. As in good clinical work, progress begins to occur when a therapist and young person or family begin a dialogue to share their different perspectives, to try and understand each other and the issues at hand, and find ways to work together to move forward. It is in this spirit that I write, in the hope to create dialogue and understanding, to share learning and perspective, to build and improve.

Let me make my position clear. I believe CYP-IAPT, CORC and Outcome Orientated Child and Adolescent Mental Health Services (OO-CAMHS)/Partners for Change Outcome Management Systems (PCOMS) are entirely complementary. I think at their heart their philosophy is the same: to work to improve services for children and young people. Embedded in each is the ambition to improve the relationship between children, young people and families, and between the therapist and services. All three recommend the use of tools to facilitate better understanding and collaborative practice. All recommend the Outcomes Rating Scales (ORS) and Session Rating Scales (SRS) as useful tools to facilitate these discussions – I was one of many who fought to have the ORS and SRS included in the CYP-IAPT toolkit. CORC and CYP-IAPT produced a book dedicated to the use of feedback and outcomes tools in facilitating better collaboration: a whole chapter is dedicated to the ORS and SRS and PCOMS model, another to the cultural sensitivities of using feedback and outcomes tools. Whole modules in the CYP-IAPT training are dedicated to training therapists and supervisors in the collaborative use of feedback and outcomes tools – these core skills are drummed into trainees before they even start to specialise in a particular therapeutic modality.

Sure there are problems, and sure there is learning that has been, and still needs to be, done in what and how service improvement is implemented. None are perfect, certainly CORC and CYP-IAPT make no claims to be the answer to all the problems in children and young people's mental health services. Any large-scale, publicly funded attempt at service improvement has to strike a balance between collaborative principles and non-negotiables, to ensure some fidelity and uniformity across the country. CYP-IAPT is rolled out through five regional learning collaboratives that actively promote the discussion and sharing of practice experiences – good and bad – in an attempt to refine and improve best practice, including how feedback and outcomes tool are best used.

So to my predicament and a need to understand better. My experience does not fit with the description set out in Sami's paper, far from it: mine is of an iterative, learning collaborative that tries hard to promote personalised, evidence-based practice. To me this is not diametrically opposed to what I understand of OO-CAMHS/PCOMS. I struggle to understand why Sami and I see things so differently. Why our perceptions of the principles and practices behind CORC, CYP-IAPT and OO-CAMHS/PCOMS seem so out of step? It seems to me that there is a need for dialogue to better understand our different perspectives – that is where progress begins.

Declaration of interest: D.J.L. is Clinical Lead for the London and South East CYP-IAPT Learning Collaborative and member of the CORC steering committee.

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1 Timimi S. Children and Young People's Improving Access to Psychological Therapies: inspiring innovation or more of the same? *BJPsych Bull* 2015; **39**: 57–60.

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Fair criticism also needs to be based on evidence†

This entire article[1] is more focused on cobbling together a damning indictment of the two Improving Access to Psychological Therapies (IAPT) programmes than approaching the facts and evaluating them fairly. In terms of adult IAPT many areas did not have the range of services described by the author, such as pre-IAPT primary care counselling services. Giving a broad section of people suffering from mild to moderate mental ill health access to cognitive–behavioural therapy (CBT) did exactly what it said on the tin: it improved access to psychological therapies. For those of us who do actually 'believe that psychological therapies help people', this is a good thing, regardless of the limitations placed by the use of limited modalities. In my area waiting lists for psychological therapies exceeded 30 weeks and were only available via secondary care, so to completely disregard the huge impact of this programme is equivalent to moaning about the limitations of a set menu when being fed for the first time in a week.

The article cites references that are twisted to purpose, for example 'Research has found that 40–60% of youth who begin treatment drop out against advice'. This research pre-dates the introduction of Children and Young People's

†See also special articles by Fonagy & Clark, pp. 248–251, this issue, and Timimi, pp. 57–60, April issue.

(CYP) IAPT, so I fail to see the relevance. In fact, this stark statistic is probably one of the reasons why CYP-IAPT places such a huge emphasis on participation – an element of CYP-IAPT that is completely disregarded in this article.

Admittedly, the implementation of outcome data collection has been problematic, but this is a huge development on a massive scale. This is not about monitoring data in one service, this is about setting up a national system for monitoring and comparing outcomes. Anyone can set up a spreadsheet for a few patients, but linking multiple electronic patient record systems into a central reporting mechanism is a bit more of an undertaking.

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Note: The opinions expressed here are the author's own and not necessarily those of any clinical commissioning group, or Haringey Council.

