



West Midlands Division Newsletter

Autumn 2020

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Editorial

Dr Nilamadhab Kar, Editor



Clinical Practice in Psychiatry during COVID-19 Pandemic: evolving modifications

There is a massive impact on clinical practice in all areas of medical practice during the COVID-19 pandemic. Psychiatry has no exception. The changes are basically geared towards protecting patients and public along with clinicians, with a primary aim to prevent infection while continuing the services. Health care services have been modified to decrease the number of people in a confined area, to utilise technology to have remote working, assessment and intervention. Although the concept and practice of tele-psychiatry was there, it has become commonplace.¹ Royal college of Psychiatrists has provided guidance regarding the teleconsultation including that for Mental Health Act Assessments.²

There has been a mixed response to the use of technologies. Understandably being there in-house, face-to-face with the patient which has been replaced by talking to people online remotely may have impacted upon the effectiveness of communication; but it has been still possible to carry out the clinical activities through these means. In all probability, in some way or other it seems the tele-psychiatry will continue to remain even after the pandemic is over, considering the ease and speed of interaction. However, its use may grow as more and more clinical activities are being conducted this way. For example, besides usual mental state examinations and diagnostic assessments, even cognitive assessments in older adults have been possible. Psychotherapies were being conducted online for a long time now and it is certain that their use will increase. It appears the psychiatric practice will become a hybrid

model, with space for in-house, face to face assessment and intervention with tele-follow ups.

There is another major impact of COVID-19 pandemic on mental health services. A general increase in stress levels not only due to the risk of infection and related suffering, but also for the secondary stresses linked to it has been noticed. In fact the multifarious stresses linked to pandemic such as death, bereavement, unemployment, isolation/loneliness have contributed to an increase of mental health problems. There are many reports suggesting the increase in mental health issues in general population and worsening of psychiatric problems in mentally ill patients. It is going to be have an increase demand on the mental health services in both primary and secondary care level; as mentally ill patients may have exacerbations. In addition to this, presence of long COVID symptoms which involve many mental health problems among others may also increase the burden on mental health services further.

It has been observed that there is a possibility of heightened risk of infection to the clinicians considering the increased chance of exposure. Protecting patients and health practitioners has been an important aspect of efforts of the health organisations in relation to managing the pandemic, which has seen many guidelines and measures being in place. While attentions are focused towards controlling the spread of virus, treatment of COVID patients and developing a vaccine, it is also important to see that the care for patients with other physical and mental illnesses are not hampered; and the professional and nonprofessional carers who contribute to the mental health services are adequately supported.

Postgraduate training in psychiatry during this period has been challenging. Most of the courses, local teachings are happening through video link, even the exams assessing clinical skills. Although it has been possible to continue the training but there are some effects in the areas of direct face to face observation. While online courses were popular even before the pandemic, the webinars are common these days. Many professional training, courses and conferences are now being successfully conducted online and possibly some may continue that way in the future; these are already decreasing the carbon footprint!

In essence there is a major change in clinical practice of psychiatry during the COVID-19 pandemic. It appears some of the modifications have been positive and may continue to be practised beyond this pandemic era.

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Welcome

Dr Ignasi Agell, West Midlands Division Chair



@ignasiagell

Welcome to the autumn newsletter of our Division. I want to start by drawing your attention to the forthcoming elections. This is another opportunity to become involved in College activities and be an agent of change. The effects of Covid, isolation and economic recession are already starting to cause an impact in mental health and these effects are only going to increase over the coming months putting all our services under further strain. Dr Adrian James, our President, has recently stated the need for sustained investment in mental health services and social welfare measures to ensure that those who will suffer the most get the support they need. It is also important we continue supporting each other, from trainees to our more senior members, so please consider and encourage supervision and mentorship.

Last, enjoy the Newsletter!

Events

College face to face events continue to be cancelled for 2020, and until June 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.

Executive Committee

All committee meetings are being held remotely until further notice.

