

REGISTRAR: THE PTC NEWSLETTER

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Editorial

By Dr Josie Jenkinson, Chair, Psychiatric Trainees Committee



Dear fellow trainee,

Welcome to this edition of the Registrar, and my last as Chair. As another year for the PTC comes to an end it seems timely to

reflect on our work over the last year. Firstly, I want to say a big thank you to all of you who took the time to complete the various surveys we have sent you over the last few months, on higher specialist training, less than full time training and the trainee webpages. These have provided us with lots of valuable information, which will help us to represent you effectively on the former two matters, as well as to help us get to work with revamping the trainee webpages over the next few months.

One of our aims at the start of the year was to improve communication, and

we now have our own Twitter feed (@RCPsychTrainees) and Facebook page (Psychiatric Trainees Committee) – do please take the time to check these out. I hope that you have found the newsletter useful and informative, and also that you have had good access to your local PTC reps this year – if you are unsure who they are please get in touch.

I am very pleased to say that the College has now reduced the eligibility requirements for both the written exams (now zero months experience but must be post foundation) and the CASC (now twenty four months experience). The PTC feels that this is a very positive development in terms of helping core trainees to progress through to higher training. The College have also released a statement on quality control measures for the CASC (please see the next page for more information on this).

This year saw the launch of MedFest, the first medical film festival of its kind, founded by Kamran Ahmed, current vice chair of the PTC. This was a very successful enterprise, with events hosted by medical school psychiatry

societies across the UK, and will hopefully grow with the ongoing support of the PTC to be even bigger and better next year. Thanks to all of you who helped out with your local event, and I hope you can all stay involved next year.

It has been a privilege to work with so many dedicated and enthusiastic trainees on the PTC and I hope that we continue to go from strength to strength. I would strongly recommend serving on the PTC to any trainee who is interested in getting involved with training issues at the highest levels within the College and making a difference.

As ever, do please get in touch with any training issues via ptc@rcpsych.ac.uk. I wish you all a very happy rest of the summer, and also the best of luck those of you waiting for exam results!

Josie

**Dr Josie Jenkinson, Chair of the PTC
Current post: Clinical Leadership
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LATEST NEWS

MRCPsych Exams News

We are very pleased that at the July 2011 ETSC (Education, Training and Standards Committee) it was agreed that the eligibility requirements for Papers 1 to 3 be reduced to 0 months, and for the CASC 24 months. This should give trainees much more flexibility regarding when exams are taken, and from August 2012 it will mean there are 2 chances to take the CASC in CT3.

The 2011 MRCPsych exams calendar is at:

<http://www.rcpsych.ac.uk/pdf/MRCPsych%20Examinations%20Calendar%202011%20290311%202.pdf>

Read the Examinations Department's statement on how the CASC (clinical assessment of skills and competencies) exams are quality controlled at: <http://www.rcpsych.ac.uk/pdf/CASC%20Quality%20Assurance%20Statement%20-%20July%202011.pdf>

Welcome to psychiatry, new CT1s! If you haven't already, you can register with the College online at:

www.rcpsych.ac.uk/specialtytraining/trainees/



You can now follow us on twitter! Search for: **@RCPsychTrainees** for the most up to date news from the PTC.

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MRCPsych Examination Costs

Nick Craddock, the new College Treasurer has asked the Finance Management Committee to scrutinize the finances and costings relating to examinations. The aim will be to (a) be able to explain clearly and simply the costs so that Council, College members and trainees are well-informed, (b) look for any possible cost improvements, and (c) understand how current examination fees reflect the costs of running and developing the examinations. There are also discussions that are ongoing within the College about changes to the examination format that would impact the costs of examinations. Professor Craddock said "The College takes trainees' concerns very seriously and we want to ensure that trainees get good value for money and understand the costs of examination fees. We will look at this very closely and provide information to the College Council. Ultimately it is Council, the governing body of trustees that has responsibility for making decisions about examination structure and fees."

Professor Sue Bailey, New President of the Royal College of Psychiatrists, answers questions on life, psychiatry and the College

PART TWO (continued from May 2011's PTC newsletter 'The Registrar')

Dr Daniel Bennett puts the questions trainees are asking to Professor Sue Bailey in the second part of this two part interview. Prof Bailey has had a distinguished career in psychiatry and has been elected to be the next President of the Royal College of Psychiatrists. She has previously held the position of Registrar of the College and in that role was a friend to many a trainee. While you read this article please imagine conducting an interview between two mobile phones, in a car with no air conditioning or open windows on the hottest day of the year so far.

Could you describe your own career path?

As a medical student I did an elective in child psychiatry and really enjoyed it. I started off by doing some neurology and neurosurgery in Manchester but quickly realised that I wanted to go to psychiatry. I applied for and was fortunate enough to gain a place on the Manchester training scheme. After my basic training I did higher training for a year in adult psychiatry which I enjoyed. I was lucky enough to be there at the beginning of the developments of forensic services in the North-West, with the emerging build of the medium secure forensic units. I particularly enjoyed my forensic attachment, working with Dr. Campbell; the challenge of difficult and complex problems, handling risk, and working in a legal context. At that time there was no specific training programme for forensic psychiatry. I discussed this with David Goldberg, and in his usual way he set about arranging a programme for me, so I was probably one of the first formally trained forensic psychiatrists in the land. The North West had the whole gamut of forensic psychiatry; high secure, medium secure, and innovative projects working with community forensic,

in collaboration with the voluntary sector and probation. So I opened the first day centre in forensic, working in the basement of the probation office, opposite all the local pubs and drug haunts.

