sports psychiatry: a new psychiatric subspecialty in the UK?

Reshad Malik on an emerging field

#juniorcontract
Psychiatric Trainees’ Committee Response

RCPsych congress

Trainees’ experiences of the RCPsych International Congress in Birmingham
Welcome

We are delighted to present this quarter’s ‘Registrar’. You’ll find a combination of events, conference reports, opinion pieces and education & training news. We’d love to hear your views about the magazine and welcome submissions for the next edition to ptcsupport@rcpsych.ac.uk by 18th December 2015.

Lucy Potter Editor @lucy19

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T he P TC M agazine

Registrar

NOVEMBER 2015

Associate Editor: David Denton
Editorial Team: Matt Tovey Louise Murphy Laura Sutherland Nikki Cochrane
Alongside the junior doctors’ contract dispute, work continues on how the College might implement the Shape of Training Review. There is little detail on how this might look for psychiatrists at present, but the PTC is heavily involved in representing your views on this to our Dean, Dr Wendy Burn. Be assured we do not wish to see any shortening or dilution to our training but we do need to ensure we are prepared for the demographic and workforce changes that will occur over coming decades. With this in mind, the PTC is involved in a piece of work looking at how higher specialty training prepares you for the demands of emergency psychiatry practice and how this will align with the future direction of psychiatric practice.

Furthermore, the PTC has been looking to identify other issues that trainees feel strongly about. Two issues of significant concern were the anxiety felt by those returning to work following a period of maternity leave and, as discussed in a later article, the distress caused when you face the saddening experience of one of your patients committing suicide. To address these issues we are looking to develop a ‘Return to Practice’ event and some supporting guidance to help those who face a patient suicide.

The PTC continues to work tirelessly to promote psychiatry as a career, supporting local Buddy Schemes, careers events and improving our social media impact. I call on all of you to continue to support your profession by assisting where you can with this. Recruitment and retention of future psychiatrists is of paramount importance and we can all play our part with each and every interaction we have with our colleagues, students and the public.

Lastly, I hope you enjoy reading this edition of The Registrar, which is full of interesting articles written by you, the trainees. As ever, if you’d like to comment on anything I’ve mentioned here or in-fact anything else, you can contact me through ptcsupport@rcpsych.ac.uk, via Twitter (@RCPsychtrainees) or on our Facebook page (https://www.facebook.com/Psychiatric-Trainees-Committee-186606754737390/)

Enjoy!
Matt

Dr Matt Tovey, Chair of the PTC 2015/6, ST6 in Forensic Psychiatry, West Midlands
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Background

Patient suicide has been identified by psychiatric trainees as one of the most adverse professional events. Studies have shown that between 25 - 68% of psychiatry trainees experience patient suicide during their training and one study found 30% had experienced patient suicide within their first year of training. Clinicians who have encountered patient suicide have reported a range of emotions including: disbelief, shame, guilt, despair and anger. Younger and less experienced clinicians have been found to experience higher levels of distress.

Proceedings following the death of a patient such as a coroner’s inquest may further amplify the distress of the clinician. Previously, Dewar et al emphasised the need for greater availability of training in this area to allow trainees be better prepared for such an event.

We wanted to find out about the experiences of psychiatric trainees relating to this and the availability of appropriate support and training.

Method

All Psychiatry trainees in the Wessex deanery were invited by email to complete an anonymous online explorative survey between 06/02/2014 and 06/03/2014. The survey consisted of 10 questions including both qualitative and quantitative questions. It was developed by consulting the relevant literature followed by brainstorming and further discussion. A senior consultant colleague was consulted for the design of the final version. The tenth question was an open question for any concerns that had not been explored in the other questions.

We did not aim to derive hypotheses from the results, but instead, wanted to investigate common themes of experiences.

Results

100 trainees were asked to participate and 43 responded by completing the survey. CT3 trainees made up the largest proportion (28%) followed by CT2 (23%), ST6 and above (19%), ST4 (12%), and CT1
Eleven (26%) reported that they were one of the last doctors involved in the care of a patient that committed suicide. Five (12%) at the time of the survey had been asked to provide evidence at a coroner's inquest. Of those, three stated feeling either ‘anxious’, ‘very anxious’ or ‘terrified’ before the inquest.