2021 Election: The RCPsych West Midlands Division 2021 Election process has now been completed for the following positions:

- Chair
- Vice-Chair
- Financial Officer

- Executive Committee Members (x3)

The results will be declared in January 2021 and further information is available on the [college website](#).

Current Appointed Vacancies

- Child and Adolescent Psychiatry Regional Representative

The closing date is **4 December 2020**. Further information is available on the [College website](#).

Mentoring

Please continue your engagement with [mentorship](#). To join the Mentoring Meetings organised by Geoff Marston please email westmidlands@rcpsych.ac.uk.

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. WMIPG meet 3 times a year via teams/teleconference. Anyone interested can be added to the contact list by emailing westmidlands@rcpsych.ac.uk.

Twitter @rcpsychWM

I want to 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 1117 members.

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](#).

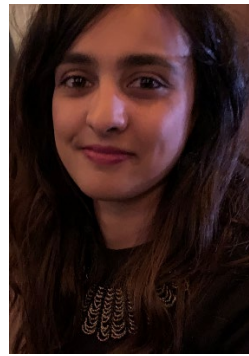
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The Pilot of a Virtual Work Experience Programme during a Pandemic

By Dr Devika Patel MRCPsych (HEE Clinical fellow, West Midlands), Dr Reena Panchal MRCPsych (ST5 Forensic Psychiatry) Birmingham and Solihull Mental Health Foundation Trust



Dr Devika Patel



Dr Reena Panchal

Acknowledgements: Dr Fiona Hynes (Consultant Forensic Psychiatrist, Birmingham and Solihull Mental Health Foundation Trust.)

Poor recruitment into Psychiatry has been recognised as a global issue. National low levels of recruitment prompted the successful “Choose Psychiatry” campaign led by the Royal College of Psychiatry.¹ Reasons for low recruitment include stigma of mental health, perceived poor prognosis of patients and lack of awareness of the career pathway. Work experience placements have been shown to be beneficial in changing attitudes to mental health,² however, can be difficult to arrange and are not accommodated by all mental health trusts due to concerns around supervision, safety and confidentiality.

In response to this, Birmingham and Solihull Mental health Foundation Trust (BSMFT) planned a 5-day careers programme aimed at students aged 16-17 with an interest in applying to Medicine or Psychology at university. There were additional workshops delivered for students interested in mental health nursing and other allied health professions. The first session ran in July 2019 and included lectures, small group sessions, simulation to practise communication skills and videos of actors depicting mental illness, in order to provide an insight into the working life of psychiatrists. 16 students attended with every student reporting they would recommend the course to other students as they found it educational

(50%), insightful (30%), career affirming (3%), helped with communication skills (3%) and helped with networking (3%).

Due to its successful pilot it was due to be re-run in February and July 2020. Unfortunately, due to the pandemic July 2020 was turned into a virtual careers event which has forced the program onto a digital platform, with both advantages and shortcomings.

Organisation and Delivery of the Virtual Event

A Microsoft Teams meeting brought together trust project managers from the learning and development department and professionals from the psychology and psychiatry department who previously delivered the careers programme in July 2019. This meeting involved a brainstorm of what the session would look like and how it could be as effective and valuable for the students as before. This meeting set the tone of what was to be the “new normal” for the coming months (!). Issues such as student engagement, confidentiality and effectiveness of content were taken into great consideration as well as potential barriers of boredom, limitation in “hands on” experience and technical problems were tackled. The team were fairly confident this could be a good substitute for a face to face event however, understandably there were concerns regarding the execution of the day.

In reflection, the day itself went well. Those delivering talks navigated through their sessions and received good interaction from the students. The programme being reduced to one day and being delivered to an audience of eight students only contributed to the event running smoothly. The trust project manager and the students’ teacher were available on standby, to address any glitches.

Evaluation Feedback from Students

The students were sent an electronic questionnaire to complete after attending the Virtual Mental Health Careers Awareness Day to capture their thoughts on this novel work experience session.

