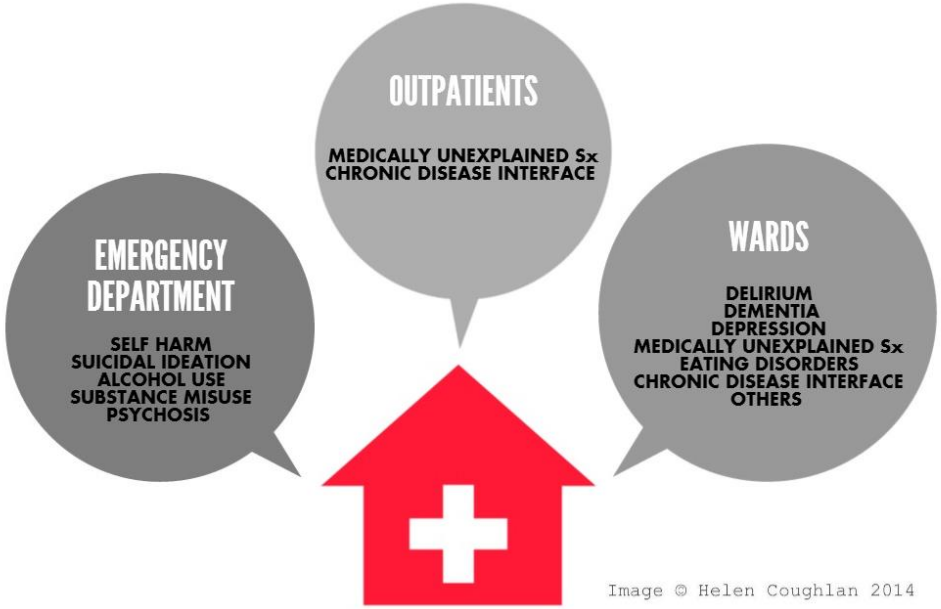
Dr Siobhan MacHale FRCPI, FRCPEdin, FRCPsych
Consultant Psychiatrist, Beaumont Hospital
& Senior Lecturer RCSI

Psychiatrists and Suicidal Behaviour: What is the Psychiatrists role?

CPI Spring Meeting 2018

Other than

- *Working in this area for 30 years, I hereby declare that I have no competing interests*



OUTLINE

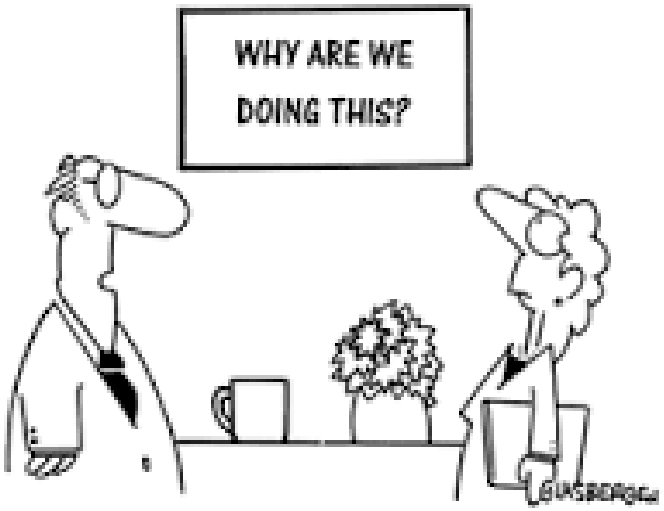
1 Perspective

2 NCP in Self Harm update

3 | Post Suicide

4 | Self Care

SECTION 1
Perspective



"It's not a great mission statement,
but we'll revise it if things get better."

Irish Journal of Psychological Medicine (2015), **00**, 1–5.
doi:10.1017/ipm.2015.28

ORIGINAL RESEARCH

Thirty years of referrals to a community mental health service

L. Douglas and L. Feeney*

Royal College of Surgeons in Ireland, Cluain Mhuire Community Mental Health Service, Blackrock, Dublin, Ireland

Objectives. In recent decades mental health services have become increasingly community based and multidisciplinary. However, it is unclear if referrals have changed over this period. The aim of this study was to compare referrals to a community mental health service over a 30-year period.

Method. New referrals to a community mental health service were randomly sampled from 4 time points over a 30-year period, 1983, 1993, 2003 and 2013, using a mental health information system. Original referral letters were retrieved and anonymised. Referrals were compared with regard to referral sources, demographics, reason for referral, psychotherapy requests, urgency, risk concerns and subsequent hospital admission.

Results. There was a 20-fold increase in the number of new referrals between 1983 and 2013. Over the 30 years there was a significant decrease in the proportion of referrals expressing concern about psychosis, but an increase in the proportion that were deemed urgent and which were concerned with suicidal risk. Referrals in 2013 were longer and more likely to contain requests for psychotherapy.

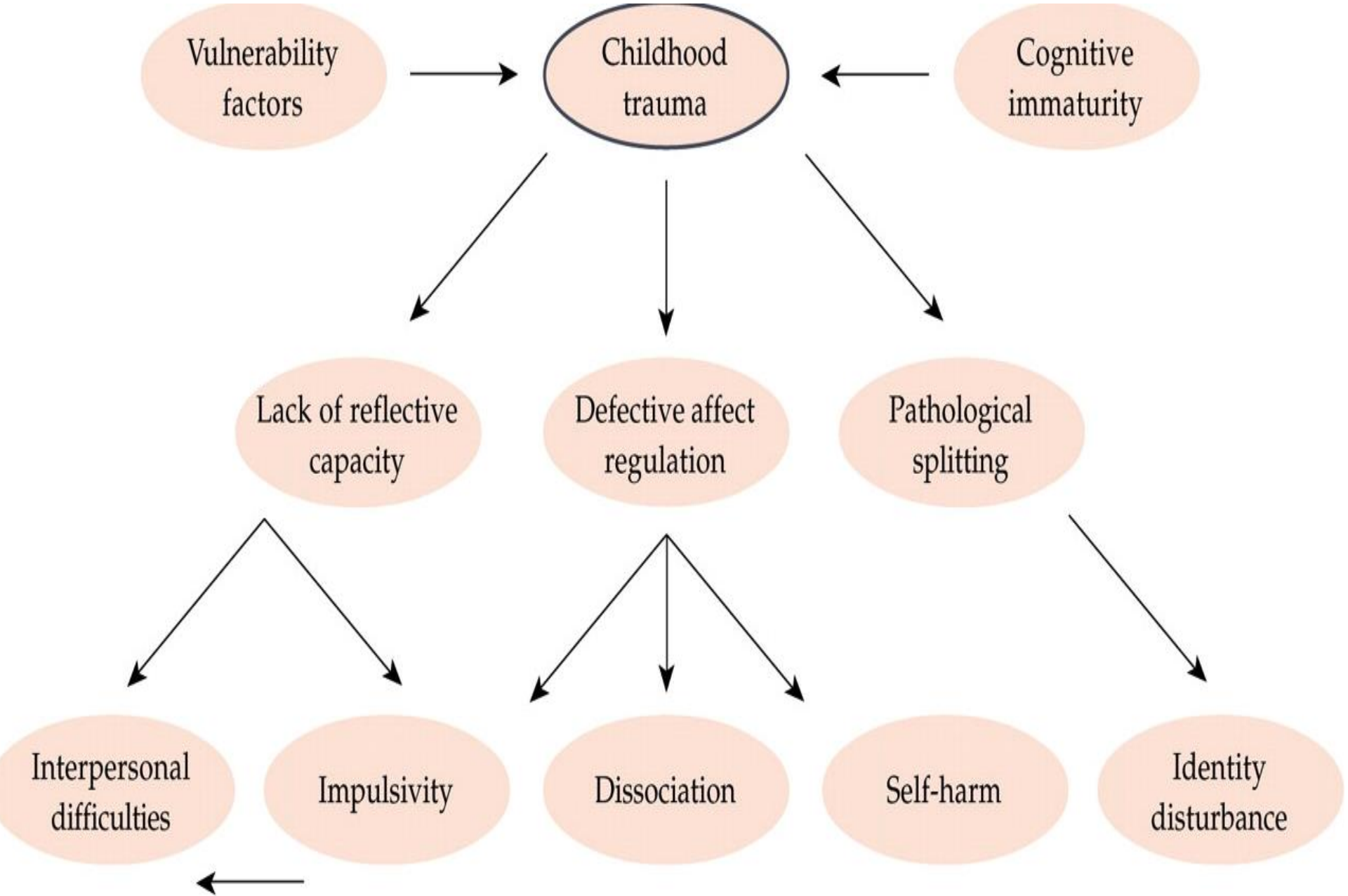
Conclusions. The work of community mental health teams is increasingly concerned with emotional crises. Although services are now more multidisciplinary, they have not been adequately resourced to meet these changing demands.

