Autumn Edition, 2021

Psychiatry-West Midlands

The West Midlands Division e-Newsletter

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Dr Nilamadhab Kar, Editor, Psychiatry West Midlands

Editorial

Dr Nilamadhab Kar, Editor

Fighting the stigma associated with mental illness: wider role of psychiatry, beyond the clinical settings

It is surprising that stigma associated with mental illness and mentally ill persons continues, in spite of the advances in the understanding about the psychiatric disorders, their causation and availability of appropriate treatment methods. This is partly contributed by many myths and misconceptions prevalent in the societies which again hinder the appropriate and timely interventions. The stigma is prevalent not only in uninformed people or those with lower education level, but in highly educated people as well;[1] and in all socioeconomic strata although their prevalence varies. Interestingly there are regional variations of levels of stigma within the same country; e.g. in England, London and southern regions had comparatively more negative attitude towards mental illness.[2]

Stigma leads to multiple issues: avoidance or delay in seeking treatment, ostracization of the patients and their family, resort to faith healing, and so on. Research suggests that stigma is also associated with reduced life expectancy, exclusion from higher education and employment, poverty and homelessness, increased risk of involvement with criminal justice systems, and victimization.[3]

People usually do not understand the range of mental illnesses and tend to overgeneralize and catastrophize them. So the impact of stigma is seen in non-clinical environment as well, such as schools, universities, work places, and during social interactions, even in professional/clinical spheres. Any suggestion of mental health issues becomes and remains apparently a concern. It becomes difficult for affected individuals to fight the societal attitude and their struggle continues.

All these suggest that there is a massive role of society at large and mental health professionals in particular to address the stigma and change the mind-set. Many initiatives and actions against stigma are observed throughout world, but whether they achieve their objectives need closer assessment. In England, a national programme against stigma and discrimination was Time to Change, which started in 2007. Although there are some positive changes in society since then, but researchers suggest these cannot be attributed to the programme;[3] and another study found no significant improvement in knowledge or behaviour.[4] However, elsewhere, there has been reports of improvement following short-term multi-method interventions.[5]

Understandably, public education would be the mainstay of the anti-stigma effort. Comprehensive, persistent, multilevel and multipronged attempts may be effective. Anti-stigma strategies related to mental illnesses should be tailored to the needs of the specific societies, racial and/or ethnic backgrounds;[6] and young people,[1] because of possible variations, and level of understanding. The information should be communicated preferably in the language they speak by the leaders in the same communities. It may be essential to associate the faith and religious leaders in the anti-stigma campaign as they are often the first contact for mental illnesses of the people in their communities.[7] Methods of public education which have been used can be really varied including printed materials, individuals sharing their mental health experience, video messages, information through news and social media, street drama, theatre, etc.

It cannot be overemphasized that the mental health professionals should continue to lead this battle against stigma associated with mental illnesses. Clinicians may spend some time in this regard when they are interacting with patients and their caregivers. Educating the significant others helps a lot, especially as they go through the process and observe the journey and outcome.

This provides the true picture of the mental illnesses and their interventions. Setting an example and highlighting the changes as they happen are expected to be effective game changers.

There are occasions when celebrities have come forward and shared their journey through mental illness, their struggles, successes and recovery. These have positive effect;[8] however these happen as rather rare examples. People often come to know from media and different sources when there are negative events like self-harm, suicide, drug or alcohol related problems, crimes associated with celebrities with mental illness. Greater sharing and positive outcomes following interventions should be given their due coverage.

Portrayal of mental illnesses in news and social media has been usually inaccurate, exaggerated and sensational, which do not help to demystify the myths and misconception surrounding mental illness and these perpetuate the stigma.[9] Unhelpful dramatization still exists in films and plays. Disclaimers if any do not help much compared to powerful acting of the characters. The reporting of positive outcomes and recoveries from the mental illnesses do not find adequate space in media coverage. While some media have become sensitive in reporting and provide sources of help, this cannot be generalised to all media sources. In summary, media can do more to help in the fight against stigma linked to mental illnesses.

In summary, stigma associated with mental illness is highly prevalent in society; and has multifarious negative effects upon patients, their families and society at large. Consistent approach to de-stigmatise mental illness is needed through specific programmes in societies by all concerned professionals, caregivers and public. Good practices in these areas should be shared. There is also a need to evaluate the effectiveness of anti-stigma strategies for mental illnesses through robust methods.

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Chairs Column

by Dr Muhammad Gul

Dr Muhammad Gul, West Midlands Division Chair

Welcome to the Autumn newsletter of our Division.

This is my first Chairs Welcome in my role as Division Chair. I'd like to thank Dr Ignais Agell for his dedication and contributions to the division as the previous Chair and for his continued support.

May I take this opportunity to thank all of you for supporting frontline services in the very difficult time, for able to meet training requirements of your trainees, and contribute into college activities at all, particularly helping with CASC Examination.

I'd like to draw you attention to the forthcoming RCPsych elections which are an opportunity to become involved in the College and make a difference to psychiatry.

I encourage you to use our Twitter account @rcpsychWM to communicate with your peers, share best practices and raise the profile of psychiatry in the West Midlands, currently with 1166 members.

I will be always open to any suggestions from members as how we can raise the profile of our division, getting more members involved in division activities, supporting our trainees, and making a voice for mental health service users. Please drop me a line via Marie Phelps, West Midlands Division Manager at Westmidlands@rcpsych.ac.uk

Thank you to Dr Nilamadhab Kar, West Midlands e-Newsletter Editor. On behalf of the West Midlands Division, I would like to give a special thank you to Dr Nilamadhab Kar whose term as RCPsych West Midlands e-Newsletter Editor has recently finished.
Dr Kar has supported our division in his role as editor since 2017 and has been a valued member of the West Midlands Executive Committee, we wish him well for the future.

Events

College face to face events continue to be cancelled for 2021, due to Covid-19 pandemic. The College is however continuing to provide online content and webinars, which I hope that you have been able to join.

Winter Academic Webinar – 3 December 2021 – 9.30-14.30

Bookings are now open for the West Midlands Division Winter Academic Webinar. To view the programme and book your place please visit our website.

Mental Health Act Section 12 and Approved Clinician Courses

Bookings are open to book your place please visit our website.

Celebrating 180 years of history

This year we're celebrating our 180th anniversary. Find out about our history and see how you can become involved with the celebrations. Celebrating 180 years of history | Royal College of Psychiatrists (rcpsych.ac.uk)

Executive Committee

Committee Meetings

All committee meetings are being held remotely until further notice. The next meeting date is 11 February 2022.

2021 Elected Committee Members:

Dr Emma Lambert
Dr Hassan Mahmood
Dr Imran Piracha

Recent Appointments:

Dr Jayanth Srinivas, Regional Advisor
Dr Rashi Negi, Deputy Regional Advisor
Dr Siraj Salahudeen, Perinatal Regional Specialty Representative
Dr Andrew Leahy and Naresh Rasquinha - Mentoring Leads
Dr Rainu Chaturvedi, Specialty Doctors Representative
Dr Masud Awal, Medical Psychotherapy Regional Specialty Representative

Recent Co-opted members:

Dr Hilary Grant, Chair of the West Midlands Medical Directors Group
Dr Rehana Kauser, Equality Champion
Dr Rano Bhandoria, Wellbeing Champion
Dr Rashi Negi, Sustainability Champion
Dr Abhinav Rastogi, Financial Officer

Current Appointed Vacancies

- Addictions Regional Specialty Representative
- E-Newsletter Editor
- Workforce Lead

Further information is available on the College website.

Mentoring

Please continue your engagement with the West Midlands Division mentorship scheme.

West Midlands Independent Psychiatrists Group (WMIPG)

The West Midlands branch of PIPSIG provides a network for independent psychiatrists, promotes responsible practice in relation to appraisals and revalidation and acts as a source and resource for continuing professional development. The WMIPG meet 3 times a year. Anyone interested can be added to the contact list.

Student/Foundation Doctor Associate

Please also invite your foundation doctors and medical students to sign up to associate status, which is free via the College website.

Please email westmidlands@rcpsych.ac.uk for further information.

Get Involved

If you would like to submit an article for inclusion in the spring newsletter, please send it to: westmidlands@rcpsych.ac.uk

The division welcomes articles of local interest relating to psychiatry. We encourage trainees to get involved as well as patients and carers.

Submissions could be along the following lines:

Interest articles: Are you personally involved in any local work that you would like to increase awareness of? Is there a topic in mental health which you find interesting and would like to share with your colleagues? Do you have a personal experience within psychiatry you'd like to share?

Event articles: Would you like to share a review/ feedback from a conference or other mental health related event that you've attended?

Opinion pieces/blog articles: Are there any issues in mental health that you are passionate about and wish to discuss with a wider audience?

Cultural contributions: This could be in the form of artwork, photography, poetry or an article relating to your insights, interpretations and observations of relevant popular culture, the arts and theatre.

Research/audits: Have you been involved in any innovative and noteworthy projects that you'd like to share with a wider audience?

Patient and carer reflections: This should be a few paragraphs detailing a patient or carer's journey - you may have a patient whose story you would encourage to share; or it could be a case study including a patient's perspective. Confidentiality and Data Protection would be need to be upheld.

Instruction to Authors: Please consider your articles to be as precise as possible. As a guideline, articles on interesting topics, research/audits, good practice and opinion pieces may be up to 1000-word limit which may include up to around 5 essential references. Articles on events or conferences should be within 500 words.

Please follow Instructions for Authors of BJPsych for reference style. Authors must obtain written permission from the original publisher if they intend to use tables or figures from other sources, and due acknowledgement should be made in the legend.

Authors are expected to be aware of and comply with best practice in publication ethics. Please declare any conflict of interest related to the article.

Disclaimer: The opinions expressed in this newsletter are those of individual authors and do not necessarily represent the views of the Royal College of Psychiatrists

The Wardrobe
adDRESSing the issue of clothing in mental health by Dr Louisa Ward

For some time I have noted that a lot of our patients do not have sufficient or appropriate clothing during their admissions. This may be due to personal circumstances at home such as financial difficulties or homelessness, admission circumstances such as those who come from the police stations, streets and A&E, or detention circumstances such as lack of leave and lack of local connections to bring them clothing. As such, they may remain in one set of unclean clothing for some time during their admission, and may have clothes which are not decent or inappropriate for the weather. This can have a huge impact on their mental health and limit their engagement with ward activities and leave. Nurses often have to try and find spare clothes in lost property, or buying clothes for patients out of their own pockets.

Our approach has been multistage to tackle the issue. Firstly, we have sent a letter out to all of the community teams and AMHPs (Approved Mental Health Professional) which is designed to be given to patients for advice around preparing for admissions, including the sort of belongings and clothes they might want to bring. We've then made it part of our admission process to identify patients without enough clothes, and trigger a call to family/friends/community teams to bring some in if possible. We also made consideration of clothes part of our weekly health check to identify those we have missed.