Thirty-five (81%) reported that they had not had any previous training relating to giving evidence at a coroner's inquest. Thirty-two (74%) were not aware of any support they could access regarding giving evidence at a coroner's inquest.

A range of experiences was described following the inquest. One stated they felt ‘horrified’ due to the press coverage, unfairly criticised and unsupported by their consultant. One felt ‘annoyed’ because they had never even met the patient and had become involved because of completing a discharge summary. One stated ‘[I] probably won’t be as terrified a second time’. Only one trainee stated feeling ‘relieved [because] it wasn’t that bad.’

Discussion

Our study was confined to psychiatry trainees in the Wessex. Therefore, the results may not be representative of psychiatric trainees experiences in general.

Just over half of our respondents were from either CT2 or CT3 level with comparatively fewer responses from both more junior and more senior trainees. Response rates have been shown to be lower in questionnaires that ask questions of a sensitive nature.11

Proceedings following the death of a patient may not be clearly understood by trainees that have not been through the process before. Many trainees may not consider this a relevant issue until they have to go through the process themselves.

We ask that programme directors and the Royal College of Psychiatrists consider implementing a requirement that formal training is provided to psychiatry trainees, preferably, early on in their training so that trainees are more prepared to give evidence at a coroner’s court.

“Supporting trainees who have experienced patient suicide is an important priority of the PTC. The committee is currently writing a guide for trainees and looking at introducing guidance for supervisors too. Please contact ptc.support@rcpsych.ac.uk if you are interested in finding out more or getting involved.” - Lucy

“Between 25 - 68% of psychiatry trainees experience patient suicide during their training”

References

Historically there has been a misconception that physically healthy athletes must be mentally healthy too, as one is a reflection of the other. This assumption is slowly beginning to be addressed in the UK. As a subpopulation, athletes suffer mental health issues as commonly as the general population. They are subject to environments and situations that the majority of the general public will not encounter and this makes them not only an interesting subpopulation to study, but a vital one if we are to maintain the good mental health of our sports professionals.

Sports psychology is a well-developed field, the focus of which is sport performance, while sports psychiatry, whose focus is mental health conditions in athletes is relatively new. It is an area that is developing rapidly, with research from the United States leading the way. In the UK there was a small peak of sports psychiatry-related publications in 2012 with London hosting the Olympics and the emergence into the public eye of psychiatrists such as Steve Peters, who worked with British Cycling. The team went on to produce 12 medals, 8 of which were gold, which was the highest British medal haul of all the sports. But since 2012 there have been few papers (none that the author could find) from British authors.

There are various hypotheses that could be put forward for this. Firstly, purely the population size differences between the US and UK, meaning that ‘more sport’ is happening at any one time. It may also be down to the different ways in which sport is considered culturally and perhaps the stigma with which mental illness within the arena of sport is currently regarded. In addition, healthcare funding differs between the US and the UK; sport psychiatry and related services are unlikely to be offered within a free-at-the-point-of-access national health service as they will not benefit the general population. Therefore in a society within which private health care prevails, it is not surprising that such a service is comparatively well developed.

Despite the large base of information coming from the US, our understanding of mental health issues in sports professionals is still limited. Reardon et al 2010 suggest that a reason for the perceived low prevalence of mental health disorders in the sport-
ing community, is likely to be the stigma attached to admitting to a diagnosis. As a consequence, the issue is infrequently addressed and thus the cycle is perpetuated, with the true burden of mental health disorders in this subpopulation going undetected.

The athlete’s relationship with his or her sport can also determine mental health outcomes and can also make it more difficult to detect underlying mental health disorders. These relationships can be broadly classified in three ways:

- **Sport as a way of managing** the mental health disorder (a theory that has been suggested for elite athletes with Attention Deficit Hyper-activity Disorder, ADHD)
- **Sport which perpetuates** the mental health disorder (for example, eating disorders in so-called ‘leaness’ sports such as gymnastics)
- **Sporting success despite** the mental health disorder

Perhaps the area of mental health in sport that has garnered most attention in the sporting arena in the UK is depression. Here, the stigma seems to be slowly lifting, as more and more sportsmen are now feeling able to talk about their depression and its impact. Examples include footballers Clarke Carlisle and Neil Lennon, cricketer Marcus Trescothick and boxer Frank Bruno. In addition, the media has reported on numerous attempted and completed suicides of high profile British sportsmen in the last few years.

