

# WOMEN IN PSYCHIATRY SPECIAL INTEREST GROUP

WINTER 2010 NEWSLETTER

## Report from Fiona Mason, Chair of WIPSIG

At this year's International Congress in Edinburgh I chaired a popular session entitled *Women as Perpetrators of Violence* with presentations by Prof Pamela Taylor, Dr Gwen Adshead and Dr Katina Anagnostakis. Their presentations are now available to view on the WIPSIG internet site ([www.rcpsych.ac.uk/rollofhonour/specialinterestgroups/womeninpsychiatry](http://www.rcpsych.ac.uk/rollofhonour/specialinterestgroups/womeninpsychiatry)). Executive Committee members Elaine Arnold and Lucy Watkin also led a useful session on CESR applications.

The 2011 Congress will be held in June in Brighton and the conference theme is *Evidence and Implementation*. Unfortunately WIPSIG was unsuccessful in their submitted sessions, despite very successful well-subscribed sessions in recent years. Focus in 2011 will therefore be on the Autumn Conference likely to be held jointly with the North West division in Manchester. The overarching theme for the conference is '*Parents as Patients – Patients as Parents*'. This will fit well with one of WIPSIG's current workstreams '*The Mental Health Impact of Caring on Women*'.

Lucy Watkin has recently resigned from the Executive Committee and I would like to thank her for so ably undertaking the role of Financial Officer and PTC rep. Judith Edwards has kindly agreed to take over the role of Financial Officer until June 2011. Beth Haider has agreed to represent WIPSIG on the Workforce Committee.

Elaine Arnold has also decided to step down from the Executive Committee. Elaine was one of the founder members of WIPSIG and her dedication and commitment to the group over the years has been exemplary. Elaine has kindly agreed to continue as an advisor to WIPSIG, particularly in relation to trainee issues. It would like to thank her for all she has done in the past and wish her well for the future.

My term of office as Chair comes to an end next year and notice of election for both Chair and Financial Officer will be circulated shortly, with new incumbents taking up office at the College's AGM next June. Dr Katina Anagnostakis has recently joined the Executive Committee.

I continue to attend the Equalities Board at the Department of Health on behalf of the College and am involved (along with Olivia Protti) with the Sexuality, Reproductive Health and Abuse steering group at the Social Care Institute for Excellence (SCIE), looking at the provision of an e-learning resource for mental health practitioners. This is due to be launched next year.

We have been pleased to support colleagues who took up the issues of flexible training with the College, in particular in relation to those women who have time off, e.g. for maternity leave and the alterations in exam regulations. Council has considered this issue and the difficulties raised are being explored in relevant forums. Dr Kata Ress talks of her personal experience within this Newsletter.

The re-arranged joint conference between WIPSIG and the Psychopharmacology SIG entitled *Gender Differences in Prescribing* was held on 29 November at the Institute of Psychiatry, which was a great success. Presentations will be uploaded onto the WIPSIG internet site.

This newsletter is currently circulated as a paper copy, however aware of the need to minimise waste, it is possible for us to circulate by email. We therefore plan to move to an electronic format in 2011. Please therefore ensure the College has your up to date email details. If you would prefer to continue to receive a paper copy, please contact [Sue.Duncan@rcpsych.ac.uk](mailto:Sue.Duncan@rcpsych.ac.uk); telephone 0207 235 2351 ext 6130.

Your Exec are always keen to hear your views, or address issues of concern where relevant. Please do feel free to write in to the Newsletter Editors, or one of the Executive.

### Dr Fiona Mason, Chair of WIPSIG

Consultant Forensic Psychiatrist & Deputy Medical Director, St Andrew's Healthcare  
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## From the Editor

Welcome to the Winter WIPSIG Newsletter.

At the time of writing on a Sunday afternoon the thought of the various tasks and upcoming events in the week ahead require planning both for family, self and work. The need for work/life balance seems particularly important to hold onto in the challenging financial times and service efficiency savings.

The BMA News recently reported on the progress in the year since the publication of the report on the national working group in medicine. Baroness Deech, Chair of the report highlighted the real lack of women in medical academic, senior management and senior positions within BMA committees and medical colleges. Encouraging more experienced female doctors to mentor junior colleagues and encourage them to take on clinical and political responsibilities was highlighted.

The WIPSIG Newsletter Editors would like to hear from colleagues where this has worked well, and to look at ways of encouraging this in areas where this is not available to female psychiatrists. WIPSIG offers a national network of support for women in psychiatry.

