



# Mind the Gap

Newsletter of the West Midlands SpR/ST4-6  
General Adult Psychiatrists

*Editors : Dr Rehan Siddiquee & Dr Aman Durrani*

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## Editorial

### 'The Pharmaceutical Industry and its role in Psychiatric Training'

**Dr Rehan Siddiquee**

**Chair of General Adult Psychiatry SpR/ST4-6 peer group**

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Those of us that attended the Reflections '09 SpR conference were fortunate to witness a debate on this very topical and important issue. The topic is one that deeply divides opinion in the medical profession and it was very useful to see both sides put down their arguments in front of the audience. Both sides put forward very cogent arguments supporting their stand on the matter.

The side that argued that the Pharmaceutical industry did have a role in training felt that the question regarding the role of the industry was a "no-brainer" and what should be up for debate was the extent of involvement the industry should have in training. This side also argued that it was up-to the psychiatrists and psychiatric trainees to be aware of the nature of training that was being offered by the Industry and make judgements based on their reasoning rather than being told what to do by a select few.

This argument was rejected by the opposing team because of the likelihood of bias in

training that is conducted by the Industry and the lasting effect it could have on the young impressionable minds of trainees.

Voting was conducted before and after the arguments were presented and although the number of votes against the industry remained the same, the number of votes for the industry were higher after the arguments. This could be explained by the fact that some of the people sitting on the fence must have got convinced that the Pharmaceutical Industry does have a role in Psychiatric training.

The closing remarks by Prof. Oyebode who chaired the debate resonated true to the fact that we live in a capitalistic economy where the onus is on selling. Therefore interaction with the Pharmaceutical industry is inevitable and hence must be regulated. At least things in the United Kingdom are not as complex as in the USA where the Industry is allowed to advertise directly to patients!

## Peer group Annual Conference

I would like to take this opportunity and use this platform to thank all the speakers that graciously accepted our invitation to speak at **Reflections '09**: The Annual West Midlands General Adult Psychiatry Higher Trainees Conference.

We the trainees are all truly humbled by the response we got. I would also like to personally thank my fellow organising committee members

Dr. Adshead and Dr. Durrani for their input in bringing this event together.

I also join the rest of the peer group in welcoming the new members that are now part of it and wish the very best of luck to those that have finished their training and will be leaving the peer group in their future endeavours.

*Dr. Rehan Siddiquee*

# Staying in touch

with Dr Rehan Siddiquee

## Mental health news in the national and international media



### The Buzz

#### Deep brain stimulation gets approval

WASHINGTON—The Food and Drug Administration has approved the first implantable device designed to deliver electrical therapy to the brain to suppress symptoms associated with severe obsessive-compulsive disorder.

The device, known as Reclaim DBS (deep brain stimulation) Therapy, is made by Medtronic Inc. The product was approved to treat patients with OCD in cases where drug and psychotherapy have failed. It's expected the device could be used in fewer than 4,000 people annually for OCD.

Medtronic said the device would be available in the middle of this year to treat OCD. The company also announced it had started a randomized clinical trial of DBS for treatment-resistant depression.

*(Dow Jones, 19-02-09)*

#### Injectable gel could heal brain injuries

An injectable "biogel" that may help wounded soldiers and car crash victims recover from brain injuries could be tested on patients in three years, it has been claimed. The material, containing a cocktail of synthetic and natural chemicals, spurs on the growth of neural stem cells which in turn repair damaged nerves. After promising studies on rats, scientists in the US say the treatment could be ready for patient trials in as little as three years.

Details of the work were presented at the Military Research Forum in Kansas City, US. The meeting is geared towards medical advances that can help members of the armed forces. It is hoped the biogel will be useful in the treatment of wounded soldiers with head injuries.

*(Telegraph, 2-9-09)*



ST. PAUL, Minn.—St.Jude Medical, Inc. today announced the first patient implants of its Libra® deep brain stimulation (DBS) system for treating the symptoms of Parkinson's disease, a progressive neurological disorder that affects a person's control over his or her movements and speech.

The announcement was made at the European Association of Neurosurgical Societies and the Société Française de Neurochirurgie joint annual meeting in Marseille, France.

"We have initiated a limited launch of these systems in Europe and have recently completed implants in Austria, Germany and Greece," said Chris Chavez, president of the St. Jude Medical Neuromodulation Division. "We look forward to expanding the availability of these systems in order to help physicians meet the needs of their patients."

*(Business Wire, 26-03-09)*

#### Erasing fearful memories

Scientists have discovered a way of preventing reactivation of fear memories in humans.