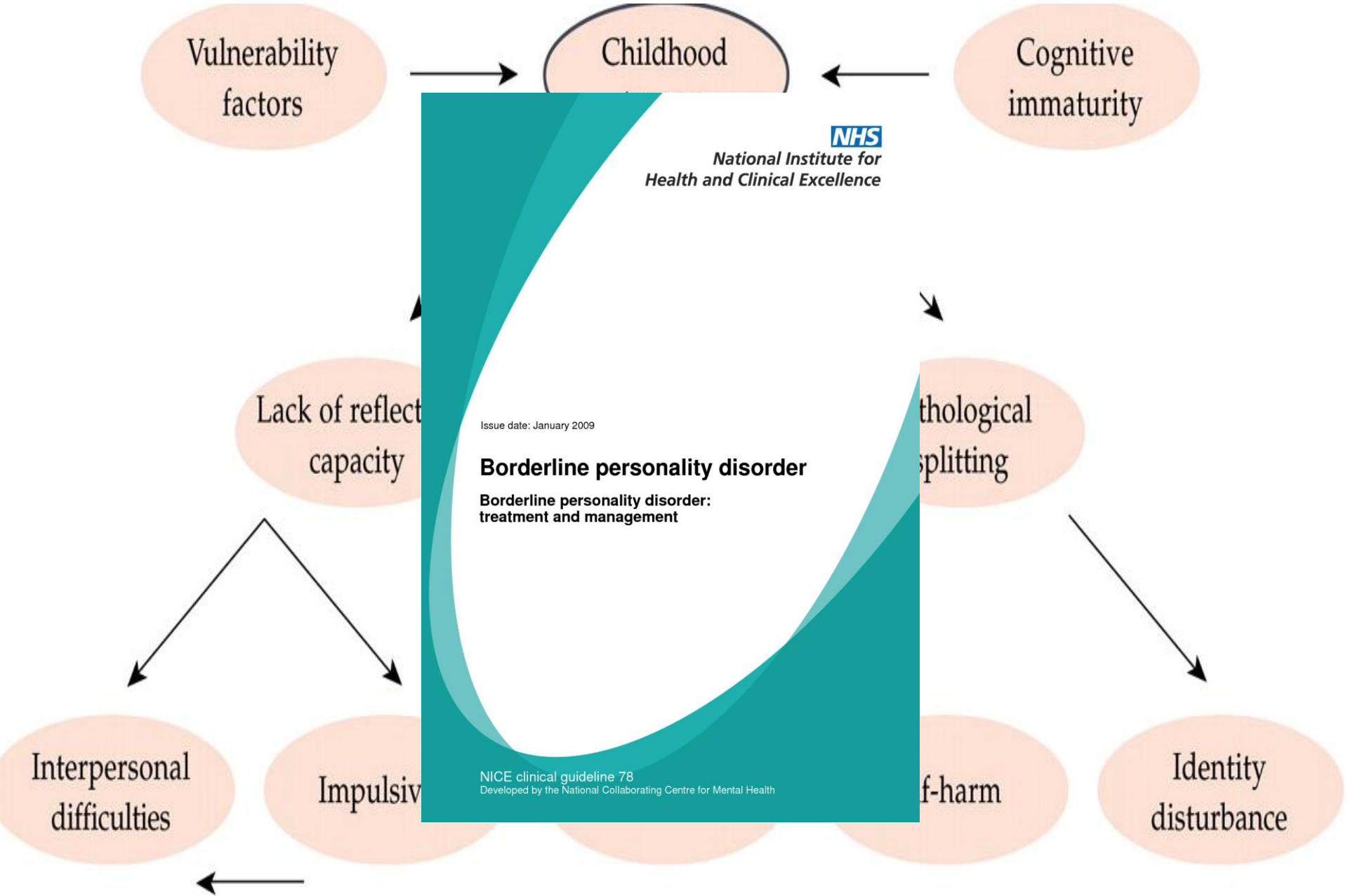
Received 17 February 2015; Revised 25 March 2015; Accepted 15 June 2015

Defining Self-Harm

A *complex behaviour that can best be thought of as a* ***maladaptive response to acute and chronic stress*** often, but not exclusively, linked with thoughts of dying

(Mitchell & Dennis, 2006)


Vulnerability factors
Childhood trauma
Cognitive immaturity
Lack of reflective capacity
Defective affect regulation
Pathological splitting
Interpersonal difficulties
Impulsivity
Dissociation
Self-harm
Identity disturbance


Vulnerability factors
Childhood
Cognitive immaturity
Lack of reflect capacity
thological splitting
Interpersonal difficulties
Impulsiv
f-harm
Identity disturbance
NHS
National Institute for Health and Clinical Excellence
Issue date: January 2009
Borderline personality disorder
Borderline personality disorder: treatment and management
NICE clinical guideline 78
Developed by the National Collaborating Centre for Mental Health

GP perspective on role of Psychiatrist

- Clarify the contribution of significant mental disorder

GP perspective on role of Psychiatrist

- Clarify the contribution of significant mental disorder

- Provide a Place of Safety

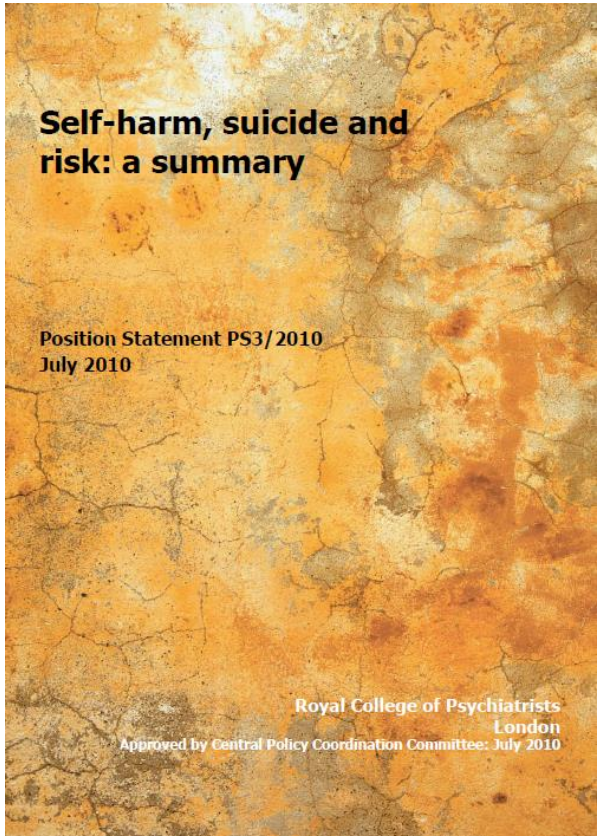
Emergency Department Staff perspective

- *"Dealing with patients who self-harm can hurt staff emotionally, simply because we feel there is NOTHING that we can do to improve their situations, we don't know how to speak to patients"* (Palmer et al, 2006; Saunders et al, 2011).

- *"When you've got a department or ward take full of severe asthma, meningitis, septicaemia...etc, and then you've got a couple of young girls who have taken a cocktail of things... They cannot... with our current resources... be looked after in the same way...which I am not saying I am proud of feeling" (Doctor working paediatrics)* (Anderson et al, 2003; Saunders et al, 2011).