In this edition as well as our Chair's Report, we have a report from Dr Olivia Protti on one of the successful WIPSIG organised sessions on women in perpetrators of violence as well as the recent *Gender Differences in Prescribing Psychotropic Medicine* conference report. WIPSIG Executive Members' reports include Michelle Gilmore updating on PTC matters as well as Gira Patel's article on *The Psychogeriatrician's Week*.

A very personal account of the challenges with the changes to the training system and how this has penalised women taking maternity leave by Dr Kata Röss has been published and the role WIPSIG had in trying to address this with the College discussed. This highlights the ongoing need for the College to monitor gender issues and address discrimination when it occurs, with WIPSIG providing a key role in ensuring this happens.

We value greatly correspondence and feedback regarding our Newsletter and this edition have published a letter from Dr Lilian Oteakpolo, STS in Birmingham. I would encourage WIPSIG members to submit letters or articles as it is important this represents your views and opinions. I would also encourage all eligible members to apply for the WIPSIG Prize which will be presented at the Autumn WIPSIG Conference in 2011.

**Dr Rebecca Horne**

**Newsletter Editor**

Consultant Adult Psychiatrist

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## CONFERENCE REPORTS

### **Psychopharmacology and Women in Psychiatry Special Interest Groups: Gender Differences In Prescribing Psychotropic Medicine** Monday 29 November 2010, Institute of Psychiatry

This meeting, re-scheduled from the meeting in April 2010, was fully subscribed and a valuable well received conference. Despite poor weather conditions and an unforeseen Tube strike, speakers and attendees travelled from across the UK and Ireland.

The first speaker Lade Smith started the day with *Gender Differences in Prescribing Antipsychotics* which emphasised the difference in plasma levels of antipsychotic in women and men, with good evidence that women required lower doses of antipsychotic and shared higher response rates when compared with men. The risk of osteoporosis secondary to hypogonadism due to antipsychotic medication was also highlighted.

Kathy Aitchison followed on by presenting *Prescribing Antidepressants – Does Gender Matter?* and showed the evidence for different responses between genders in antidepressants, of note being Nortriptyline (with an increase in suicidality in men in weeks 4-6) and women sharing better response

rates for SSRIS than SNRIS.

Michael Craig presented most recent evidence on the *Prescription of Oestrogen Therapy to Menopausal women – Effects on Memory and Mood*, with current thinking suggesting that HRT may give a protective function if given at a critical period around the menopause, although more research is required.

Bob Flanagan gave an interesting overview of *Gender Aspects of Therapeutic Drug Monitoring* focussing mainly on the significant data available on Clozapine from the Clozapine Database. The differences in metabolism and therefore dosing requirements were presented related to gender (males requiring higher doses than females) and smoking (smokers requiring higher doses than non smokers). Dosages of above 900mg a day, for women was clearly contraindicated based on the evidence presented.

Workshops in the afternoon included prescribing in pregnancy and breast feeding, prescribing for older women and prescribing for borderline personality disorder.

Details of the speakers presentations in PDF format can be found via the WIPSIG website.

The International Review of Psychiatry October 2010 published a number of articles relevant to gender differences in prescribing with papers by many of the day's speakers and are available electronically and in paper formats.

### **Dr Rebecca Horne**

WIPSIG Executive Member

rebecca.horne@nwmhp.nhs.uk

## **International Congress of the Royal College of Psychiatrists 2010 21-24 June 2010, Edinburgh**

I attended the session on "Women as perpetrators of violence: psychosis, personality disorder and Munchausen by proxy". The session was co-ordinated by the WIPSIG committee to highlight this important area that is often overlooked.

Dr Fiona Mason, our WIPSIG Chair, chaired the session.

The hall chosen was filled to capacity with some members standing for the session.

Firstly Dr Gwen Adshead spoke about Munchausen by proxy. The talk provided a detailed overview of the subject, including current controversies as well as several case studies. The talk highlighted the speaker's own years of experience of the condition.

Secondly Professor Pamela Taylor presented a comprehensive review of the literature around women with psychosis who become violent. The subject as with many other areas has not been studied extensively in women. I was surprised to learn of the number of women in secure forensic settings (up to 1/3) and prison who have children and the impact this has both on these women as mothers and the experience for their children. Prof Taylor's view was that motherhood was almost ignored in forensic settings.