The method, using beta-adrenergic receptor blockers, could be useful for weakening or erasing emotional memory of patients with post-traumatic stress disorder. Studies in animal models have shown that fear memories can change when recalled, a process known as reconsolidation, and that this reconsolidation stage is vulnerable to beta-adrenergic receptor blockers.

Merel Kindt and colleagues did a double-blind study in humans, where subjects learned to associate pictures of spiders with a mild shock, creating a fearful memory. Later, they were given a beta-blocker, propranolol, or a placebo.

Merel Kindt and colleagues found that the group given propranolol had a greatly decreased fear response to the spider pictures 24 hours later. Strikingly, the propranolol-treated subjects showed no reinstatement of the fear response, suggesting that their fear memory was completely erased.

*(Nature Neuroscience, 15-02-09)*

## **Audit: Management of Insomnia - a completed audit cycle** **by Dr R Ganapathy (SpR General Adult Psychiatry), Dr N Butt (Staff Grade Psychiatrist), Dr I Akin-Ojo (ST2 Psychiatry)**



### **Background**

National Institute of Clinical Excellence (Nice) published guidelines regarding the management of Insomnia in 2004. A survey completed in the UK in 2006 reported the prevalence of Insomnia as 37% in the general population. Insomnia was reported not only with mental disorders but also with physical illness and social problems.

We completed an audit cycle on the management of Insomnia at Newington Centre, Birmingham and Solihull Mental Health Foundation Trust. Newington centre is the base for the community mental health teams covering the northern areas of Solihull within the trust.

### **Aim**

To determine the extent of adherence to NICE and BNF guidelines with regards to the management of Insomnia in secondary mental health services as well to see if there has been an improvement in the adherence to national standards as compared to the initial audit.

### **Standards**

- ◆ All patients with insomnia should initially be offered non-pharmacological treatment
- ◆ Hypnotic drugs should only be used in the short-term management of insomnia interfering with normal daily life after consideration of non pharmacological treatment.
- ◆ The drugs should be prescribed for short periods of time only, in strict accordance with their licensed indications as per BNF.

### **Method**

The study period was randomly chosen and included patients seen in the outpatient clinics at Newington centre during a 1 month period in both the audits. All outpatients pre-

senting with insomnia during the study period were included in the sample. The data was collected from case notes, GP letters and EPEX. The re-audit was completed a year after the initial audit.

### **Results (see Table 1 below)**

The re-audit showed an improvement in the adherence to national guidelines with respect to all the standards considered for the audit.

### **Conclusion**

The completion of audit cycle demonstrates not only an improvement in area of practice thus enhancing the quality of care which is the cornerstone of clinical governance but also emphasizes the importance of resources not being wasted by not completing the audit cycle.

A study in the UK in 2001 reported that only 24% of the audits were re-audited thus completing the cycle. There can be practical difficulties for basic specialist trainees in psychiatry to complete an audit cycle as they move from one placement to another every 6months but higher specialist trainees and career grade doctors may be in a better position to complete audit cycles due to the longer duration of placements.

### **References**

1. <http://www.nice.org.uk/Guidance/TA77>
2. BNF 55, March 2008
3. Stewart R, Besset A, Bebbington P, Brugha T, Lindsay J, Jenkins R, Singleton N, Meltzer H. Insomnia co morbidity and impact and hypnotic use by age group in a national survey population aged 16 to 74 years. Sleep, 2006, vol. 29, no11, pp. 1391-1397
4. Gnanalingham J, Gnanalingham M G, Gnanalingham K K. An audit of audits: are we completing the cycle? Journal of Royal Society of Medicine, 2001; 94:288-289

<b>Table 1: Results</b>	<b>Initial Audit</b>	<b>Re-Audit</b>
All patients with insomnia have been offered non-pharmacological treatments.	24%	34%
Hypnotic drugs prescribed only after due consideration of non-pharmacological methods.	23%	41%
The drugs should be prescribed according to the BNF guidelines.	23%	50%



## A study of risk of suicide and self harm during the integrated drug treatment journey in HMP Birmingham

Dr. Jayaprakash Rajendran, Dr. Rehan Siddiquee & Dr. George Georgiou. (Birmingham and Solihull Mental Health NHS Foundation Trust)

### **Aim**

The first 28 days of integrated drug treatment in prisoners carry the highest risk of suicide and self harm. Prisoners are continuously assessed for self harm/suicide risk during the custody and those identified to have elevated risk are placed on ACCT regime (Assessment and Care in custody Team) on various levels of observation till the risk subsides.