Palmer *et al*., 2006, Better services for people who self-harm. Royal College of Psychiatrists, London
Anderson *et al*., 2003, Journal of Nursing Studies. Vol.40(6), 587-597.
Saunders et al., 2011, Journal of Affective Disorders. Doi: 10.1016/j.jad.2011.08.024

RCPsych perspective



"Our central theme is that the needs, care, wellbeing and individual human dilemma of the person who harms him or herself should be at the heart of what clinicians do. We must never forget, however, that we are not just dealing with social phenomena but with people who are often at, and beyond, the limit of what they can emotionally endure. Their aggressive acts towards themselves can be difficult to understand and frustrating to address but this is precisely why psychiatrists need to be involved to bring clarity to the differing causes for the self-destructive ways in which people act and to assist in managing the problems for the people concerned including family, friends and professional carers, who sometimes find themselves at the end of their tether in the face of such puzzling and destructive behaviour. Public health policy also has a vital role to play and psychiatrists should not leave these crucial political and managerial decisions to those who are not professionally equipped to appreciate the complexities of self-harm and suicide."

Lord John Alderdice, Chair Working Group.

Psychiatrist's challenge

Pokorny's complaint

The insoluble problem of the overwhelming number of false positives generated by suicide risk assessment

96% of high risk predictions are false +ves

ie no suicide in high risk

> 50% suicide in low risk group

Nielssen et al. BJPsych Bulletin (2017), 41, 18-20

Psychiatrist's challenge

Pokorny's complaint

+LONG WAITING LISTS

+LACK OF RESOURCES

+ NOT OUR ROLE

+

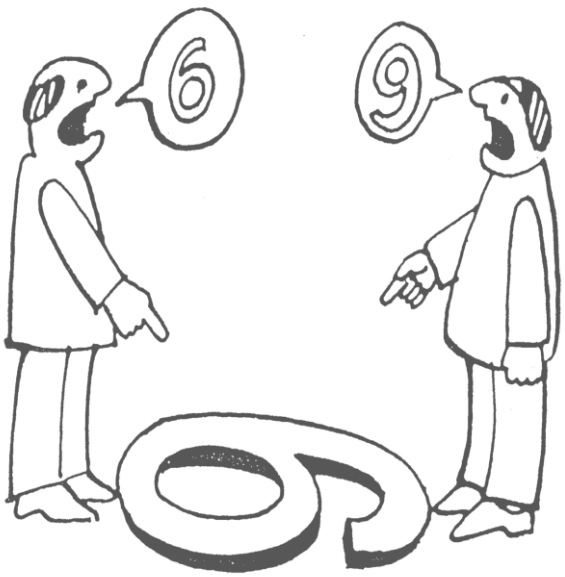
+

ED

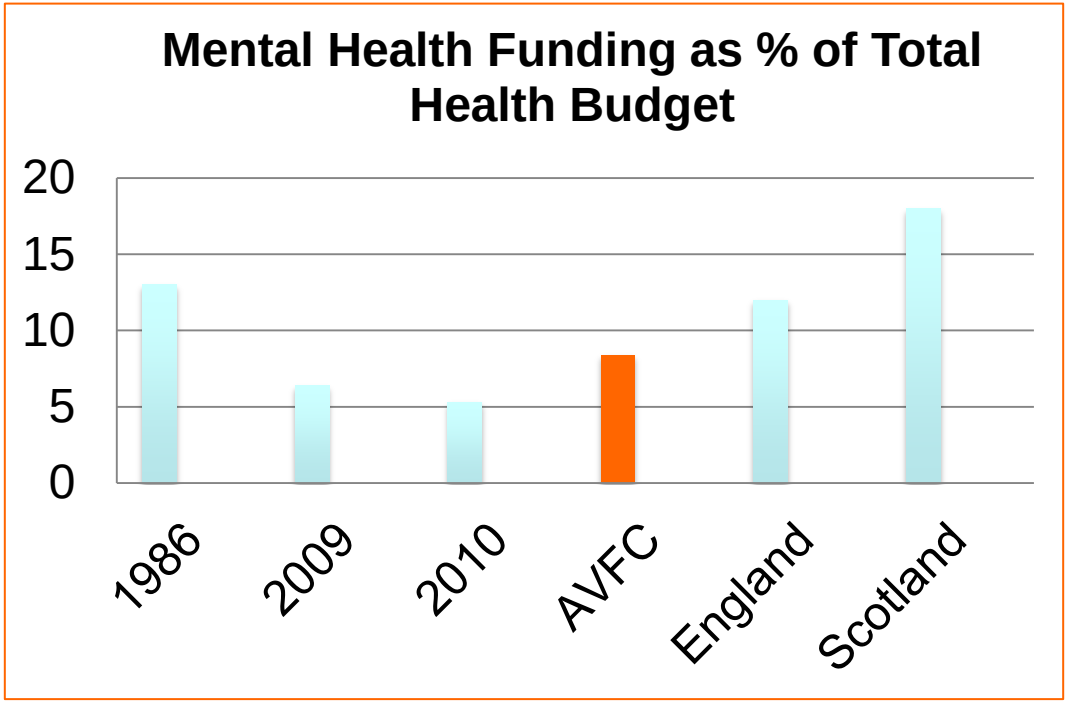
“Patients with mental health problems are treated badly and neglected by ED staff”

“ED staff are left to care for patients who are severely mentally ill with no responsibility taken by mental health staff”

WHY?

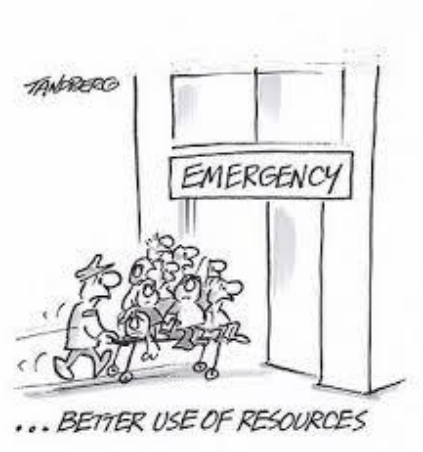


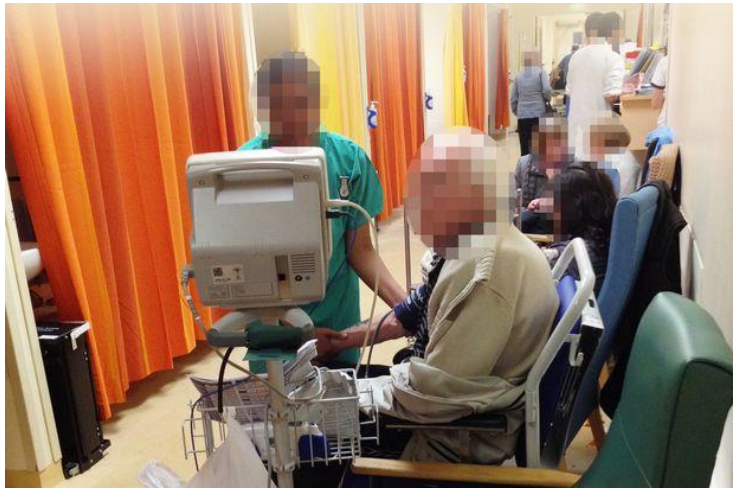
Difficult for both sides



2010 staff moratorium has **disproportionately impacted** on the mental health services:

mental health	9% of healthcare work force
	20% of the 1,500 posts lost





RTÉ Jan 21, 2014 - Overcrowding in hospital emergency departments is "unequivocally **dangerous** for patients", according to emergency medicine specialists

Galway nurses to protest 'severe overcrowding' in galway-university-hospital-protest-Sep 15, 2014 - The INMO said today nurses are finishing shifts “in a **distressed** ...

.Jan 9, 2014 - **EXHAUSTED** emergency department nurses are “checking in” to their own workplace as they **struggle** to cope with overcrowding at University

'horrendous' overcrowding at Limerick ED Sep 27, 2014 - CONDITIONS at the emergency department at University Hospital Limerick have been described as “**horrendous**” by a County Limerick man ...

Beaumont **'unsafe** for patients', says CEO Sep 8, 2014 - Beaumont Hospital chief executive Liam Duffy made the claim in a letter to staff, warning that emergency department overcrowding ...