The final talk in the session was by Dr Anagnostakis who spoke comprehensively about the relationship between women with personality disorder and violence. She spoke of the greater likelihood of disposal under the Mental Health Act for women compared to men who might be remanded into

custody. The incidence of violence perpetrated by women with personality disorder approximated that of men with women more likely to murder those that they are related to. She spoke at length about the women's own experiences of violence both in childhood and intimate relationships and how this impacted on their carrying out acts themselves.

I was particularly struck by the quote: "damaged people are dangerous as they know how to survive."

Full details of the lectures given are available on the college website.

### **Dr Olivia Protti**

Consultant Perinatal Psychiatrist

North East London Foundation Trust



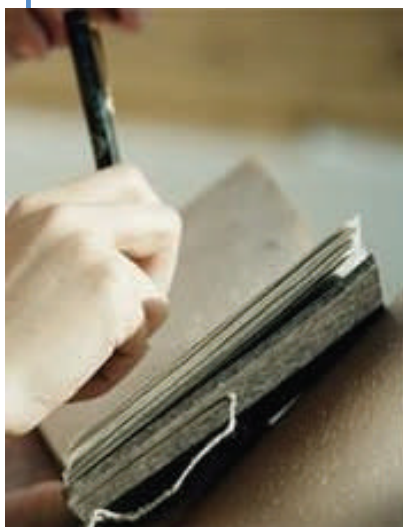
### The Psychogeriatrician's Week...

#### Monday

On Monday, I am a psychogeriatrician and a street wise Londoner. I see Bill, 86, who lives alone in a grotty council flat with the occasional cockroach for company. Bill has chronic schizophrenia. Though surrounded by hundreds of people on the council estate, Bill lives in his own world, he doesn't wish for company and he bothers nobody. His neighbours don't know or care that Bill is targeted every Friday by drug addicts, who pretend to be housing officers. Naively perhaps, he lets them in; he fondly remembers this kind of camaraderie from his merchant navy days. They come in and shoot up in his bathroom and steal his weekly Giro. The police officer is concerned about Bill letting strangers in.

*Why is an 86-year old man living alone in the first place, Doctor- shouldn't he be in care?*

The housing estate manager is concerned about Bill. *I've seen him go out at 5pm every evening, Doctor, he forages in bins for food; he should be in care.* So today, I see Bill and educate my colleagues about the reality of life for some elderly people with mental illness in London. I tell the police officer about the hundreds of people like Bill who have lived alone for years, totally hidden from society. I tell him that in my line of work, age does not determine where or how you live. I tell the housing estate manager about the 'Freegans', the thousands of people who root in London's bins daily searching for perfectly edible discarded food from sandwich chains. I tell him that hawk-eyed Bill spotted a pair of nearly-new trainers last week in the bin and they fit him perfectly. I suggest Bill is not the problem. Bill is perfectly happy where he is. I suggest instead of moving Bill into care, they might want to look at how to deter the unscrupulous criminals and cockroaches from the estate. On Monday, I was a psychogeriatrician and a street wise Londoner.



#### Tuesday

On Tuesday, I am a psychogeriatrician and advocate. I see Sadiqa, 70, who lives alone in a small flat. For Sadiqa, who devoted her life to raising 6 children in Somalia then fleeing war and arriving in the UK, life is just not worth living anymore.

She is trapped within her four walls and her body by morbid obesity, heart failure and depression. She cannot bend down to see what is causing the constant prickly sensations in her legs. She cannot see the pitting oedema and angry cellulitis, instead she believes rats have got in and have been nibbling at her legs. At least, that's what her daughter tells her. The rats should hurry up and eat her to death, Sadiqa wishes. Her daughter, the official carer according to the local council, lives near by but Sadiqa tells me she is too busy to visit her regularly. Sadiqa has not been washed for weeks and pressure sores are developing. Her daughter refused external carers because she convinced the council the family would manage the care responsibilities. Today I speak to the daughter and ask what is going on. I don't see any daytime care being given, just an elderly lady being exploited and neglected by her own daughter, a lady literally unable to stand up for herself. A daughter exploiting her mother's illness to cheat the system for her own gain. A daughter not acting in her mother's best interests. I raise the alarm at this injustice and cruelty. On Tuesday, I was a psychogeriatrician and advocate.