We aimed to explore the determinants and associations of self harm and suicide attempts in prisoners with recent substance misuse (SM) history prior to imprisonment, to identify the strength of association between self harm/suicide prevention observation levels, self harm repetition, nature of substance misuse and treatment plans.

### **Method**

Prisoners who were placed on ACCT regime during the 1 year period from May 2007 were identified and studied.

Clinical details such as recent substance misuse, physical complications, co-morbidity and treatment plans were collated from the prison health care database. Time length for sentencing, nature of offence and sentence length were collected from the prison database (LIDS). Data on the nature, methods of self harm/suicide attempts, levels and duration of observation were gathered from ACCT case notes.

Prevalence ratios, suicide/self harm risk rates in various categories of SM, differences in the mean length of stay and mean number of attempts among different groups were calculated using standard statistical methods (descriptive, cross tabulation and 2 t test).

### **Results and discussion**

Of 8214 prisoners held in HMP Birmingham during the study period, 6%(495) were estimated to carry high risk of self harm or suicide and placed on ACCT regime. 50% (246) had recent alcohol

or drug misuse issues at time of imprisonment. 21% (102) had mental illness ranking the third commonest co-existing condition. Only 30% (148) had no identifiable mental health or substance misuse issues.

In both categories (prisoners with & without SM issues) self harm/suicidal expressions/attempts were highest during the first week, particularly on day1 of entry to prison. Though the risk appeared to decrease over the next 4 weeks, there was reemergence of risk in week 5 and beyond, more so in the SM group.

Of the 246 prisoners with SM issues, alcohol, polysubstance (mainly Alcohol+ Cannabis+ Benzos) and Opioids formed the main three categories. Prisoners with SM issues repeatedly expressed or self harmed more than those without these issues (328 vs 301-individual ACCT episodes).

Though cocaine only use was one of the least prevalent within the population as a whole (46/8500), a disturbingly high proportion 57% (25/46) required ACCT regime. Poly substance and Cocaine abuse category of prisoners present with risk during third and 4th week as compared to the Alcohol and opioids who mainly presented during the first and 2nd week.

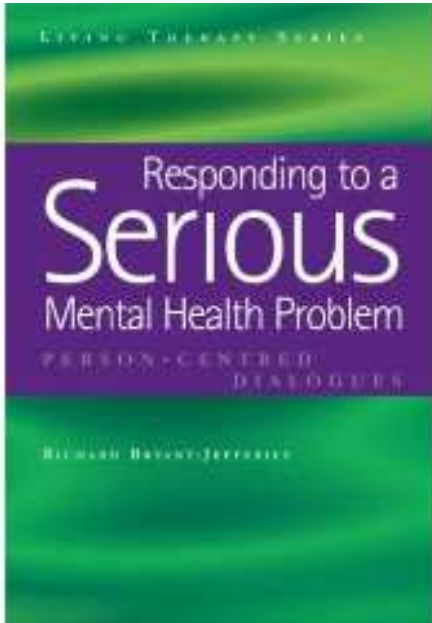
### **Recommendations**

With the advent of Integrated Drug Treatment System (IDTS) and early clinical management of SM issues, the risk period is shifting from the initial 28 days to week 5 and beyond. Post detox phase, longer trial/remand phase are likely to shift the risk of self harm to week 5 and beyond. Risk management should be emphasised throughout the IDTS journey with special attention during the first 28 days.

As Cocaine only abusers carry the highest risk of self harm compared to other categories, the role for stimulant monitoring is emphasised to contain the risk throughout IDTS journey.

***The first 28 days of integrated drug treatment in prisoners carry the highest risk of suicide and self harm***

**Book Review by Dr Rajashree Ray**  
**Responding to a Serious Mental Health Problem: PERSON-CENTRED**  
**DIALOGUES by Richard Bryant-Jefferies (2005)**  
 Radcliffe Publishing ISBN:1857757033 RRP £ 24.95



Developed in the first half of the 20th century by the American psychologist Carl Rogers, person-centred therapy departed from the typically formal, detached role of the therapist in psychoanalytic interventions to the more non-directive, supportive role of the counsellor in helping 'clients' increase their self-esteem and facilitate greater openness to experience. While the client determines the general direction of therapy, the therapist employs three interrelated attitudes of congruence, unconditional positive regard and empathy to open doors to self-actualization and in-depth self-exploration.