For those who cannot get clothes, we have established the Wardrobe. This is a large storeroom in our main hospital which serves all of the teams in our county. It is kitted out with shelves, rails, storage boxes and a steamer donated by a charity and full of clothes donated by a number of charities and companies. This includes tops, bottoms, jumpers, socks, pants, bras, shoes and coats. Additionally, we have a workwear section and work closely with our employment support team to identify those who need clothes for interviews/ work. We also have a sportswear section and trainers for those on the ward and in the community who want to engage in our physical exercise initiatives. If possible, we try and loan items until patients can get their own, but we are happy for patients to keep. We have had a lot of interest from patients, families, staff and the public to donate clothes directly which will be easier with less COVID restrictions. We sign out items to keep an audit of use and to help guide ongoing stock requests to the companies who have agreed ongoing support for us.

The project was launched by myself with support of keen members of staff, but we now have a service user who has been formally registered as a volunteer for the trust who is helping with the ongoing running of the project. She actually came up with our name and logo and has since decided to apply to be a peer support worker for the trust. My aim is that eventually the project will be very much led and run by service users. I am hoping that this project can be replicated in as many trusts as possible, as I cannot see that anywhere else has done anything similar despite it being a common problem. We are hoping to have a website up and running soon to help communications as there has been interest in a JustGiving page which would enable us to collect funds for specific items such as less common sizes or underwear which has to be new. This project gets used on a daily basis and the stories of the patients behind the use are very rewarding to hear.

Author
Dr Louisa Ward SAS
Herefordshire and Worcestershire Health and Care NHS Trust

Developing Psychiatric Resources for the new Foundation Programme Curriculum by Dr Drew Kinmond and Dr Aqib Hussain

In August 2021, there are changes afoot in the foundation program curriculum that underpins the foundation program, with more emphasis than ever being put on the awareness of mental health. It is recognised that mental health disorders are both common[1] and frequently missed by doctors in all specialities. Although the foundation curriculum is broad and does not usually include specific diseases, the new foundation program curriculum makes a specific statement regarding the importance of mental health and has specified a syllabus covering this important area of medical practice.[1]

The United Kingdom Foundation Programme (FP) is a two-year, structured, supervised training programme of learning in the workplace designed to prepare medical graduates for all paths of speciality training[2]The Foundation Curriculum is being updated to better reflect the GMC Standards for Post Graduate Curricula and to echo the identified contemporaneous developments training needs for doctors in the UK.[1]

The successful completion of the Foundation Programme normally require trainees to complete a rotation in a community placement, e.g. but only around 45% of trainees are expected to have placement within a specific mental health setting.[2] Though other community placements may provide some exposure to the acute challenges of mental health, this is not guaranteed. Therefore it is essential that foundation doctors have access to up to date and comprehensive learning resources to cover their learning requirements in mental health.[3]

Therefore we aimed to develop an easily accessible, relevant and deliverable resource to meet the training requirements of the new foundation curriculum for Foundation Trainees in the West Midlands. We developed a virtual resource, with information targeted at the correct knowledge depth, whilst also being flexible enough to allow trainees to access the materials to overcome the challenges of remote learning. The West Midlands currently holds approximately 1,300 places for foundation training with an increase in numbers planned for 2023 and 2024. These resources can be accessed at any time of the day, at any point of foundation training, with each module certificated to show evidence of the attainment of foundation competencies ready for students ARCP (Annual Review of Competence Progression).

In order to develop this resource, volunteers were sought within the local psychiatry training network, to work together to develop the learning resources. Topics were identified from the Foundation Programme curriculum and educational sessions were developed to cover the broad range of topics. Each presentation was to include: Aetiology, Presentation, Investigations, Course, Treatment and MCQs. Topics were prepared as PowerPoint slides which were then to be e-converted to PDF files to facilitate storage and presentation online.

The content development and checking was successfully carried out over a period of approximately three months. A programme of evaluation and effectiveness will be undertaken when the new curriculum goes live to review the effectiveness of the resource. There will also be opportunity for further development and modification of the curriculum based on the results of the evaluation.

As we expect the number of training Foundation doctors to go up within the next 5 years, the demand for this training is expected to increase over time. As the understanding and awareness of the interaction between physical health and mental health continues to develop, we expected the use of this resource grow into the future, and we look forward to developing this resource over time.

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Authors

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Acknowledgements: Dr Fiona Hynes (Consultant Forensic Psychiatrist & Foundation Training Programme Director- Psychiatry Birmingham and Solihull Mental Health Foundation Trust.)

Hearing Voices Groups: A Narrative Review by Fauzia Khan

Fauzia Khan

Abstract:
Over the last twenty-five years hearing voices groups have increased in popularity across the world with reports of wide ranging benefits. The present paper provides a narrative review of hearing voices groups, exploring the benefits they afford.

Introduction

The last twenty-five years has seen the increasing rise and popularity of the Hearing Voices Movement also known as the Maastricht approach, which was founded in the 1980s by Professor Dr Marius Romme (Psychiatrist) and Dr Sandra Escher (Science Journalist and Researcher) in the Netherlands.[1] The movement has been characterised as a paradigm shift by many researchers and clinicians alike, for changing the way in which the phenomenon of voice hearing is understood and conceptualised by both voice-hearers and professionals.

In traditional psychiatry, the experience of hearing voices (auditory hallucinations) is considered a symptom of a number of psychiatric disorders, most notably Schizophrenia.[2] Research arising from epidemiological studies has indicated that approximately 10-39% of the general population have experienced voices at least once in their lifetime,[3] and the lifetime prevalence of the experience is postulated as being much higher.[4]

The literature suggests that many people who hear voices only respond partially or do not respond at all to neuroleptic medications,[5] and a significant proportion of individuals continue to experience distressing voices despite taking medication.[6] Furthermore, neuroleptic medication has been found to be efficacious in only reducing the frequency and intensity of the voices as opposed to getting rid of them altogether.[7] For some individuals, the voices may be perceived as being a positive experience and may not cause any concerns. However, for others, it can have a negative impact on their quality of life, resulting in depression and anxiety.[8] Hence, the need for seeking alternative treatment approaches is considered not only beneficial, but also highly important.

Hearing Voices Groups

Hearing voices groups have risen in popularity over the last twenty-five years. The Hearing Voices Network initially developed by Romme and Escher in 1988 lends support to the development of hearing voices groups. The network endorses the view that there are a plethora of different explanations for the occurrence of voices and recognizes voices as an experience that can be meaningful.[1] The success of the network has led to the development of Intervoice, which is an international organization joining twenty-three countries around the world such as England, United States and Australia, who endorse this philosophy.[9] Hearing voices groups are underpinned by the approach advocated by this movement.

The Benefits

Hearing voices groups provide a non-judgmental space to talk openly about the experience without being ostracized. It allows individuals to make sense of their experiences, explore different ways of coping and coming to terms with the voices, as well as normalizing and validating experiences. Through support, individual's gain back some of their power over the voices.[10] Furthermore, these groups place importance on equal partnership between voice-hearers and clinicians, whereby the voice-hearer is seen as an expert-by-experience, thus challenging the conventional psychiatric relationship where traditionally the patient plays a passive role and the clinician plays a dominant role. This shift creates a myriad of opportunities for clinicians in supporting individuals in their recovery journey.[11]

The voice-hearing experience is considered taboo and therefore carries a lot of stigma. The experience often also carries stereotypical societal labels where individuals may be labelled as being “mad” or “violent”, which can often result in feelings of loneliness and isolation.[1] These groups empower voice-hearers and creates a shared identity with individuals that have similar experiences, leading them to feel like a community.

Conclusion

Hearing voices groups allow members to connect with other voice hearers and to support their peers to become aware of and develop their strengths and resources. Individuals are able to ask each other questions, offer and take suggestions and listen to others experiences allowing them to feel less alone.[11] They are also able to see parts of themselves that they may have otherwise discounted or overlooked, allowing them to build on their capacity for resistance.[11] Furthermore, Individuals who may be withdrawn in other settings for instance in clinic appointments have also been found to make beneficial contributions in the presence of their peers.[11] Through this, individuals are able to build their understanding and narratives around their voices allowing them to gain further insight, giving them increased control over their voices.

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Legal status of patients admitted in older adult wards: A service evaluation project of older adult inpatients in an inner city in WM by

Dr Asma Javed , Dr Saima Jehanzeb & Dr Farooq Khan

Introduction

Older adult psychiatric services provide specialist care and treatment to patients often presenting with complex combination of physical, psychological, social, cognitive and behavioural issues. A great emphasis is given to provide person centred care, social inclusion and to promote independence of older people with mental health difficulties[1]. Biopsychosocial interventions should be provided to people in the most independent living circumstances as possible before considering admission. Mental health services need to take account of Mental Capacity Act 2005[2] and Mental Health Act 1983[3] as amended 2007 when admitting any patient in the mental health services. According to Mental Capacity Act (MCA) 2005 [2], patients admitted to all inpatient units should have capacity assessed for the admission and clearly documented. If patients lack capacity to give informed consent, then they should either be detained under Mental Health Act (MHA) 1983 [3] or Deprivation of Liberty Safeguards DoLS (Mental capacity Act, 2005).[2]

We conducted a service evaluation project to analyse if assessment of capacity for admission is carried out as per recommendations.

Aim

To ascertain the legal status of all patients admitted to the older adult wards, whether there is a clear documentation of capacity assessment for consent to admission. If patient lacked capacity, whether they were admitted under DoLs or Mental Health Act.

Method

Retrospective cross-sectional analysis of electronic case records of all the patients admitted to acute organic (dementia) and functional (depression or psychosis) inpatient older adult units on or before 17th of January 2018. Data was populated in a Microsoft Excel stored in a secure drive.

Information was gathered whether they were admitted under Mental Health Act, Mental Capacity Act (DoLS) or as informal patient (where neither MHA nor MCA was used)

Analysis

Data was analyzed for the legal status of patients as follows.

·Patients who had capacity and admitted as informal patients.

·Patients detained under MHA.

·Patients who lacked capacity and admitted under provision of Deprivation of Liberty safeguards (DoLS)

·Patients who lacked capacity but admitted as informal patients.

Special consideration was given for documentation of Mental Capacity Assessment at the time of admission, if mental capacity status changed subsequently, whether reassessment of capacity was conducted and if patient lacked mental capacity at any point, whether consideration was given to make a referral for DoLS assessment.

Results

Total Patients: 64, Male (54) 84%, Female (10) 16% .