Which job or trainer most inspired or influenced you?

That's a really hard question. It's an amalgamation; a child psychiatrist called Dr Joe Erulkar, with whom I did an attachment as a medical student, inspired me by the values and principles through which he practiced his child psychiatry (incidentally he was one of the first overseas doctors to come and work at the Maudsley and had great stories about having to rush out of the building to open the car door for Aubrey Lewis). In those days he did quite an unusual thing, and moved to the North-West, where he became the inspiration and leader for child psychiatry in the North-West, through his quiet and thoughtful approach. Throughout his life, I could always rely on him as a mentor.

Angus Campbell was a great trainer, again a very principled individual who has put and continues to put the patient in the individual centre-stage. And of course it was a great privilege

and never a dull moment to work with David Goldberg. Professor John Gun and Dame Fiona Caldicott have always been there in the background across my career to listen and offer wisdom. I will be forever grateful to the still much loved and sorely missed Richard (Dick) Harrington, who had a belief in me and many other clinicians that we could successfully pursue and deliver research for patient benefit.

What are the best things about being a psychiatrist?

It's definitely the best discipline to work in; its intellectually stimulating and more of a challenge. The work is genuinely unpredictable and there is more often than not a dawning realisation that the reasons you have been asked to see someone are totally different to the real difficulties they hold and have. Additionally, I think we tend to forget that we do have good and effective treatments available. And in forensic CAMHS clinical practice there are genuinely no two days the same.



What do you think is the worst thing about being a psychiatrist?

This must be the fundamental frustration that it is still so difficult to ensure that our service users and their carers get the help and treatment they deserve on their route to self-directed recovery. I've learned that the best way to deal with this is to work closely with other agencies, and in particular the voluntary sector, to tap into the services they have to offer. I am, as anyone will tell you, not a born manager in the traditional sense. I have of course been put through the various courses, but having led for many years a very specialist adolescent forensic service, I have learnt what I think I need to know, which is: to know who my friends are, to respect the team I work with, and to choose my battles very carefully.

What are the major challenges facing your own area of clinical practice?

In CAMHS there is an automatic response when a new children's minister comes into post; to have a pop at CAMHS by reviewing their services again. CAMHS is a specialty that has to be all things to all people, and I think the

solution is for CAMHS to be more direct in saying what they can do well, what they can't do, and what is out with their brief to be asked to do. I also think that it would greatly help CAMHS if we are seen to be and are actually working more directly with the community.

I am hopeful that forensic psychiatry in England will be going into an improved period, even in times of economic restraint, as we should benefit from the implementation of the Bradley review. It is good that the previous mental health czar, Louis Appleby, will now have a key role, working across the two government departments to ensure that forensic patients get the services they deserve. The major challenge will be making diversion work.

I also think the elephant in the room, across adolescent services, general community psychiatry, substance misuse, and forensic, is what we are going to do for those with personality disorder and substance misuse. I think we have to decide what we are able to do from the evidence, but more importantly what we as professionals have the will to do. I think there is a further risk in forensic psychiatry that medium secure units are becoming larger in size, and as they do, so do the problems and difficulties faced by the previous large high secure hospitals. The final challenge, which I think we are tackling, is how forensic psychiatry integrates with the rest of psychiatry, particularly adult general psychiatry, and how CAMHS integrates properly with adult psychiatry at the transition.

What would you like to change about the way psychiatry is practiced and mental health services in general while you are President?

That's difficult because I have to represent the voice of the whole of psychiatry, across all of the specialties. I think that the main thing that brings us together is everyone outside the College understanding the context in which we work, and in which we find our users and carers. Our users and carers have to exist, and therefore it is important how we, together with external colleagues, can improve how we work across families. When I say this it is sometimes misunderstood to mean that everyone has to have family therapy. Indeed, many people would benefit from this, but this is not what I am saying. I am saying that we need to look for better ways of working across families. How often do we find when working with a member of one family, that a colleague working in an office along the corridor, or two miles down the road, is working with the same family. Surely this is an area where we can be cost effective and make a real difference across generations for the future. This is an obvious thing to do, but I suspect will be difficult to achieve.

What single thing would you want all medical students and foundation doctors to know about a career in psychiatry?

For all of those young people to understand the value and worth of the experience of undertaking psychiatric training, whether they are going to be career psychiatrists or not. If they want to be good holistic doctors, they need to have done some psychiatry. And when they do, it is up to us, each and every member, to then prove to them that this is the best specialty, and that they should stay in it.

Are there any barriers to a woman succeeding in psychiatry?

I can only speak as I have experienced, but I have never seen my gender as a disadvantage, indeed I have always found it to be an advantage in psychiatry. I can honestly say that I have not encountered difficulties, or if I have I have been sufficiently robust not to choose to see them as difficulties.

What do you think are the main research priorities for psychiatry?

It is critically important to continue with the dynamic and ground-breaking work that is happening in the UK and across the world in neurobiology, neuroimaging and genome programmes. But for this to translate into patient benefit, and particularly prevention on a day to day basis in clinical practice, this science has to be embedded into social and policy based research. It is the uniting of these two parts of research that will deliver what is best for patients, and bring research and psychiatry the respect and funding it deserves but does not currently receive.