#### Wednesday

On Wednesday, I am a psychogeriatrician and a family counsellor. I see May, 75, living alone in a comfortable council flat. May is surrounded by photos of her family to whom she is very close. She has become depressed these past few months after developing tinnitus and hearing problems. She is petrified that she may have a cancer in her head and that she is dying but she won't tell her sons as she doesn't want to worry them. *They have got their own lives, Doctor.* Her sons have seen her withdrawing from family contact these past few months. She doesn't talk as much as she used to, she can't follow the conversation. *Is it Alzheimer's, Doctor, does she need to go into a home?* They don't want to tell May their concerns because she'll be worried sick. I sit the family down together and surface all the unspoken worries. There is relief. I arrange an audiology appointment and ask the sons to accompany May. She knows her boys have got their own lives, but now she knows she is still very much a part of that. On Wednesday, I was a psychogeriatrician and I helped a family to talk and share their worries.

#### Thursday

On Thursday, I am a psychogeriatrician and a fortune teller. I see Mohammed, 77, living with his wife, son, daughter-in-law and 3 month old grandson. Mohammed has spent his entire adult life suffering repeated episodes of severe psychotic depression. He has always been tormented by

voices telling him to kill himself and has made several actual attempts. He knows the hospital wards better than his home. His brain has been pumped with heavy-duty tranquilizers for almost 60 years. He has been acting strangely again these past few months, distressed, confused, pacing, shouting and doubly incontinent. *We think the voices are back, Doctor. We have locked away the knives so he won't try to cut his throat again.* Today, I tell the family the results of his tests that confirm Mohammed has severe dementia. I tell them what I predict will happen in Mohammed's time limited future. I tell this already devastated family what I predict will be the impact on them. I think of Mohammed, who forgets every day he has a new grandson. I think of his grandson who will never get to know him. I think of the family who lost him years ago. On Thursday, I was a psychogeriatrician and I predicted the future.

### **Friday**

On Friday, I am a psychogeriatrician and a ray of sunshine. I see Aggie, 89, who lives alone with her cat. Aggie is debilitated by a chronic painful blistering skin condition for which every known treatment is being tried unsuccessfully. She has agonising sores on her legs and back that make

sitting down unbearable. She has sores in her mouth that have deprived her of the pleasure of a hot Builder's Brew for two years. She is deeply depressed and considers her life merely an existence. Her daily district nurses come and go, they dress her blisters; they apply the lotions and potions and administer her countless other medications. They cheerfully chat about the weather all the time, but what use to Aggie who can't go out to experience the weather herself? I phone Aggie before I go to see her and ask if she would like me to bring her something, perhaps a newspaper. Aggie tells me I am the first person in months to offer her something she wants, to even ask her what she wants. She cries with gratitude when I arrive with her newspaper. Aggie cannot enjoy the autumnal weather but on Friday, I was a psychogeriatrician and her ray of sunshine.

**Dr Gira Patel**  
WIPSIG JISCmail  
Lead and Specialist  
Registrar in Old Age  
Psychiatry, London



## **Training and exams from a mother's perspective: *A Personal Journey***

I first became a member of WIPSIG 3 years ago when all psychiatric trainees were offered to join different special interest groups. I have always found the role and situation of women in society special with very particular challenges and a constant need for creative coping strategies to balance our lives within and outside the home environment.

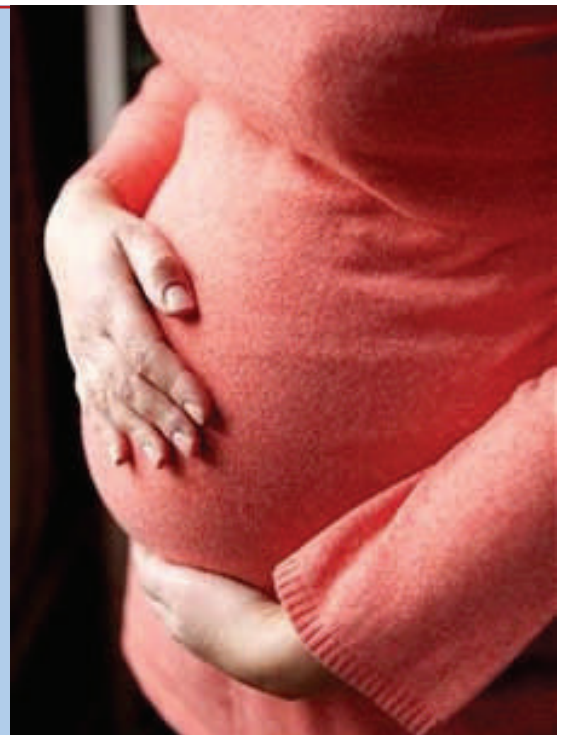
Having been drawn to Child and Adolescent Psychiatry since university, I've always found the importance of undisturbed mother and baby bonding unquestionable - something that I almost religiously believed in. This pertained not only to how I practiced my profession, but, as you would expect, to how I handled my personal life. When the time came, I knew I wanted to make sure that I would be able to offer my undivided attention to baby while so young and dependent.

