Careers
Perinatal Psychiatry

Feature
Shadowing a local borough commissioner in CAMHS

Reflection
Thoughts on the 2017 Maudsley Liaison Psychiatry Summer School
Welcome

Hello! Welcome to this edition of the Registrar. We hope you enjoy reading, and if you would like to contribute to a future edition or simply would like to get in touch then please don’t hesitate to contact us via email at ptcsupport@rcpsych.ac.uk or tweet us at RCPsychtrainees! We look forward to hearing from you.

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REGISTRAR
The Psychiatric Trainees’ Committee Magazine
December 2017

Disclaimer: The opinions expressed in this magazine are those of individual authors and do not necessarily represent the views of the Royal College of Psychiatrists.
Hello and welcome to the December 2017 edition of the Registrar. Since the last edition of the Registrar the Psychiatric Trainees’ Committee (PTC) has held their annual meeting in Liverpool, welcoming new reps elected from the college divisions. We continue to work with the College on key issues affecting psychiatric trainees, particularly recruitment, retention and ensuring high quality training. The projects we have chosen to focus on for the next 12 months reflect this. As well as PTC led projects a PTC rep sits on nearly all college committees to provide trainee opinion. These include each of the speciality faculties, special interest groups, as well as training, education and exams.

Our primary role is to represent you in the College and ensure that the trainee voice is heard. To do this effectively we need your views and your feedback, you can contact us via twitter @RCPsychtrainees or via email at ptcsupport@rcpsych.ac.uk.

You may be aware of the PTC published report ‘Supported and valued,’ a trainee-led review into morale and training within psychiatry. Focus groups were held in all of the college divisions, ensuring views of psychiatric trainees from all four nations. ‘Supported and valued’ identified positive aspects of psychiatric training, including protected teaching and supervision, flexibility and autonomy of training.

‘Supported and valued’ also identified changes that could improve work-life balance and training. We wanted to ensure supported and valued drives change in working environments and culture for psychiatry trainees across the country. One of the key outcomes was implementation of enhanced junior doctor forums. The PTC in are in the process of producing a series of case studies of trainee lead enhanced junior doctor forums, for trainees to use as guidance to help set up enhanced junior doctor forums in their own trusts.

We will continue to work with the College to ensure that there is tangible action on a national level. This is reflected in the national interest that supported and valued as gained, having been referenced in several key reports focussing on working environments for junior doctors.

Our next focus is to review fatigue and sustainability for psychiatry trainees whilst on call. Psychiatry is a unique speciality in terms of on call requirements. Throughout training may of us will have worked a mixture of non-resident and residential on calls as well as covering multiple sites, resulting in significant mileage. “Supported and Valued” referenced the importance of trainees having access to appropriate rest facilities whilst on call and protected rest time. Please look out for our sustainability survey in the coming new year, and take a few moments to complete it. The information you provide will form part of a national review, in turn to improve on call environments for trainees across the country.

Previous RCPsych president Simon Wessley has been asked to chair the Mental health act review. To ensure trainee views and opinion feature in this, the PTC have been asked to complete a national survey on trainees use of the mental health act. The survey takes a few minutes to complete, with links on the PTC twitter account and in recent trainees letter. (Priya the survey shuts early December so if the registrar is going to be printed after this please feel free to delete this paragraph).

Finally hopefully you have seen coverage of the “Choose Psychiatry” campaign lead by the college. Please spare a few minutes to review the Choose psychiatry section of the website and show your support on Twitter. We are the greatest advocates for recruitment into psychiatry. A engaged trainee will inspire a potential future psychiatrist. Please look for recruitment events in your local divisions and if you can spare a couple of hours to help out at local events.

Thank you,

Dr Charlotte Blewitt
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**EPA 2018**
26th EUROPEAN CONGRESS OF PSYCHIATRY

MENTAL HEALTH
INTEGRATE
INNOVATE
INDIVIDUALISE

Nice, France
3-6 March 2018
#EPA2018

**Upcoming**

**global mental health: children in crisis**

**Date**
Tuesday 9 January 2018

**Day**

**Venue**
Royal Society of Medicine
1 Wimpole Street
LONDON
W1G 0AE

**Organised by**
Psychiatry Section

**Accreditation**
6 CPD Points

Psychosomatic Medicine Congress 2018

25th International Conference on
**Psychiatric Disorders & Psychosomatic Medicine**

July 11-12, 2018
Sydney, Australia

THE ROYAL COLLEGE OF PSYCHIATRISTS
INTERNATIONAL CONGRESS 2018

BIRMINGHAM, 24-27 June 2018
Faculty and Section Conferences

January 2018

Second Symposium of the Evolutionary Psychiatry Special Interest Group
Date: Fri 12 January
Location: RCPsych, London