Where do you see psychiatry in 30 years' time, when trainees

today are getting towards retirement?

My three magic wishes would be to see psychiatry up there in the top three medical specialties. I would like to see the social sciences embedded within holistic care and treatment provision for service users and carers. I would like the College to continue to be united as a family and exposed to the outside world, while dealing with any family business and disagreements internally. I would like to see a stronger sense of European psychiatry with harmonized training across Europe, so we could work seamlessly across the European countries. And furthermore where European psychiatry and classifications were as respected and indeed more respected, than the other classifications, and with the classifications used for research.

Above all, I would like to wish for, but suspect we may not be there, that the inequalities, discrimination and stigma that dog our users and carers were at an end. But I'm a realist, and therefore it will be for the trainees of now in thirty years time to pass this banner on to their next generation of trainees.

What are your main interests outside of work?

I love the arts in all their varied forms, but am artistically without talent. However, my family more than make up for this, all working in the fields of arts, and particularly how arts can improve the mental health and well-being of society. I enjoy going to all the exhibitions and events that they are involved in. After a bad day, I also really enjoy taking things out on the garden, but hopefully seeing a positive result.

Can you give us an obscure fact about yourself?

Unfortunately with me, what you see is what you get so there isn't anything particularly obscure to tell you. However, I thought my mother would know and she did; she told me that when I was little, if I was naughty (brought up as I was in a mill town, Oldham, in Lancashire) I would either end up in Strangeways prison or the local county asylum in Prestwich. I have exceeded her expectations, and have ended up in both, but I hope I haven't been too naughty.

As told to: Dr Daniel M Bennett, Clinical Lecturer in Psychiatry and Honorary Specialty Registrar in Forensic Psychiatry, University of Aberdeen
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If you would like to know more about the College's management structure go to:

<http://www.rcpsych.ac.uk/systempages/aboutrcpsych/councilstructure.aspx>

MSc in Psychiatry: The Way Forward?

By Dr Howard Ryland, CT2, Sussex Partnership Mental Health Trust/KSS Deanery,

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Psychiatry places a prominent and laudable emphasis on providing doctors with structured education within training programmes. The most palpable expression of this impulse is the existence of the MRCPsych course; a cornerstone of Core Training providing essential preparation for the membership examinations.

There are a number of Academic Departments which have taken the opportunity of using their local course as a springboard to additionally offer the possibility of gaining a University qualification: commonly an MSc Psychiatry. Although these degree courses show considerable variation in their eligibility criteria and mode of delivery, most are aimed principally at junior doctors within Core Training programmes. Many are also accessible to other doctors or professionals in related fields and some offer the option of distance learning.

Degrees are usually completed part time, over two to three years, with the formal taught component initially centring on the MRCPsych curriculum. As courses progress the focus typically moves away from obtaining membership, towards acquiring research skills and the development of a supervised research project, in anticipation of completing a dissertation.

Research is a key component of the RCPsych Core Curriculum² and one that trainees can have difficulty in actively engaging with. Frequently cited obstacles are time pressure, lack of access to supervisors and difficulty choosing a suitable project³. An MSc in Psychiatry provides one potential route for the junior trainee to develop research competencies in a supported framework, which is tailored to fit with their other considerable commitments.

The most demonstrable outcome, the qualification itself, does not necessarily provide the primary benefit. Greater advantages may be reaped from engaging in the learning opportunities and practical processes involved. In the hierarchy of the ST4 shortlisting criteria, a completed Masters award may earn only a single extra point, but up to three points are available for exhibiting an understanding of and involvement in research⁴. Arguably, even more important is the potential for tangential gains in a trainee's clinical practice and personal development⁵.

Systemic benefits may result for those MRCPsych courses forming a component of a higher degree, by promoting quality and safeguarding standards. Such courses will be subject to external scrutiny and obliged to meet the rigorous demands of a University postgraduate programme. Organisers need to be wary that this could result in greater emphasis being placed on tangible academic achievement, at the expense of clinically relevant communication skills.

There is marked heterogeneity in the personal financial costs associated with undertaking this type of degree. Doctors on training programmes may receive significant contributions from their employing body, often study budget funds that would have been assigned to pay for an MRCPsych course anyway. Dependant on a particular University's regulations, students with previous postgraduate credentials may be

asked to contribute more and even higher supplements can apply to those with overseas fee status.

Is developing MRCPsych courses to lead to a Masters a way forward for formal education within Core Training? There are clear advantages in forging closer links between University departments and training programmes, facilitating research at an early career stage and allowing junior trainees the opportunity to obtain a higher degree in a manageable timeframe. Challenges centre on the feasibility of offering such courses at a reasonable cost to all trainees. The uncertain state of funding for higher education means finances for postgraduate degrees are likely to remain in flux. These are issues which need to be considered nationally as part of a wider debate about the on-going development of training opportunities, informed by the feedback and active involvement of trainees.



Editor's Note

A wide variety of MRCPsych courses exist across the UK, and the College is currently undertaking a large piece of working looking at how these might best be augmented, including using facilities such as e-learning and podcasts.