Earlier this year, the Sport and Recreation Alliance together with the Professional Players Federation and supported by mental health charity Mind, created the Mental Health Charter for Sport and Recreation. The Charter sets out how sport can use its collective power to tackle mental ill health and the stigma that surrounds it, as well as encouraging sporting organisations to take positive steps to address mental health issues. This may be a sign of a change in the way we think about mental health in sport in the UK.

The data we do have on mental health in sport, especially depression, comes from the US, and suggests that the prevalence is similar between both the athlete subpopulation and the general population. However, triggers between the two groups may differ, reflecting the particular pressures sports professionals may face during their career. These factors can include burnout and overtraining (OT), injury and other related physical health conditions. Other studies have shown more complex factors such as limited scope to develop personality outside of the all-consuming sports arena which has lead to highlighting the importance of treating clinicians being able to distinguish the person from the ‘athletic persona’ when addressing depression in this population.

Further studies on former National Football League (NFL) players in the US have shown that times of career transition, namely retirement, can also trigger depressive symptoms, which can be linked to maladaptation to inactivity and also pain related to their former footballing careers. It would be interesting to determine if this finding can be replicated in sports in the UK.

These unique risk factors, along with factors such as demand for high performance suggest a better understanding of depression in this subpopulation is needed, specifically in the UK, as these factors will need to be considered in any management plans if we hope to develop effective and supportive mental health services for professional athletes.

Further research into the prevalence of mental health disorders such as depression in UK sports is needed, as well as looking into the impact of stigma and how elite sports people view mental health conditions, diagnoses and mental health workers. Risk factors that have been identified in US studies as described above should be further investigated in the UK, so that if similar outcomes are found, appropriate services can be developed to manage these. The first step towards this may be consideration of sports psychiatry as a distinct subspecialty in itself.

### References

In February this year I attended the ‘Lessons Learned’ conference. The brainchild of Bjorn Thomas and Christopher Orton, the ethos here is not about finger pointing but learning from mistakes.

Wrapped in a blanket of confidentiality, everyone from psychiatrists to surgeons, juniors to professors, shared their errors with refreshing frankness through short presentations. Given the atmosphere of transparency the choice of venue, White-hall’s National Liberal Club, felt fitting.

The format made for a captivating day; this was warts and all medicine. Honest mistakes, cover-ups gone wrong, well-disguised eponyms or missed barn-door red flags, sometimes leading to catastrophic consequences when the metaphorical Swiss cheese holes aligned.

From the near-miss incorrectly placed nasogastric tube to the steroid induced psychosis that did result in a bloody end, hanging learning points on real-life cases as an educational tool kept content memorable and patient centred. Each session (acute medicine and psychiatry, gastroenterology, cardiology, respiratory) felt engaging; and the usual post-hearty-conference-lunch slump never reared its head.

A soon-to-retire GP told me afterwards, that so buoyed was she by the younger trainees enthusiasm to improve patient care that she felt, somewhat ironically, she was leaving the NHS in safe hands. And a trainee conference can’t aspire to do much more than that.

The next Lessons Learned Conference is on 24th Feb 2016. More details can be found at: www.medicaleducationuk.com
Opening Day

Around 2500 people were welcomed to the Birmingham International Conference Centre (ICC) for this year’s RCPsych International Congress: Psychiatry at the Forefront of Science. I arrived at the start of the conference on Monday lunchtime.