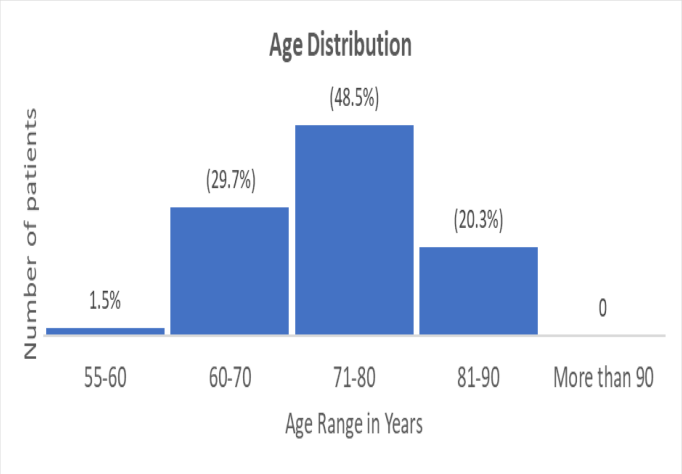

Figure 2: Age Distribution

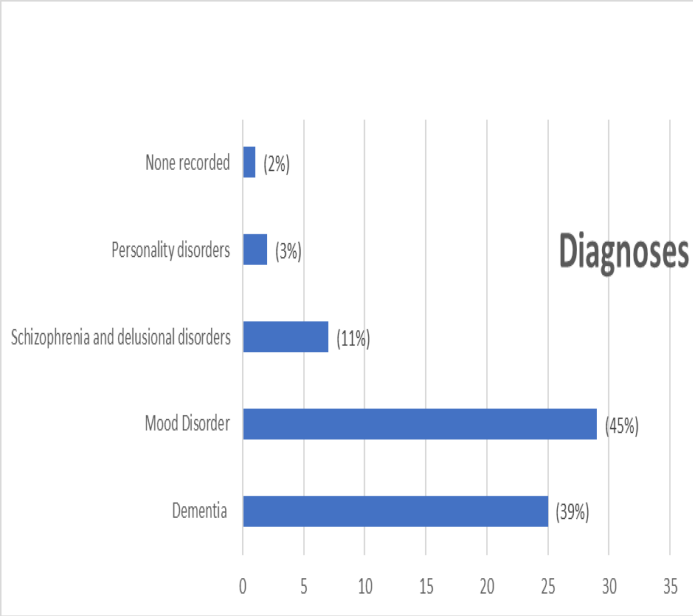

Figure 3: Diagnoses

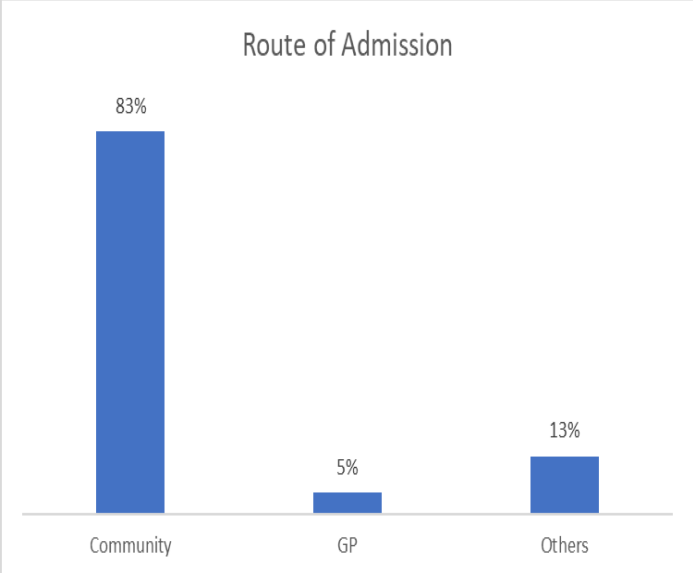

Figure 4: Route of admission

*Others include Rapid Assessment interface and Discharge, Home Treatment team, Street Triage, Care homes etc.

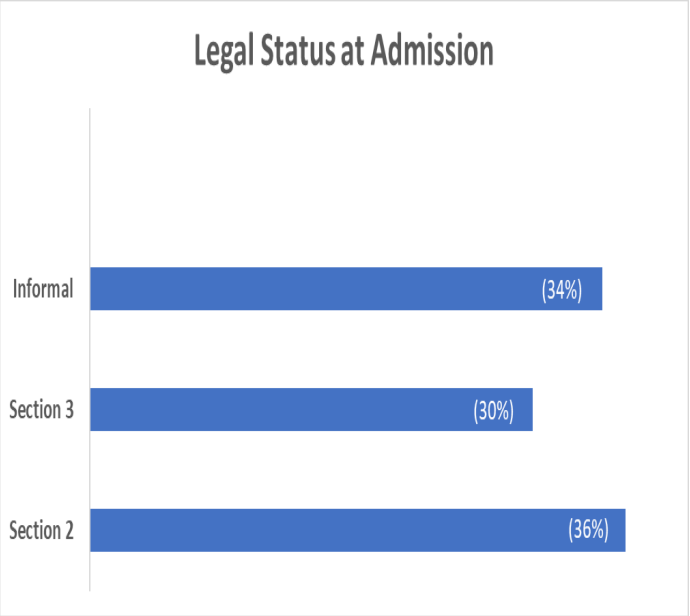

Figure 5: Legal Status at admission

Main findings

Amongst the 34% informal patients, 25% had capacity to consent to admission and treatment, whereas 9% patients lacked mental capacity to make decision about admission and treatment.

Amongst six (9%) patients' issues were identified as they lacked mental capacity to make decision about admission and treatment.

Two patients were admitted informally, and Deprivation of liberty (DoLS) application was put in place after admission. One patient lacked capacity to consent but was not refusing any medications. DoLS application was not put in place and DoLS assessment took place after few months of admission. Another patient was admitted informally and DoLS was considered 15 days after admission. One of the patients was admitted informally but they lacked capacity at the time of admission and DoLs was considered after a month. And one patient was admitted under section 2, but the initial section 2 papers on admission were invalid (form H3 was not completed on initial section papers made prior to admission). This patient was transferred from another trust and was placed on Section 5(2) after a month of admission and section 2 was completed on the following day.

Discussion

A gap was identified in the provision of treatment to older adult inpatient units in incapacity/informal group. It highlights the dilemma faced by the clinicians at the interface of Mental Health Act and Mental Capacity Act as they must consider two legal frameworks when admitting the patients. This complexity has been recognized in previous studies[4]. 9% of the informal patients admitted to older adult services, fell into the anomalous group where patients lacked mental capacity but not detained and clinicians found themselves in the conundrum of applying Mental Health Act versus Mental Capacity Act (Deprivation of Liberty) as patient is not objecting to treatment but still lacking the capacity to understand the treatment. In our studied cohort, 39% of patients were diagnosed with organic illness (dementia) whereas 61% of patients had nonorganic illness such as mood or psychotic disorders.

Further analysis of our data revealed that five out of six of the patients in which the issues were identified had a diagnosis of dementia whereas only one patient had a diagnosis of bipolar affective disorder. Majority of the patients admitted were referred by Community services. These findings were discussed in Clinical Governance meeting that highlighted the need for both community and inpatient services to be vigilant about the assessment of mental capacity of patients especially when it is fluctuating when referred for admission and treatment.

Limitations

It is a retrospective study, and our assessment of capacity was taken from clinical documentations on patient electronic case notes and not at the time of admission. We did not use any formal tools to assess the capacity ourselves to check the validity of results.

Recommendations and Conclusion

Mental incapacity is common in patients admitted to psychiatric wards [5] and every effort should be made to make an appropriate assessment of capacity. Clear guidelines should be provided to junior doctors about checking the capacity and Mental Health Act status of all patients admitted to the ward. All section papers should be checked at the time of admission and documented in the electronic records ensure that they are valid. A mechanism should be developed in MDT to check the mental capacity of patients.

We suggest that another cross-sectional study should be conducted in 9-12 months' time to look at the MHA status of all older adult inpatient units.

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Survey exploring the experience of telepsychiatry amongst doctors working in a MHT in West Midlands, UK during COVID 19

by Dr Pallavi Chandra, Dr Nilamadhab Kar and Dr Abdalla Yahia.

Introduction

COVID19 is a global pandemic having direct and indirect impact on the mental health of the population. The infection being highly contagious and the UK being in the third wave, several measures have been taken to prevent the spread of COVID amongst uninfected individuals. One of them has been reducing direct patient contact and the use of telemedicine for supporting patients in the community. Telemedicine has been practised for many years and it involves provision of healthcare and exchange of healthcare related information across distances.[1] It includes a range of activities such as diagnosis, treatment, prevention of disease, ongoing education of health care providers as well as research.[2] This model of care has been in practice in several specialities of medicine including psychiatry in both developed and developing nations.[3]

Studies have confirmed that telepsychiatry can be implemented across a wide range of services and patient population. They have highlighted benefits for both patients and providers, as well as multiple non-clinical uses.[4] However, there appears to be many barriers including technical challenges and difficulty establishing a good therapeutic relationship with the patients which has resulted in poor provider satisfaction.[5] Multiple surveys across the world have already been undertaken to understand the experiences of psychiatrists using this model of care provision during the pandemic.[6,7] However, there is not much information on doctors' experience of telepsychiatry in the UK. It was therefore pertinent to understand the experiences of psychiatrists practising telepsychiatry in the UK.

Aim

On the above background we intended to explore the experience of doctors working in psychiatry services during the COVID19 pandemic using telemedicine for provision of care in a Mental Health Trust covering four cities in West Midlands.

Method

The study was conducted as an anonymised questionnaire survey. A 10-item questionnaire was designed with questions related to the clinical outcomes, challenges and provider satisfaction when using telepsychiatry and had mostly yes/no dichotomous responses along with scope for making additional comments for each question. A Survey Monkey link was sent via email to a total of 159 doctors of all grades working across the Mental Health Trust. The survey was open for a period of 3 months between July-Oct 2020 with monthly reminders being provided to improve response rate.

Results

Out of the 159 doctors, 34 doctors responded (21.3% response rate). There were 41.2% consultant psychiatrists, 26.5% SAS/Staff grade doctors, 14.7% specialist registrars, 14.7% core trainees and 2.9% of foundation doctors among the respondents. Over half (52.9%) the responders were working in general adult psychiatry, 26.5% in older adult psychiatry, 8.8% in CAMHS, 2.9% in LD, 2.9% in perinatal services and 5.58% in other subspecialties of psychiatry. Most 97.1% of the responders had used telepsychiatry during the pandemic; and amongst them 50% had used both telephone and video consultations and 47.1% had used only telephone consultations.

Table 1. Experiences of the doctors in telepsychiatry practice

	Yes n(%)	No n(%)
Used telepsychiatry during the COVID pandemic?	33 (97.1)	1 (2.9)
Were the clinical outcomes affected by using telepsychiatry?	19 (58.8)	15 (44.1)
If so, were there any negative outcomes?	16 (47.1)	18 (52.9)
Did you find that limitations/ challenges of using technology impacted on delivery of care remotely	25 (73.5)	9 (26.5)
Were you satisfied with the process as a provider of telepsychiatry?	22 (64.7)	12 (35.3)
Overall would you like to use telepsychiatry in the future after the pandemic as well?	27 (79.4)	7 (20.6)

Some of the positive comments highlighted that the process expedited delivery of care and saved clinical time as well as travel time for patients thereby reducing the DNA (did not attend) rates and helped include carers in the consultations. It also ensured successful multidisciplinary team meetings.