ROLE OF THE PSYCHIATRIST in ED

To assist ED staff in the management of their patients' mental health needs

Incorporating

- Different patients
- Different environment
- Different language

Team working

- **Unidisciplinary** - practitioner works autonomously with limited input from other practitioners
- **Multidisciplinary** - various health care professionals working independently, collaboratively, in parallel, each responsible for a different patient care need
- **Consultative approach** - one practitioner retains central responsibility and consults with others as needed

VS

Interdisciplinary

INTERDISCIPLINARY WORKING

A dynamic process involving two or more health professionals with complementary backgrounds and skills, sharing common health goals and exercising concerted physical and mental effort in assessing, planning, or evaluating patient care.

This is accomplished through **interdependent collaboration, open communication and shared decision-making**. This in turn generates value-added patient, organisational and staff outcomes.

Nancarrow et al. Ten Principles of good interdisciplinary team work Hum Resour Health. 2013; 11: 19.

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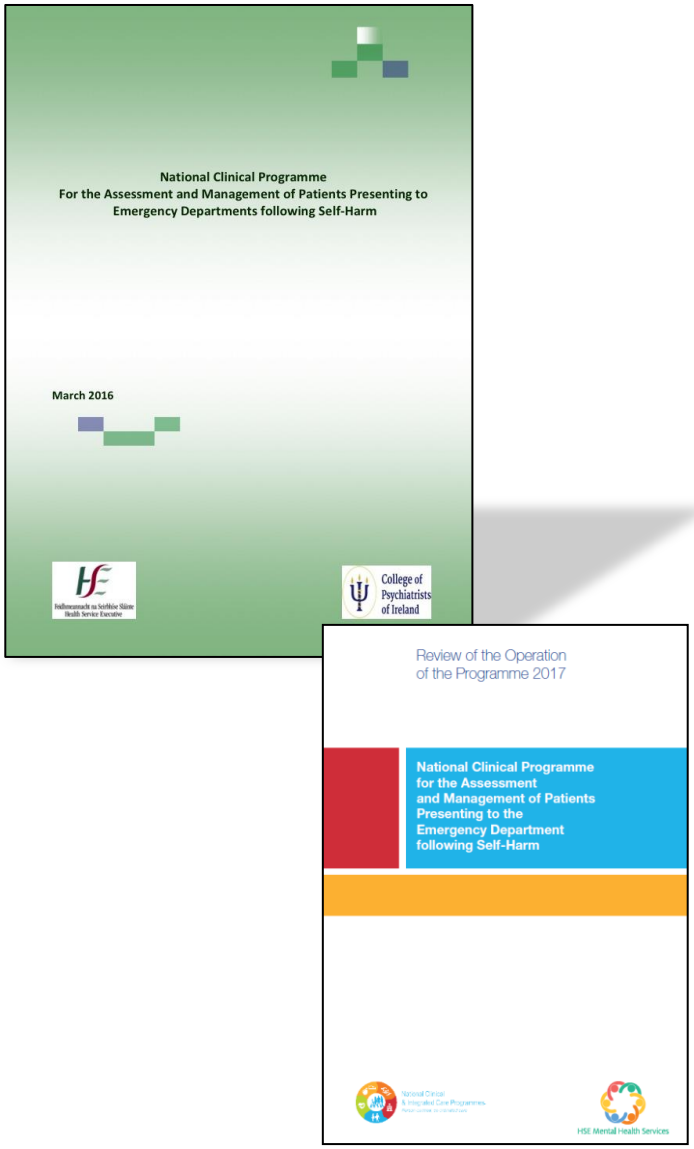
Parallel Pathway

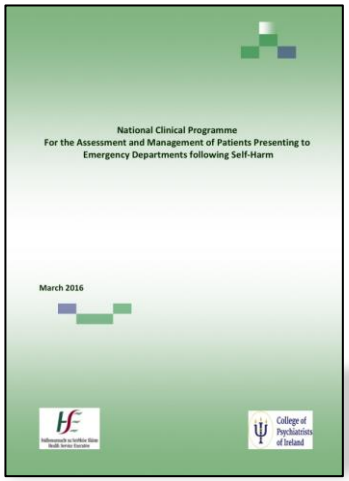
SECTION 2

NCP in Self Harm update

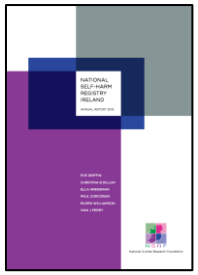


Background reading

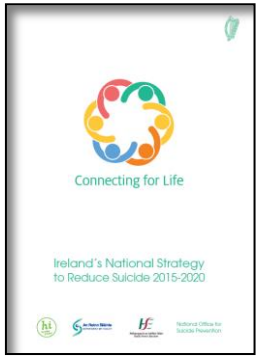
- **NICE**



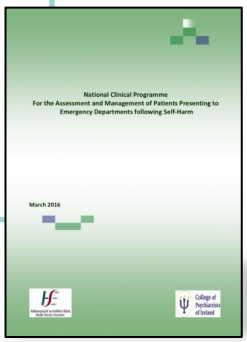
- **NSRF**



- **Connecting For Life** 2015-2020



OBJECTIVES



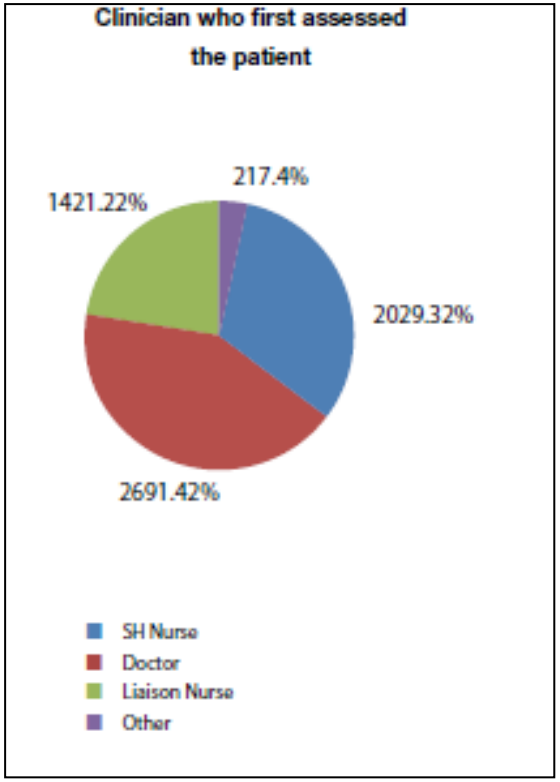
- improve the ***assessment and management*** of all individuals who present with self- harm to the ED
- ***reduce*** rates of repeated self-harm
- improve access to ***appropriate interventions*** at times of personal crisis
- ensure rapid and ***timely*** linkage to appropriate follow-up care
- optimise the experience of ***families and carers*** in trying to support those who present with self-harm

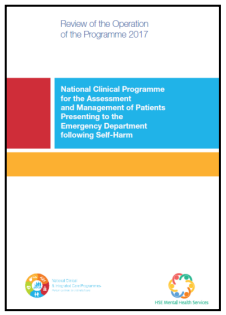
Review of the Operation
of the Programme 2017

National Clinical Programme for the Assessment and Management of Patients Presenting to the Emergency Department following Self-Harm

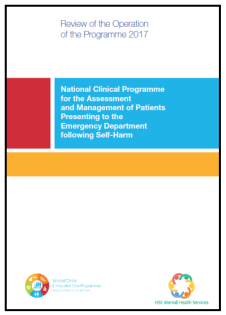
National Clinical
& Integrated Care Programmes

HSE Mental Health Services





Good Practice Point: A team approach – where the NCHD provides a respectful, compassionate assessment, involves family members in the assessment and suicide prevention, provides an Emergency Care Plan and letter to the GP; where the consultant on call provides clinical advice and support in implementing the NCP, and where the NCHD hands over to the CNS for follow-up and bridging to next care – will ensure the delivery of the clinical programme for all patients presenting to the ED following self-harm or with suicidal ideation.



- In 2016, out of 6,928 presentations of patients who had self-harmed or who were expressing suicidal ideation, 90% received a biopsychosocial assessment from an expert mental health professional.

- All CNSs have been offered training in raising awareness and skills for ED staff working with patients with mental healthcare needs. In three EDs, this training has been formally delivered. It is recommended that all CNSs be supported in delivering this training.

