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Derby GP Specialty Training Programmes

GPSTR ST1/ST2 Specialty Guide

PSYCHIATRY

Derbyshire Mental Health Services NHS Trust

based at the Royal Derby Hospital

GPSTR Doctor:

DATE OF COMMENCEMENT	
CONSULTANT/S	
DATE OF COMPLETION	

NOTES

NOTES

INTRODUCTION

Ninety percent of people with mental health problems are cared for in General Practice. One in three consultations has a mental health component.

Depression is very common in General Practice so it is essential GPs can recognise it and assess its severity *(see Appendix A).*

All depressed patients should be screened for suicidal intent.

People with chronic severe mental illness have a high level of physical co-morbidity which should be looked for and screened by General Practitioners.

The skills to recognise and manage somatisation would lead to huge savings in patient suffering and healthcare costs *(See Appendix C).*

All physical illness has a psychological component and this element should be addressed by any management plan.

GPs need to strive for excellence in communication and patient-centred practice.

The commonest types of psychiatric morbidity seen in General Practice are as follows:

- Neuroses
- Mixed anxiety and depression
- Alcohol dependence
- Generalised anxiety

Others include:

- Eating disorders
- ADHD
- PTSD
- Drug misuse

TRAINING AIMS

The Derby GP Training Psychiatry ST1 and ST2 posts at DCGH provide jobs giving an ideal mix of experience for a future GP.

This guide is designed to help you identify the clinical learning opportunities within the post.

The Psychiatry teaching staff will be able to help you define and remedy any gaps in your knowledge or experience.

They will provide you with a series of clinical assessments (see below). You are responsible for making sure these take place and that they are properly documented.

The Psychiatry team have kindly agreed to ensure that you will be able to attend the GP Training Half Day Release Teaching Sessions. At times this will inevitably clash with your on-call responsibility.

Apart from the Wednesday afternoon GP Training sessions you should try to attend the in-house educational meetings which are usually at lunch time.

ASSESSMENTS

RECORDING ASSESSMENTS

All assessments should be recorded in your e-portfolio. This is your responsibility although your Clinical Supervisor and Educational Supervisor will also have to complete assessments on your e-portfolio. The e-portfolio forms a continuous record of your progress and will be submitted to the Deanery to "sign you off" at the end of your training. If you are having technical problems with the e-portfolio please contact the e-portfolio Enquiries/Help.

Some Guiding Principles for the Development of the Recovery Process

1. The mental health system must be aware of its tendency to promote service user dependency.

2. Users of service are able to recover more quickly when their:

- Hope is encouraged, enhanced and/or maintained
- Life roles with respect to work and meaningful activities are defined
- Spirituality is considered
- Culture is understood
- Educational needs as well as those of families/significant others are identified
- Socialisation needs are identified
- They are supported to achieve their goals

3. Individual differences are considered and valued across the life span.

4. Recovery from mental illness is most effective when a holistic approach is considered; this includes psychological, emotional, spiritual, physical and social needs.

5. In order to reflect current 'best practices' there is a need for an integrated approach to treatment and care that includes medical, psychological, social and values-based approaches. A recovery approach embraces all of these.

6. Involvement of a person's family, partner and friends may enhance the recovery process. The user of service should define whom they wish to involve.

7. Mental health services are most effective when delivery is within the context of the service user's locality and cultural context.

8. Community involvement as defined by the user of service is central to the recovery process.

- Failure to recover in the expected time from an illness, injury or operation
- Failure of reassurance to satisfy the patient for more than a short period
- Frequent visits by a parent with a child with minor problems (the child as a presenting symptom of illness in the parent)
- An adult patient with an accompanying relative
- Inability to make sense of the presenting problem

Source: McWhinney A. *Textbook of Family Medicine*. Oxford: Oxford University Press, 1997, Ch 7.