The MSc is available at the University of Brighton, which Howard is currently doing, but similar courses are available at Cardiff (full time and distance options) and Manchester and the University of Hertfordshire. Oxford offers an MSc Psychiatry, but this is by research alone and not related to the MRCPsych course. There are also MScs in Psychiatric Research at the IOP and UCL, but these are again independent of MRCPsych courses, with their own taught components.

We are very keen to hear from you about your local experiences and ideas as to how MRCPsych courses could be improved upon. Email ptc@rcpsych.ac.uk, or tweet us @RCPsychTrainees

References

¹ <http://www.rcpsych.ac.uk/pdf/CORE%20CURRICULUM%20October%202010.pdf>

² Fogel J. Research as part of a career of a psychiatrist entering clinical practice. *The Psychiatrist* (2009); 33: 269-271.

³ <http://www.rcpsych.ac.uk/pdf/ST4%20Shortlisting%20frame%20work%202011-final.pdf>

⁴ Freeman C, Tyrer P. *Research Methods in Psychiatry* (2006); p.3

How to (hopefully) inspire the next generation!

Ideas on how to improve recruitment to psychiatry in your area

By Dr Andrew Horton, ST4 trainee, South Yorkshire, drandyhorton@doctors.org.uk

Recruitment into psychiatry as a speciality can be a challenge at times and people often argue that the experience on placement in medical school sets a precedent for future career choices. There is a lot of work nationally in encouraging students from sixth form to foundation doctors in becoming psychiatrists. In Sheffield, tried and tested methods are used along with more innovative ways to promote psychiatry in a positive way.

'Speed dating'

This concept which became a craze in the early 00's can be adapted to promote psychiatry very well. It works on the principle of a circuit of individuals from each speciality spending 5 to 10 minutes with students or trainees. The session can be organised so questions can be asked or answered in a specific period of time before moving onto the next topic.

Sheffield's Summer School

The 3 day event is mainly targeted at those students who are seriously considering a career as a psychiatrist and it involves formally applying for a place. The programme aims to develop their understanding by becoming more 'hands on' and receiving lectures from prominent clinicians in the field. These students have the opportunity to undertake field trips in a range of areas.

Recruitment Fairs

These are still the preferred method by the numerous medical schools and involve multiple medical staff 'selling' their specialities. One of the benefits is that a large number of students can be targeted at once with questions being answered individually and leaflets outlining training provided.

Taster Days

There are useful for trainees (especially in Foundation Years 1 and 2) who are still unsure as to their future career when qualified. The taster days provide an opportunity for these doctors to spend a short period of time outside of their post in an area which they have a particular interest, which should be allowed for as study leave by the trainees' Foundation School. The days are focused and arranged within the clinical team to identify each individual's specific interests.

Sixth Form School Students

Arguably, these students would only be considering applying to medical school and not be fully focused on which speciality they may wish to take up in the future if successful. There are, however those students who may be taking psychology at A level and applying to medical school who have an understanding

of psychiatry and would be keen to pursue this.

Prospectus

Both psychiatry and the deanery can be promoted in written form. Prospective students and trainees are able to read about the area of psychiatry and the organisation they may wish to train in. The prospectus can include information on how to apply to training and share clinicians personal stories.

Student Organisations or 'Psychsocs'

There has been an increase in student psychiatry organisations throughout medical schools in the UK in recent years. These involved students from all years of medical education who have an interest in psychiatry. It offers the opportunity to discuss issues with peers and undertake social activities that have a link to psychiatry.

There are many ways to promote psychiatry in a positive way to prospective students and trainees. Each method has its individual benefits and hopefully these can be used to continue to attract those who would be an asset to the speciality of psychiatry.

Editor's Note: Recruitment into psychiatry remains a challenge and is a main area of focus for the College this year. There are numerous creative and innovative schemes across the UK to help with this, and thank you to Andrew Horton for these ideas from Sheffield. For further information on psychsocs/recruitment fairs, if you would like to get involved, or if you have a new idea, please share it with us at ptc@rcpsych.ac.uk

The European Federation of Psychiatric Trainees (EFPT) 2010-11

By Dr Meinou Simmons, ST5 in CAMHS, Cambridge, and EFPT Child and Adolescent (CAP) Secretary, meinou.simmons@gmail.com

Since my election to the steering committee of the EFPT last summer as the Child and Adolescent (CAP) secretary it has been a whirlwind year for me at the helm of this exciting and dynamic organisation. For those who don't know, the EFPT is the largest European trainees' association composed of psychiatrists who represent their national training organisations (such as the PTC) from all over wider Europe. Each country can send two delegates: a general psychiatry and a CAP trainee from their national associations. It is an expanding organisation, and this year we had 32 full members and further candidate members including Azerbaijan and Montenegro, who both desperately need peer support as their training opportunities are almost non-existent.

We work to help promote all aspects of psychiatry training all over Europe, and there are always several projects going on, from international collaborative projects such as looking at burnout amongst trainees to helping small countries with very poor health infrastructure setting up training organisations. Projects begin at summer forums in working groups, and continue online through the year. I was lucky to get an inside view of



most of the activities within the organisation through sitting on the Board and many times thanked my lucky stars for training in a system such as the UK with such a sophisticated training infrastructure and trainee support. I learnt a lot about the dedication of trainees to improve standards in many areas.