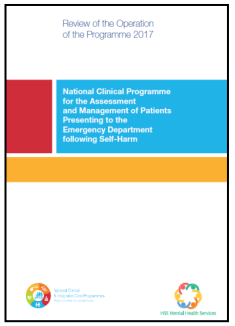
- Twelve of the 29 (26 Adult, 3 Paediatric) EDs in the country have a dedicated, suitable room for the assessment of patients with mental health needs. It is recommended that all EDs be provided with a suitable room.

- It is recommended that all patients receive parallel assessments, which has been shown to reduce waiting times to assessment

- In 2016, of 6,239 presentations where the patient received a biopsychosocial assessment, 32% were assessed by the CNS, 42% by the NCHD and 22% by a liaison nurse. The NCP recommends that all patients receive a biopsychosocial assessment from a CNS, a psychiatrist or a non-consultant hospital doctor (NCHD) in psychiatry.

- Communication with the GP is paramount. In only 61% of presentations was a letter sent to the GP within 24 hours of discharge. It is recommended that the proportion be increased to 100% for those who have a GP.

- Each patient should receive a follow-up phone call within 24 hours of discharge from the ED. A phone call was received in only 47% of presentations. It is recommended that all patients, including those who present out of hours and are assessed by the NCHD, should receive a phone call from the CNS within 24 hours of discharge from the ED.



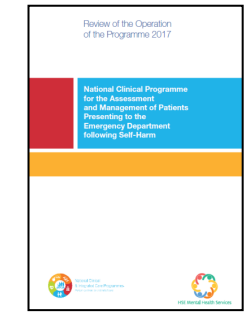
- Support and supervision are essential to ensure that staff remain healthy, and to prevent compassion fatigue and burnout. This review makes recommendations on the support, supervision and training of NCHDs, CNSs, liaison nurses and consultant psychiatrists.

- In each service, the NCP is delivered by the CNS and a clinical lead, who is a consultant psychiatrist. The success of this NCP relies on true interdisciplinary working between the CNS and the clinical lead. The report makes recommendations to help ensure that the clinical leads are supported in their role.

- A total of 61% of presentations in 2016 included the patient's next of kin in assessment and management. It is recommended that this number be increased to 100%.

- In many services, it was clear that out-of-hours NCHDs were completing biopsychosocial assessments but did not fully comply with the NCP. Recommendations are made to ensure compliance. Extra training will be provided for NCHDs.

- A high number of patients without physical health needs have been presenting to the ED. They would be better assessed by a Community Mental Health Team (CMHT). Recommendations are made as to how the Executive Clinical Director (ECD) can work with CMHTs and the clinical lead so as to address this.



The Patient Journey

The patient presents to the Emergency Department (ED) following self-harm or with suicidal ideation.

The patient is triaged; the CNS from the NCP (MHCNS) or on-call non-consultant hospital doctor (NCHD) is informed of the patient's presentation, at the same time as the patient is referred for physical care.

The MHCNS/NCHD assesses the situation, identifies whether the person is fit to be assessed, and agrees a management plan with the ED staff.

The MHCNS/NCHD gathers information from the GP, Mental Health services and patient's next of kin (NoK). ED staff and NoK are given support by the MHCNS/NCHD. When the patient is fit for full assessment, the MHCNS/NCHD carries this out, in a safe and private environment. All sources of information are included in completing the assessment of needs and risks.

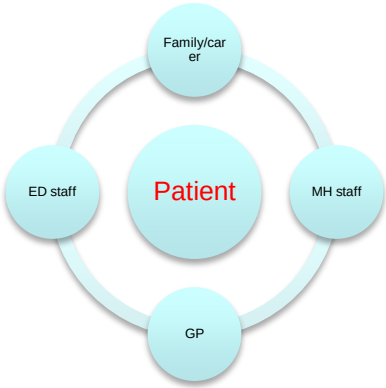
The MHCNS/NCHD provides information for the patient and NoK on suicide prevention, identifies the most appropriate next care, includes this in an Emergency Care Plan (ECP), and informs the patient they will receive a follow-up phone call from the MHCNS the next day.

Once assessment is complete the MHCNS/NCHD gives a copy of the ECP to the patient, and sends a letter and copy of the ECP to the patient's GP.

The MHCNS: phones the patient the next day to provide support and review the ECP, ensures that the patient has dates for next appointments, contacts the patient prior to next appointment to encourage attendance,

Referral options include

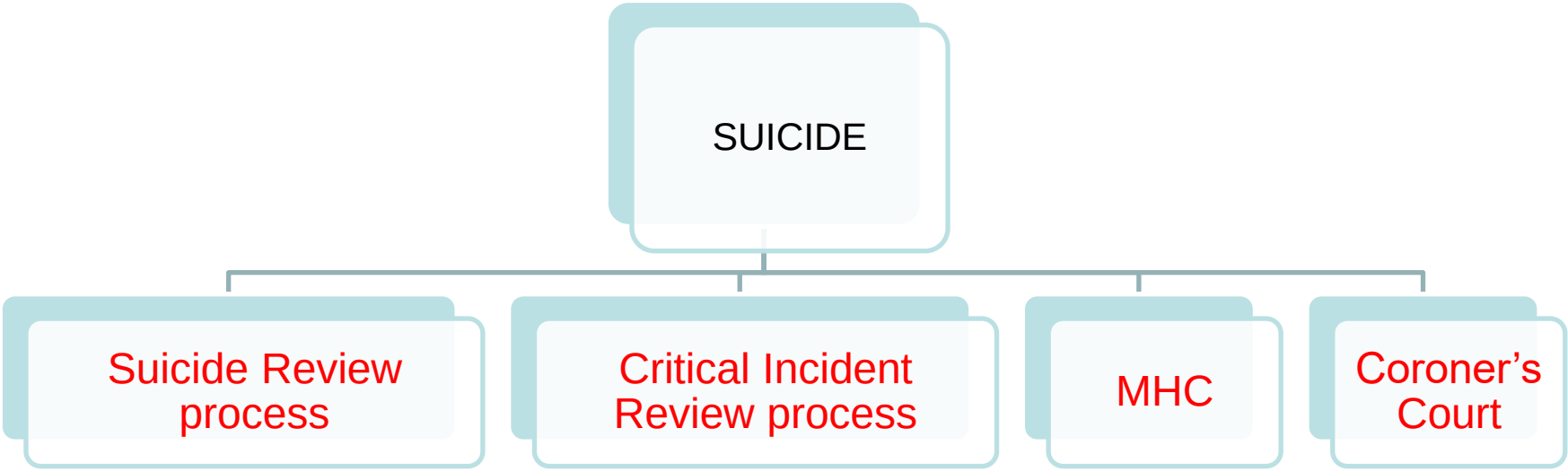
In ED: ED staff, SW, Alc Liaison Nurse, Security etc.



- GP
  - CIPC (medical card holders)
- Voluntary services eg
  - Pieta House
  - Counselling services
  - Addiction eg Aitlinn, Barkie, North Dublin Drug Taskforce, Trinity Court
  - Men's Sheds, MABS
- Youth eg
  - Jigsaw
  - Crosscare
  - SASSY
- Others
  - Exchange House, LGBT, Spirasi, support groups – AA/Aware/GROW/Recovery
- CMHT/ CAMHS

SECTION 3

Post Suicide


SUICIDE
Suicide Review process
Critical Incident Review process
MHC
Coroner's Court

