the columns

correspondence

Career progression – use of the trainee logbook

As senior house officer trainees approach the end of their training and prepare to apply for higher specialist training, they become more concerned with the 'publications' section on the job application forms for specialist registrars. By then they have either already published something in a journal or are desperately trying to do so. Recently, with the increased competition for higher specialist training posts, it has become an unwritten rule that one is unlikely to get short listed if the 'publications' section is left blank. The consensus is that trainees at senior house officer level are competing in terms of how many published letters or articles they have written/co-written.

We do not question the value of published work in the selection process, nor do we doubt its relevance to career progression. However, we wonder if the field of vision has become unhelpfully narrow. We wonder whether, in parallel with the ongoing changes in the training of psychiatrists, the assessment of suitability for career progression should shift from cross-sectional to longitudinal assessments of trainees' performance. An excellent tool for assessment, which trainers and trainees have long used, is the College's trainee's logbook (http://www.rcpsych.ac.uk/PDF/LogBook.pdf). It includes almost all that is essential for a comprehensive evaluation of a trainee. The two sections of training goals and supervisors' feedback are particularly useful for acquiring an overall view of career development.

Psychiatric training in the UK is constantly evolving. In August 2007, the Postgraduate Medical Education and Training Board will supersede the Specialist Training Authority and the Joint Committee on Postgraduate Training for General Practice. It is hoped that the selection of trainees for higher specialist training will involve a more-balanced structured assessment rather than a tick-box format. However, the assimilation of the current trainees into the new system is yet to be clarified. Advertising for specialist registrar posts will cease after August 2007. Guidelines for their point of entry into the new training scheme are not very specific. One worry is that the unfortunate ones will be forced to settle for non-training career grade posts. A way of allaying such anxiety about job prospects in higher training is to allow the use of relevant documentation compiled by trainees throughout their training. The logbook is a very useful tool for writing and updating CVs and for the purpose of interviews. We believe it has greater potential as a genuine record of experience and a reflection of the aptitude and suitability of a trainee for a job.

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Impact of a waiting list initiative of a child and family out-patient mental health team

This initiative sought to reduce the waiting list and to improve the triaging process of an out-patient multidisciplinary team based at the Royal Hospital for Sick Children in Edinburgh. The team consists of 6.5 whole-time equivalent clinicians and receives 250 referrals of children aged under 14 each year. All referrals (n=66) on the waiting list were offered an initial assessment during a 2-week period in July 2005. Interdisciplinary pairs were formed and each pair was assigned a clinic session comprising two 1-h assessments. A weekly meeting was held to discuss all cases and to prioritise and allocate according to need and the skills required to manage the problems.

Sixty-six patients were offered appointments and 46 of these attended. Thirty-seven patients (56%) were allocated to clinicians for further management, 21 (32%) cases were closed and 8 patients (12%) remained on the waiting list for further management. After 6 months, there were 33 on the waiting list, with an average waiting time of 5 weeks, which was down from 4.5 months.

The initiative was an effective way of assessing and allocating patients in a more appropriate and timely fashion, and resulted in a considerable improvement in the service offered. It also resulted in the establishment of regular 'initial assessment clinics'. The experience had the effect of motivating the team, encouraging the sharing of ideas and generating action.

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Research day for specialist registrars

Okolo & Ogundipe (*Psychiatric Bulletin*, July 2006, **30**, 275–277) have raised important issues regarding the research day for specialist registrars. Although it has been considered appropriate for the research day to be used for high-quality audits, teaching/training and postgraduate courses in addition to field research, our deanery expects concrete proof of publications and/or research funding, as part of the Record of In-Training Assessment. We constantly find ourselves having to explain the gap between achievements and expectations.

Some trainees are clearly not interested in research and it is not ideal to force disinterested people to undertake research projects. For trainees that are interested in research, the opportunities are not readily available. Guidance and advice are poor, unless trainees are able to tap into an ongoing project. The alternative is for the trainee to spend all their training trying to understand the system, which has been my experience.

More thought needs to go into the use of the research day and if trainees are expected to produce results they need the resources to enable them to do this. The programme director needs to be involved in tailoring the research day to the interests of the individual trainee.

I hope that the Postgraduate Medical Education and Training Board takes this into consideration before the new system

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is established, so that this whole process represents good value for money and effort.

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Additional drug use on methadone programmes – often cocaine rather than heroin

It was interesting to see the issue of whether dosage of methadone affected the use of additional drugs raised in the *Bulletin* most recently by Kernan & Scully (*Psychiatric Bulletin*, June 2006, **30**, 234). Although many clinicians are reluctant to prescribe high doses of methadone, the evidence does seem clear that heroin use tends to decline as methadone increases.