On the other hand, challenges were noted in specific subspecialties such as older adult psychiatry where sensory, cognitive deficits and technological difficulties hindered the process of a complete assessment. It was a similar observation in young people who did not engage well, and doctors had to rely on carers for information. It was also noted that follow-up assessments of familiar and stable patients could be completed confidently in comparison to new patient assessment especially those who were acutely unwell or in crisis. It was felt that doctors could potentially miss out on crucial non-verbal cues especially with telephone consultations or in situations where technical glitches resulted in poor consultations. Some doctors reported that they had patients who expressed dissatisfaction with remote consultations.

Discussion

Based on this survey results, it can be identified that while doctors have experienced some challenges in providing care remotely to patients during the pandemic, they also feel positive about its use due to which it can be implemented in the future in a more targeted setting and to specific patient populations.

It appears consultations of familiar patients or those with a stable mental state can be achieved successfully using tele-psychiatry. Some patients may need face to face consultations, especially those who have difficulty in communicating or using technologies or present with complex clinical scenarios.

There might be wider acceptance if process is enhanced by using video consultations for outpatient appointments where possible and standardised virtual assessments are implemented. There is a need for staff to have adequate technical support and training which might facilitate seamless assessments and interventions.

There are a few limitations. The small sample size, the varying grades of technical and psychiatric expertise amongst responders as well as the different modes of delivery of this model of care might make it difficult to generalise the results.

The survey did not explore the area of confidentiality during telemedicine and there is scope for further research into this topic. Processes and procedures need to be defined and implemented to safeguard patient during telepsychiatric assessment and interventions.

Conclusion

The survey gives some understanding about the experience of doctors practising telepsychiatry and provides opportunity for further research on this topic. Overall, tele-psychiatry seems to have been accepted by a majority of the proportion of psychiatrists in the Trust who are also willing to use it as part of their future practice. There is a need for further research with larger sample size and to explore patient satisfaction which will enable us to provide a holistic experience of telepsychiatry.

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RUN TALK RUN : ALTERNATIVE THERAPY by Dr Shahnaz Hassan and Dr Hussain Al-Zubaidi,

The Run Talk Run Leaders from left to right: Hussain Al-Zubaidi, Shahnaz Hassan, Stephen Gallagher, Dominic Shepherd and Mick Hurrell

Have you ever got your heart rate up when not feeling your best? Perhaps you went for a walk or jog. No doubt you felt better for it after. That's because exercising releases those ''happy hormones''- endorphins. These lift our mood, help us de-stress and sleep better. That sense of achievement in completing the often evaded physical activity gives us confidence that we can do it which in turn lifts our self-esteem. If these outcomes were the effects of a tablet it would no doubt be highly sought after.

Telling yourself or others to get active is easily said but often there are challenges to overcome to get there. That is where run talk run can help. It is a weekly mental health support running group that aims to break down barriers to exercise whilst providing a safe space for people to talk about good days, bad days and everything in between. It is a national turned global initiative that was launched in 2017 by Jess Robson who herself at the time was experiencing depression and found running with others helped her to open up about her mental health.

Clarendon lodge medical practice in Leamington spa launched the first west midlands run talk run in July 2020. The group is led by a diverse team: Dr Hussain Al-Zubaidi- general practitioner, Dr Shahnaz Hassan- psychiatrist, Mick Hurrell- Fitness coach for the over 50s, Dominic Shepherd- social prescriber and Stephen Gallagher- practice manager

Participants have come from all walks of life to join in the weekly adventure. Each has their own reason for attending; some have diagnosed mental health conditions, some come for their physical wellbeing and others for the social aspect. The feedback has been overwhelmingly positive with the benefits of the group far reaching into all components of life. Just some of the advantages participants have reported back include reduced social isolation, overcoming agoraphobia and anxiety, better sleep, the motivation to stop smoking and reach activity goals from being able to talk and run at the same time to running in races. One of the most gratifying aspects for us as leaders is to see the community come together to support each other in their goals and form connections outside the group. Several runners now meet on Saturdays to do the parkruns (1) together and this week two runners planned to tackle the Yorkshire peaks together on a weekend away. Some were inspired to set up other run talk runs and there are now 3 available in the Warwickshire area on different days of the week.

There is a wealth of research on the benefits of physical activity on mental and physical health and our project has allowed us to witness this first-hand. Our participants have shared the rewards they have reaped with others and as such the group has grown as people invite family and friends along. Our efforts also attracted the attention of the local media and we have spoken to the local newspapers (2) and BBC radio about the initiative.

Shahnaz Hassan (2nd left, top row) and Mick Hurrell (3rd left, top row) leading a session

So if you have been convinced that social exercise has a vital role to play in wellbeing why not try out your nearest run talk run (3). We would also be delighted to host you at Clarendon Lodge, Leamington spa on Tuesdays at 6.30pm (4). However if you have been charmed and enthused to go further, then maybe you want to consider being a run leader. Dr Al-Zubaidi, regional lead for run talk run west midlands is your go to for advice and support: westmidlands@runtalkrun.com. Happy running!

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https://www.runtalkrun.com/run-with-us

https://www.clmp.org.uk/Patient-Participation/Run-Talk-Run

Authors

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Assessment of undiagnosed Autism in Community Mental Health services

by Dr Sahrish Khan, Dr Jayne Greening and Dr Yasmin Spaulding

Introduction

Autism spectrum disorder (ASD), a social and communication disorder, is no longer regarded as a rare disorder. It contributes to a substantial societal burden and can be challenging for adults and carers combined. Being diagnosed correctly with ASD can be valuable to the patient as a diagnosis opens up a range of autism services, such as social groups, support to live independently, and support with finding and remaining in employment. With the right support, many adults with ASD can live and work independently, and lead fulfilling and rewarding lives.

There is a high rate of co morbidity with other psychiatric disorders that have been observed in adult psychiatric disorders such as mood disorders, anxiety disorders, attention deficit hyperactivity disorder (ADHD), personality disorders, and this may cause diagnostic confusion [1]. It can be challenging to identify ASD in adults who have not been diagnosed in childhood as existing diagnostic instruments ideally require input from a parent that may not be available. The main diagnostic challenge for psychiatrists is to identify adult psychiatric patients who may have undiagnosed ASD for further diagnostic investigation. Individuals with ASD account for a small but challenging subgroup of service users (1.4–3.4 per cent) using psychiatric services [2] that may have significant unmet needs [3].

Aims

To assess how many patients within a general adult CMHT caseload in Solihull may have a potentially previously undiagnosed ASD.

Overall we would like to improve clinicians' awareness to screen for ASD in patients that present with other mental health disorders that have similar symptoms that can be seen in ASD and may be seen as part of other MH conditions only.

Method

A retrospective study was carried out and we performed a case note review of the sample. Patients' notes were reviewed via Rio electronic system. We used a systematic sampling method and collected data for the time period between February and March 2021. The sample size included 46 patients.

Results

The results of the audit identified that 57% of patients who were referred to secondary care with undiagnosed autism were female compared to 43% who were male. The age of the patients involved in the audit ranged between 20 years and 69 years. 30% of patients were aged between 20 and 29years, whilst only 7% of patients were aged between 60 and 69 years. 2% of patients had a forensic history.

10 patients with undiagnosed autism had previously been admitted to hospital. Of these 10, 7 patients were admitted once and 3 patients were admitted on 2 occasions. 5 patients were formally admitted under section 2 and 1 patient was formally admitted under a section 3.

We assessed whether any of the patients had been reviewed by other sub-specialties within secondary care. Half (50%) of the patients had not been reviewed by any other sub-specialty and 39% of patients were reviewed by psychology.

Table 1: Diagnosis of patients included in the study

Diagnosis	Number **of patients**	Percentage **of patients**
Emotionally unstable personality disorder	12	26%
Anxiety disorder	17	37%
Depressive disorder	27	59%
Social anxiety disorder	3	7%
Gender identity disorder	1	2%
Other	21	46%

Figure 1: Breakdown of 'other' diagnosis

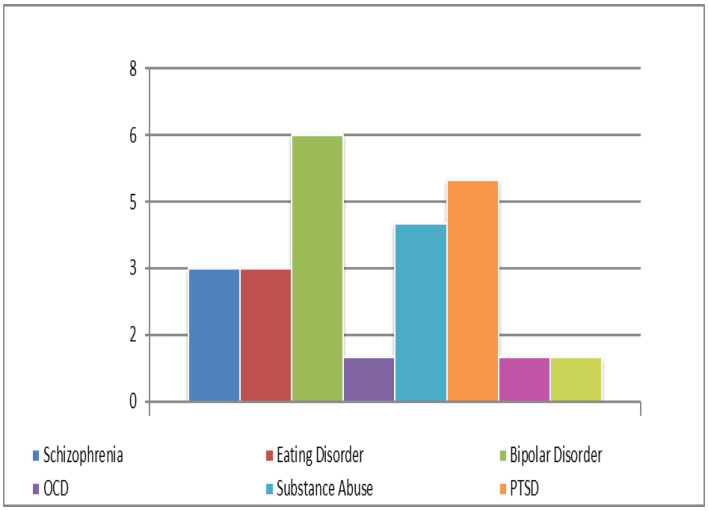
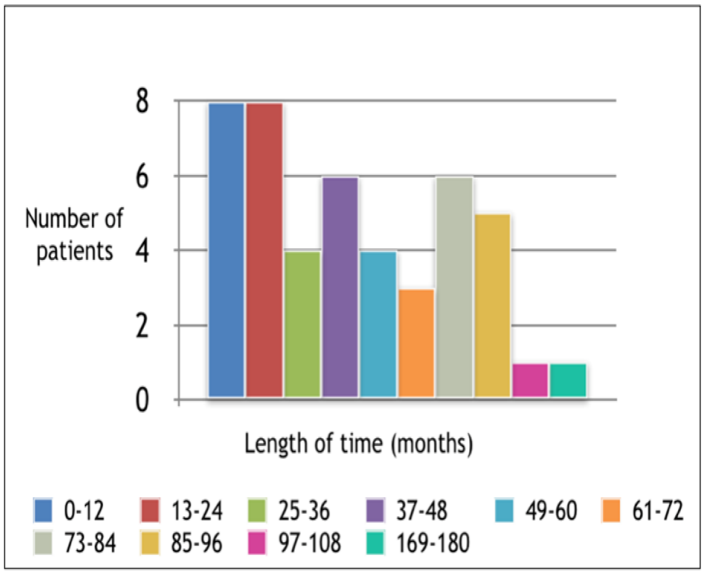


Figure 2: Length of time in psychiatry service prior to ASD diagnosis



We assessed the length of time patients spent in secondary care services before a discussion regarding a potential autism diagnosis was had.

The results identified that most patients were in secondary care for 0-24 months (0-2 years) before autism was discussed.

The longest length of time was between 169 -180 months (14-15 years), which was spent by 1 patient.

Key findings

From our findings it is clear that there is a delay between initial referral to psychiatry services and a diagnosis of ASD being made. This varied from an average of 2 years to as long as 15 years.

In our caseload, most of our patients had a discussion about an ASD diagnosis within 24 months of referral to our service. All the patients were posted out an AQ questionnaire which was filled out by the patient and returned back to us. Their score and clinical history would lead to a referral to the ASD specialist service.

Our clinical commissioning service funds referrals to the ASD specialist service for diagnostic needs. CCGs across the country will vary with which services are funded for ASD patients in their locality.