The forum this year was in Prague in July 2011, and was

brilliantly organised by the local committee, with some input from the Board through skype meetings. We had a general assembly and discussed a broad range of issues, and spent time in our working groups, getting focussed about planning on how to set up projects over the coming year. We also had social activities and entertainments, and I am always overcome with what a fantastic bunch of people attend these organisations: everyone has an international outlook, and it's wonderful to exchange ideas and experiences. As our next president is Italian, the next EFPT forum will be in Sorrento in May 2012, and two PTC reps will be able to attend as UK delegates. A handful of others from the UK can also attend as observers and if you are particularly interested in this get in touch with the PTC reps to check out how many are going from the UK delegation.

My main focus over the past year in chairing the Child and Adolescent Working Group was to improve representation of child and adolescent psychiatry trainees (CAP) in the organisation, and to start a database to begin systematically collecting data on CAP training across Europe. The reason for this is that in most European countries CAP is a separate specialty from general psychiatry from the start of training. CAP trainees in many countries have very poor training opportunities, and are often not represented by national organisations. This is reflected by poor CAP representation at the EFPT forums. We managed to improve representation in 2011 and had productive working group sessions. Over the course of the year we have also now produced a database of detailed training information from 32 countries which I have recently submitted for publication. We found huge disparities in CAP training across Europe: from years of training, frequency of supervision to research and psychotherapy opportunities. It has been a lot of work, and I am pleased to say the new CAP secretary is equally enthusiastic to expand the database and continue the work over the next year.

A Flavour of Liaison Psychiatry

By Dr Abrar Hussain (abrarhussain@nhs.net) and Dr Anupam Verma (anupam.verma@nhs.net)
ST5 Specialty Registrars in Liaison Psychiatry, Charing Cross, Hammersmith and Queen Charlotte's Hospitals, West London Mental Health NHS Trust and Imperial College Healthcare NHS Trust



Liaison Psychiatry is the practice of psychiatry in a general hospital setting. Although basic principles in the diagnosis and management of mental health problems remain the same, there are key

differences in some aspects. We have put together this brief article to give trainees an insight into how Liaison Psychiatry differs from mainstream psychiatric practice. At the time of writing this article, we have both completed 12 months of training in a busy Liaison team based across 2 sites of Imperial College Healthcare NHS Trust.

Geographical boundaries

As liaison psychiatry is based in the acute trust setting, the question of geographical catchment areas tends not to apply. Unlike CMHT's, Mental Health Inpatient Units, and Crisis Team's, the remit of liaison psychiatry includes anyone and everyone who is an inpatient within the acute hospital and any psychiatric patient presenting to the accident and emergency department. The patients' GP or postal codes do not influence matters. Referrers welcome it, and professionally it feels more satisfying to be able to focus entirely on the patient's clinical picture rather than, as is often the case, unintentionally being perceived as unhelpful when re-directing referrals to the 'correct' team.

Interventions

Whether patients need pharmacological, psychological or social interventions, Liaison Psychiatry is about being creative and thinking outside the box. Medication prescribed needs to suit the physical health profile of patients and have the least risk of drug interaction with physical health medication. Treating teams seek advice regarding patients' regular psychotropic medication and their potential side effects. Apart from pharmacological intervention, working in Liaison Psychiatry helps develop therapeutic interactions using a range of techniques from Cognitive Behavioural therapy, Psychodynamic Psychotherapy, Motivational interviewing and Solution focussed therapy. Wider interventions also involve identifying and addressing dynamics between patients and their teams, especially in chronic conditions like malignancies, renal and haematological disorders. Social interventions involve liaising with families and support systems to ensure patients get optimal environmental support for recovery from physical and psychiatric problems after discharge.

Clinical Presentations

Medical teams find a formulation more beneficial than categorical ICD 10 diagnoses especially in patients with personality disorders and neurotic presentations. On a practical level, it may not be possible to provide a

psychiatric diagnosis with one patient interaction anyway. Liaison Psychiatry helps in developing the skill of 'translating' psychiatric diagnoses and terminology into simple language for professionals caring for the patient.

Medically Unexplained Symptoms, thought to account for up to 30% of primary care consultations and up to 50% of secondary care outpatient appointments with the bulk of presentations in Neurology and Gastroenterology are best managed by psychiatrists and physicians working in partnership. Apart from diagnosing and treating co-morbid mental illness, aims include providing consistency and a therapeutic space to avoid potentially unnecessary medical investigations, reduce distress for the patient and their family and improve quality of life and daily functioning. In the increasingly cash strapped climate, liaison psychiatry serves an important role in assessing and working with this patient group as the annual cost to the NHS is in the region of £3 Billion. It is a skill set that every psychiatrist would benefit from; particularly as many such patients are seen by general adult psychiatrists in the community.

Legislative frameworks

The use of the Mental Health Act is usually in patients presenting to the Accident and Emergency department. Rarely, it is used in patients admitted to the wards. Psychiatrists are best placed to oversee the implementation of the MHA. Liaison Psychiatry provides the unique opportunity of organising MHA assessments at short notice and ensuring risk is managed effectively especially in A&E where there are several vulnerable patients and risk is more dynamic with high turnover of staff and patients and environmental factors.