APPENDIX D

Depression

Primary care practitioners should be alert to the possibility of depression in the following groups:

- Those who have suffered recent unemployment, bereavement (or any form of loss),
- divorce, financial difficulties or housing problems
- Women with a recent childbirth, demanding child care or menopausal symptoms
- Those who have been bereaved in the last 12 months, those who are caring for a disabled relative and those who are living in residential care
- Those who are suffering from a recent myocardial infarction or cerebrovascular accident, or malignancy
- Those with early dementia, Parkinson's disease, Huntington's disease, diabetes mellitus, chronic obstructive pulmonary disease, chronic pain – and other long-term conditions
- Patients with multiple unexplained symptoms

Source: Jones R, Britten N, Culpepper L, *et al*. (eds). *Oxford Textbook of Primary Medical Care.* Oxford: Oxford University Press, 2004 (with additions).

WORKPLACE BASED ASSESSMENTS

A series of workplace based assessments are also needed. These are similar to the foundation post assessments you may have already done.

During your 4 month post you will need to do the following Assessments:

⇒ **2 x Mini-cex** (Clinical Examination exercises)

⇒ **2 x CBDs** (Case-based Discussions)

⇒ **1 x MSF** (Multi-source Feedback)
5 Clinicians only

⇒ **2 DOPS** (Direct Observation of Procedures)

Your consultant will also need to complete a **Clinical Supervisor's Report** which he/she will discuss with you before submitting.

Remember: "The E-portfolio is King"
You must keep a copy of all assessments as they will be needed in the future

HOSPITAL JOB ASSESSMENTS

You will be contacted by the Deanery (via your E-portfolio) to complete an on-line assessment of your hospital post. (Bristol on-line Survey) This is mandatory and is a requirement of training.

SKILLS

The GP Curriculum is keen to divide skills into three categories.

⇒ **Communication Skills**
⇒ **Clinical Management Skills**
⇒ **Practical Skills**

There is obviously considerable overlap.

COMMUNICATION SKILLS

To be able to recognise and establish rapport with people experiencing mental health problems	Unsure ☐ Satisfactory ☐ Confident ☐
To be able perform a thorough mental state examination in a sensitive patient-centred and holistic way. This may involve several interviews and often interviews with third parties	Unsure ☐ Satisfactory ☐ Confident ☐
To know how to screen and diagnose mental illness using effective instruments where they are available	Unsure ☐ Satisfactory ☐ Confident ☐
To know how to communicate effectively and safely with distressed, disturbed or potentially violent patients to ensure the safety of all concerned	Unsure ☐ Satisfactory ☐ Confident ☐
To remain patient centred and give patients choices where appropriate	Unsure ☐ Satisfactory ☐ Confident ☐

Referral to other agencies may be necessary. Criteria include the following:

- Any form of suspected abuse (social services)
- Young person who is no longer in the care of their parents and is at risk of harming
- themselves or others (social services)
- Young person who is at risk of harming other children or adults (police)
- Young person with school attendance problems (Educational Welfare Service)
- Young person with suspected specific learning disability (school special needs department)
- Young person with a substance misuse problem (local young person's drug and alcohol services).

Voluntary organisations can often help children and adolescents with emotional or behavioural problems – for example, the NSPCC, local parental support groups (e.g. ADHD groups) and parenting groups run through programmes such as Sure Start.

When making a referral to other service providers, the GP should have access to a local resource directory.

APPENDIX C

Identifying People at Risk

Consultations where physical/organic illness is less likely:

- Frequent attendances with minor illnesses
- Frequent attendance with the same symptoms or with multiple complaints
- Attendances with a symptom that has been present for a long time
- Attendance with a chronic disease that does not appear to have changed
- Incongruity between the patient's distress and the comparatively minor nature of the symptoms

- Where the GP feels that the therapeutic relationship with the patient has broken down
- Where primary care interventions and voluntary/non-statutory options have been exhausted
- Where there is severe physical deterioration of the patient
- Where particular psychotropic medication is required (e.g. clozapine, lithium or donezepil)
- If the patient requests a referral

When making a referral to secondary mental health services, social services or voluntary/nonstatutory organisations, the GP should:

- Have access to a local resource directory
- Consider coordination issues around the referral (e.g. care programme approach, care manager)
- Consider implications for the continuing care of the physical health of the patient.