That year, after months of uncertainty around the introduction of MTAS, when we all had to re-apply for our jobs, I finally landed the rotation I was hoping for. A few months later I sat and passed Part I of the "old" MRCPsych exam. I was already pregnant. Luckily, my first pregnancy was a reasonably easy one, or so it seems now, from the perspective of a second and much more challenging one.

Naturally, I was still quite anxious when it came to the OSCEs. I remember standing in front of the circuit, desperately trying to focus on the instructions written for each station, whilst my mind was being completely sidetracked by the acrobatic movements of my foetus who'd received a stout kick of coffee that morning. On the upside, at least I didn't feel the fatigue that is so usual with pregnancy!

I passed. Needless to say I was over the moon, and was eagerly anticipating a step forward in my career after my maternity leave. But even more eagerly, I was looking forward to meeting my first child.

It all seemed to go according to plan. Life seemed to be fair and I was enjoying maternity; busy meeting



new mums and immersed into a delightfully new world with my baby. I knew this was not just self-indulgence, and that being enriched by this new role would also have a beneficial knock-on effect on my professional life. Only a slight shade of self-doubt crossed my mind as I returned to work after a full year on maternity leave.

However, any self-doubts were swept away within days of starting work again. I returned as a part-time trainee, and was lucky enough to join a brilliant team, working with an amazingly supportive consultant. I was highly motivated, and my appraisal read: "She is an excellent trainee. She is so hard-working that one forgets that she is working part-time." That's probably enough of self-praise and pride. The only reason I'm writing it down is to prepare you for the contrast that was yet to come. Life, it turned out, was not to stay as rosy as one expected.

### **The Turning Point and Beyond**

I took and passed Paper 3 in August 2009 with little effort, as I happened to be familiar with most of the concepts in research and evidence-based medicine. The years of additional study suddenly slotted into place.

But then I went on to prepare for the final clinical exam, now called CASC. One of the eligibility criteria to sit the CASC is to complete 30 months full-time equivalent experience in Psychiatry. Maternity leave and flexible training has slowed down my progress in training and I was ready to receive the CCT proportionally later than if I had worked full-time continuously. In summary, I had not been eligible to take the exam before March 2010.

This is when the difficulties started to kick in: in January 2010 the Royal College of Psychiatrists published a new addition to the existing exam regulations regarding the expiry of the "old" Part I exam. The new rule stated that everyone who held a Part I exam should attain their CCT by July 2010 (meaning they must have passed all of their exams by that date), otherwise they must re-take Paper 1 and 2 before they can further proceed to sitting the final clinical exam. This new rule was to dominate my life for a good while, because between March and July; in other words, between my completing the requirements and the expiry of my previous exams; I was to have one single opportunity of sitting and passing the CASC.

In March 2010, I sat the exam with this in mind. I did not pass. A few weeks later, when I read through the list of candidates who passed, I realized that my professional life has just taken a sickening turn for the worse: I was potentially going to have to re-take all of my exams, starting from the very beginning. Everything that I'd worked for and have continuously excelled at was suddenly being thrown out of the window. Working and studying hard whilst pregnant and then with a young baby was to be for nothing, and the passes attained in my previous exams were suddenly invalidated.

It was in these initial days of desperation that I also found out I was expecting again. The feelings of being penalized for being a mother whilst training in Psychiatry were mixed with the joy of this new event. If I had not previously known what ambivalence was, this was the time I could really find out for myself.

I spent the next few weeks ruminating about the future scenarios of my life, and feeling completely let down by the very people whom I thought were there to help. The most I ever received was a sympathetic remark, and a few light-weight attempts at reframing the situation.