The use of the Mental Capacity Act in non-capacitous refusal of medical interventions which are least restrictive and in the patients' best interest can generate questions for medical teams ranging from who needs to assess capacity to what is the patients' best interest. Psychiatrists therefore have the opportunity to educate medical colleagues and in complex cases undertake joint capacity assessments. In complex scenarios, 'best interest' meetings are organised and/or referrals made to clinical ethics committees. Liaison Psychiatry therefore provides an enriching experience of understanding more about caveats of mental capacity.



Overall, we found working in Liaison Psychiatry an extremely beneficial and clinically enriching experience. For more information see: <http://www.rcpsych.ac.uk/specialties/faculties/liaison.aspx>

The Concept of Trauma in Psychotherapy

A postscript on chapter 22 of the “Textbook of psychotherapy in psychiatric practice”, by Caroline Garland: “External disasters and the internal world: an approach to psychotherapeutic understanding of survivors”

By Dr Farshad Shaddel, CT1 in Psychiatry, Oxford Deanery



Introduction

In Freud’s account, trauma is an external event or excitement strong enough to affect **normal** psychic activity and defence mechanisms. ICD-10’s definition of trauma is: “an event that is outside the range of usual human experience and that would be markedly distressing to **almost anyone**”. Therefore, it would be reasonable to accept the conclusion that “If an external event wants to be considered as a mental **trauma**, it should be intense enough to affect almost everybody”. Events such as natural disaster, sexual abuse... But why are the presentations and their consequences different? What is the role of pre-morbid mental health status in a current presenting picture?

The vulnerability theory applies here. Vulnerability in psychic function originates from previous experiences, particularly in childhood when the internal world is still developing and external experiences are able to shape it. For example, a person who has had the experience of losing a sibling due to choking in childhood is more vulnerable to smoke and choking scenes of a fire incidence. But the person with childhood experience of high fever would be more vulnerable to the possibility of burning to death in the same fire incident. So we can summarise that quantity and intensity of an external event would determine whether or not a person would be affected by that incident, whereas the quality of interaction between this event and previous experiences of person (vulnerability) would determine the presentation and, particularly, the long term consequences of that traumatic event. We can conceptualise this conclusion in the diagrams below:

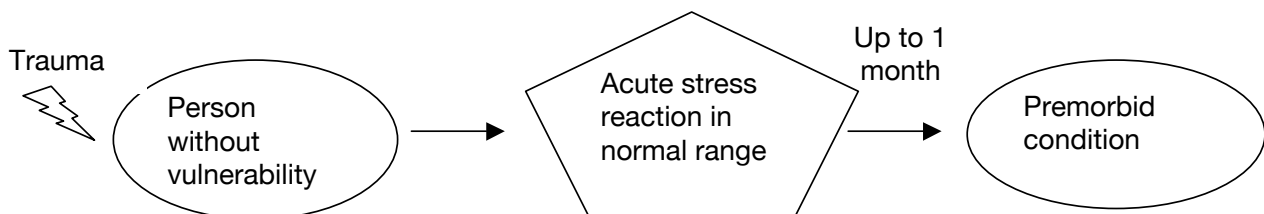


Diagram 1: Trauma in a person without vulnerability

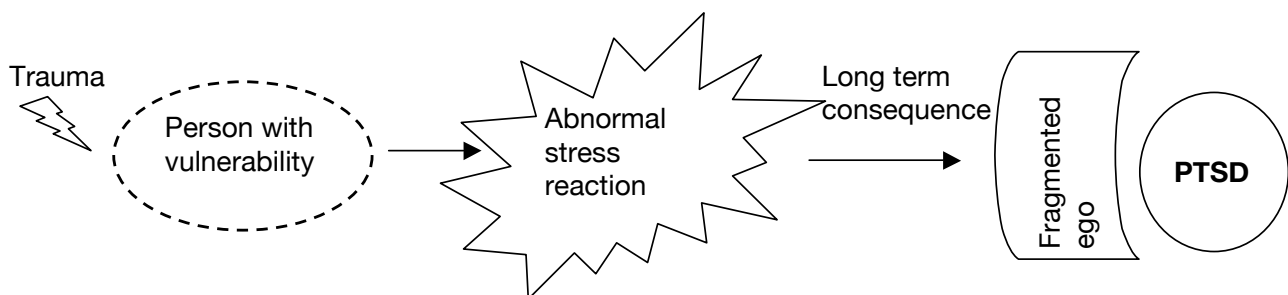


Diagram 2: Trauma in a person with vulnerability

Concept of Trauma in Psychotherapy (continued)

By Dr Farshad Shaddel, CT1 in Psychiatry, Oxford Deanery

What is a normal acute stress reaction?

Stage 1: In the first 48 hours, the survivor needs and wishes to find something or someone he can perceive, even temporarily, as offering primary maternal care. For many this will be a pressing need to return home.

Stage 2: After the first 48 hours, people who start talking about the incident recover their equilibrium more effectively than those who do not. This stage may last up to one month.

What are abnormal stress reactions?

In some survivors (who are vulnerable), they remain in the first stage of regression to concrete thinking for many weeks and months. In addition, some patients who continue to feel overwhelmed by unmanageable aspects of their experience and show prolonged symptoms such as those now collected under the heading of PTSD shall be considered abnormal too. Both of these conditions need outside help and treatment.

