Leadership & Management Scheme 2025/26 Module 4 Case Study 1

A day in the life of a General Adult psychiatry SpR

An NHS Mental Health Trust covers several densely populated urban centres as well as extensive rural regions. Due to its geographical spread, specialist registrars (SpRs) in General Adult Psychiatry on the on-call rota face diverse demands, covering community crises, several A&E departments, psychiatric inpatient wards, police custody, and several Section 136 places of safety. Junior doctors are available on-site, working 12-hour shifts, while SpRs undertake demanding 24-hour shifts. Consultant psychiatrists are contactable via telephone but rarely present physically during out-of-hours.

Assessments under the Mental Health Act (MHAAs) require close collaboration with Approved Mental Health Professionals (AMHPs), who work for the local council authority, a separate organisation with its own management structures and shift patterns. AMHPs operate on a 12-hour rota, frequently resulting in a conflict between SpR and AMHP availability. AMHPs have overall control over the scheduling of MHAAs and often contact SpR unexpectedly expecting to be able to do an assessment soon.

SpRs are responsible for assessing and managing patients aged 16 and above. However, any decision regarding admission for 16-17-year-olds must be agreed upon by a Child and Adolescent Mental Health Service (CAMHS) practitioner, who typically has not directly assessed the patient. CAMHS consultants are available by phone, but there is no dedicated CAMHS SpR for out-of-hours assessments.

Any inpatient admission, particularly informal ones, must also be gatekept by the Home Treatment Team (HTT) and coordinated via a central Bed Hub. HTT staff frequently challenge referrals, citing lack of clarity about their role or the appropriateness of their involvement without directly assessing the patient themselves.

The process is characterised by constant external pressures: A&E departments demand rapid action to alleviate overcrowding; police officers want to handover patients held under Section 136; liaison psychiatry colleagues seek support for distressed patients on general medical wards. Police custody officers pressure SpRs to expedite assessments to facilitate removal of patients to a psychiatric setting. Forensic SpRs focus primarily on detained patients within secure forensic units and rarely engage directly with police custody assessments.

Further complicating matters is the persistent shortage of inpatient psychiatric beds. This scarcity regularly forces clinical staff into making difficult medico-legal decisions. Patients are often turned away or discharged prematurely or are temporarily held in inappropriate environments under tenuous legal frameworks. SpRs frequently balance significant risks against systemic pressures to rapidly

discharge patients or find alternative community-based management solutions, which prove hard to source because of reluctance of those teams to accept patients.

In your small groups answer the following questions:

1. How would you describe this system? What are linear and non-linear elements?

2. Can you think of any emergent properties or feedback loops that could arise in a system such as this?

3. What are the various subsystems within this larger system? Where are the different subsystem boundaries?

4. Can you identify any instances of a double-bind?

5. Can you think of an example of a 1st order change for a system like this? What would be an evidence-based 2nd order change?