But however I looked at it, I was in grief. Initially passive and hopeless, I eventually mustered up the courage to contact the College in order to describe my "particular" situation and seek a second attempt at the exam. My letters were all but dismissed, resulting only in an impersonal response that was a standard form stating there was nothing to be done. At the same time, pregnancy symptoms were also ratcheting up, with bouts of sickness and fatigue-attacks. Were they just pregnancy symptoms, or was I depressed - I sometimes wondered. The weeks passed, and my mood was not getting any better.

Finally, I decided to take matters into my own hands. I started writing letter after letter, trying to contact people who I thought would have some influence on such far-reaching decisions. I was well aware that making an exception in my case could open up a potential can of worms for the College, but at the same time, I felt that just having a baby should never put anyone in such a disadvantaged position. All the other "normal" trainees had 4 or 5 opportunities, why should I only have one?

I knew I had to cry for help to stop this from happening. I would have done the same for any patient under my care - I could not afford not to do it for myself.

This was when WIPSIG so helpfully stepped in. Not only did they instantly respond and express their understanding, they also took the trouble to put my case forward. I hung on to this sudden sliver of hope and wrote to more people, many of whom also turned out to be supportive.

Only later did I realise that there was group of Part 1 trainees who were in a similar situation of potentially having to restart from the beginning. They'd managed to secure a meeting with the President of the

College. I joined them, and on a warm Friday evening in early July, we went to see him. The President listened carefully to our personal stories and heard our requests. This was followed by the ETC and CEC meetings within the College, where several members stood up for us trainees.

The outcomes were positive albeit provisional: we were allowed another attempt at the CASC, with the validity of our Part I exam extended until the end of October. We are still not sure what happens afterwards - but until then, we at least had another "one and only chance".

### **Why write about this?**

I remember talking about my personal life openly in front of my colleagues and the President with some embarrassment. I have always preferred to separate personal life from my work as much as I could, and probably would never have spoken from a woman's perspective if not pushed into such an awkward situation. However, my reticence was swept aside by colleagues intent on doing the right thing: seeing the Person behind the roles we play, and using their skills to disentangle me amongst other trainees from the trap of over-growing and rules and regulations. At last, I was allowed to take another deep breath. And with that same breath, to face another attempt at the exam.

You can only help someone if you understand who that person is - we often hear this in Psychiatry. It's become such a cliché that I doubt if anyone really gives it conscious thought. Maybe because we do it without thinking about it, naturally, skilfully. But perhaps not: maybe we are one of those who'd rather live by rules, textbooks and regulations, no matter what happens to the other person - keeping it all sterile, distant and under control. Which one are we? Only introspection can tell.

As for me, I am able to confirm that this rite of passage has resulted in a change for the better. I've made my choice, and I will always strive to see the Person behind the label, whether it's a case number, a training number, a diagnosis or a forensic report. And I quietly hope that in the end, I will be able to exercise these values in clinical practice.

**Dr Kata Ress**

ST3 in Psychiatry

## **WIPSIG EXEC ARTICLES**

### **Meeting the Challenge.... highlighting women's mental health needs**

Scanning the BMA News, warnings regarding the need to have honest debate on the futures of health services echoes the on the ground plans to reduce costs. Despite the public message that the NHS will be protected this is at odds with what clinicians are being told by their organisations and are experiencing with recruitment freezes reduced use of locums and tightening of study leave budgets.

Not only is the squeeze going to be felt in the workplace in psychiatry, with the likely increase in demand in business with the negative impact of the financial downturn on mental health; there is likely to be the personal squeeze we will all face with rising bills, a freeze on pay rises and relatively less disposable income, in addition to the potential impact on personal wellbeing with increased stress.

Coordination of care between providers to improve efficiency of working and following care pathways based on clinical needs it is hoped will improve clarity and provision of services.

Locally we do not have a specialist perinatal service, the coordination of obstetric, psychiatric, midwife, health visitor, social services and GP care has developed seemingly in tandem with patients tapping into each part of the service. Focus on efficiency and bringing strands of care together around care pathways and improving joint working will hopefully bear fruit and benefit the patient.

Increased efficiency in clinical services will require strong and effective clinical leaders in organisations where managers and executive members are willing to engage and allow clinicians to lead services. This will be a challenge with the necessary balance between increased clinical demands and the necessary time needed to allow clinician-led service development. Clinician engagement between primary and secondary care is clearly vital with GP commissioning to ensure that the services commissioned meets the needs of our patients. Highlighting the needs of women patients and ensuring that specialist services, serving female patients are retained is important.

Promoting the needs of women patients and ensuring the wellbeing of women psychiatrists we must all support and invest in.