Suicide Review Policy

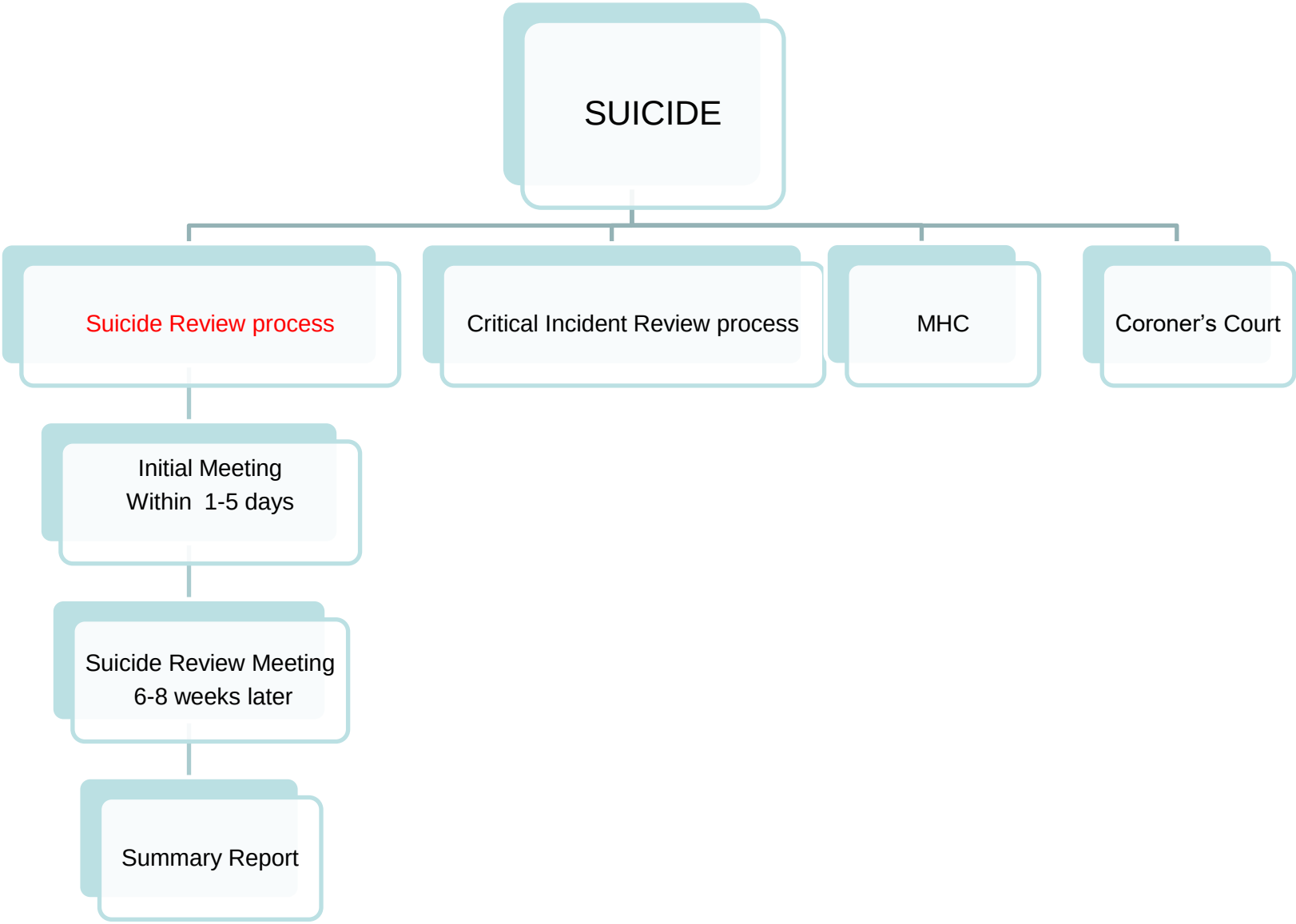
Suicide rare but traumatic

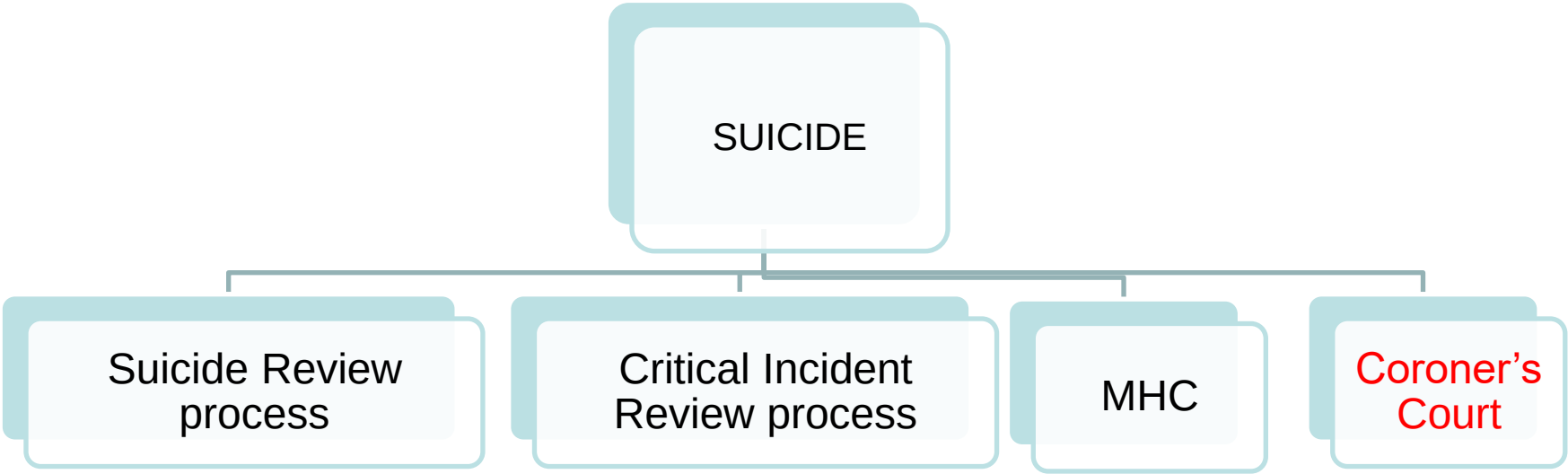
Assessment/treatment based on a concept of working in a team leads to a *shared responsibility* which enables staff to work through their feelings

Suicide reviews are developed for *staff support and learning* - they are not quasi-enquiries

Clinical Governance: SRP allows *better clinical practice* to emerge and Risk Management to proceed

Critical incident review should be kept distinct from the suicide review process


SUICIDE
Suicide Review process
Critical Incident Review process
MHC
Coroner's Court
Initial Meeting
Within 1-5 days
Suicide Review Meeting
6-8 weeks later
Summary Report


SUICIDE
Suicide Review process
Critical Incident Review process
MHC
Coroner's Court

Coroners Court

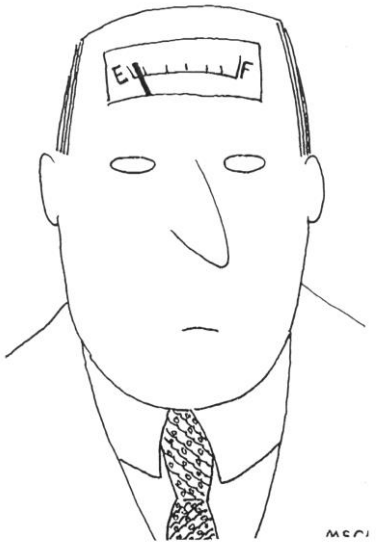
- An inquest is a public enquiry into the circumstances surrounding a death due to unnatural causes.
- The Coroner's duty is to protect the interests of the deceased and also the public interest.
- The purpose of an inquest is to ascertain:
  - Who the deceased was
  - How, when and where the death occurred
  - To provide a verdict
  - To provide a death certificate
- Investigative; not adversarial

SECTION 3

Self Care

Carers needs

- Family/other



Suicide Support and Information

Search

Home | Bereaved Family Members | General Practitioners | Mental Health Professionals | Project Management | Video Gallery

Suicide Support and Information

Developed by the **National Suicide Research Foundation** and funded by the Health Research Board (HRB) this website provides evidence based information on bereavement following suicide and responding to people at risk of suicide. The information is tailored for people bereaved by suicide and for health professionals, including GPs and mental health professionals, as well as the general public.