Students felt that the session helped them to understand the difference between psychology and psychiatry, the career pathways, various roles in psychiatry and also the potential challenges and rewards associated with working in mental health services. Comments included “a career in psychiatry is rewarding because doctors can have in- depth conversations with patients” and “the

roles that psychiatrists were said to have played during this pandemic was useful to know". It was positive to note the students' previous ideas that mental disorder was "untreatable" had changed and that issues around stigma had been addressed and other myths debunked. Students were also encouraged to pursue a career in the NHS, the majority recognising their own strengths that would be favourable to being a doctor.

The students' overall experience of the event being delivered via a virtual platform was also explored. Students identified their favourite talks of the day, which included the psychiatry and psychology careers talks and Medical Mavericks session. Eighty percent of students said they would recommend the event to their peers, describing it as "entertaining", "informative" and "insightful".

Concluding Remarks

The Royal College of Psychiatrists has vocalised its strong commitment to recruitment and promoted initiatives such as "Choose Psychiatry" for many years; however in amongst its many consequences, the COVID 19 pandemic, the way in which aspiring medical students and potential future psychiatrists access valuable work experience has changed. Although virtual work experience has its draw back such as limitations in experience of the real environment, technical issues and challenges in engagement, there is a need for more creative ways of providing career insight to the "COVID generation" of students.

Inspiration can be drawn from the Royal College of General Practitioners³ and medical specialties in rural settings,⁴ who have assembled a comprehensive online virtual package for school students to gain work experience during the pandemic. Perhaps this is a new steer for all medical specialties to consider. There are also virtual apprenticeship schemes available for students in other professions such as law, marketing and IT.⁵

The BSMHFT Virtual Mental Health Career Awareness Day was received positively by the cohort of sixth form medical students and is encouragement to develop and deliver a larger virtual event to a wider audience in the future. Live talks, pre-recorded sessions, tours of the workplace and interactive Q&A sessions would be desirable options to consider.

There is a huge potential with delivering work experience to students in this way; and it may be an avenue the

Royal College of Psychiatrists wish to explore and capitalise on.

A project which was set up to fill the gap in providing work experience is evolving into a digital work experience programme which has potential to reach more students nationally, with the on-going goal of improving recruitment to Psychiatry and other careers within mental health.

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A holistic model for Clozapine monitoring at Coventry and Warwickshire Partnership Trust

by Dr Shahnaz Hassan and Dr Bettahalasoor Somashekar

Background

The clozapine monitoring service, Lakeview Clinic at the trust is held in high regard by patients and clinician's alike having already received a quality award from the trust for respect for everyone. Run by enthusiastic and experienced staff who are dedicated to patient care, this clinic not only allows clozapine to be safely issued by ensuring compliance with blood test monitoring but also goes beyond to complete annual physical health checks. The alliance between the staff and patients serves as another source of mental health support for one of the patient groups, who by the chronicity of their illness needs it the most.

This was not a service that could stop running amidst the COVID 19 pandemic and staff donned personal protective equipment and courageously put themselves on the frontline to continue to provide care.

As a frequent dependant on the services provided by clinic, I set out to learn more.

Aims

1. To understand the size and the scope of the service including what additional health care the clinic provides.
2. To establish the model used to provide this service.
3. To gather data on the staff and patient experience.

Method

A list of all the patients open to the service was provided to me by the clinic manager, Tracey Williams, who I also interviewed to establish what other physical health care elements are provided. A questionnaire via survey monkey was sent to staff to understand their experience; they were asked how satisfied they were with their job at the clinic on a scale from 1, not at all to 5, very much. Patients in the waiting room were approached during one clinic session and asked if they would be willing to

provide feedback on the service via rating their experience on a scale from 1, poor to 5, excellent. Both groups were given an opportunity to provide any additional comments.



Lakeview clinic staff: from left to right, Greta Chieza, Cholika Kumar, Amy Kelly, Tracey Williams, Johnny Kingham, Sarah Barrett.

Results

There are 211 patients open to the service and they are all registered with the clozapine patient monitoring service (CPMS). Of these 95% (200/211) were established on a monthly monitoring regime whilst 11 were having more frequent tests. The compliance with monitoring is 100% as the staff will contact patients about missed appointments as clozapine cannot be dispensed without a satisfactory blood test result.