**Dr Rebecca Horne**

Consultant Psychiatrist in General Adult Psychiatry  
WIPSIG Executive Member

## Executive Members Update

Over the past year I have had what might be termed a portfolio role within the WIPSIG Executive.

In September 2010 I agreed to take on the role of Treasurer, taking over from Lucy Watkin, (whom I must thank on behalf of all for her sterling work), and who has given me some preliminary guidance on the intricacies of monthly accounting. Apparently our accounts are quite simple and in excellent order, but I hope to have a greater understanding following my College Induction as a financial officer in October.

Also in September I attended an inaugural meeting, on behalf of WIPSIG, of the working party set up by the Department of Health (DoH) on 'Responding to Violence against Women and Children, the Role of the NHS, in response to the Taskforce on the Health Aspects of Violence against Women and Children. A number of exciting initiatives were discussed including the new Diploma on the Forensic and Clinical Aspects of Sexual Assault, is aimed at Forensic Medical Examiners who are often the first, but also the front line clinical contact persons, and who can have a vital role in managing emotional distress, as well as their more traditional skills in physical examination.

The DoH meeting emphasised the need for cooperation and collaboration between differing professionals and specialities in all situations, and

the need for education in order that staff achieve the necessary core skills and competencies. There was reference to the need for a culture of enquiry, with professionals having the skills and confidence to ask the right questions.

This theme seems to resonate with the discussions of the Primary Mental Health Forum, the joint collaboration between the Royal College of Psychiatrists and the Royal College of General Practitioners. Recent topics have included the need for shared care for those with long-term mental health difficulties, and for there to be greater collaboration between primary and secondary care. As so much of the focus of the Forum's work relates to General Adult Psychiatry, my colleague Dr Rebecca Horne has kindly agreed to be a co-opted WIPSIG representative.

I was struck by the current climate of discussion, and how the 2 separate work groups spoke of the need to have a more joined up approach to mental health care with different professionals, specialists and patients coming together.

So there is a lot going on which is stimulating and encouraging, and I hope to update you further in the next newsletter.

### **Dr Judith Edwards**

Forensic Consultant Psychiatrist  
Broadmoor Hospital

## Update from the PTC

Lots more change this year with Josie Jenkinson, a South Eastern Division trainee, taking over the reins as chair from Jon van Niekerk.

Lucy Watkin has stepped down from the PTC and WIPSIG and will be greatly missed from both committees.

Emma Lambert, a West Midlands division trainee has become the new PTC WIPSIG representative and both Emma and I will share Lucy's previous role as PTC representative on the equivalence committee.

Plans are afoot for a UK wide psychiatric film festival to be run through the university psychiatric societies.

The new online portfolio went live in August 2010 and trainees are encouraged to use the portfolio with their Consultant. Support is available through the online team and feedback is welcomed.

While overall pass rate for the most recent CASC was low (32%), trainees who have graduated from UK universities and are in PMETB approved posts continue to have the highest pass rates.

Eligibility rules for examinations are also planned to change. The first examination can be taken with 6 months

experience and time to complete all exams will be extended to 1643 days (with 12 month extension per pregnancy, full time equivalent for those working part time and extensions possible if illness). A sponsor will no longer be required for the written paper.

2011 is also the first year of interviews for all core trainees hoping to progress to higher training so 2010 - 2011 promises to be a busy year for all concerned.

Responses, comments and queries welcome to [michellegilmore@me.com](mailto:michellegilmore@me.com)

### **Michelle Gilmore**

WIPSIG Executive PTC Representative

## Correspondence

I currently work in the West Midlands Deanery as an ST5 trainee in General Adult Psychiatry. I found the article by Dr Olivia Protti very relevant to current psychiatric practice.

A significant chunk of our caseload comprise of women of child-bearing age. It is well known that the physical health of female psychiatric patients is compromised by poor lifestyle choices even before becoming pregnant. They are also less likely to plan pregnancy and engage in regular antenatal care that further complicates mental and obstetric risk.

The importance of counselling female patients and their relatives on issues relating to pregnancy and psychiatric treatment or care cannot be overemphasized. I have come across a case where a woman prescribed lithium reduced her medication whilst trying to get pregnant without informing the clinical team leading to a major relapse in mental state.