The ICC is a large venue. The glass entrance hall spans the width of the building, with Centenary Square on one side and the canal on the other. Inside, lecture theatres and seminar rooms were upstairs with coffee shops and restaurants below. A large exhibition hall held a number of stands and tables, with the RCPsych logo projected on to huge screens suspended from the ceiling. Professor Sir Simon Wessely, President of RCPsych, gave the opening keynote speech. Simon spoke without slides, and ranged from humorous and irreverent to profound. He welcomed everyone to the conference and described the programme for the week. His introduction was interspersed with jokes at the expense of Nobel Laureates and President Barack Obama. He then outlined what he feels to be the biggest issues facing our profession today. He identified recruitment into psychiatry as a key challenge. Many new foundation training posts have been created. If the foundation doctors have a good experience, we can attract people to psychiatry. Equally, if they have a poor experience, we can deter them. He made a direct appeal to his audience: with foundation doctors, he said, the future of our profession is in our hands.

In the afternoon I visited the trainee’s lounge. I found a colleague browsing the latest copy of The Registrar which was on the table. A group of higher trainees were chatting about out-of-programme experiences and consultant jobs. They told me about a local higher trainee CPD group which included career discussion and balint sessions. They found it really helpful to gain support and advice from their peers.

I attended a workshop entitled ‘Summoned to an inquest: present your risk assessment.’ We were given some notes from a patient’s hospital admission. We were asked to play the role of the consultant in charge of her care. She had committed suicide whilst on leave. A simulated Coroner’s court was convened with a real-life Coroner, Dr Sam Bass. I volunteered to stand at the podium, in front of the court and the rest of the workshop, to justify why I had allowed the patient leave from hospital. It was a nerve-wracking experience, but it will make actually being in the Coroner’s court less daunting.
Day Two

Having recently started a neuropsychiatry liaison job, I couldn’t believe my luck to see the neurology and psychiatry interface stream running through the second day of the congress. I arrived just in time to hear Dr O’Sullivan’s keynote speech about psychosomatic illness. In the spirit of integrated care, it was great to hear the neurologist’s perspective. Despite the difference in terminology - ‘psychosomatic’, ‘functional’, ‘dissociative’, ‘medically unexplained’, ‘conversion disorder’ - the approach between the neuropsychiatrists and neurologists seemed reassuringly similar. The key message was to validate the person’s experience and treat them with respect, advice you can take forward in any specialty.

I then had the opportunity to take part in one of the Cradle to Grave Balint groups for trainees. I was initially sceptical of how a stand-alone Balint group would work in a conference setting. However, with the skill of Balint group leaders Esti Rimmer and Sue Mizen, the group quickly felt safe and all present reflected on the impact our patients have on us and vice versa. I left reinvigorated about my clinical work and convinced about how important this model is. This session was completely immersive and counteracted the feeling of anonymity that you can experience in such a large congress.

In the afternoon, I went to the Parity of Esteem session. I can never underestimate how powerful it is to hear people’s experience of mental health services as patients or carers. Speaker Marie Grattan said ‘parity begins at home’ and discussed the influence of the wider public and government attitudes towards mental health. There was a hopeful discussion about the changing attitudes from professional groups towards patient care and that the culture was shifting towards a more person centred approach.

The last session of the day was about factitious disorders by Dr Chris Bass. This was an incredibly useful session that had direct relevance to my clinical practice. It was clinically focussed and the speaker made the topic accessible and relevant. I reflected on how more common factitious disorder is than I expected and the psychiatrist’s fear of broaching this subject with patients. Again, the overarching theme was the importance of confronting the patient about their illness behaviour in a non-judgemental, non-punitive fashion.

I participated in the buddy scheme this year and my buddy was a medical student just about to start their first clinical year. She was debating between a career in paediatrics and psychiatry. We had a great discussion in the trainee lounge with a CAMHS consultant about childhood psychosis. I am sure that by the end of the day we had her completely convinced by a psychiatry career... and the trainee dinner that followed confirmed her career choice!

Written by

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DAYS THREE & FOUR

On Wednesday afternoon Simon Stevens, NHS England’s Chief Executive, addressed the Congress. He provided energy and enthusiasm telling us, “we’re on the cusp of something big”. He talked about how the health service is raising its game and he highlighted that mental health is one of his four key priorities. Among other developments, he touched on the role of technology and digital therapies in psychiatry, including a number of new accredited CBT apps on the NHS choices website. Hearing so many positive developments from the most senior leader in the NHS felt extremely exciting and important.

