ELECTIVE (SSC5c) REPORT (1200 words)

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

Newham is a deprived borough with a large migrant population that is also highly mobile. In addition, Newham also possesses the third highest level of alcohol abuse in the UK, and the highest level of TB in Europe. This leads to several problems as multiple risk factors for mental health problems are present as a result. Moving to a new area produces risks of social isolation as well as issues with adjustment. Community structures that were present in a migrant's country of origin will often be lost and it can be difficult for them to adapt to new conditions. Furthermore, many migrants are not completely proficient with their use of English which makes integration into society more difficult. In addition, expectations of the new country are often not met, with difficulties finding jobs and cramped accomodation forming further stresses. Overall, the prevalence of most psychiatric conditions are greater than the rest of the United Kingdom.

The Newham psychiatric liason service is organised on the RAID model, one of many in use throughout the UK. These models are fundamentally chosen in order to produce efficiency and generate improved patient care as well as reducing admissions. Psychiatric liason teams act as the interface between medical and psychiatric teams and in Newham forms the link between the General Hospital and Newham Centre for Mental Health. They work alongside other teams in order to ensure effective assessment and correct management of patients. The psychiatric liason teams at Newham form one service but they are split according to the profile of the patients they manage. For example, there are separate groups for the Emergency department, inpatients with psychiatric problems and old age teams. Together, these teams are able to filter patients so that they are referred appropriately. For example, many patients do not need to be treated in hospital if they can be referred to community teams such as the Home treatment team or Community mental health team. The ability to refer a patient is an art in itself and the liason teams ensure that a patient's case goes to the right team.

In addition, compared to other specialties, the divisions between doctors and other health care proffesionals such as nurses is much less distinct. The responsibilities and roles overlap much more, and as a result, teams work much more closely.

This is a great strength of the psychiatric liason service, offering (almost) instant expertise to doctors that may lack experience in psychiatry. However, this can lead to problems when interacting with teams that may have other agendas such as the need to free up beds for other patients. The need for clear transparency and trust is always necessary in order to ensure teams are able to work and function together effectively.

According to the team I was working with, the conditions that have recently come into prominence are those of people with personality disorders. Due to changes in social funding and lack of affordable housing, the safety net provided by the state to society's poorest members has tightened, leaving fewer resources for a population that is struggling at large to be able to support itself. Notably this has only recently taken off in the last year, probably as the cuts took time to implement and as patients used up their life savings in order to get by. However, this reserve has now broken, with huge amounts of repeat admissions by patients with personality disorders. The team expects that this

trend will only get worse in the coming years unless the government chooses to provide more services and funding towards welfare.

People with personality disorders are complex patients to manage, often making decisions that seem out of line with the main bulk of society. These are patients that are frequently admitted to hospital and often very quickly discharged. With their issues being behavioural in that they were done under full capacity and not as a result of mental illness, this puts the actions of the patient in a different light that requires an alternative approach.

For example, there may no grounds to section some patients under the mental health act as they are acting under full capacity, though often they are not. Patients can be unwilling to engage with the community services that would be able to help them, and prefer to stay in hospital in spite of the fact that this is not always helpful for their treatment. Patients can often be looking for some kinds of benefit such as housing which they believe they can obtain by acting in the ways they do. Furthermore, these patients are at risk of becoming medicalised as they spend huge amounts of time in hospital as well as opting to get themselves back into hospital as soon as they are discharged. In one case, a patient was discharged that had been on a psychiatric ward after one month of being treated for depression. Eight days later, they stopped using their insulin, leading to an admission to hospital with severe diabetic ketoacidosis. One motivation uncovered was the fact that the patient was homeless and wanted a house to live in.

My prior experiece of psychiatry was focused mainly on psychosis, which though very good, gave me only a small amount of exposure to the multitude of areas psychiatry encompasses. I noticed many similarities with the way services were organised between these two services with strong links to community teams.

With liason psychiatry, the focus is on patients with have medical problems as well as mental health problems. This revealed the delicate interplay between deciphering the functional and the organic, something that I could not appreciate on my previous placement where the health problems patients faced were purely mental health. These cases were more clear cut mental health issues. Across both, there were the fundamental questions of risk management with the question of whether it was safe for a patient to leave or whether they needed to be detained for their own health and safety. As this was rarely a purely opaque question but rather shades of grey, it was interesting to see the thought processes at play between different members of the team according to their own natural tendencies.

It was interesting to see the types of conditions that I had only read about before playing out in front of me. For example, personality disorders are renowned for their ability to split teams against each other, and this was exactly what I observed. I had not expected the descriptions that I had read to be so closely reflected in practice.

The team also taught me on much more than just psychiatry, emphasising the importance of communication not just with the patients that we treat but also the other professionals we work with. A simple act of miscommunication could lead to much anguish between teams.