In terms of who takes responsibility, I believe the clinical teams in particular care coordinator and treating doctor should regularly discuss patients' plans regarding pregnancy and reviews should be part of CPA (care plan approach). Patients expressing desire to become pregnant should be counselled and advice sought from perinatal team. For the group of women sexually active and not willing to get pregnant, they should be advised and supported in accessing birth control services.

In conclusion, the GP also has a valuable role in supporting women of child bearing age who suffer from severe mental illness. They should enquire about plans for childbearing when the opportunity presents and liaise with mental health services as required

### Lilian Obakpolo

ST5 General Adult Psychiatry  
Birmingham and Solihull  
Mental Health NHS  
Foundation Trust



## WIPSIG RESEARCH PRIZE 2011

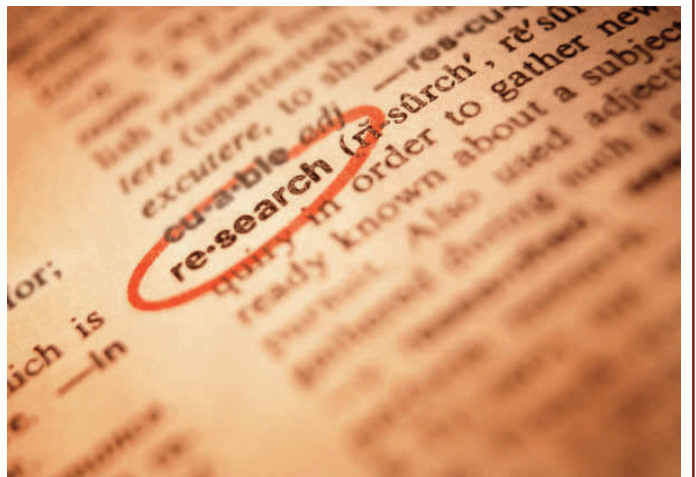
WIPSIG has established an annual prize for the best project conducted by medical undergraduates, medical foundation trainees or psychiatry trainees, SAS grades or consultants in their first three years of substantive posts (male or female).

The work can be based on literature review, research, or audit but needs to comply with the regulations below.

<b>Prize:</b>	<b>£250</b>
<b>Frequency:</b>	<b>Annually</b>
<b>Eligible:</b>	Medical undergraduates Psychiatry trainees New consultants (within 3yrs of first consultant post)
<b>Topic for 2011:</b>	The Mental Health Impact of Caring on Women
<b>Where presented:</b>	WIPSIG Autumn conference

### Regulations

1. Applications may be from undergraduates, trainees in psychiatry in a recognised unit in the UK or Ireland, non-career grade staff doctors or within 3 years of appointment as a consultant psychiatrist.
2. Notice of the Prize will be given annually in the WIPSIG newsletter, with a deadline for submission to the Chair each year. Candidates should prepare a summary of their project (maximum length 2000 words including a structured abstract). Entries will



be short listed to a maximum of four by 2 members of the WIPSIG Executive and one independent assessor from the College.

3. The prize winner will present their paper at the WIPSIG meeting and will be judged by three WIPSIG Executive members.

4. The subject matter should be in the form of either research, a review or an essay on the subject.

5. No Prize will be awarded if it is judged that submissions are of an insufficient standard.

**Closing Date: 31 July 2011**

Submissions should be made to the Academic Lead (Professor Howard) of the Women in Psychiatry Special Interest Group in both electronic and paper versions c/o Sue Duncan at the Royal College of Psychiatrists (sduncan@rcpsych.ac.uk)

## What is WIPSIG?

Membership of the Women in Psychiatry Special Interest Group (WIPSIG), established 1995, is open to all Members, Inceptors and Affiliates.

The aims of the group are to:

- **Focus on the mental health of women and services for women patients, and**
- **Promote the careers of women psychiatrists**

For information on how to join the group, please contact:

The Registration Department  
The Royal College of Psychiatrists  
17 Belgrave Square  
London SW1X 8PG  
or call 0207 235 2351 (ext 280 or 102).

### Submitting Articles

Contributions, including articles and letters from readers, are actively encouraged and welcomed. All submissions should be in MS Word format and sent by email. Please remember to include your full name, preferred title, place of work and email contact details. A digital passport-style photo of yourself can also be submitted for inclusion with your article. The editor reserves the right to edit contributions, which should be limited to 700 words unless otherwise agreed. Letters should not exceed 200 words.

Opinions expressed in the Newsletter are those of the authors and not of the College unless otherwise stated.

Contact details for the current editors are shown below.

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