Collaborative approaches to the mental health of children: from issues to interventions
Date: Tues 30 January
Location: RCPsych, London

February 2018

Advances in Clinical Practice for Older People with Substance Misuse
Date: Thur 15 -Fri 16 February
Location: RCPsych, London

Belief Systems, Culture and Mental Health - Transcultural SIG Conference
Date: Monday 19 February
Location: RCPsych, London

Faculty of Forensic Psychiatry Annual Conference
Date: Wed 28 February - Fri 2 March
Location: Nottingham

March 2018

Faculty of Old Age Psychiatry Annual Conference
Date: Wed 7 March - Fri 9 March
Location: Newcastle Gateshead

Other conferences

Global mental health: Children in crisis
Date: 9 January 2018
Location: Royal Society of Medicine, 1 Wimpole Street, London, W1G 0AE
As part of my development into management as a senior trainee, my consultant suggested I shadow the local borough commissioner for the day. Prior to this I had little working understanding of a commissioner’s role and I was even a little sceptical of what they do. However by the end of the day, I learnt that commissioners do a lot of joint working with NHS providers to understand what the local needs are and aim to use their budgets to provide the most effective outcomes for young people. I encourage all trainees to learn more about commissioning in their local area; its useful for consultant interviews and our careers!

Q. How did you end up becoming a commissioner and what do you enjoy about the job?

I first came into commissioning while working in Public Health as a mental health promotion specialist. There was an opportunity to develop and commission an IAPT service and I was particularly interested in making the links with talking therapies, mental well-being and primary care. I enjoy seeing things work well for local people.

Q. What does your role entail and what is a typical day at the office?

My role is wide ranging, I work directly with providers in terms of contract monitoring and service development. Sometimes I have time limited projects to work on that contributes to a broader agenda for example SEND (Special education, needs and disabilities). I also have a role doing direct work to co-ordinate care, support and funding for CYP so various needs are met, for example the Transforming Care programme of work, and chairing care, education and treatment reviews (CETRs).

There are no typical days, things change quickly in commissioning, I sometimes have to do briefings and reports for boards and committees and attend a variety of meetings. I have to be flexible to deal with unplanned/ unexpected occurrences.

Q. Could you tell us (in a few sentences!) how local NHS services come to be commissioned?

Local NHS services are commissioned based on the needs of the population or as mandated by NHS England. Commissioning may also come about following engagement with local people who are vital in the commissioning process in telling us about their experience of services and where there are gaps in provision.
Q. Do you liaise with secondary care providers and hospital doctors about what services are needed in the local area?

Yes, we discuss with providers the needs of local population and trends in services. There is also learning about what is needed from deep dives and quality reviews that are always on the go within services.

Q. What do you think are the challenges that face children and young people’s mental health services?

There is rising need and demand for services on one hand, but also there may be a lack of confidence for children, young people and families in approaching health and care services to get the right help at the right time. This may be as a result of stigma associated with mental ill-health as well as shame/embarrassment/anger around social care issues, these need to addressed as they prevent people asking for the help they need before problems reach crisis point.

Q. How has the 5 year forward view been put into action for CAMHS in the local area?

We have worked hard to ensure that our transformation of mental health and services is based on local need. We have enhanced several local CAMH services and we are working to set realistic outcomes for all services commissioned.

Q. Doctors often say that we need to persuade or convince commissioners that our services are providing efficient and effective care – what is your take on this style of communication?

This may be the case when commissioners are unable to clearly see the impact of the service delivered for the patient, the quantified return on investment or the value for money, especially when commissioners are faced with a reduction in budgets for services.

Q. How can trainee Drs and consultants improve their insight and communication with commissioners?

A practical thing might be to look at the commissioning section on the NHS England website
The best training I have attended in the past does not give out reams of data, but is experiential and invites the audience to debate, learn from each other, challenge each other. One leaves exhausted but excited, eager to take new ways of seeing ones work out to the world. I think it is hard to know how to aim a lecture at a mixed audience. As an ST6 I felt frequently like I was back at medical school. There were some useful gems of information, I definitely went away with a renewed confidence in talking to patients about their functional disorders in a more open and honest way, a testament to John Millers’ talk about dissociative seizures. However, I was disappointed to find this was not the advanced course I had hoped for, but more like revision for me. New facts are always welcome, but can be learnt more effectively on the job from others and from reading up when faced with a new problem. My nursing colleagues tell me they found the course useful, though when I ask them for specifics it seems they cannot offer any and mention that they felt certain lectures were not relevant to them. This in itself speaks of a failure of the course to engage the nurses and lift up their confidence. A positive outcome for all of us would be to enliven everyone to want to get back to work and try out new skills and learn new knowledge from our respective nursing and medical colleagues, rather than continue the “this is my job, that is yours” dogma that holds back teams.

