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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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).