All referral criteria constitute part of the guideline for that particular disorder and assume that, as far as possible, the guideline for diagnosis and management has been followed.

Referral to Child and Adolescent Mental Health Services

Referral to Child and Adolescent Mental Health Services (CAMHS) should be considered in the circumstances:

- Where the young person is displaying signs of suicidal intent
- Where assessment of the young person is not suitable for primary care (e.g. psychotic symptoms, attention-deficit/hyperactivity disorder [ADHD])
- Where the young person is likely to require medication and treatment is not suitable for primary care (e.g. depressive disorder in a child, severe obsessive-compulsive disorder)
- Where the young person is so disabled that they cannot go to school or see friends
- If the young person or parent requests a referral
- Where primary care or other options have failed

COMMUNICATION SKILLS, continued

To know how to nurture hope and encourage positivism whenever possible in order to promote recovery *(see Appendix D)*	Unsure ☐ Satisfactory ☐ Confident ☐
To understand the relevance of "transference" and how this can be detrimental to the well being of both us and our patients if not recognised and managed appropriately	Unsure ☐ Satisfactory ☐ Confident ☐
To be able to recognise symptom groups which may indicate underlying mental health issues, e.g. "tired all the time", insomnia, panic attacks, anxiety and multiple somatic symptoms such as light-headedness, parasthesiae, IBS-type symptoms, tension-type headaches, etc. and at the same time taking steps to reasonably exclude physical causes	Unsure ☐ Satisfactory ☐ Confident ☐

CLINICAL MANAGEMENT SKILLS

To keep yourself and your patients safe, e.g. understand the principles of assessing and managing the potentially violent patient	Unsure ☐ Satisfactory ☐ Confident ☐
Manage patients experiencing mental health problems and be able to use the variety of interventions available when necessary	Unsure ☐ Satisfactory ☐ Confident ☐

CLINICAL MANAGEMENT SKILLS *continued*

Know the guidelines governing management of individual conditions as published in the SIGN (Scottish Intercollegiate Guidelines Network) or NICE guidelines	Unsure ☐ Satisfactory ☐ Confident ☐
Know when and which physical examinations or investigations are appropriate	Unsure ☐ Satisfactory ☐ Confident ☐
Know when referral to other members of the primary care team e.g. CMHT or CAMHS is appropriate and be able to work with these colleagues *(See teamwork learning resource at: www.nimhe.org.uk)*	Unsure ☐ Satisfactory ☐ Confident ☐
To know when referral to secondary care is appropriate *(see Appendix B)*	Unsure ☐ Satisfactory ☐ Confident ☐
To understand the importance of continuity of care	Unsure ☐ Satisfactory ☐ Confident ☐
To understand the prevalence of different mental health problems in the practice population	Unsure ☐ Satisfactory ☐ Confident ☐
To know the principles of mental health promotion and to understand the important role social circumstances can play in perpetuation of ,or recovery from, mental illness	Unsure ☐ Satisfactory ☐ Confident ☐

- Past history or family history of depression
- Low social support
- Suicidal thoughts
- Associated social disability

3. Factors that favour referral to mental health professionals:

- Poor or incomplete response to two interventions
- Recurrent episode within one year of last one
- Patient or relatives request referral
- Self-neglect

4. Factors that favour urgent referral to a psychiatrist:

- Actively suicidal ideas or plans
- Psychotic symptoms
- Severe agitation accompanying severe (more than 10) symptoms
- Severe self-neglect

ICD-10 definitions: mild depression, four symptoms; moderate depression, five or six symptoms; severe depression, seven or more symptoms, with or without psychotic features.