The evidence base represents up-to-date information from international systematic reviews and outcomes of a HRB funded study: *Psychosocial, psychiatric and work related factors associated with suicide in Ireland: A case-control study (SSIS-ACE).*

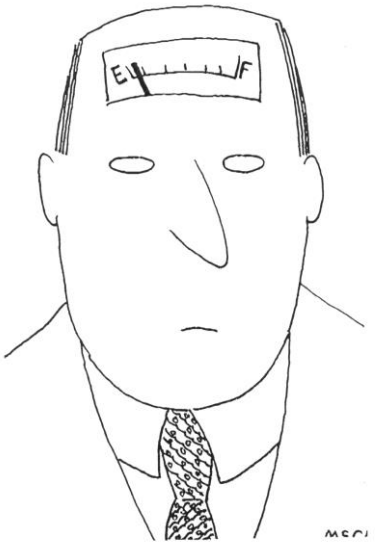
The **Suicide Support and Information** website is a timely resource, which meets a key objective of the Irish National Strategy for the Reduction of Suicide, ***Connecting for Life***, 2015-2020: *To enhance accessibility, consistency and care pathways of services for people vulnerable to suicidal behaviour.*

Home | Bereaved Family Members | Grief and Meaning Making After a Suicide Death | Grieving Family and Friends | Practical Advice in the Aftermath of a Suicide | Support After a Suicide | General Practitioners | Aetiology and Risk Factors for Suicidal Behaviour | Responding to a Suicide Death | Responding to People at Risk of Suicide | Self-Care and Peer Support | Mental Health Professionals | Common Myths about Self-Harm and Suicide | Aetiology and Risk Factors for Suicidal Behaviour | Responding to a Suicide Death | Responding to People at Risk of Suicide | Self-Care and Peer Support | Project Management | Video Gallery

National Suicide Research Foundation | SSIS-ACE | HRB Health Research Board | UCC

www.suicidesupportandinformation.ie

Carers needs



- Family/other

- Mental health of Staff
  - Staff — acknowledged feelings (anger, frustration, depression)
  - Affect

    Clinical decisions
    Behavior with patients
    Quality of care
    Risk of burnout

Meier et al, 2002

Self-Care: An Ethical Imperative

In Health care settings
we are often focused on helping others,

we fail to care for, nourish and replenish
ourselves in order to mitigate the occupational
hazards of our profession and thrive within our work

> "self-care is an ethical imperative for … given the innate occupational hazards relevant within our field including job stress, professional burnout, primary trauma, vicarious trauma and compassion fatigue"

http://creativewellnessworks.com/wp-content/uploads/Perspectives-January-2011.pdf

lynda Monk, msw rsw CPC

AS AN EMPLOYEE

Employers have a duty of care but employees also have certain responsibilities to 'take reasonable care for his or her safety, health and welfare, and the safety, health and welfare of any other person who may be affected by the employee's acts or omissions at work'

Safety, Health and Welfare at Work Act 2005

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Safety, Health and Welfare at Work Act 2005

AS A DOCTOR

Irish Medical Council

- Professional ethical standards that require doctors to exercise self care as of one of the 8 domains of good professional practice
- Established Health Sub-Committee to monitor & support

RCPI

- Notes doctors less likely to access support
- Professional standards include the ability to care for one's own physical and mental health, recognise stressors and access appropriate supports
- Advises physicians that they have a responsibility to themselves, to their families and their patients to take care of their own health

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AS A DOCTOR

Irish Medical Council

- Professional ethical standards that require doctors to exercise self care as of one of the 8 domains of good professional practice
- Established Health Sub-Committee to monitor & support

RCPI

- Notes doctors less likely to access support
- Professional standards include the ability to care for one's own physical and mental health, recognise stressors and access appropriate supports
- Advises physicians that they have a responsibility to themselves, to their families and their patients to take care of their own health

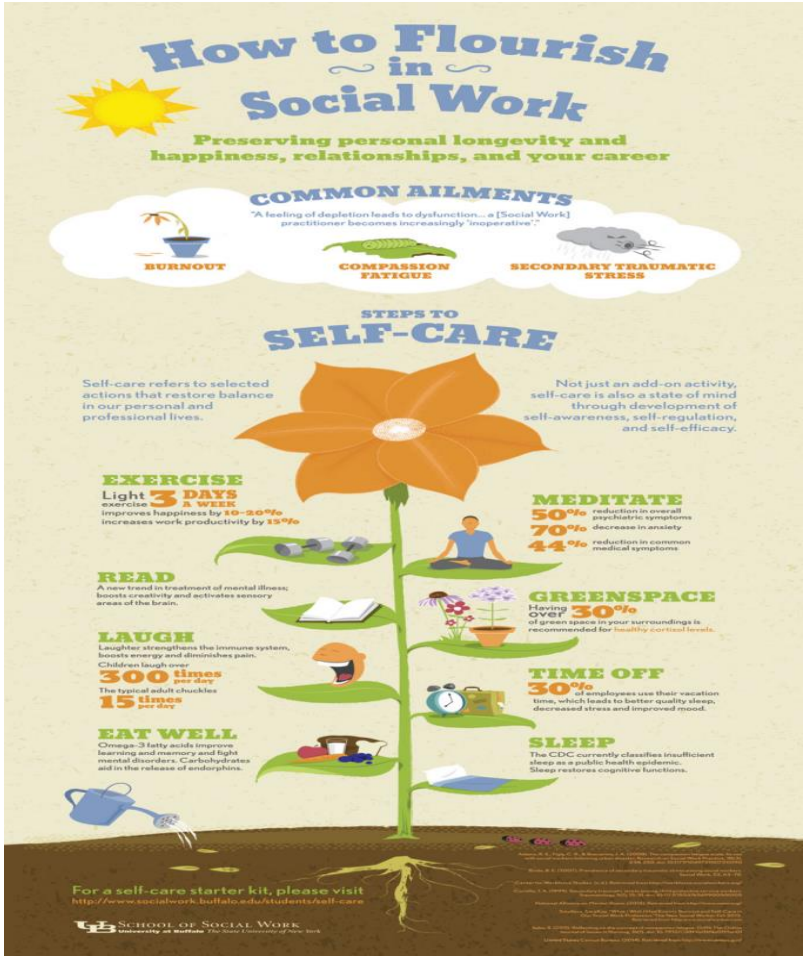
"The term *self-care* refers to activities and practices that we can engage in on a regular basis to reduce stress and maintain and enhance our short- and longer-term health and well-being. Self-care is also necessary for you to be effective and successful in honouring your professional and personal commitments"

How to flourish

Common Ailments
BURNOUT
COMPASSION FATIGUE
SECONDARY TRAUMATIC STRESS

Steps to self care:
EXERCISE (light)
READ
LAUGH
EAT WELL
MEDITATE
GREENSPACE
SLEEP

http://socialwork.buffalo.edu/resources/self-care-starter-kit/introduction-to-our-Self-care-program.html



Stress Management

1. WHAT IS STRESS?

Stress arises when there is an imbalance between the demands present in our lives and the resources available to cope with these demands. Our increasingly dynamic lifestyles mean that our lives are constantly undergoing changes. While imbalance may occur through such changes, it is our reactions to these changes and events that determine when we feel stressed.

How do I begin to manage stress?

FIND THE SOURCE OF ANY PROBLEMS.

The first step to effective stress management is to identify the changes and imbalances that are causing you to react. In addition, however, it is also important to note you may be causing your own stress through personal expectations, feelings and thoughts.

Some of the most common areas that may cause stress include:

1. **Time constraints/deadlines**
2. **Character clashes with others**
3. **Money problems**
4. **Sudden/unexpected changes**
5. **Excessive responsibilities**
6. **Spousal problems**

2. REACTIONS TO STRESS

Reactions to stress depend greatly on the individual with symptoms manifesting themselves both physically and mentally. The most common reactions to stress include:

1. **Eating too much**
2. **Drinking too much**
3. **Inability to sleep**
4. **Smoking**

In the most extreme cases, people who maintain high levels of stress are at greater risk from heart disease, high blood pressure and often suffer from chronic hostility and cynicism. However, the more common symptoms resulting from stress are as follows:

1. **Upset stomach**
2. **Tight neck muscles**
3. **Irritability**
4. **Headaches**

LOWER YOUR TENSION LEVELS

Although negative reactions to stressful situations may be difficult to avoid at times, it is worth taking the time to analyse your negative reactions and consider how these might be changed to more positive reactions. For example:

Negative Reactions	Positive Reactions
Worrying/rushing	Organising/prioritising
Overspending	Budgeting
Blaming others	Accepting responsibility
Feeling fearful	Asking for help
Insulting/judgmental remarks	Talking it over
Eating too much	Exercising/physical activity

3. COPING WITH STRESS

THINK ABOUT IT

Coping with stress means coming to grips with the fact that some situations are beyond our control. As well as altering your reactions to stress you must also equip yourself with the following skills for coping with stress.