In addition to blood tests recommended nationally for clozapine monitoring the clinic automatically completes clozapine levels, an electrocardiogram and psychotropic monitoring bloods each year. Clinicians can also directly request additional monitoring if required. Each time the patient attends for their blood tests they will have their weight, blood pressure, heart rate, temperature, and stool type recorded to monitor for the side effects of clozapine. Patients are also given a choice of music to listen to whilst in the clinic room. Development of this monitoring approach was supported by Consultant Psychiatrist Dr Somashekar who took an unpaid clinical leadership role out of interest to advise staff on best practice for clozapine use.

The service is run by 8 staff consisting of 5 nurses, 2 health care assistants and 1 administrative personnel. 6 of the staff are part time working at 60-80%.

There are 2 allocated clinic rooms, a waiting room and an administrative office. The service has their own point of care haematology machine to give immediate results on clozapine monitoring bloods to allow swift dispensing of medication.

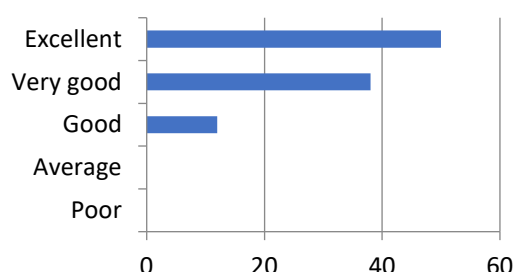


Figure 1: Results from patient feedback survey question- 'How would you rate your experience of Lakeview Clinic so far?'

Eight patients agreed to give feedback and 88% found their experience to be very good or excellent (figure 1). Comments included 'staff are superb-very friendly-they look after you'. Six staff responded to the anonymous survey and they all rated their experience of working in the clinic as very or very much satisfactory.

During interview Tracey gave examples of how social and other mental health support is provided, beyond the remit of the clinic, such as liaising with third party organisations and providing reassurance and advice on non-clinical issues.

Discussions

This robust service represents best practice of managing clozapine as guided by the Maudsley prescribing guidance. Serving a population of 211 patients with the equivalent of 6.15 full time staff suggests a very cost-effective service. The high compliance with treatment has likely prevented relapse and hospitalisation.

Comments provided from staff reflected that it was team dynamics that made the job fulfilling. The high levels of job satisfaction amongst staff likely translate into the positive patient experience as all patients who provided comments reflected the caring and supportive nature of the staff.

Psychiatric patients are at high risk of developing physical health care complications, due to various factors such as

medications prescribed, lifestyle choices and diagnostic overshadowing. This is reflected in a London based study that revealed a 12.9 year reduction in life expectancy for males and 11.8 year reduction in females with a serious mental illness compared with the general UK population.¹ Therefore, incorporation of physical health care into mental health care is paramount to achieving better quality of care in psychiatry and this model serves as an optimum way to achieve that.

We would recommend this holistic service model for use by other mental health care providers. This would require a medical professional with an interest in physical health care to take on a clinical leadership role to work collaboratively with a multidisciplinary team to develop such a model.

Limitations

It is not possible to quantify the direct impact that the care provided at the clinic has on mental and physical health outcomes as well as the cost benefit of this.

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Reflections of an FY1 Doctor Working in Psychiatry During the COVID-19 Pandemic

by Dr Faiz Masood, Penn Hospital,
Wolverhampton, Black Country Healthcare
NHS Foundation Trust



Dr Faiz Masood

During my final year of medical school, I would receive a reoccurring recommendation from doctors; to avoid beginning my foundation career *in psychiatry*. I had always aspired to pursue psychiatry and so it seemed counter-intuitive to me to recommend against it during the early stages of my career. Eventually though, I came to understand the logic behind these recommendations. Psychiatry is a vast and distinct branch of medicine, unlike other areas in many respects; the pharmacological arsenal of a psychiatrist is nearly unique compared to other specialties, while the spectrum of non-pharmacological options is deep and wide. It is this reason exactly why the skillset of a psychiatrist has been traditionally regarded to only have limited overlap with the skillset of doctors from other specialties. The skillset of a non-specialist, foundation doctor is understandably required to be 'broad'.