APPENDIX B

Referral to Adult Specialist Primary Care or Secondary Mental Health

Referral to secondary mental health services should be considered in the following:

- Where the patient is displaying signs of suicidal intent or if there seems to be a risk of harm to others
- Where the patient is so disabled by their mental disorder that they are unable to leave their home, look after their children or fulfill other activities of daily living
- Where the GP requires the expertise of secondary care to confirm a diagnosis or implement specialist treatment

THE FOLLOWING ARE EXTRACTS FROM THE RCGP GP CURRICULUM

APPENDIX A

Assessing the Severity of Depression in Primary Care

Key symptoms:

- Persistent sadness or low mood, and/or
- Loss of interests or pleasure
- Fatigue or low energy

At least one of these, most days, most of the time for at least two weeks.

If any of above present, ask about associated symptoms:

- Disturbed sleep
- Poor concentration or indecisiveness
- Low self-confidence
- Poor or increased appetite
- Suicidal thoughts or acts
- Agitation or slowing of movements
- Guilt or self-blame

Then ask about past, family history, associated disability and availability of social support

1. Factors that favour general advice and watchful waiting:

- Four or fewer of the above symptoms
- No past or family history
- Social support available
- Symptoms intermittent, or less than two weeks duration
- Not actively suicidal
- Little associated disability

2. Factors that favour more active treatment in primary care:

- Five or more symptoms

CLINICAL MANAGEMENT SKILLS *continued*

To know which groups are particularly at risk of developing Mental Health problems	Unsure ☐ Satisfactory ☐ Confident ☐
To be able to assess risk/suicidal ideation	Unsure ☐ Satisfactory ☐ Confident ☐

To be aware of treatment options and their use and availability:	
• CBT	Unsure ☐ Satisfactory ☐ Confident ☐
• Simple behavioural techniques	Unsure ☐ Satisfactory ☐ Confident ☐
• Problem solving	Unsure ☐ Satisfactory ☐ Confident ☐
• NLP	Unsure ☐ Satisfactory ☐ Confident ☐

To be able to manage emergencies in a safe way for all concerned	
• Sectioning a patient and the rules surrounding this procedure	Unsure ☐ Satisfactory ☐ Confident ☐
• How to implement the MHA fairly	Unsure ☐ Satisfactory ☐ Confident ☐
• Psychosis	Unsure ☐ Satisfactory ☐ Confident ☐
• Agression / violence	Unsure ☐ Satisfactory ☐ Confident ☐
• Attempted or threatened suicide	Unsure ☐ Satisfactory ☐ Confident ☐
• Overdose	Unsure ☐ Satisfactory ☐ Confident ☐

PRACTICAL SKILLS

To be able to perform a mental health examination and also any necessary physical examination	Unsure ☐ Satisfactory ☐ Confident ☐
To be able to assess suicide risk	Unsure ☐ Satisfactory ☐ Confident ☐
To be able to distinguish between depression and emotional distress/ unhappiness and to avoid medicalising such distress	Unsure ☐ Satisfactory ☐ Confident ☐
To be able to tolerate the feelings of uncertainty that some groups of patients generate within us e.g. frequent attenders patients who demand drugs chronic self harmers/borderline personality disorders	Unsure ☐ Satisfactory ☐ Confident ☐
To be able to deal with associated physical problems of people with mental health problems	Unsure ☐ Satisfactory ☐ Confident ☐
To be able to work with patients' carers and families and respect diversity of all types	Unsure ☐ Satisfactory ☐ Confident ☐
To be able to practice ethically, recognising the rights and aspirations of patients and their families	Unsure ☐ Satisfactory ☐ Confident ☐

PRACTICAL SKILLS *continued*

To be able to recognise early signs of mental ill health in younger age groups and to act in a timely manner to prevent deterioration	Unsure ☐ Satisfactory ☐ Confident ☐
To acknowledge and understand how our own prejudices might influence our reactions to patients and to prevent them from adversely affecting their care	Unsure ☐ Satisfactory ☐ Confident ☐
To challenge inequality	Unsure ☐ Satisfactory ☐ Confident ☐
To be aware of our own mental health and not to allow ourselves to become mentally unfit - this requires us to be reflective about ourselves and our performance and to establish "boundaries"	Unsure ☐ Satisfactory ☐ Confident ☐
Keeping up to date with evidence based best practice	Unsure ☐ Satisfactory ☐ Confident ☐