This is a substitution approach, but patients on methadone programmes can develop as many problems from ongoing cocaine as from heroin use (notably financial and psychiatric problems). This appears to be widespread (Gossop *et al*, 2002), and in two related investigations of our own patients undergoing opioid substitution (n=57 and n=72) cocaine was used by many of the 77% of patients showing some additional drug in their urine. Abstinence from substance use was related to female gender (χ^2=0.62, d.f.=1, $P<0.1$), type of substitute medication (χ^2=6.8, d.f.=2, $P<0.05$) and being longer in treatment (t=1.61, $P<0.1$), but for overall drug use the dosage of maintenance agent had no effect. For cocaine this was one of the weakest relationships (χ^2=0.2, d.f.=1, $P>0.1$).

Outcomes in maintenance treatment are usually related to limiting heroin use, and the fallback measure of increasing methadone to achieve this has been attractive. We believe that the frequent use of cocaine among this population will render methadone treatment much less straightforward, with more requirements for additional behavioural treatments (Schottenfeld *et al*, 2005).

GOSSOP, M., MARSDEN, J., STEWART, D., *et al* (2002) Changes in use of crack cocaine after drug misuse treatment: 4–5 year follow-up results from the National Treatment Outcome Research Study (NTORS). *Drug and Alcohol Dependence*, **66**, 21–28.

SCHOTTENFELD, R., CHAWARSKI, M., PAKES, J., *et al* (2005) Methadone versus buprenorphine with contingency management or performance feedback for cocaine and opioid dependence. *American Journal of Psychiatry*, **162**, 340–349.

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Changing role of the junior psychiatrist – implications for training

Imagine the daily life of the junior psychiatrist in the not too distant past: clerking of new admissions to the ward day or night; physical examinations and routine phlebotomy; providing a service to the general hospital for psychiatric emergencies, including overdose assessments; reviewing the patients' mental state in the clinic and prescribing medication; responding to requests from nursing staff manning the wards when all others are sleeping.

How the life of the junior doctor has changed! The first to go was routine phlebotomy, closely followed by a variety of other tasks which are now performed by non-medical professionals whose roles are ever increasing. As highlighted by Woodall *et al* (*Psychiatric Bulletin*, June 2006, **30**, 220–222), liaison assessments are increasingly being carried out by specialist nursing staff, with an inevitable effect upon the experience gained by senior house officers. The driving force behind this remains unclear. The European Working Time Directive has been implicated in these changes, but the other more cynical view is that doctors' time is more costly than that of nursing and auxiliary staff.

With nursing staff taking on prescribing, triaging of emergency calls and assessment in all settings and at all hours, what are the doctors left with? How ironic that junior doctors who no longer perform these roles as part of their training will very soon, with the introduction of the run-through grades, be supervising the practice of these highly experienced non-medical professionals.

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Woodall *et al* (*Psychiatric Bulletin*, June 2006, **30**, 220–222) describe how the introduction of nurse-led liaison services has left senior house officers (SHOs) with little to do on call. Senior house officers are left with routine ward work while nurses become skilled at emergency psychiatric assessment. The original purpose of the changes was to leave some of the simpler tasks to nurses, freeing the SHOs to carry out work traditionally considered to require a doctor. The pendulum has now swung too far, with specialist nurses taking over increasing amounts of doctors' work.

These changes resulted from the implementation of the European Working Time Directive after vociferous protest by earlier generations of SHOs over poor pay and excessive working hours. The government, for financial reasons, was happy to heed these protests and has implemented these changes at a time when the length of postgraduate training is being reduced by the Modernising Medical Careers initiative.

The remedies proposed by Woodall *et al* are primarily bureaucratic and will take valuable time to implement. A more prompt and practical remedy would be for SHOs to return to where they belong, in the acute clinical front line, alongside their specialist nursing colleagues. Evaluation of the efforts of both, using audit systems already in place, would provide a useful opportunity to test the fundamental and as yet unanswered question that lies behind the current changes: do doctors have more to offer than nurses in the assessment and management of acute psychiatric emergencies?

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Woodall *et al* (*Psychiatric Bulletin*, June 2006, June 2006, **30**, 220–222) highlight the potentially adverse effects on the clinical experience of psychiatric trainees of increased reliance on liaison nurses to conduct emergency psychiatric assessment. As members of the liaison team in the hospital in Wrexham where the study was conducted, we would like to respond.

Liaison psychiatry, in particular the assessment of patients after self-harm, offers excellent opportunities for trainees to develop a range of clinical skills, including rapport in difficult circumstances, comprehensive history-taking and mental state examination, case formulation, risk assessment, negotiating a management plan with the patient and communicating effectively with all parties.

We wholeheartedly support the development of the role of liaison nurses because it increases capacity and improves service delivery. However, we are concerned about the effect that this might have on the clinical experience of psychiatric trainees. Hence for some time we have invited trainees to voluntarily undertake psychosocial assessments jointly with liaison nurses. However, the uptake of this offer has been variable and this latest study has underlined the need for a new approach.

With the consensus of consultant colleagues, all junior psychiatrists will now be required to complete ten joint psychosocial assessments every 6 months in addition to their on-call work. They will observe the first few assessments while the liaison nurse takes the lead, and then take the lead on the remaining assessments. Trainees will also continue to

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