This book is one of the many in the Living Therapy series based on person-centred dialogues. It focuses chronologically through the emotional journey of a mother and her 19-year-old son who was manifesting mental health problems of cannabis dependency. It provides the reader a rich insight into the counselling process by using narrative to describe what is happening.

It is divided into two parts; Part I entitled : A mother seeks counselling, where in five chapters the author takes us through five person-centred counselling sessions and two therapist supervision sessions . The Part II of the book: Her son begins his own counselling process, provides further step-by-step

learning of this therapeutic process by elaborate descriptions of seven client sessions and one therapist supervision session.

In the Introductory chapter the author provides a background description of the concepts of this therapy and its application to mental health and diagnosis, assuming minimal prior knowledge of its readers. He then brings them to life in the chapters to follow and provokes us to examine them in the context of the counselling. He has successfully attempted to piece together the impact of substances on adolescent mental health, sensitive religious and cultural issues, family relationships and a mother's deep struggle to support her son in his increasing difficulties. What is further useful for beginners is the built in description of supervision sessions providing both invaluable insight into its process, and an awareness of its integral role in therapy. Another beauty of this book is the appropriate use of the boxed comments, which give not only a self-reflecting space, but also illuminates the process and references of the therapy.

I suppose what could have further benefited readers, is to have experienced some more understanding of the interplay of medication and therapy through the clients eyes, particularly when there is a strong suggestion of the organic aetiology of the illness. I also felt a bit spaced out when trying to picture in my mind the untold therapy sessions the son had when he was attending inconsistently. I feel it would have been useful to know how engagement was achieved in a little more detail to facilitate learning.

Overall, this is a highly enjoyable and informative read, especially for trainees and provides further materials and ideas to explore and discuss amongst professionals in the form of questions and tasks in the Points for discussion section.

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## Becoming a Higher Specialty Trainee A Daunting Experience?

by Dr Mosun Fapohunda (ST5)

The transition from an SPR to a Consultant has always been regarded as a large and daunting step, requiring a lot of preparation and support. Not much has been said about the transition from an SHO to an SPR (now ST-3 to ST-4), which usually occurs within a space of 24hrs. Couldn't this be daunting for some trainees as well?

### Training expectations

The expectations are certainly higher, with more senior responsibilities, independent working with clinical competencies and non-clinical competencies like teaching, leadership and management roles, audit, research and special interests.

### Clinical competencies

One had better have something to show for three or more years of core training. You are the team's senior trainee and that role you must play. Who cares if you're first or final year of Specialist Training ? One had better appear confident and competent or team members may soon lose faith in you and hardly involve you in any clinical decisions.

There is the ethical dilemma of the acceptable limits of wrong decisions in an attempt to achieve independent practice versus knowing your limits and seeking help promptly.

Worse still is the psychological burden of potential dangers of clinical decisions made – typical with advice given to core trainees during assessment of suicide risk in A&E. New on-call commitments may also involve covering police stations and working with other multi-agencies which can also be challenging.

### Non Clinical competencies

#### **A. Teaching**

On my first day of starting work as a Specialist Trainee (ST-4 level), I received a letter with an undergraduate students handbook and a list of medical students in my tutorial group. What cheek! I thought this was meant to be voluntary. Do I have to be a teacher as well?

#### **B. Research**

Can all trainees possibly be researchers? How many of us are truly motivated and enthusiastic about research or it is the love for our CV's and portfolios? Does this not then bring into question the quality and usefulness of any research done?

***One had better have something to show for three or more years of core training. You are the team's senior trainee and that role you must play.***

***Who cares if you're first or final year of Specialist Training ?***

Contributing to trainee's research phobia may be feeling of lack of adequate knowledge and skills, difficulty getting the support of an experienced researcher, lack of secretarial support and insufficient time. The old SPR'S used to have a full day/week off for research- to whom much is given, much is expected. As we, ST-4'S are given half a day , does this make the expectation any less? – You must be joking.

#### **C. Postgraduate degree**

Post graduate degree as an alternative to research? - I think not. Just like all trainees can't possibly be researchers, we can't all possibly have postgraduate degrees either. By the way, choosing between the commitments of a post graduate course and research is like making a choice between the devil and the deep blue sea.

#### **D. Audit**

This is the one thing that was bearable and quite easily done until we were recently informed that Audits would no longer be acceptable unless the cycle was completed. Can things get any worse?

**E. Special interest sessions**

If this included shopping, childcare etc, would the world not be a better place? No, it's got to be a noble course, with every second accounted for.

**Solution**

Yes, there's a solution.