The physical health issues of COVID-19 are relatively well documented within media, though the mental health issues which have resulted have not received the same limelight. Mental health in the public has significantly deteriorated compared to pre-COVID times.¹ The last few months of human history have been unprecedented. People have been pushed into metaphorical corners and have faced challenges both physical and mental. COVID-19 seems to have found its way into almost all of my patient's stories, whether they directly suffered from it or were affected indirectly by it in some way.

Many of the patients I have cared for have had relationships crumble, others have been severely isolated from their usual network, but almost all were able to identify COVID-19 as a contributing factor to their psychopathology. To me at least, the burden of COVID-19 on mental health is all too obvious.

Working within psychiatry during the pandemic has been both a tiring and enriching experience. It has emphasised to me the need to remain 'broad' in my skillset and to remain vigilant of the physical issues of COVID-19, whether it's associated to an active infection, or an issue occurring post-infection. But it has also given me the realisation that a 'broad' understanding of *psychiatry* is equally necessary among doctors, probably now more than ever. Though distinct and separate, physical and mental health are clearly intertwined in a complex web that can have influence upon each other. To treat illness, health care professionals must understand not one, but both of these aspects to give the best outcome for a patient. Further to this, to treat COVID-19, we must remain holistic in our approach – not all its effects can be investigated from blood tests and scans but instead require careful exploration of psychosocial circumstances.

Practise within psychiatry has changed dramatically within the last 6 months, with a massive shift towards 'virtual consultations'. Society is rapidly shifting towards a digital world, which has been recognised by many within the field, including the Royal College of Psychiatrists who published guidelines on changing practise.² Many of my colleagues have embraced the shift, while some have remained sceptical. More so than any other speciality, psychiatry demands time and effort to develop a therapeutic relationship with patients. Psychiatry demands *connection*, but can a clinician truly *connect* with their patient without face-to-face contact? My own perspective is of cautious optimism. Limitations such as availability of technology and usability will remain for the time being, but so too will the risk of COVID-19. At times I have felt frustrated when reviewing patients over the phone and having no body language to put things into context; these subtle cues are helpful in communication. I have seen this made easier during video consultations, though there remains a sense of something lacking compared against face-to-face. Equally, to have someone so easily and quickly accessible via video call

can make all the difference to patients and their care, particularly while they are acutely unwell. Mastering the 'virtual consultation' will take experience and time, though I believe there will be a permanent place for it parallel to traditional practise.

The learning I will gain from my upcoming medical and surgical rotations will no doubt be valuable experiences for me, but the last few months of my training have taught me much more about the struggles of life in a post-COVID era than I ever imagined to. In my case, I have felt very fortunate to begin my career as a doctor in psychiatry, particularly during the pandemic, as it has taught me the both the value and seemingly endless burden upon the mental health teams within our NHS.

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Hearing Voices Groups: A Helpful or Unhelpful Phenomenon?

By Fauzia Khan BSc (Hons), MBPsS, Assistant Psychologist, Black Country Healthcare NHS Foundation Trust and Samina Allie, CPsychol, AFBPsS, Senior Counselling Psychologist, Black Country Healthcare NHS Foundation Trust



Fauzia Khan



Samina Allie

Abstract

The present paper provides a qualitative account from psychologists running a Hearing Voices Group at Hallam Street Hospital, an acute inpatient psychiatric hospital setting. The psychologist facilitators reflect on their experience of facilitating the group over the years, and how patients have benefited from attending it.

Introduction

The development of hearing voices groups has gained increasing popularity across the world over the last twenty-five years. One of the primary reasons for this has been because 25-30% of people continue to hear voices despite taking neuroleptic medication [1], so the need for alternative treatment strategies has become all the more important. Hearing voices groups allow voice-hearers to talk freely about their experiences without being judged. It serves as a forum for raising awareness about voice-hearing as well as encouraging learning [2]. Voice-hearers are free to explore the content of their experiences in great detail, without the risk of censorship [3].