Risks

Undiagnosed autism in a patient can be a burden for the both the patient as well as CMHT services. Misdiagnosis might lead to inappropriate medication regimes or even the most extreme outcome of formal admission to a mental health ward.

Patients that are receiving long term treatment for enduring mental health disorders may also have symptoms of ASD that due to 'diagnostic overshadowing' are not being recognised and managed properly. Due to the complexity of ASD, symptoms of anxiety, low mood and psychosis may be incorrectly misattributed to developmental disorder and remain unnoticed. The most common co-morbidity in our patient population were depressive and anxiety disorders.

Conclusion

Overall, it is clear that ASD is undiagnosed in a large number of our patients. Patients are often diagnosed with other mental health disorders such as depression, bipolar disorder, anxiety disorder and emotionally unstable personality disorder.

In the area of Solihull, West Midlands, there aren't specific services that are set up for patients with a diagnosis of ASD. Due to the associated high levels of anxiety, specifically when there are traumatic life changes or periods of crisis, these patients can present with suicidal thoughts and difficulty in engaging with psychiatry services. Current therapy options are not geared towards patients with ASD and these results in a lack of psychology services for this group of individuals.

Despite guidance that adults with this dual diagnosis should be treated in mainstream mental health settings [4], staff generally feel this responsibility is beyond or outside their job role [5]. Awareness of the overlap of ASD with other conditions is vital for devising effective and appropriate treatment plans [6].

It would be greatly beneficial to patients with ASD if there was a modification in all services, to help treat and manage these patients in the community. Training health care professionals in ASD presentation, management and psychological intervention will provide a more holistic care for patients with ASD. We should be able to take into account that patients with ASD are likely to have a co-morbid psychiatry diagnosis.

Dr. Jayne Greening, the local Consultant in General Adult Psychiatry, developed a resource document to be made available for patients to include national and local ASD supportive organisations, and we often provide trust-developed self-help material on social anxiety, depression, coping with stress and sleeping well. Referral to group workshops is often recommended as first line but patients with ASD seem less willing to engage and we then have little recourse to offer one to one so self-help is often relied on.

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5 Minutes with a Psychologist working within a Clinical Health Psychology Service by Fauzia Khan

Dr Lelanie Smook

Abstract

This interview was conducted by Fauzia Khan with Dr Lelanie Smook Principal Counselling Psychologist, who currently works at Essex Partnership University NHS Foundation Trust. The interview provides an insight into the role of a psychologist working within a Clinical Health Psychology service, and highlights the varied benefits that psychology affords such services.

Fauzia: Can you tell the readers a bit about your background and what your role as a psychologist entails?

Lelanie: I trained as a Counselling Psychologist and was fortunate to have my first placement within a Clinical Health Psychology (CHP) service, working with clients living with persistent pain. From there I was hooked and spent much time across the CHP field, working in cardiology, renal, stroke, and CFS. Within all these roles there is a strong focus on adaptation and change. Many of our clients are faced with circumstances beyond their control, and need ways to manage not only the physical limitations they face, but the losses, fears and despair linked to their health. Our clients can also present with pre-existing mental health concerns, which were exacerbated by their poor physical health, so it can be a complex picture. Very many clients also have a trauma history, contributing to a lack of safety and increased vulnerability.

Aside from the clinical role, there is also a strong focus on staff wellbeing, and we embed reflective practice and opportunities for informal client discussions. CHP offers a wonderful opportunity for inter-disciplinary work within in-patient wards and in the community. As such much of my role is about formulation, discussion and close collaboration with colleagues.

There is also time to spend on service development and evaluation, always planning towards future service needs and adaptations required for effective service provision.

Fauzia: How does psychology fit into physical health settings?

Lelanie: CHP brings its own challenges in the clients working to make sense of both their psychological and physical challenges. Physical ailments often impact on whole families or groups, not just the individual, so we may be involved with a larger group of people alongside the client. As a Psychologist working in CHP, I bring Psychological ways of thinking to the rehabilitation sessions with colleagues, and also compassion and understanding in an environment where clients may feel a failure for struggling to cope. We often work alongside colleagues trained within the medical field and there is scope for holistic formulation and treatment planning which recognises the full Bio-psycho-social needs of the client.

Fauzia: What made you choose this career path?

Lelanie: Psychology is my second career, and I found a natural progression towards this field as I was curious to better understand myself, especially at times when I struggled, as well as better understand others. Through completing my studies, I believe I hold a little bit of information on a small component of being human, and there is always much more to learn. I also value the research and scientific practitioner roles of a Psychologist which uses evidence based practice to better support psychological distress.

Fauzia: What is a typical day at work for you like as an applied psychologist?

Lelanie: Due to Covid, a large amount of my work remains virtual. The days are filled with client work, Multi-disciplinary meetings, case discussions and time for reflection and supervision. I am also developing and updating materials for reflective practice and workshops and deliver training around a variety of Psychology related topics to colleagues. I am currently supervising a trainee Psychologist studying the links between cultural orientation and persistent pain.

I also offer a placement to an undergraduate Psychology student and a trainee Clinical Psychologist. Lastly, I co-facilitate Schwartz rounds and regularly meet with prospective panel members.

Fauzia: What motivates you at work?

Lelanie: I love people and have always been curious to find ways to support anyone that struggles. The best feeling is when a client is able to complete their sessions, feeling better equipped to self-manage their physical- and psychological health. Within a more medically-related setting there can sometimes be very many different approaches and view points, and it offers a great opportunity to reflect on how we use language and work effectively within a team of different disciplines.

Fauzia: What do you enjoy most about your job?

Lelanie: I really enjoy the creativity and variety within our roles. I also love learning from colleagues, as they often have brilliant knowledge and ideas.

Fauzia: What are some misconceptions that you think psychiatrists might have about psychologists working within physical health services?

Lelanie: I believe it is easy for any profession to misunderstand another, or to hold a limited understanding of each other. It may be that Psychology could at times be misunderstood as an occupation wholly focused on therapy provision. There could also be a tension between the use of diagnoses and medical terms on one side, and holding a space for the client as a person, who happens to have physical- and psychological needs. Ultimately it could be that our individual backgrounds and training could lead to a familiarity with a certain type of language or way of approaching clients, which in isolation could seem miles apart, but in collaboration, could be highly effective.

Fauzia: What is one thing you would like psychiatrists to know about psychologists working with physical health settings?

Lelanie: I would suggest there are many shared values and hopes in common, between Psychology- and Psychiatry colleagues, especially within the field of CHP where we are working with clients who live with persistent or prolonged physical ill health. Sometimes in the busy day-to-day working, our similarities and shared goals can become lost, and I would strongly encourage taking a curious and open-minded interest in all colleagues, to remind us all we were working towards the same end point, to assist the clients in their management of complex health- and psychological needs.

Author

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Non-attendance at psychiatric outpatient clinics: A retrospective comparison of clinical, demographic and risk factors before and during Covid-19

by Dr Mahum Kiani and Dr Nilamadhab Kar

Background

Psychiatric outpatient appointments are historically poorly attended; rates of non-attendance have been reported between 20 and 50% – up to twice the rate of other specialties.[1] With Covid-19 affecting services drastically, we identified a need to investigate the effects of the pandemic on rates of non-attendance at psychiatric outpatient clinics. This led to the introduction of tele-psychiatry as the primary method of outpatient communication.

The *British Medical Journal* discussed the benefits of telephone consultations, which include speed, improved access and convenience to patients. Evidence in this systematic review suggested that public satisfaction with telephone consultations is high, and that interventions implemented by telephone are comparable in success rates to face-to-face contacts.[2]

A study published in the *Irish Institute of Psychological Medicine* looked at the experience of psychiatrists experiencing remote consultations in outpatient psychiatry. It suggested that there were a number of challenges associated with tele-psychiatry, including diagnostic uncertainty (due to a lack of visual cues), difficulty in forming a therapeutic relationship, and technical issues.[3]

An Italian study conducted following the first wave of the Covid-19 pandemic looked at the effects of the virus on an outpatient psychiatry clinic. The study found that between up to 77% of patients may have missed their first or follow-up appointments in outpatient psychiatry due to government restrictions.[4] This shows the importance of having an alternative means of communication in order to conduct appointments.

They key objective of this study was to identify the impact of Covid-19 and the changed outpatient review method (tele-psychiatry) on attendance at psychiatric outpatient clinics. It was also to identify the clinical, demographic and risk profiles of non-attenders in this setting. Our hypothesis was that the rate of attendance and the profile of non-attenders changed due to Covid-19.

Criteria and Standards

There is existing guidance from the Black Country NHS Healthcare Trust on patients who do not attend Psychiatric outpatient clinic appointments.[5] This outlines policies for prevention, management of missed appointments in the context of new or follow-up patients and how to manage patient cancellations; it also includes guidance on recording DNAs and cancellation, and discharging patients following non-attendance. The Trust policy was used as a frame of reference to see if pre-defined guidance is being followed. In terms of comparison, good practice is constituted by a low rate of non-attendance at outpatient clinics, and the ultimate aim of this project would be to identify the features preventing attendance and put in place systems to improve attendance.

Methods

A comparison was made between consecutive non-attenders at community Psychiatric outpatient clinics in January and November 2020. This was a retrospective analysis conducted on two months of outpatient clinics, which were chosen due to the delivery of services having changed as a result of the Covid-19 pandemic.

The number of consecutive non-attenders in each month was identified and formed the samples for comparison; January 2020 (n = 23) and November 2020 (n = 32). These two groups were compared using the appropriate statistics (percentage, chi-square, t-test) based on the following variables: Clinical (Diagnosis, Medical and psychological treatment, Care programme approach, First contact or follow-up, Risk of harm to self or others) and Demographic (Age, Gender, Ethnicity, Accommodation type, Occupation, being on Benefits)

Results

The overall rate of patients who did not attend their appointment was 20% prior to Covid-19 compared with 22% during.

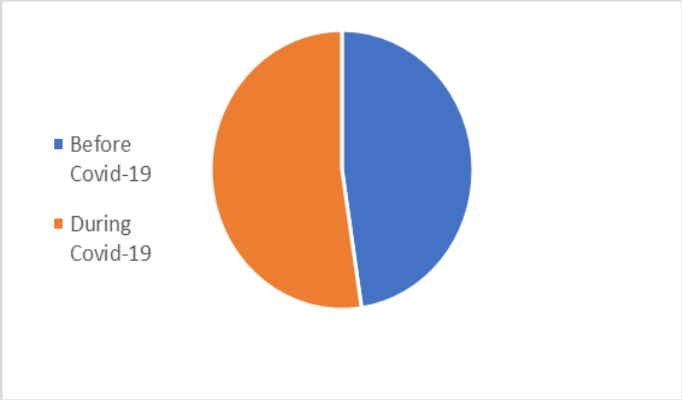

Fig 1: Rate of non-attendance before/during Covid-19

There was a statistically significant difference in the gender distribution of non-attenders, with females less likely to attend prior to Covid-19 and males less likely to attend during Covid-19 (p = 0.029).