On Thursday morning I attended the Policy Lab in the Trainee Lounge, where we learnt how to get involved from those already influencing the shape of mental health policy. We were taught about patient centered care and how to ‘think like a patient and act like a tax-payer’. The experts explained that policy is about setting the direction of travel we want to go in. They told us there are three main factors, which affect it, namely financial influences, international drive and domestic opinion.

In the afternoon Alistair Burt gave his first ever speech in his new role as Minister for Community and Social Care. This was an eagerly anticipated keynote, with the audience keen to find out how his approach would compare to his Lib Dem predecessor Norman Lamb.

The minister reported that he remained committed to investing in Child psychiatry, which he stated was his top priority. And he said he admired Health Education England’s work in increasing the number of psychiatry placements for junior doctors - over half of us will undertake a psych placement by next year. He also spoke of investment in mental health crisis care and a £30 million injection for liaison services. I guess it remains to be seen how these commitments will pan out over the course of the next year.

The week concluded with a broad range of workshops, incorporating sessions on psychopharmacology, management of personality disorders and cutting edge science. It was a truly fantastic week and we’re already looking forward to next year’s event in London.

Written by

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Psychiatric Trainees' Committee Response to the UK Government's Intention to Impose a New Contract Upon Junior Doctors

The Psychiatric Trainees’ Committee would like to express its dismay at the Government’s latest morale crushing decision to go ahead and impose a contract on junior doctors by August 2016.

At a time when there are widespread difficulties in recruitment and retention in psychiatry, this can only serve to worsen the issue. This makes us very concerned for the future care of our patients with mental health needs; already a very vulnerable group.

Whilst the detail of the enforced junior contract remains unclear, it is likely that it will be based upon the recent DDRB recommendations (our response to which can be found below) and hence is likely to be disproportionately detrimental to psychiatrists in training.

We have serious concerns about the implications of this imposition and would ask that Jeremy Hunt considers seriously the effect that this will have upon the ability of the nation to adequately meet the needs of those with mental ill health in future generations.

For more information please contact ptcsupport@rcpsych.ac.uk

Dr Matt Tovey
Chair, Psychiatric Trainees’ Committee

PTC's Response to the DDRB Recommendations on Junior Doctors’ Pay

Summary

The Psychiatric Trainees’ Committee (PTC) recognises the importance of independent scrutiny of the remuneration of doctors. However, we are concerned that the DDRB (Doctors’ and Dentists’ Remuneration Body) recommendations may have a significant and detrimental effect upon the attractiveness of our speciality. Psychiatry is a shortage speciality, with difficulties recruiting spanning many years. It is largely a community speciality, with junior doctors often covering multiple sites when on call, seeing patients both in hospitals and in the community. It appears to us that the DDRB recommendations penalise this unduly.

Extension of standard time

We cannot support extending the 'standard time' such that many more of the current 'on call' hours will be classed as 'standard time' and therefore paid at a lower rate. Psychiatric trainees spend much of their time working during hours that many would consider unsociable. To devalue these further does a disservice to those doctors.

Removal of pay protection

As a speciality, we welcome those who have had valuable life experience and consider psychiatry further into their careers. The recommendation of removing pay protection will be a disincentive to them entering the profession.
Removal of banding arrangements

We are concerned about the removal of current banding arrangements. We call for continued recognition of unsociable hours worked and would want to see tough safeguards applied with regards to the numbers of hours worked. We do not want overworked and tired doctors looking after our patients. Crucial decisions are made in conjunction with patients and their families out of hours, and they deserve to see a doctor who is fit to make safe decisions and give appropriate advice.

Allowance for non-residential on call

With regards to Recommendation 9, a set ‘allowance’ for non-residential on calls, we think that this would disproportionately affect psychiatrists in training, as many on-call rotas are non-residential. This is not to suggest that they necessarily involve less work than ‘on-site’ on calls, but can be reflective of doctors covering multiple units over wide geographical areas. Additionally, the work can be emotionally demanding and anxiety provoking, (e.g. forming a safe plan for a suicidal patient who presents in the early hours at A&E). To remunerate a fixed and small percentage in contrast to doctors whose on call is residential will make psychiatric training less attractive. We feel that more data about workloads and responsibilities of doctors working non-residential on-calls are required before considering such a blanket change.