Hearing voices groups promote the validation, normalisation and acceptance of the experience of voice hearing. It also links professionals from all disciplines, voice hearers and non-voice hearers, who take the view that there is no single treatment or causation for voices and that they are not necessarily symptomatic of psychiatric problems [4].

They further challenge the conventional psychiatric relationship of “them vs. us”, where the clinician plays a dominant role, while the patient plays a passive recipient role [3]. Instead, these groups work on fostering mutual respectful relationships amongst its members. Emphasis is placed not on the pathology of the experience, but on what the experience symbolizes for the voice-hearer, enabling experiences to be shared constructively [5].

Hallam’s Hearing Voices Group

The Hearing voices group at Hallam Street Hospital is a weekly-facilitated support group for individuals that hear voices and have other unusual experiences, such as tactile sensations and visions. The group allows voices-hearers to make sense of their experiences and connect with others who have similar experiences to them. In the group, patients are given a safe place to explore and learn different coping strategies and ways of accepting their voice hearing experience. The aim of the group is to support patients in understanding their voices and changing their relationship with them.

The group has also established links with similar groups that run in the community, and so patients are supported to make connections with these groups during their inpatient stay, in order to support them with the transition from the inpatient setting to the community. ‘Expert-by-experience’ facilitators that run these groups are often invited to sessions to talk to inpatients about the group, what it entails and how patients can join. Our patients have found this very helpful, and many go on to join these groups.

Reflections from Facilitators

The Hearing Voices Group at Hallam Street Hospital was first established in 2007, and has been running successfully ever since. Over the years, members of the multi-disciplinary team have supported the facilitation of the group. This has included psychiatry, nursing, and occupational therapy colleagues, who have found this a greatly beneficial experience in allowing them to develop their skills and confidence in working therapeutically with this client group [6]; [7].

The Hearing Voices Group is underpinned by the ethos advocated by the Hearing Voices Network, which was founded by Romme and Escher in 1987. In the group, we encourage a curious approach in learning about the relationship between the voice-hearer and their voices. The strength of this approach lies in the voice-hearer holding the ‘expertise’ in the room, which helps to shift the

balance of power within their relationship with their voices.

Patients are supported to make sense of and understand their voices through making links, for example by exploring past traumas and possible links between their voices and traumatic life experiences. Some patients attending the group are also coming to terms with a diagnosis of psychosis, which can be overwhelming, and the group is a safe space for them to explore the challenges of a diagnosis and what this might mean for them. Facilitators are available to provide assistance, and to support them to develop further links with other support mechanisms in the community post discharge.

Running the group over the years has been a humbling experience. It has taught us the power of the patient's narrative and their story, and through supporting patients using voice dialogue work and other explorative means; we can significantly contribute to a better understanding to support them to gain increased control over their experience.

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Life outside psychiatry: Intimate pictures from the 7th Continent

By Dr Fiyinfoluwa Akinsiku, Core Psychiatry Trainee in the West Midlands

Travel is a great privilege, a privilege to learn, to see the world through the eyes of strangers, to find kindness in places unknown, to get lost in the bliss of roaming cities whose language you do not understand, to learn that the world has several shades of grey.

Travel has left me in awe of the planet, and the majesty of it all. It has made me drool at nature. Every chapter has been a new memory, a new journey in the adventure called life.

She has given me a sense of adventure, a sense of being, of freedom, of experiencing new cultures and knowing things I would not have learnt in my local microcosm. Travel ignites my soul and sends the sparks of living life into one huge beautiful conflagration. Because I am alive the most, when I travel.

The Antarctica



I could talk about this beautiful lady all day. This beauty called Ocean Diamond took us to Antarctica and back via the Drake Lake and the Drake Shake.



Catching a glimpse of Antarctica in the distance



Day 1: Enterprise Island. The Staff let down the zodiacs off the mammoth ship.