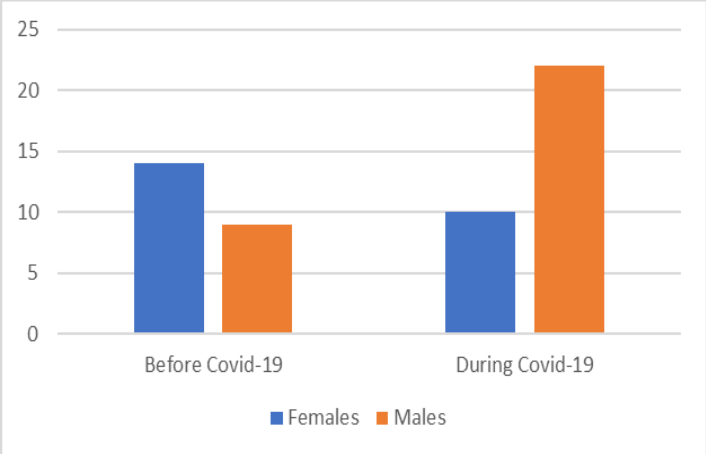

Fig 2: Gender distribution of non-attenders before/during Covid-19

The mean age of patients who did not attend their appointments reduced, from 45.3 to 36.4 (p = 0.035).

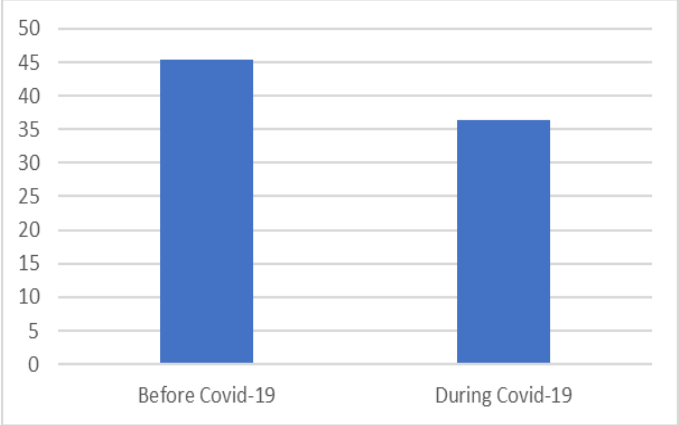

Fig 3: Age distribution of non-attenders before/during Covid-19

All patients who did not attend were contacted as per local Trust guidelines, however the *percentage* of *patients* discharged from services during Covid-19 significant increased from 8.7% to 34.4% (p = 0.027).

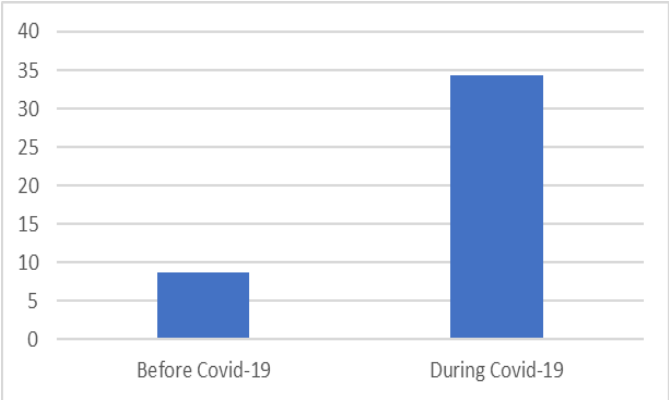

Fig 4: Patients discharged from services before/during Covid-19

The proportion of patients posing a risk to themselves and others significantly increased during Covid-19 (p = 0.027, p = 0.014).

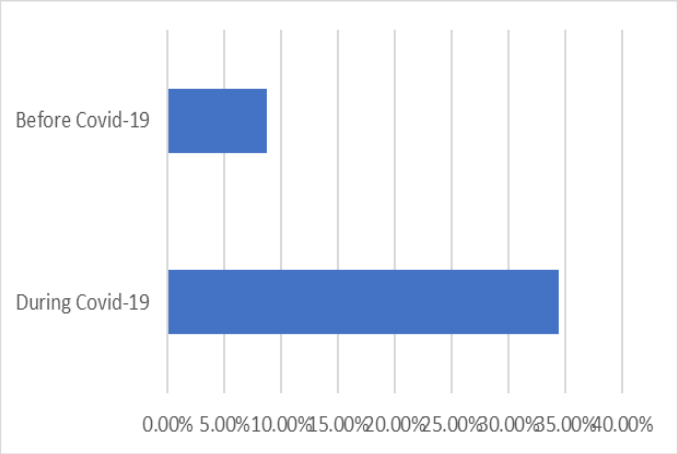

Fig 5: Proportion of patients posing a risk to themselves before/during Covid-19

Recommendations and Learning Points

Non-attendance at psychiatric outpatient appointments is a concern, particularly for younger and male patients. It is important to continue to promote engagement in services for these particular patients. Considering the clinical risks associated with this patient population, efforts need to be taken to improve their engagement with mental health services.

Possible recommendations to improve engagement could include:

A reminder service offered to patients – this could be an automated service which patients have the option to opt into, which texts reminders to patients prior to their appointment

To explore the possible reason for non-attendance and offer patients a suitable follow-up appointment to improve attendance.

Learning points from the clinical audit project include:

Access to both prior paper notes, and the Rio clinical information system, was prudent in order to be able to conduct this research

It may be useful to have lager sample from multiple units of the Trust for a more representative sample.

It is uncertain whether investigation into the patient's employment status or housing offered any value to the research, and was the most time-consuming part of data collection – consider whether this is necessary to include

Future studies may explore patients' perspectives of non-attendance and how to ameliorate any hindrances to attending. They could also look at the impact of Coronavirus, and how this affected patient engagement and attendance of outpatient appointments. It is clear that this area of research continues to be a problem, and the background information suggests that the field is in need of more up-to-date research.

Acknowledgement:

This audit was presented in the Academic Psychiatry Trainee Conference, 2021.

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Authors

Dr Mahum Kiani (FY2) and Dr Nilamadhab Kar (Consultant Psychiatrist) Black Country Healthcare NHS Foundation Trust, Wolverhampton

RCPsych Medical Training Initiative (MTI) by Charlotte Callaghan

Abstract

The RCPsych Medical Training Initiative (MTI) provides the opportunity for a small number of Psychiatrists from low- and middle-income countries to train in the UK for up to two years before returning to their home country. Employing Bodies can benefit from the diversity and experience that MTI Fellows bring, along with their unique insight into patient care. MTI Fellows can fill vacant CT3 training posts, including converted ST posts, or Trust posts which provide sufficient educational and training content. The RCPsych MTI team provide support throughout the entire process of employing an MTI Fellow and can offer a flexible approach based on the individual needs of the Employing Body.

Full Article Text

The RCPsych Medical Training Initiative (MTI) is coordinated by the RCPsych in collaboration with the Academy of Medical Royal Colleges (AoMRC). A small number of suitable doctors from low- and middle-income countries are selected each year to experience training in the NHS, before returning home to share their newly acquired knowledge and skills. The MTI scheme provides successful International Fellows with a unique opportunity to gain experience in several sub-specialties, gain exposure to the NHS regulatory framework and work in a multidisciplinary team.

MTI Fellows provide valuable contributions to the UK workforce, with the diversity and skills they bring to their workplace. This is in addition to providing unique insight into overseas medical education and patient care for their UK peers.

The RCPsych MTI team provides support to Employing Bodies throughout the MTI application and employment process and will continue to provide holistic support to Fellows throughout their MTI placement. RCPsych will provide the doctor with GMC sponsorship and coordinate the application to the Academy of Medical Royal Colleges (AoMRC) for a Certificate of Sponsorship, for the doctor's Tier 5 visa application to enter the UK.

Employing Bodies can apply to RCPsych to employ an MTI fellow if they have vacant training posts which cannot be filled by UK trainees. MTIs can also fill converted ST posts, or Trust posts which provide sufficient educational and training content. The posts must not disadvantage UK trainees nor adversely affect the training of existing trainees in the location. MTI posts must not disadvantage UK trainees and the local Deanery are asked to confirm this. MTI Fellows should start at CT3 but may progress to ST level after a few months with agreement from the MTI Fellow and Employing Body.

Interested Employing Bodies can read the RCPsych MTI Employer Guidance Document and RCPsych MTI Employer Guidance: An Overview for more information about the scheme. Employing Bodies can apply to employ an MTI doctor by completing an Employing Body Submission Form and submitting this to mti@rcpsych.ac.uk. The MTI team will quality assure the post before matching the Employing Body with a suitable doctor.

The Employing Body application period will be open from January to March 2022 for doctors to start placements from August 2022, however the RCPsych MTI team is happy to provide a more flexible approach, based on the needs of the individual Employing Body.

There is an Employing Body administrative fee of £750 for each doctor RCPsych successfully matches with a post. The fee allows the RCPsych to continue the scheme and provide a high level of support to both Employing Bodies and MTI Fellows from application right through to the end of placement.

If you are interested in the MTI scheme, or have any questions, please contact the team at mti@rcpsych.ac.uk.

Author

Charlotte Callaghan, Medical Training Initiative Coordinator - Royal College of Psychiatrists

Mentoring Update Autumn 2021 by Dr Naresh Rasquinha and Dr Andrew Leahy, Joint RCPsych Mentoring Leads

Dr Naresh Rasquinha

Dr Andrew Leahy

Hello to everyone. What an extraordinary time we are living through. Congratulations to all of you for working so hard in such difficult conditions over the past 2 years. I am optimistic that mentoring and coaching will be tools that can use to help with the challenges that will continue to arise.

You may be aware that Geoff Marston has relinquished the post of mentoring lead for the West Midlands College division so there are two new people in post: Dr Naresh Rasquinha and Dr Andrew Leahy.

Naresh is the Regional Medical Director (Midlands & Wales) for Cygnet Health Care. He is new to the mentoring group and brings a wealth of experience and fresh ideas.

Andrew Leahy is a semi-retired child and adolescent psychiatrist who has worked in various areas of the West Midlands including the private sector. He has been mentoring and coaching enthusiastically since 2015 when he acquired a qualification. He is continuing his education in the field.

Whilst both of us are pleased to be the joint mentoring leads it is with sadness that we say goodbye to Geoff in his role as mentoring lead. It has been a pleasure and a privilege to have worked with Geoff.

He has provided great leadership at a difficult time for all of us. Fortunately, he is continuing his involvement.

Geoff and Jan Birtle, his predecessor and now the national mentoring lead, have left mentoring among psychiatrists in the West Midlands in a strong position and indeed other regions have looked to the West Midlands as a model.

Geoff has had great support from the college, particularly Jan Birtle, whom we are fortunate to have in the West Midlands, and Marie Phelps and Daljinder Waterhouse, who have provided excellent administrative support, organised things and ensured we have kept within college guidelines!

We intend to build on the firm base that Geoff and Jan have created.

Both are continuing to support mentoring and coaching in the West Midlands and nationally. They have produced a short article.

