ELECTIVE (SSC5a) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

I was lucky enough to receive the help from my previous Psychiatry placement supervisor, Dr Baillie, to organize three weeks in three different subspecialties of psychiatry. Prior to my placement in fourth year, I had never particularly considered psychiatry as a long-term option for me. I had always been very open-minded throughout my time at medical school, and went into psychiatry with the same attitude. I was surprised to find how much I enjoyed it, and therefore chose to organize an elective in psychiatry to explore this interest, and confirm whether or not psychiatry is a field I should think about returning after my first two years as a foundation doctor.

During my week in Forensics, I spent time in the medium secure unit and seeing people in their community accommodation. From the very first patient, I was fascinated by the stories and by the crossover between medicine and the law. The criminal element to the cases felt so new and sensational, however, the lives of the patients were anything but. One situation that stuck out for obvious reasons was a patient on 24/7 observation who had nothing in his room except a mattress on the floor, as a consequence of violence against staff. Restriction of liberties in psychiatry was not a new concept to me, but in forensics this element was an unavoidable and core aspect of patient care. I discussed this at length with the consultants, and we had some interesting discussions about the flaws in the system, and how it works to the advantage and disadvantage of people who are mentally ill. Forensics draws on ethical principles, political stances and legal arguments, and it encouraged me to think in a way that I have not ever had to in other areas of medicine, which I really enjoyed. The patients I met were varied, different from what I was used to in general adults –less acutely ill, though there were exceptions, and mostly a far cry from the people you would imagine committing the crimes described in graphic detail in the corresponding media articles. Seeing these sharp distinctions has encouraged me to read more around the topic and to challenge my ideas of crime and punishment. The power the consultants held was unlike anything I had seen in other areas of medicine, including psychiatry. The medium secure unit was effectively a prison with small privileges that can easily be removed. I suspect for me, this would be the element of the role that I would least enjoy. I continue to be curious about forensics and the patients it treats.

CAMHS I found to be a world away from forensic psychiatry, resource-wise. One of the doctors told me “If we put more resources into CAMHS, maybe we wouldn’t need as many resources for forensics,” which I think was a striking introduction into the extremes of the dark trajectories young peoples’ lives can take without the right intervention early on. I think the contrast was stark in terms of power too, as CAMHS seemed powerless by comparison to forensics. Despite this, I found the stories very interesting and varied, and was new to understanding the factors contributing towards poor mental health in young people, such as school, bullying, exam stress and home environment. Also, seeing familial support as such a key element in consultations had not been the norm in my psychiatry experience thus far. General adults had a fairly mixed picture and inpatients had very restricted visiting hours, and with the homelessness team I went on to afterwards, any support I saw came from fractured and unstable familial or partner relationships. The dynamic in the parental relationships I saw existed on a spectrum - some parents spoke for the child, some were happy to give their child space and privacy and some allowed their own mental health issues to spill into the consultation. Managing this dynamic and the expectations of parents as well as the needs of the child, too young to fully advocate for themselves, was challenging at times and

required strong communication skills. Domestic abuse was a fairly inescapable feature of all the cases I saw. I do not have anything particularly profound to say about this, nor do I feel I have any ways to expand my thoughts on this without having read much around the subject yet. From what I could see this often had a huge ripple effect throughout the family which, in some cases, seemed to extend on indefinitely. In all of the cases that I saw, the perpetrators were male against female. In all of the cases I saw, it was women bringing their child to the appointments. The way that domestic abuse either rips families apart, displaces them, or begins a cycle of violence is something that did not pass me by.

I had always wanted to organize an elective that involved working with the homeless population, and so was very pleased to hear that Dr Baillie had recently been moved to a rough sleepers mental health team. The team I was with is fairly new, and it struck me early on how the way the team works is really well-suited to the population it serves. The members of the team would use all sorts of ways to make plans and communicate with people – opportunistic drop-ins, notes through letter boxes, leaflets and visiting known outreach centres or spots people would visit or sleep in. This was not always easy and being a rough sleeper is in itself a huge barrier to accessing healthcare, but it was interesting to see incooperating many different ways of working to do the best by the client. To contrast this way of working to CAMHS where I had just come from, it felt very refreshing to be rid of years-long waiting lists. I learnt quickly that being a rough sleeper is a huge spectrum, and it is something that people can fall in and out of throughout their life depending on factors such as substance misuse, broken relationships and financial difficulties. I went on an evening out with the outreach team to walk in central London to offer vouchers and speak to people rough sleeping. It was a slightly Intimidating experience, as I was advised to expect the unexpected and that is certainly what I found. The rough sleepers I saw were far from a homogenous group, with responses ranging from total ignorance to violent threats made at us. Again, the attitude of the staff inspired me and gave me so much hope for the service. To see up close the sleeping conditions was a humbling experience but also challenged so many pre-conceived notions I didn't know I had about homelessness – many "choose" to rough sleep, however informed that decision, and mistrust in professionals is a widespread attitude that lead some to reject even food vouchers. As Dr Baillie said, "our drugs need to outcompete their drugs", which unfortunately tend to pale in comparison to street drugs in their speed of onset and ability to anaesthetise. I met one client in private accommodation, who kindly agreed to let me join to meet for a coffee. It was incredible to see how he had built himself a new life, how his mental health condition continues to affect him and how the rough sleeping team continue to work with him to minimize the impacts of his mental health condition on his new life.

I thoroughly enjoyed my time experiencing more of psychiatry, and will certainly remember my experiences when thinking about my career after my foundation training.