Antarctica: 10.15pm



The penguins behind were making a lot of noise, LOL





This should be the biggest iceberg we saw



Picturesque Antarctica



If there are reasons I strongly recommend Antarctica as a number one bucket list destination, it's the mad icebergs and wildlife – from Seals to Whales to Penguins. Antarctica has got them in different species. The picture above is the Humpback Whale which can grow up to 60 feet in length. What I mean is that this picture does not do justice to its mammoth size.



The mountain of ice.



Penguins and a Seal

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Physical health monitoring before commencing regular antipsychotics in a Psychiatric Intensive Care Unit (PICU) - a Quality Improvement project

By Dr Divyanish, CT3; and Dr Afshan Channa, Specialty doctor



Dr Divyanish



Dr Afshan Channa

Background

Antipsychotics are the cardinal treatment of schizophrenia,¹ as well as being used to treat Bipolar Affective Disorder, drug induced psychosis and an agitated patient.

Among the most serious of antipsychotic side effects are arrhythmias and sudden cardiac deaths.² There is some evidence that Asian patients of Chinese origin seem to have lower threshold for EPSE3 and Black patients are more likely to be prescribed higher dose of antipsychotics as compared to white inpatients in the UK.⁴

Patients with first episode of illness generally have higher response rates than chronic patients.⁵ They respond on lower antipsychotic doses and are more sensitive to adverse effects.⁶

It is imperative to monitor physical health, focussing on physical examination and initial investigations including blood tests and an ECG, in order to prevent complications associated with antipsychotics.

This audit is designed to identify inadequacy in physical monitoring before commencement of antipsychotics in a PICU setting.

Objectives

To compare the practice in a PICU setting against the standard practicing guidelines before commencing antipsychotics with regard to: physical examination, ECG, baseline blood investigations, and personal or family history of medical conditions.

Standards

Within the first 24 hours, each patient admitted to PICU should have physical examination baseline blood tests: FBC, UCE, LFT, HBA1C/fasting glucose, lipid profile, prolactin and an ECG.

Methodology

Data was collected from a PICU, Macarthur centre, Heath lane hospital, which is a part of Black Country Healthcare NHS foundation trust covering Walsall, Dudley, Sandwell and Wolverhampton sites. All patients who were admitted in PICU from 1st March 2020 to 30th September 2020 were included. A total of 37 patients were admitted between March and September 2020. 30 case notes were included. One patient was admitted twice, first in March and second time in May 2020, thus case notes for only one admission of that patient were taken for data collection.

The data was collected retrospectively within two weeks from 21 September 2020 to 2 October 2020 from case notes in health records. Investigations were accessed through electronic information system for current inpatient admission and 12 months prior to the admission to the PICU.

Results

Mean age of the sample (n=30) was 34.26 years. 37% of patients had physical comorbidities and a family history of medical conditions was documented for only 3% of cases. A large proportion of inpatients (53%) refused to have blood investigations before treatment and only 13% of blood investigations were completed before commencing treatment. Only 7% of patients consented to an ECG prior to commencing treatment. 27% of patients had a physical examination, including vitals, before starting treatment, a further 37% had just their vitals taken within 24 hours of admission and 20% refused any form of physical examination during their inpatient admission. 7% of cases had complications due to a lack of investigation.

Variables	% (n)
Ethnicity	
Asian	30 % (9)
Mixed	13% (4)
White	37% (11)
Black	20% (6)
Section of MHA on admission	
Section 2	60% (18)
Section 3	30% (9)
Recalled on Community treatment order (CTO)	3% (1)
Section 48/49	7% (2)
Diagnosis	
Schizophrenia	13 % (4)
Schizoaffective	10% (3)
Bipolar Affective Disorder	17% (5)
Drug induced psychosis	17% (5)
Dual Diagnosis	43% (5)
First Episode	17% (5)
Physical comorbidities	37% (11)
Family History of medical conditions	3% (1)
Drug Allergies	13% (4)
Investigations done in last 12 months before admission	
Done	17% (5)
Not done	70% (21)
No record	13% (4)
Mental Capacity on Admission	
Assessed	83% (25)
Not Assessed	17% (5)
Mental capacity present in assessed patient (25)	4% (1)
Mental capacity absent in assessed patients (25)	96% (24)
Physical health complications due to lack of investigation	
No complication	93% (28)
Complication	7% (2)
Blood Investigation before commencing treatment	
Refused before commencing treatment	53% (16)
Completed before commencing treatment	13% (4)
Done later during admission	33% (10)
ECG before commencing treatment	
Refused before commencing treatment	53% (16)
Completed before commencing treatment	7% (2)
Done later during admission	40% (12)
Physical Examination before commencing treatment	
Refused before commencing treatment	20% (6)
Completed before commencing treatment	27% (8)
Completed examination later during admission	30% (9)
Vitals assessed within 24 hours	37% (11)