ACCEPTANCE

Some stress can be relieved if you just accept that in some situations, you have very little or no control. Once you have accepted this fact you can reduce stress levels by using language such as "Some day I'll laugh about this", or "This is a learning experience".

ATTITUDE

When faced with a stressful situation, be positive. Ask yourself "What can I learn from all this?" Through positive thinking, stress levels will be reduced, your mind will become clearer and solutions will be found more readily as a result.

PERSPECTIVE

All too often we become stressed over things which never happen or scenarios which never take place. Put things in perspective. Ask yourself, "In the grand scheme of things, how important is this situation?", "Is there anything I can do?", and, "In five years time, will I even recall this event?"

4. THINK POSITIVELY

TAKE ACTION

Don't let stress control you. Take positive action which will reduce your levels of stress.

SELF TALK

"Self talk" is when we express our expectations and thoughts on a situation and its potential outcome as we see it. This can be both helpful and detrimental to our levels of stress as there can be positive and negative ways in which we might perceive the outcome of a situation.

Positive self-talk

Thinking of positive ways to view a situation can provide an effective weapon against stress."I'm in control," and "I can meet these challenges" are examples of positive self talk.

Negative self-talk

Thoughts such as "I can't","This is too difficult" or "I have to be perfect" are negative and produce stress.

Negative Thought Patterns	Positive Thought Patterns
SITUATION: You make a mistake at work.	**SITUATION:** You make a mistake at work.
STRESS THOUGHT: "I can't do this" "I've failed at my job".	**EMPOWERING THOUGHT:** "What can I do to improve?" "How can I prevent this from occurring again?"
REACTION: Sadness, low self-esteem	**REACTION:** Feeling of mastery and self-confidence

5. TIME MANAGEMENT

Organisation and forward planning is central to managing your time effectively.

1. **Make an achievable "to-do" list and prioritise tasks.**
2. **Remember that sometimes it is not possible to get everything done in one day. There is always tomorrow.**
3. **Get yourself a personal organiser and make sure you utilise it.**
4. **Break up each of your tasks into small, easily achievable chunks.**
5. **Delegate as much as you can.**
6. **Handle each document only once.**
7. **Prepare agendas for meetings and keep those present on track.**

6. BALANCE WORK & FAMILY

Sometimes the pressures of balancing a career and a family can be overwhelming. Gain control by using the following suggestions.

KEEPING BALANCE AT WORK

- **Work to a strict timetable and stick to limits you have set.**
- **Learn to say no without feeling guilty. Practice by making two positive statements followed by one negative, followed again by one more positive statement. For example:**

  "I enjoy working on this project and I enjoy working with you, but I can't stay tonight. I will do it first thing tomorrow"

- **Be brief. The longer you talk the more likely you are to give in.**

KEEPING BALANCE AT HOME

- **Cook in large quantities and freeze individual meals.**
- **Set up daily and weekly routines for chores and share with other family members.**
- **Schedule quality time with family members.**
- **Prepare for unexpected eventualities. For example: Keep a spare set of car keys in case of an emergency.**
- **Allow yourself to switch from a working role to a family role.**
- **Use your commute time to prepare for your next role.**

7. COMMUNICATION

Communication is all important if you are to work effectively with others and if you are to get the understanding of your work colleagues and family members.

EFFECTIVE COMMUNICATION

Outgoing communication

- **Organise your communication method.**
- **When speaking, express your individuality by using " I " statements. For example, "I believe that...".**
- **Don't judge others.**
- **Do not call people names.**
- **Be able to receive feedback in both positive and negative forms.**

Incoming communication

- **Establish and maintain eye contact.**
- **Listen to the entire message. Understand not only the content but also feelings and meaning.**
- **Ensure you have understood the message through summarising what you have heard.**

Build a support system

- **Form bonds with people at home and work.**
- **Create a good network within which you can obtain care and support.**
- **Express negative feelings to others as this makes way for positivity.**

8. BREAKING THE CYCLE

TAKING TIME OUT IS IMPORTANT

- **Get away from it all. Read a book, listen to music, read a meaningful quotation.**
- **Laugh. You deserve it. Share jokes.**
- **If you feel tense, close your eyes, breath deeply, or go for a walk.**

EXERCISE

- **Remember that exercise can reduce tension, leaving the body better equipped to handle stress.**
- **Pick a form of exercise you like. Do it for 20-30 minutes, 3-4 times per week.**
- **Stretch breaks can relieve tension.**
- **Going for a walk is a simple form of exercise.**

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MIND BODY **MEDICINE**

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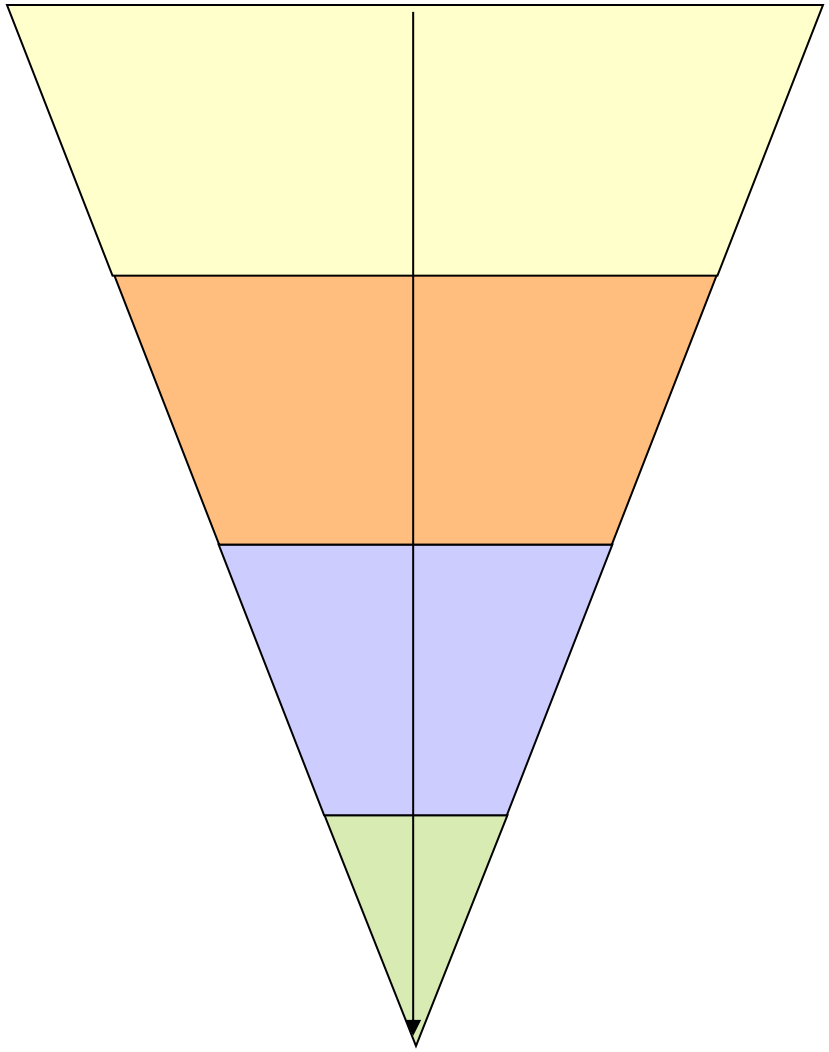
WHAT IS THE PSYCHIATRIST'S ROLE?



Nationally

Consensus of opinion

Contribution to debate
Education
Research

Locally

Cascading skills & link support
- Voluntary organisations
- Primary care team

Individual

Skills development-
problem solving
DBT

Role of medication

Acute assessment /crisis management
- NCCP

WHAT IS THE PSYCHIATRIST'S ROLE?

Nationally

Locally

Individual

ort


I
MY
GP
www.lmc.org.uk


Thank you for listening!
QUESTIONS?
ALWAYS
WELCOME!