Face reality and get down to completing all competencies as soon as you can. Those of us who have gone through the MTAS employment application process know better than going through 3 years of training without ticking all the relevant boxes in the portfolio. You stand no chance of employment.

In fact, these days, to be different from a typical trainee, you probably need to have multiple on-going research interests and a couple of postgraduate degrees. Unfortunately, there isn't the option of preferring to concentrate on clinical work, which in reality constitutes the day-day working of consultants, especially in the new era of Foundation Trusts.

**Home truth**

The truth they say is bitter, but actually application for higher specialty training has always been voluntary and the curriculum has never been a secret.

So applying trainees should be well aware of the expectations and prepare for it. Remember, there was always the option of a non-training post which may be less demanding. "If you can't take the heat, stay out of the kitchen". This is my personal opinion.

**Consolation**

The new curriculum developed by the College in conjunction with PMETB is learner centred and flexible, allowing trainees to be in control of their training to an extent. It is a 6 year long curriculum covering the entire period of training.

**Choosing between the commitments of a post graduate course and research is like making a choice between the devil and the deep blue sea**

My advice to current core trainees is to start to attempt various competencies to varying degrees as early on in their training as possible. This will definitely make the transition from ST-3 to ST-4 less marked and less daunting.

Also, the days when trainees were left unsupervised are long gone. I think it's important in the initial meetings with the educational supervisor to explicitly declare any deficiencies in required

competences. There is also the need to develop and maintain a supervisory relationship to prevent the risk of "premature independence".

I wonder if it's worth carrying out a survey amongst trainees. If most do find this transition daunting, more support may be provided, just like over the years, the need to support new Consultants has been recognized and acted upon.

*Dr Fapohunda wrote this article soon after her transition to ST4, while working with Dr Milner in Solihull.*

*Comments are welcome to [mosunfolarin@yahoo.co.uk](mailto:mosunfolarin@yahoo.co.uk) or via the editorial team.*

Peer group	reps
Chairperson	Rehan Siddiquee
Vice Chair	Arif Rahman
Secretary	Sadira Teeluckhdary
<b>Regional representatives</b>	
North Birmingham	New reps to be elected at peer group meeting
South B'ham & Solihull	
Coventry, Warwick, Worcs, Hereford	
Staffs and Shropshire	
Black Country	

# *Pearls of Wisdom*

*Invaluable advice to trainees from senior clinicians*

**Dr Gillian Wainscott**  
**Consultant Perinatal Psychiatrist, BSMHFT**

- ◆ **Always listen to the patient**
- ◆ **Try to see situations from the patients perspective**, remembering that they have different background experiences, different levels of functioning and different ways of responding from your own
- ◆ **Be aware of your limitations.** You cannot 'cure' a patient. You can only use your expertise as best you can to improve the quality of life for any particular patient. You cannot take on their total burdens
- ◆ **There may be a considerable difference between what the patient thinks they want and what they actually need** – and a high level of skill may be needed to explain this to the patient.
- ◆ **Beware the patient who at first consultation says that you are the best doctor they have ever seen.**
- ◆ **Contemperaneous note taking is the aspirational ideal** – and a clinic is not finished until the letters are dictated!.
- ◆ **Do not take on too much** – and learn to say no.



## DIARY

### Peer group meetings

15 September 2009  
10 November 2009  
12 January 2010  
9 March 2010  
11 May 2010  
13 July 2010  
14 September 2010  
9 November 2010

### RCPsych

**15-16 October 2009**  
Faculty of General & Community  
Psychiatry Annual Meeting @ Cardiff

**Friday, 4 December 2009**  
West Midlands Division Winter  
Meeting @ Learning centre, Stafford

**21-24 June 2010**  
College Annual Meeting: 'Advancing  
Science' @ Edinburgh

### BMI

**6th October**  
Clinical leadership and medical  
(dis)engagement  
*Peter Spurgeon*

**3rd November**  
Annual Dinner (speaker TBC)

**1st December**  
Cloake Medal

**12th January 2010**  
Valedictory lecture  
*Dr Manny Bagary,*  
BMI President 2009-10

This newsletter is intended to inform and promote the positive work of the West Midlands General Adult Psychiatry Higher trainees. It is also hoped that it provides a platform for junior trainees, trainees in other specialties and Consultants. We aim to publish this newsletter quarterly. Portfolio certificates are provided.

**Contributions** should be sent to the editors ✉ [rehan\\_007@hotmail.com](mailto:rehan_007@hotmail.com) ✉ [amandurrani@gmail.com](mailto:amandurrani@gmail.com)