My greatest concern about the week, however, was the absence of the patient. The three big “disorders” seen by liaison are people who have harmed themselves, delirium and functional disorders/MUS. These to my mind can all frequently be understood as dissociative events; delirium is not strictly speaking an emotionally dissociative state, but does result in a highly confused, frightened person who forgets who or where they are with often an ensuing amnesia; self-harm is often performed in, or brings about, a dissociated state as part of a developmental adjustment to unmet emotional need and by way of dealing with overwhelming feelings; medically unexplained symptoms, are recognised as being...
dissociative – a physical manifestation of unrecognised emotional pain or conflict. In all the discussions on these presentations, though this understanding was touched on (and some speakers paid more attention to this than others) this was only ever really as an aside, rather than a real examination and recognition of its centrality to the presentation. In this way the patients core pain and distress was not addressed. Just as the patient cuts off from unmanageable and unfathomable feelings, it seems to me that so too did this course. I found this saddening, but worse than this, I found that on occasions derogatory or critical language towards such patients was left unchallenged in the room. To my mind making this the central issue is the way to promote understanding, compassion and care within staff. It’s also the way to help teams deal with the intensity of confusion and negative feelings these patients, and their medical teams, provoke in us. This is the advanced skill I believe liaison teams need.

There were highlights in this course. Tuesday was spent in Lambeth at the Maudsley Simulation Centre where the group was split into two groups of 12. Everyone took turns to interview an actor by video link and on their return to the group a discussion was had about what went well, could have been done differently and what was the “golden moment” (the point at which the interview turned and opened up). People were encouraged to be open about how they had found the experience and to learn from each other. The scenarios were beautifully crafted to throw up interesting dilemmas and really challenge the group. This was a packed, intense day, but everyone left feeling lifted, enlivened. Equally the Monday had some useful talks about service design and breakout exercise of drawing up a proposal for a new service, which while not particularly well organised or explained and with too little time, had the potentially to evolve into an excellent and fun exercise.
During my fourth year of study, I undertook a 6-week student selected module with the Northumberland, Tyne and Wear Perinatal Mental Health Service. As medical students, our psychiatry exposure typically starts with lectures and ends with role-players. So the prospect of an extended period of time to explore psychiatry as a specialty really appealed to me. When scanning the list of local psychiatric services, the perinatal service struck me as being the most intriguing. Being a service to which medical students are not ordinarily assigned, I was curious to see for myself the extent and impact of perinatal mental health problems in both inpatient and outpatient settings.

A few months and e-mails later, I arrived at the Beadnell mother and baby unit expectantly having read up on post-natal depression. On arrival, I was given a timetable filled with a range of outpatient clinics, home visits, meetings and ward time. One outpatient clinic in, I quickly realised that I would be seeing much more than post-natal depression…

I particularly enjoyed the time spent in the community. Attending a number of home visits alongside both the medical team and CPNs meant that I saw more of the North East than I had in all of my previous placements combined! Visiting patients in their own environment and hearing their narratives cemented to me that mental health problems, particularly those that occur in the time surrounding pregnancy, can affect women from all walks of life.

Equally, I valued the opportunity to speak at length to inpatients on the mother and baby unit. The luxury of time meant that I was able to fully explore their complex social circumstances, something which is not as easily achieved with a role-player. Furthermore, the opportunity to hear from patients’ relatives evidenced how great of an impact that mental health problems can have. Through attending weekly meetings on the unit I learnt the true meaning of a multi-disciplinary team.

I was impressed to see the way that many professionals from varied disciplines worked together to ensure the best outcome for each individual.

My experiences over the 6-week period portrayed psychiatry as an attractive career choice. Alongside the fascinating conditions I encountered, I also liked the continuity of care and the opportunity to establish a trusting rapport with your patients. Seeing even small improvements in a patient’s mental health over time was incredibly rewarding. Choosing to undertake a student-selected module in psychiatry was undoubtedly worthwhile. Indeed, my time with the perinatal mental health service confirmed my interest in psychiatry as a future career. I’m now in my final year at Newcastle University and am looking forward to my upcoming senior rotation in psychiatry and what hopefully lies beyond graduation.

Kaisha is a final year medical student at Newcastle University, though originally from Sussex. She is interested in both psychiatry and general practice, but outside of working hours enjoy cooking and keeping fit.