Treatment options

It is clear that in psychologically sound people with no vulnerability, recovery happens quickly and spontaneously. The maximum care that they need is blankets, holding, warmth, and the presence of a supportive human being in the first stage and an empathetic listener in the second stage. However, for people with abnormal reactions, particularly those with long term consequences of trauma, outside help is necessary to restore equilibrium. It would not be surprising that, given the importance of vulnerability in shaping the picture of a current presentation, the main focus would be on vulnerability as the main target of treatment.

It has been observed that treating vulnerability would help the patient to react to trauma in a more normal pattern and thus restore equilibrium. It was discussed that psychotherapists believe that vulnerabilities originate from early childhood experiences that have been repressed in the unconscious part of the mind. This is the rationale behind psychotherapeutic treatment (and maybe to our surprise) when survivors of a disaster are asked to link the current incident to a childhood experience and then try to heal it by talking through it and letting it to open up. This dissection of old and most probably painful experiences in an already disturbed patient would aggravate anxiety and distress for a while but would be followed by a pleasant and rewarding improvement not only in current symptoms but also in long lasting vulnerability of the patient to similar situations.

For further information on core psychotherapy training requirements and on higher training in psychotherapy, go to www.rcpsych.ac.uk/specialties/faculties/psychotherapy/training.aspx

Training in Addictions Psychiatry

By Dr Greg Lydall, Consultant Psychiatrist in General Adult and Addiction Psychiatry, Guernsey, grelza@yahoo.co.uk



Humans, it seems, have always experimented with mind-altering substances, including alcohol. But why do some people continue using substances when it is causing them harm? Why do people with addictive disorders choose their 'hit' over their health (or relationships, family, work, quality of life, life)?

Addiction psychiatry is an exciting and evolving psychiatric sub-speciality encompassing the mental, physical, social and legal aspects of substance misuse and addictive behaviour. Working in the field offers both challenges and rewards. Difficult-to-treat addictions, damaged lives, and a changing NHS landscape make for interesting times. The rewards include helping someone move from dependence into recovery (or in many cases making health gains by reducing the harm they do whilst using substances), improving their quality of life, and grasping redevelopment opportunities.

Addiction psychiatry is recognised by the Royal College of Psychiatrists and General Medical Council (GMC) as an endorsement on the Specialist Register. The College's Addictions Faculty is very active in engaging with Government and key stakeholders, and in supporting their members. The UK highlight is the Faculty Annual Conference. This year the Conference included the opportunity to hear and question a Member of Parliament, and a wide range of absorbing sessions: from setting up a "Legal Highs" treatment service to the therapeutic effects of Mindfulness based Cognitive Behavioural Therapy. As a group, Addictions psychiatrists are in my experience friendly, bright, creative, and it has to be said, often a bit alternative.

To train in addiction psychiatry requires one year whole time equivalent in an approved training post, as part of Higher Training, along with gaining specific Curricular Competencies. Training posts are varied and, due to NHS re- and de-commissioning are falling in number. Trainees should gain a wide range of experience in team-based community treatment of drugs and alcohol problems as well as in-patient and hospital liaison work.

Key skills:

- Addiction psychiatrists are highly trained experts in assessing and managing addictive disorders.

- Psychiatric assessment of the complex interplay between mental health, substance use and dual diagnosis (having both a psychiatric and substance misuse disorder).
- Assessment and prescription of medication for opiate substitution (typically methadone or buprenorphine), detoxification, and relapse prevention.
- Physical health skills (assessment of injecting sites, examining for alcoholic end organ damage) and psychological skills (maintaining empathy and boundaries, but also helping the person move towards healthy lifestyle choices) are as important.
- Psychological techniques to improve motivation by encouraging the patient to compare their own values with their present behaviours, thus creating cognitive dissonance, and enabling positive change.
- With further interest one can work in more specialised fields like compulsive gambling; also research and public health.
- Flexibility and creativity (the field is advancing, but so is the development of new mind-altering chemicals).
- Interface working – with your own multi-disciplinary team and colleagues in linked disciplines (medical, criminal justice, social services, charitable sector, academia, and so on).
- As a more experienced Consultant one may get involved in service design, development and bidding for contracts.

Personally, the opportunity to work with interesting people (both clientele and colleagues!), the refreshing breadth and depth of clinical, managerial, and academic skills, and the opportunity to make a difference were most important in my decision to choose this field. I find that delivering safe, effective, innovative services to vulnerable and complex clients who are often stigmatised by both medicine and society is really exciting. If you are interested in learning more, including some fascinating podcasts of patients' stories, please check out the Addictions Faculty page: <http://www.rcpsych.ac.uk/specialties/faculties/addictions/publicinformation.aspx>



An experience of core training in Perinatal Psychiatry

By Dr Katie Williams, CT3 in Liaison Psychiatry, Queens Medical Centre, Nottingham



General Adult Psychiatry has always appealed to me due to the diversity of disorders and patients found in this broad specialty. One area within General Adult Psychiatry, in which I was fortunate enough to spend six-months during the third year of my core training, was Perinatal Psychiatry.

Having had no experience in an obstetric post during my foundation years, I wondered whether this might prove challenging due to the extent of overlap between psychiatry and this medical specialty, however I was excited about working in my local Mother and Baby Unit, as it is a specialized tertiary unit, and one of only 22 in the country. As the junior doctor in a team that provided a service to a busy urban centre and the surrounding county areas, I was able to experience working with patients in many settings as I was involved with assessments and follow-up in the community, out-patient clinics, and in hospital (both inpatients on the Mother and Baby Unit and regular urgent referrals from the obstetric wards on two city sites).