We are also pleased to introduce **Dr Mella McCarthy**, the mentoring lead for trainees, who has been working with trainees to ensure they receive the benefits of mentoring. She will continue working with trainees although she is now a consultant. Mella has described her work below.

We have plans for the next year that we expect will fit in well with the NHS plans to extend mentoring and coaching and will be useful to all whether they are doing things informally or on a more formal basis.

We are starting off with a two hour workshop on line on **Wednesday 1 December 2021 from 2-4 pm**. All are welcome (including trainees and SAS doctors) whether or not they have been before and whether or not they have formal training in mentoring. All that is required is an interest.

The workshops will be quarterly. They exist to support and enable people to discuss any issues that their own mentoring or coaching have raised and for people to present educational topics / exercises to expand our knowledge.

We are arranging a mentoring event on **Friday 21** January **2022.** Please save this date further details will follow.

We are also intending, in line with NHS policy, to look at how mentoring and coaching can be useful in direct patient care.

Of course, the big NHS drive to introduce coaching and mentoring at all levels will mean that we will hear much more about it in our own workplaces.

Geoff and Jan have produced a useful article which explains why mentoring and coaching are useful to everyone. This, and Mella's description of the trainees' programme now follow.

Please note: Anyone who wishes to come to the workshop on Wednesday 1 December please e-mail: west.midlands@rcpsych.ac.uk

Anyone who wishes to discuss any issues around mentoring/coaching can contact us via the same e-mail. We hope to see/hear from you all soon.

Trainee Mentoring Network in the West Midlands

Dr Mella McCarthy, Mentoring Lead for Trainees

We are currently very excited about the development of a formalised network for mentoring West Midlands psychiatric trainees. In the past access to mentoring has been variable and hence our aim is to be able, in time, to offer all trainees the chance to be involved.

Over the past 12 months interested higher trainees have been recruited to become mentoring champions. The champions have been offered two opportunities to attend formal training provided by experienced mentors/coaches in the field and further training is being planned for later this year/early next. Monthly supervision is also provided to support new mentors and to aid further development of their skills. We currently have 10 champions and 8 of these are actively involved in mentoring. The remaining two are waiting for mentees to be allocated. Further recruitment of both mentors and mentees is ongoing and the college recognises the positive impact it has on trainees' own development as well as individuals' wellbeing.

Any enthusiastic trainees interested in joining the network either to become a mentor themselves or to take up mentoring for their own development, as mentee, should contact Dr McCarthy in the first instance.

mellamccarthy@nhs.net West Midlands divisional lead for trainee mentoring.

Why should Mentoring and Coaching for psychiatrists be supported? A resource for facilitating conversations with trusts, colleagues and yourself

Dr Geoff Marston and Dr Jan Birtle, RCPsych National Mentoring Lead

This article is written in response to a number of requests from colleagues, asking about how they can protect time in their job plans to support mentoring and coaching and gain funding to access training. We aim to share our thinking around the potential areas of benefit to individuals and Trusts, in the hope that some of the references and ideas prove helpful when approaching job planning discussions or accessing training budgets.

We strongly believe that mentoring and coaching have an important role in enhancing the development of psychiatrists at all stages of their career; this in a number of different ways, examples of which might include:-

- Supporting doctors through transitions (eg from trainee/SAS grade to consultant, retirement, organisational changes)
- Helping doctors when taking on new roles (eg management positions, academic roles)
- Supporting doctors through difficult times (eg pandemics, whistle blowing, serious incidents)
- Giving doctors safe space to explore and challenge their practice, developing existing strengths and learning new skills
- Supporting career development in potentially vulnerable groups such as psychiatrists from the BAME community, IMGs, SAS grade and LTFT workers and the LGBTQ community.

Indeed, mentoring and coaching support is one of the areas recognised in the recent HEE 'NHS Staff and Learners' Mental Wellbeing Commission (Feb 2019)[1] and BMA Caring for the mental health of the medical workforce (2019) [2] reports, as important in maintaining the wellbeing of NHS Staff.

Within the College it is a fundamental pillar of the StartΨell programme[3] (for new consultants and soon for SAS grade psychiatrists) and MTI programme. [4] College approved Job descriptions are now also recommended to contain a section encouraging wellbeing, which includes mentoring support [5].

We also believe that mentoring and coaching skills enhance psychiatrists already excellent communication skills and are transferable to other settings such as:-

- supporting patients through change/treatment decisions (HEE recognises health coaching as an important tool in improving patient-centred care and self-management 6)
- improving leadership skills when managing individuals and teams
- supporting discussion and self- reflection when working as a medical appraiser (skills are often taught during appraisal training),
- working as an educational supervisor, teaching and supporting junior doctors
- As well as many other areas in our work and personal lives.

Finally, we are also expected to do it! The GMC's good medical practice 7 guidance states '57. You should be willing to take on a mentoring role for more junior doctors and other healthcare professionals. 58. If you have agreed to act as a mentor, you must make sure that you are competent to take on the role … including undertaking appropriate training and keeping your skills up to date. You must be clear about the aims and purpose …the scope … and your availability to provide advice and support when needed.

We acknowledge and would like to thank the many regional and national NHS and Independent trusts who encourage and support mentoring / coaching for doctors, recognising its potential benefits to the individual and organisation. For those working in less receptive Trusts, we hope this article is helpful when putting forward your case for individual support or in developing mentoring/coaching business plans.

For more information or to find out how you can become a mentor or access training and support resources please contact Westmidlands@rcpsych.ac.uk

References

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3 https://www.rcpsych.ac.uk/members/supporting-you/new-consultants-startwell
4 https://www.rcpsych.ac.uk/training/MTI
5 https://www.rcpsych.ac.uk/improving-care/workforce/job-description-approval-process
6 Health coaching | Health Education England (hee.nhs.uk)
7 https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice

West Midlands Updates

Summer Academic Webinar

The West Midlands Division Summer Academic Webinar was held on 11 June 2021 with 42 delegates in attendance. Thank you to Professor Saeed Farooq, Academic Secretary for organising an impressive programme that received excellent feedback.

Dr Ignasi Agell, Division Chair opened the meeting with the annual report. This was followed by a presentation by Dr Rashi Negi, Consultant Psychiatrist for Older People at Midlands Partnership NHS Foundation Trust on Delirium: Simple but Complex.

The research presentation competition followed and featured three entrants who had been shortlisted to present their research. The panel of judges assessed the presentations and selected this year's winner (see below).

The morning session included a presentation by Professor Golam Khandaker, Professor of Psychiatry at the University of Bristol on The role of the immune system in depression: exciting therapeutic opportunity or fake news?

Professor Femi Oyebode, Professor of Psychiatry at the University of Birmingham closed the webinar with his presentation on Delirium, dementia and depression in literature—lessons for psychiatry.

Thank you to all our speakers and to all of the delegates who attended, your support is greatly appreciated.

Research Presentation Prize Winner

The 2021 Research Presentation prize was awarded to Dr Amy Burlingham for her presentation on Vitamin Sea: Exploring the engagement and effectiveness of a sea swimming course for anxiety and depression.

Further details about divisional prizes can be found on the website or by contacting the divisional office.

Winter Academic Webinar

The West Midlands Division Winter Academic Meeting is taking place on Friday 3 December 2021. To book and for further information please visit our website.

Section 12 (2) and Approved Clinician Training Courses

Our online courses comprise of e-learning modules with recorded presentations, interactive learning exercises and end of module tests, along with a live online session with our expert panel. Our courses are approved by the Department of Health and Social Care's National Reference Group representing all four National Approvals Panels in England.

For further information and to book your place please visit our website.

Executive Committee

The West Midlands Division Executive Committee meets three times a year and next meet virtually on 11 February 2022. Approved minutes from previous meetings can be assessed online (member login is required).

Research Prize Abstracts

Vitamin Sea: Exploring the engagement and effectiveness of a sea swimming course for anxiety and depression.

Background

Increasing numbers of people suffer with depression and anxiety, exacerbated recently by the SARS-CoV-2, with 1 in 10 adults experiencing depression before the pandemic, doubling to nearly 1 in 5 in 2020. Since antiquity, sea bathing has been prescribed as a treatment. Outdoor swimming has become increasingly popular with enthusiasts claiming benefits to mental health. However, there is limited research into the area.

Aims

To assess the feasibility of conducting a trial of outdoor swimming for participants with depression and anxiety. Primarily, we aimed to establish recruitment and retention rates for a sea swimming course. Secondly, to trial quantitative and qualitative data collection methods including biological markers of inflammation.

Method

61 participants were recruited through GP surgeries, social prescribers and social media to participate in a sea swimming course. Self-administered questionnaires (Patient Health Questionnaire 9, Generalised Anxiety Disorder Assessment 7 and Work and Social Adjustment Scale) were completed at baseline, post-course and at 3-month follow-up. A point-of-care C-reactive protein device was used pre- and post-course. 8 sessions took place over 4 weeks (2/week) or 8 weeks (1/week).

Results

Overall attendance was 90.1%, and the mean number of sessions attended was 7.3. There were significant reductions ($p<0.01$) in the mean severity scores in depression pre- (mean ±SD, 13.0 ± 6.24) to post-course (5.1 ± 4.95) and anxiety pre- (2.2 ± 4.65) to post-course (5.0 ± 4.03). There were high recovery rates immediately post-course (80.6 % for depression and 70.5% for anxiety) and at 3-month follow up. The qualitative data added further depth with reports of increased confidence, feeling energised, but also calmness, and building a social network.

Conclusions

This study provides preliminary support for the acceptability and efficacy of sea swimming for depression and anxiety. Strong inferences cannot be made, but the findings don't appear to be due to chance. While talking therapies and medication are the mainstay of treatment, it has been recognised that preventative and community asset approaches need to be considered. There is an argument for a larger scaled randomised control trial that can better examine the therapeutic potential of this intervention.

Authors

Amy Burlingham - ST5 Dual GA/OA Psychiatry Trainee, Hannah Denton, Mark Harper, Heather Massey, and Naomi Vides.

Retrospective 2 and 4 year follow up of 16-18 year olds discharged from CAMHS

Objectives

To gain a better understanding of common mental illness in young adults, who have been discharged from CAMHS following turning 18 years old.

Methods

Study population: CAMHS service in England covering a total population of 46364 5-19year olds.

Records identified of those who turned 18 and were under CAMHS between 01.01.2014 - 31.12.15 (243 patients). Retrospective review of notes of those transitioned to AMHS by child and adolescent psychiatrists (CAP) was undertaken to ascertain whether they were still known to AMHS 2 and 4 years after they were last seen in CAMHS.

Results

202/243 (83%) were not transitioned to AMHS. They were either discharged back to the care of the GP following therapy or for ongoing medication management, had only been seen once for a deliberate self-harm assessment from out of area and discharged back to respective GP or no file was found (5/202 3%).

41/243 (17%) had been transitioned AMHS by CAP. The AMHS included general adult, intellectual disability, eating disorder and early intervention service.

2 years following their last seen date in CAMHS 17 patients (42%) and 4 years following 12 patients (29%) remained under AMHS.