1 Timimi S. Children and Young People's Improving Access to Psychological Therapies: inspiring innovation or more of the same? *BJPsych Bull* 2015; **39**: 57–60.

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Raising the standard: it's time to review the MRCPsych examinations

The MRCPsych examinations are the qualifying examinations for membership with the Royal College of Psychiatrists and are generally undertaken in the second and third year of core training. In combination with workplace-based assessments and the Annual Review of Competence Progression (ARCP) the exams are essential to progressing to advanced training and eventually a Certificate of Completion of Training (CCT). The exams currently involve three multiple choice (MCQ) format papers and a single clinical skills examination consisting of 16 varied stations (Clinical Assessment of Skills and Competencies, CASC).

No one doubts that to pass the exams necessitates a significant investment of time and energy, which detracts from trainees' experience on clinical placements, other educational opportunities, and their personal lives. Trainees' efforts should be rewarded with a process of learning and enrichment that develops their skills and knowledge, not simply another 'hoop to jump through' on their way through training. The MRCPsych courses offered by training hospitals go some way towards providing additional education, however, it is significant that trainees universally rely on practice questions rather than course attendance to pass exams. Some trainees will even pay for additional, privately run courses that focus solely on preparation for the exams. This suggests a fundamental disconnection between the exams and the learning objectives of training programmes that needs to be bridged.

The curriculum available to trainees is vague and fails to provide any real guidance towards training in the first 3 years. Content is frequently outdated and does not reflect the realities of clinical practice. The MCQ format is overly reliant on rote memorisation of lists of facts without regard to the context and complexities of clinical decision-making. The exam process neither encourages nor rewards trainees who take time to read broadly around the curriculum themes, instead relying on a narrow set of questions that are recycled year after year.

There is a lack of depth in the content tested, exemplified by the 'history' component which requires trainees simply to associate a list of important figures with a one-line description of their contribution. No attention is paid to the complex history of Western psychiatry or to important issues that are ongoing. Psychiatry more than any other field of medicine suffers from controversy regarding its role and relevance, and questions about aetiology, nosology, treatment and ethics. It is crucial for trainees to progress with an appreciation of these topics, yet the MRCPsych exams completely fail in this regard.

I suggest that a complete review of the MRCPsych curriculum and examination is overdue. The MCQ component should be reduced in favour of short-answer and/or clinical scenario formats. The curriculum should be updated to include more current research in basic sciences, as well as milestone papers in the history of psychiatric research. Historical, cultural and philosophical themes should be included in the curriculum and represented in assessments. Learning objectives for each theme should be specific, and accompanied by essential reading lists to guide trainees and exam questions.

In summary, if the goal of training is to produce highly skilled, well-rounded trainees, then the curriculum and examinations should reflect this. Instead, they assess a bare minimum level of competency, neglecting important developments and issues that are highly relevant to our daily practice. I believe that new psychiatrists deserve more than 'minimal' competence in return for their efforts, as does the profession, and most importantly, our patients.

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The Royal College of Psychiatrists' response: Examinations have been a feature of medical training for centuries both in undergraduate and postgraduate education. The primary purpose of such examinations has been to define a minimum standard that the public and fellow professionals have confidence in. In recent years there has been a drive for examinations to also inform the learning process and to be conducted in a format that is evidence based. The current MRCPsych examination was introduced in 2008 within parameters laid out by the Postgraduate Medical Education and Training Board (PMETB; Principles for Assessment Systems). The requirements of PMETB were for all Colleges to use assessment formats that were supported by evidence in the literature as being a reliable assessment method.
As a consequence, all Colleges developed written paper examinations that were based on the multiple-choice question (MCQ) format and clinical examinations in an Objective Structured Clinical Examination (OSCE) format. These two formats are regarded as the most reliable. The written papers moved away from short-answer and essay questions as there are concerns about the reliability of these formats. The current MRCPsych written papers have extremely good reliability (Chronbach's α consistently greater than 0.9) and the Clinical Assessment of Skills and Competencies (CASC) also has good reliability (Chronbach's α 0.75–0.85).

The performance of the examination is closely monitored by the Royal College of Psychiatrists' Examinations Sub-Committee with robust quality assurance processes in place. The content and performance of each item is scrutinised pre- and post-examination. The College is also required to provide data and reports to the regulator (the General Medical Council, GMC) and any proposed changes to the examination require GMC's approval. Recent changes approved by the GMC include a reduction from three written papers to two (introduced from this year) and a change to the CASC marking scheme from the Hofstee method to borderline regression (from diet 2 this year). As part of the process to reduce the number of written papers, the written paper question banks have been fully reviewed and updated. The statement that MCQs are continuously recycled year after year is incorrect. New questions are constantly being developed and every examination paper has about 40% of new questions. All questions have been mapped to the examinations syllabus and new question writing is focused on areas of the question bank where the range of questions is limited. There is also a focus on developing a greater range of questions testing clinical management within Paper B.