I needn't have worried. I found the job varied, rewarding and even challenging at times, but learnt a great deal. My favourite part of the job was spending time with the women who were inpatients on our unit. In this specialty I met the most unwell patients that I have ever come across in my three years of psychiatry training, and witnessed the most incredible transformations as they started to recover. The most rewarding part for me was to see the change in the relationship between a mother and her baby as the mother's mental state began to improve; the pure

delight that the mother experienced from her baby in contrast to the anxiety, fear or disinterest that she might have felt towards the child previously.

Working in this specialty also made me realize that mental illness in pregnancy and postpartum can affect anyone, as I followed the experiences of women who had previously been psychiatrically well, some of whom were pre-morbidly highly functioning in jobs similar to my own. I was also fascinated by our patients' differing social and cultural circumstances, although I sadly saw how unsupportive relationships had in some cases had a catastrophic impact on patients' mental wellbeing.

The job offered much experience in working in a busy multidisciplinary team and with other medical disciplines and agencies such as Social Services. I am now working in Liaison Psychiatry, another subspecialty where psychiatry interfaces with other areas of medicine. As I commence my Specialist Registrar training in General Adult Psychiatry, I feel that the sub-specialties of Perinatal and Liaison Psychiatry have taught me the importance of taking a holistic view of the patient. I have learnt not to underestimate the significance of personal and social circumstances, or indeed of physical health. I hope to spend another year during my higher training in Perinatal Psychiatry in a few years time.



Editor's Note: We hope that in the next few months, perinatal psychiatry will be approved for an endorsement as part of a general adult CCT by the GMC.

For further information on perinatal psychiatry and training in the specialty, go to: <http://www.rcpsych.ac.uk/members/sections/perinatal.aspx>

UPCOMING EVENTS

Save the date for the Liaison Psychiatry Trainees and New Consultants' (TNC) Conference in Exeter, 18-19th September 2011.

Further info to follow.

BOOK NOW:

Forensic Psychiatry Trainees Conference - Brighton, £140/£160 with dinner, 8-9th September 2011

http://www.rcpsych.ac.uk/pdf/Flyer_Forensic

See your local division's website for further RCPsych Events coming somewhere near you.

Click here to access it:

<http://www.rcpsych.ac.uk/rollofhonour/divisions.aspx>

See <http://www.rcpsych.ac.uk/events/collegediary.aspx> for all RCPsych events

BOOK NOW: General Adult and Community Psychiatry Trainees Conference - Bristol Zoo (£65 includes free zoo entry!), 9th September 2011 <http://www.rcpsych.ac.uk/specialties/faculties/generalandcommunity/>

Date	Conference	Place
8-9 September	Section of Neuropsychiatry Annual Meeting	Robinson College, Cambridge Limited number of free conferences places available to medical students: kkottasz@rcpsych.ac.uk
21-23 September	Faculty of Child & Adolescent Annual Meeting	Robinson College, Cambridge
6-7 October	Faculty of Learning Disability Annual Meeting	Mariott Royal hotel, Bristol
7-8 October	Philosophy and Psychiatry Special Interest Group	Suttie Centre, University of Aberdeen
13 - 14 October	Faculty of General & Community Annual Meeting	Hilton hotel, Newcastle Gateshead
4 November	Section of Eating Disorders Annual Meeting	International Coffee Organization Conference Centre, London
17 - 18 November	RCPsych in Scotland Psychotherapy Faculty AGM	Murrayshall House hotel, Perth
17- 18 November	Faculty of Rehabilitation & Social Psychiatry Annual Meeting	Radisson Edwardian hotel. Manchester
25 November	Section of Perinatal Psychiatry Annual Scientific Meeting	Hallam Conference Centre, London
25 November	RCPsych in Scotland Joint Child & Adolescent Mental Health and Learning Disability Section meeting	Thistle hotel, Glasgow
20 January 2012	Faculty of Child & Adolescent Psychiatry	Cavendish Conference Centre, London
26 January 2012	Joint RCOG/RCPSYCH Meeting Hormones and Mood Disorders in Women	RCOG London

Coming Dec 2011:

Interesting things psychiatrists do when they're not doing their day job...

We're looking for articles from people with second jobs, whether it be playing in a band, balancing parenthood and work, or being on TV!

Please do email us with ideas for new articles, and any original submissions. Deadline for the next newsletter is 20th November 2011. Contact: ptc@rcpsych.ac.uk

Prizes and Bursaries

The College offers various prizes and bursaries for attending events. Details can be found at:

<http://www.rcpsych.ac.uk/>

PSYCHIATRISTS' SUPPORT SERVICE

Need help or advice?

Contact the Psychiatrists' Support Service in confidence.

Telephone (direct line):

020 7245 0412

You will initially speak to the service manager, and will then be contacted by a trained doctor advisor if needed.

Email: psychiatristssupportservice@rcpsych.ac.uk

Find out more at:

<http://www.rcpsych.ac.uk/rollofhonour/psychiatristssupportservice.aspx>

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Comments and feedback to ptc@rcpsych.ac.uk

Disclaimer: The opinions expressed in this newsletter are those of individual authors and do not necessarily represent the views of the Royal College of Psychiatrists.

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