Out of those 12 patients their diagnoses included 1) Paranoid schizophrenia, ASD, Foetal Alcohol syndrome, 2) Depression with psychotic symptoms, 3) Undifferentiated schizophrenia, 4) Mild LD, ASD, emotional dysregulation, 5) Bipolar affective disorder,6) Treatment refractory schizophrenia, 7) Mild LD, ASD, Psychosis in remission, 8) 1 patient has been re referred by GP and awaiting appointment with psychiatrist and 4 YP with ADHD.

Conclusion

Further exploration would be needed however the following inference can be made: YP known to CAMHS and transitioned to AMHS have gone on to receive a diagnosis of a severe and enduring mental illness or continue to receive management for a neurodevelopmental disorder which is pervasive in nature.

Author

Dr Kiran Panesar, ST5 CAMHS higher trainee, Birmingham and Solihull Mental Health NHS Foundation Trust

Association between behaviour that challenges and the prescription of antipsychotics in a total population with an intellectual disability open to the local community psychiatric services

Purpose

To assess the association between the prescription of antipsychotics and behaviour that challenges in a psychiatric service for people with intellectual disabilities (PWID).

Design/methodology/approach

Information for patients open to community psychiatry consultants was obtained from their medical files (paper and electronic). Association between variables was initially assessed using X^2. Logistic regression was used to assess the adjusted effect between behaviour that challenges and prescription of antipsychotics.

Population

There were 520 patients in total. Three patients were eliminated from the sample because they were assessed by the service and they did not have an intellectual disability. This means that we had 517 patients with leaning disability open to the ID psychiatric community services in this area.

Findings

Prescription of antipsychotics for PWID (63.7%) was higher than previously reported. Male patients, those with the diagnosis of depression, psychosis and autism as well as those with behavior that challenges were more likely to be prescribed antipsychotic medication. Diagnosis of ADHD or Down's syndrome and having a positive behavioral plan were protective factors.

Research limitations/implications

Causality cannot be established in this cross-sectional audit. It included a geographically defined population and some prevalence data may not be generalizable.

Practical implications

Prescription of antipsychotics in PWID may be justified by the complexity of patients open to secondary psychiatric services, and is not only targeting behaviour that challenges. The multidisciplinary care approach with a person centered positive behavioural plan could contribute to a reduction in the use antipsychotics. However, it needs to be recognised that for some of the patients the discontinuation of antipsychotic medication could contribute to the reduction of their quality of life in the community and due to the complexity of the cases, they may require hospitalisation further on the line.

Social implications

Local psychiatric services for PWID may need to work with a multidisciplinary team approach. Person centered positive behavioural plans require of enough resources and support workers that are trained to work and adapt the physical and social environment to meet patient's needs.

Originality/value

This is the first cross-sectional study which includes the total population of PWID in a geographically defined area and therefore, there are no questions about any bias in the prevalence and associated factors. This study has become the baseline data for health improvement projects in this community population.

Authors

Dr Sandra Reyes-Beaman, ST6- Acting Consultant in Psychiatry in ID, Coventry & Warwickshire Partnership Trust

Dr Sanjay Nelson, Consultant Psychiatrist in ID, East London Foundation NHS Trust

Dr Shakeel Islam, Consultant Psychiatrist in ID, East London Foundation NHS Trust

The research was supported by the employing organisations and no external research funding was received.

To assess the confidence of junior doctors in dealing with the diagnosis of Dementia - A Qualitative Study

Aim

The study aims to know how unfazed junior doctors are in the face of breaking the news of dementia diagnosis to patients and families and to know how their confidence can be further boosted.

Background

In older adult psychiatry, dementia is a common diagnosis. Tact, empathy, and good communication skills are some of the qualities a good clinician must have in breaking this diagnosis.

There is also a push by the Government to improve dementia diagnosis rates especially in Primary care. This will enable GPs to diagnose dementia and shorten waiting times.

Methods

A short online questionnaire was prepared and distributed amongst all junior doctors working in the Trust. The participants were asked to indicate their level of training, if they have ever discussed the diagnosis of dementia before, if they are likely to do this in their career, rate how confident they are in the discussing this diagnosis, and the three things could help improve their confidence in discussing the diagnosis of Dementia with patients.

Results

A total of 50 trainees working within the Trust were identified. 22 responded to the survey.
68% have discussed the diagnosis of dementia before. 21 of the 22 respondents are likely to break a diagnosis of dementia in their career.

9 % rated themselves as very confident, 18% rated themselves as confident, 45% rated themselves as somewhat confident, 18% are not so confident, 9% said they were not confident at all.

Summary/Conclusion

Trainees would benefit from more teaching time on dementia and working with Older Adult Psychiatrists. Other suggestions that could help include the use of dementia leaflets and updated NICE guidelines for dementia diagnosis. In conclusion, Trainees acknowledge there is gap in their knowledge of dementia and would like more teaching sessions which could help bridge this gap.

Author

Dr Lathika Preeni Weerasena (Consultant Older Adult Psychiatrist, Herefordshire and Worcestershire Health and Care NHS Trust)

Dr Fiyinfoluwa Akinsiku (CT2 Older Adult Psychiatry, Herefordshire and Worcestershire Health and Care NHS Trust)

Lockdown: What was the impact on older adult self-harm? A service evaluation comparing liaison psychiatry referrals in 2020 and 2019

Background

Loneliness and social isolation are predictors of mental illness[1]. During the COVID-19 lockdowns, older adults (OA) have been told to shield; whilst this may limit the impact and reduce the mortality from COVID-19, it can also be seen as a significant trigger for the development of mental illness with an increased risk of deliberate self-harm (DSH) [1, 2]. The OA population that presents with a history of self-harm are at increased risk of suicide.

Methods

A service evaluation of liaison psychiatry (LP) referrals of people over the age of 65 presenting with DSH in Birmingham acute hospitals from March 24th to September 23rd, 2020 compared with 2019. A retrospective review of data for DSH presentations to LP within Birmingham.

Results

Total referrals to liaison psychiatry dropped during the first three months of the National Lockdown (March-June 2020). During the 6 month time period there was a small increase in the proportion of self-harm referrals in 2020 (7.7% 2019 vs 9.3% 2020). Rates in each site were markedly different. Severity of DSH may have increased as more referrals resulted in psychiatric admission (11.6% 2019 vs 19.4% 2020), of which more required use of the Mental Health Act (3.1% 2019 vs 8.7% 2020). Most patients had a previous history of mental illness (57.8% in 2019 vs 72.1% 2020). More people presenting with DSH in 2019 lived alone (59% vs 45%) and more were taking psychotropic medication at time of presentation in 2020 (55% 2020 vs 47% 2019).

Key Messages

OA DSH is an important public health issue. Lockdown has led to a small increase in the proportion of LP referrals presenting with DSH in those over 65 years and may have led to increased severity. Furthermore, OAs with a previous mental health illness may have been more affected.

References

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Sterope A, Steel N. The experience of older people instructed to shield or self-isolate during the COVID-19 pandemic. ELSA

Authors

Delaney M (Foundation Year 1) Pabani K, (Foundation Year 1), Qureshi A (Foundation Year 2), Sharif F (Locum CT3), Holmes J (Specialist Registrar) and Ormerod S (Consultant) at Birmingham and Solihull Mental Health NHS Foundation Trust.

Evaluation of Video Consultations in Community Mental Health Setting

Aim

To evaluate the overall experience and satisfaction with AA video consultations in adult CMHT.

Background

The increased use of the digital world is evident via Ofcom Tele Report 2019. UK Government's Five Year Forward View and initiatives, such as 'Digital First', aim to reduce face-to-face consultations. Past reports have supported video consultations in systematic reviews and qualitative studies and Covid-19 outbreak prompted its use.

Attend Anywhere (AA) can be accessed anywhere via the web on Google or Safari. It provides a single, consistent entry point with an online waiting area.

Methods

Two separate questionnaires, for service users and staff were designed, with additional clinical questions for staff.

Data collection at the end of AA consultation: 2 months from 01.04.20.

Results

Total respondent 44=20 service users & 24 staff.

For Service Users

The respondents' age range was 19-62 years, 80% females. The majority were follow-ups with three new assessments. About half of them had previous contact with the staff. 15 consultations were carried out by the doctor, four by the psychologist, and one was a joint doctor-psychologist consultation.
95% reported their overall experience to be very good-good. 90% found it easy to use: 95% would use it again.

For Staff

The respondents' age range was 30-50 years, 87% females. The majority were follow-up assessments with one-third new. 16/24 respondents were doctors and eight psychologists. 58% had a previous meeting with service users.

83% reported the overall experience as very good to good: one third felt it's time-saving. 100% reported it's easy to use, would re-use and recommend to others.

For clinical questions, the responses were very good-good as Rapport 87%; Risk assessment 83%; care plan 83%; History taking 78%; Mental state/Cognition 66% and providing support 65%.

Author

Dr Sadia Tabassum Javid, ST5 Dual Old Age and General Adult Registrar in Stoke on Trent

Service Evaluation: The Effect of COVID-19 on perinatal mental health and experience with perinatal mental health service delivery: A study in Wolverhampton

Background

The aim of this service evaluation was to explore the perceptions of COVID-19 and experience of healthcare of women who were in the perinatal period, in particular their experience of a specialist perinatal mental health service in the Black Country, UK.

Methods

Patients due for review over a month's period in outpatient perinatal psychiatry clinic were contacted by phone and answered questions to a proforma comprising of quantitative responses along with open-ended questions regarding their experience of COVID-19. Thematic analysis was conducted for the responses to the open-ended questions.

Results

Thirty-eight women participated. The main concerns centred around reduced support from close ones during the perinatal period due to the lockdown (71.1%), anxiety regarding COVID transmission (42.1%), lack of presence of a supporting person in antenatal clinics (47.4%), difficulty accessing support from midwives (23.7%) and health visitors (10.5%), delays in accessing perinatal mental health services (13.2%) as well as the use of virtual clinics for mental health consultations (28.9%). The open-ended responses provided further insight into the experience of women during the perinatal period in the pandemic, along with the influence of changes to perinatal mental health services.

Conclusion

Based on the findings a few suggestions can be made to improve the experience of women in perinatal service; prominent ones are: facilitating face-to-face consultations when requested, identifying those who require further psychosocial support post-partum and monitoring their needs closely, and specifically eliciting causes of any worry and addressing these expeditiously. Support can be given by providing information, psychoeducation, improving access to services. These can be done via online support, compiling a guide of useful resources for women and providing access to peer support groups. Perinatal service can facilitate the peer group which may have women who access the service as members and can support each other.

Author

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The Royal College of Psychiatrists is the professional body responsible for education and training, and setting and raising standards in psychiatry.

The West Midlands Division is made up of members from Birmingham and the Black Country, Staffordshire, Shropshire, Warwickshire, Herefordshire and Worcestershire.

We would like to thank all members for their contributions towards West Midlands Division activities throughout the year.

Deadline for next edition Submit your articles for the Spring 2022 edition by 31st March at westmidlands@rcpsych.ac.uk

Royal College of Psychiatrists - West Midlands Division E-Newsletter

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