The MRCPsych examination is under continuous review and development by the Examinations Sub-Committee. An external review of the examinations was commissioned in 2014 and we are following up on recommendations for further enhancements to the MRCPsych. These are due to be published at the end of 2015.

The curriculum, like the examination, is under constant review in a process that involves a wide community including lay people, trainees, medical managers, psychiatry experts and trainers. All changes have to be approved by the GMC and there is regular dialogue between the College and the GMC. A major revision of the core curriculum is being planned and will include the incorporation of the examination syllabus.

While we understand that trainees may feel the MRCPsych is another hurdle, ultimately, the College is responsible for ensuring that quality and patient safety are at the forefront of its examination processes. We are satisfied that the current standard is appropriate for entry into higher training. While it is our ambition to drive up the standard, we are aware that a significant proportion of core trainees struggle to achieve the standards set by the examination. The College is keen to influence training and the learning experience of trainees. To this end we have introduced Trainees Online (TrOn; http://tron.rcpsych.ac.uk), a series of online learning modules for trainees that will eventually cover the whole MRCPsych examination syllabus. We have also been working with MRCPsych course organisers to improve the standard and consistency of courses. We hope that increased clarity about what trainees need to know will lead to higher examination pass rates as well as the acquisition of knowledge that will support clinical practice.

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Psychiatry is more than neuropsychiatry

In his editorial, Fitzgerald[1] rehashes the well-trodden arguments for the reunification of neurology and psychiatry, suggesting the time has finally come. What he fails to address is that the trend in every sphere of medicine is towards further specialisation and not integration. Why psychiatry and neurology should be the exception to the rule goes unanswered.

It is only ever academic psychiatrists, appearing out of touch with clinical practice, who propose that psychiatry has advanced to the point where it is indistinguishable from neurology. On the contrary, despite the calls for psychiatry to become a clinical neuroscience discipline,[2] psychiatric practice has remained untouched by developments in neuroscience. To be sure, neuroscience is a core basic science for psychiatry. But the claims that psychiatric disorders are simply brain disorders, or that our observations or interventions are not worth a jot if not based in neuroscience, are part of a creeping trend towards neuroessentialism in every sphere of life.[3] Psychiatrists do not simply deal with brain disorders – to claim otherwise is to impoverish our field. Psychiatry is at its best when embracing a pluralistic approach to the disparate range of problems that fall under our gaze. To neglect insights from the psychological, sociological and anthropological sciences and the narrative approach to formulation does a disservice to our patients. The patient who becomes suicidal after a relationship breakdown and the patient who becomes panic-stricken and housebound after a rape do not have problems that can be made sense of in the same way as the patient with visual hallucinations and bradykinesia, or the patient with impulse control problems after a brain injury. Put simply, even if we accept the claim that psychiatric problems are brain disorders, many problems can be effectively treated without thinking about the brain.

Psychiatrists could certainly benefit from a stronger training in clinical neuroscience and neurology in general, and neuropsychiatry and behavioural neurology in particular. But as Alwyn Lishman said, 'You have got to have a finger in every pie in psychiatry and be ready to turn your hand to whatever is the most important avenue: an EEG one day, a bit of talking about a dream another day. You just follow your nose. All psychiatrists should be all types of psychiatrist'.[4] I could not agree more.

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1 Fitzgerald M. Do psychiatry and neurology need a close partnership or a merger? *BJPsych Bull* 2015; **39**: 105–7.

2 Insel TR, Quirion R. Psychiatry as a clinical neuroscience discipline. *JAMA* 2005; **294**: 2221–4.

3 Reiner PB. The Rise of Neuroessentialism. In *The Oxford Handbook of Neuroethics* (eds J Iles, B Sahakian): 161–75. Oxford University Press, 2011.

4 Poole NA. Interview with Professor William Alwyn Lishman. *Psychiatrist* 2013; **37**: 343–4.

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A more practicel solution is needed

Professor Fitzgerald is worried about the serious recruitment crisis in psychiatry. His answer is to advise psychiatrists to abandon their specialty and 'return home to neurology'. In his opinion, a merger of the two professions would encourage clinicians to focus on careful clinical analysis and diagnosis,

reduce professional isolation and stigma, enhance status and so improve recruitment. This may or may not be true, but I wonder about the attitude of neurologists to his proposal. The working life of a general adult psychiatrist is not easy and I think neurologists are likely to resist his advances. I don't know many who would be willing to regularly attend community-based mental health act assessments in inconvenient circumstances, subject themselves to cross-examination by enthusiastic lawyers in front of their patients at mental health tribunals, defend their practice at critical legalistic external inquiries, or subject themselves to the restrictions imposed by 'new ways of working'. Psychiatric practice certainly needs to be reformed but a more practical analysis of our problems is urgently required. In my opinion, our College must lead on these issues. If it continues to equivocate it will quickly become an irrelevance.