Fees for professional work

Under recommendation 22, the DDRB proposes any private professional work conducted during NHS time ought to be reimbursed to the NHS employer (It is important to highlight that presently it is best practice that any such work conducted in NHS time is then made up later). We anticipate such a recommendation may have unforeseen adverse consequences for services that currently fall outside the NHS Act 2006 but are essential to putting patient’s needs first. For example, mental health act assessments require approved doctors with specialist knowledge (‘section 12 doctors’). In some areas, there can already be delays in getting hold of a section 12 approved doctor, and we feel this recommendation will worsen this, leading to unacceptable delays for patients and their families at a time of crisis.

Flexible pay premia

The PTC is concerned about the recommendation of using ‘flexible pay premia’ to support the filling of vacant places in hard to fill specialties, such as psychiatry. Whilst superficially this may seem appealing, given the context of the other changes, and the fact that the total monetary pot for training in medicine remains the same, it seems that this represents misdirection. We have already discussed the proposed change to non-resident on-call payments, which will affect psychiatry disproportionately, so the most that this might achieve is some financial balance. Furthermore, we agree with the BMA stance that recruitment difficulties reflect wider systemic issues that are not simply addressed by short-term pay incentives, such as the stigmatisation of psychiatry as a profession.

Dr Matt Tovey, Vice-Chair of the PTC - @drmtovey
Dr Karl Scheeres, Chair of the PTC - @karlscheeres

On behalf of the PTC, August 2015

Notes:

The Psychiatric Trainees’ Committee (PTC) at the Royal College of Psychiatrists represents psychiatrists in training in the UK. It is made up of approximately 40 elected representatives from across the four nations. Please note this statement represents the views of the PTC, and does not represent the opinion of the Royal College of Psychiatrists.

We welcome feedback from psychiatrists in training and others:
@RCPsychTrainees
ptc@rcpsych.ac.uk
http://www.rcpsych.ac.uk/traininpsychiatry/trainees/ptc.aspx
MrCPsych Examinations Calendar

Application Periods:
Paper A
12 October - 30 October 2015
CASC
26 October – 13 November 2015

What is the EFPT Exchange Programme?

A short-term observership programme for psychiatric trainees in Europe established in 2011, offering placements in different fields of psychiatry all across Europe.

The programme can be tailored to individual wishes and availability. The host countries provide various opportunities within clinical work, research and teaching. The programme may contain visits to geographically different institutions. EFPT also wishes to encourage a variety of social and cultural activities in the host country.

The NEXT application period will open on 1st of November, 2015, for exchanges from January 2016 to July 2016. Please visit the Apply page for more details.

Psychiatrists’ Support Service (PSS)

The Psychiatrists’ Support Service (PSS) is a free and confidential phone service providing support and advice to all RCPsych members (all categories, including PMPTs, associates, etc). We can also signpost to other appropriate organisations. Our advisors are all psychiatrists, working voluntarily to support their peers. To arrange to speak to an advisor, please call 020 7245 0412

Author recruitment

Call for authors - basic science, critical review and clinical modules

Trainees Online (TrOn) is looking for post-membership trainees to author a number of eLearning modules spanning the basic science, critical review and clinical areas of the MRCPsych syllabus. We are commissioning modules on a wide range of topics.

If you are interested in writing a module please send an application (following the instructions below) to Victoria Walker. The deadline for applications is midnight on Friday 6th November 2015.

Please note that you must have passed all of the College membership exams, including the CASC, to be eligible to submit an application. You may choose to work with a co-author or small writing team, and not all contributors need to have a medical background, as long as the person submitting the application is a post-membership trainee with the College.

Please refer to our Author information for details on the commitment we require from our authors.

A new RCPsych film aimed at Medical students and Foundation Doctors (https://www.youtube.com/watch?v=UFsxQ5rsujw)
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.