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1 Fitzgerald M. Do psychiatry and neurology need a close partnership or a merger? *BJPsych Bull* 2015; **39**: 105–7.

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Can psychiatry and neurology 'simply' merge?

I appreciate Professor Fitzgerald's citation of my 2005 article, titled 'Why psychiatry and neurology cannot simply merge',[1,2] however, he seems to have misconstrued the essential nature of my argument. He positions his discussion of my article just after the statement, 'The chorus of disapproval against neuropsychiatry has certainly grown'. But I would like to assure Professor Fitzgerald that I am not, nor have I ever been, part of such a 'chorus'. A careful reading of my article will show that the key word in my argument is 'simply'. I am not opposed in any way to integrating neurology and psychiatry; rather, I argue that certain types of 'bridging' concepts and constructs would be necessary to bring about such a union.

I describe neuropsychiatry as 'a vitally important transitional stage in the development of brain science'. Indeed, I would argue that neuropsychiatry is the crucible within which the discourses of psychiatry and neurology will eventually 'bond', producing a narrative that incorporates the dialectical and subtextual understanding of psychiatry into the framework of neurophysiology and neuropathology. But until such a meta-narrative has evolved, there cannot be a genuine merger of psychiatry and neurology. Or rather, we should say that without such a meta-narrative, the nature of the merger would be more like the grafting of an oak branch onto a maple tree than the hybridisation of two varieties of rose.[2]

I fully agree with Professor Fitzgerald that 'the separation of neurology from psychiatry has led to a separation of the brain from the mind – the physical from the mental – which has been unhelpful for both disciplines'. That said, I do not accept the view that psychiatric disease is best described as 'brain disease' or that mental constructs are 'reducible' to mere physiological or neuroanatomical terms. But this is a complicated philosophical issue best left for a longer communication.[3]

Stated briefly, I believe that 'disease' is most usefully predicated of persons, not minds or brains, and that there are ways in which a union of neurology and psychiatry could contribute to a very rich understanding of the human person, and how personhood is undermined and compromised by disease states like schizophrenia.[4]

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1 Fitzgerald M. Do psychiatry and neurology need a close partnership or a merger? *BJPsych Bull* 2015; **39**: 105–7.

2 Pies R. Why psychiatry and neurology cannot simply merge. *J Neuropsychiatry Clin Neurosci* 2005; **17**: 304–9.

3 Pies R. Mind-language in the age of the brain: is ''mental illness'' a useful term? *J Psychiatr Pract* 2015; **21**: 79–83.

4 Pies R. Trivializing the suffering of psychosis. *Psychiatr Times* 2014; 22 December.

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Fully inform the Martian

At first glance, Reilly's thesis appears reasoned and structured.[1] But his argument is flawed, such that he misses the most important reason for the distinction between psychiatry and neurology, with which a Martian would surely concur.

Reilly states that 'most organs (such as lungs, kidneys, hearts and eyes) are treated by a single medical specialty'. Not so. A cardiac surgeon operates on the heart, determines which patients would benefit from surgery, and manages pre- and post-operative care. A cardiologist's talents lie elsewhere.

Similarly, the division between psychiatry and neurology is defined by knowledge and skill. This is no artificial distinction imposed by a quirk of history, but reflects a difference in the very nature of the knowledge and skill base developed by doctors as they specialise. One cannot expect every trainee neurologist to additionally become expert in, say, holistic and developmental assessment, psychological formulation and complex diagnostic classifications of a nature unknown outside psychiatry. These are for trainee psychiatrists to focus on.

Doctors do not practise in isolation, but as members of multidisciplinary teams. Nurses and others develop similarly specialist knowledge and skills to work with patients with broadly different presentations.

Of course, there are small areas of overlap, but Reilly falsely dichotomises these to fuel his argument: I had no idea conversion disorder was the preserve of neurologists. At best, he puts forward a case for closer working and more shared care of patients between the two specialties. But two specialties they most assuredly are.

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1 Reilly TJ. The neurology–psychiatry divide: a thought experiment. *BJPsych Bull* 2015; **39**: 134–5.

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