Recommendations

1. The clerking proforma should include family history of physical health problems.
2. Blood investigations should be requested after discharge from hospital as per standards at 8 weeks, 6 months and 12 months.
3. The patient records should be accessible within 24 hours from various agencies.
4. The therapeutic effective dose of antipsychotics should be prescribed utilising GP reconciliation, electronic records and relevant investigations.
5. A training or refresher session could be arranged for ward staff (nurses and healthcare assistants) to learn to take vitals, do ECGs, and blood samples to aid assessment and to provide timely care to patients.

Conclusion

Although there are standard guidelines for the PICU setting, it has been noted that these guidelines aren't always implemented. Multiple factors have a role to play such as: non-consenting patients, inaccessibility of previous records, initial assessment forms being incomplete including assessment of mental capacity and lack of follow up with physical investigations by both primary care and secondary mental health services.

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Evaluation of Video Consultations in Community Mental Health Setting - Pilot Project of Service Evaluation

by Dr Sadia Tabassum Javaid, ST4 Dual GA and OA Psychiatry and Dr Ravindra Belgamwar, Consultant Psychiatrist
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Dr Sadia Tabassum

Background

The use of the digital world is ever increasing with more people exploring choices on how they communicate and participate in the wider world. During 2019, internet uptake remained at 87%, with a 0.5% increase in the number of UK broadband connections at the end of 2018.¹ With 79% of UK adults owning a smartphone, there has been an increase in the ability of people to access other forms of communication, such as email, web-based messaging services and social networking sites.¹

Alongside the shift in engagement towards a digital world and the exploration of digital platforms, the UK Government's Five Year Forward View² focused on the increased use of information and communication technology to better improve care and enable greater access to services. Initiatives, such as 'Digital First',³ aim to reduce face-to-face contact between service users and healthcare providers by encouraging greater use of video-based consultations.

Past reports have shown video consultations to be non-inferior to face-to-face consultations in systematic reviews and qualitative studies.^{4,5,6,7}

Due to the Covid-19 outbreak and the contagious nature of this disease, face-to-face consultations became risky for patients and healthcare staff. This led to a significant change in how we do consultations at Lyme Brook centre, an Adult CMHT; we started using telephonic consultations, later followed by video consultations via Attend Anywhere (AA).

Attend Anywhere is a purpose-built suite of services, tools, and resources. It is accessed wholly via the web on Google or Safari. It can be used anywhere on all everyday devices with a good internet connection. It provides a single, consistent entry point on the service's webpage, where patients enter an online waiting area for their appointment.

Aim

To evaluate the overall experience and satisfaction of service users and staff with AA video consultations in adult CMHT.

Methods

1. Two separate questionnaires were designed, one each for service users and staff, to capture relevant information on a Likert scale. We also asked for staff views on various areas of clinical consultation compared to face-to-face reviews.
2. At the end of the consultation, the clinical staff completed their questionnaire as well as supported the service users either by verbally taking them through the questionnaire or by screen share option.
3. The data collection forms did not include any identifiable service user or staff information. Completed forms were returned to us.
4. This project was registered and accepted by the Trust Innovation team
5. Data were collected for two months from 1st April 2020.

Main Results

Out of a total of 44 respondents, 24 were staff and 20 were service users (Figure 1).

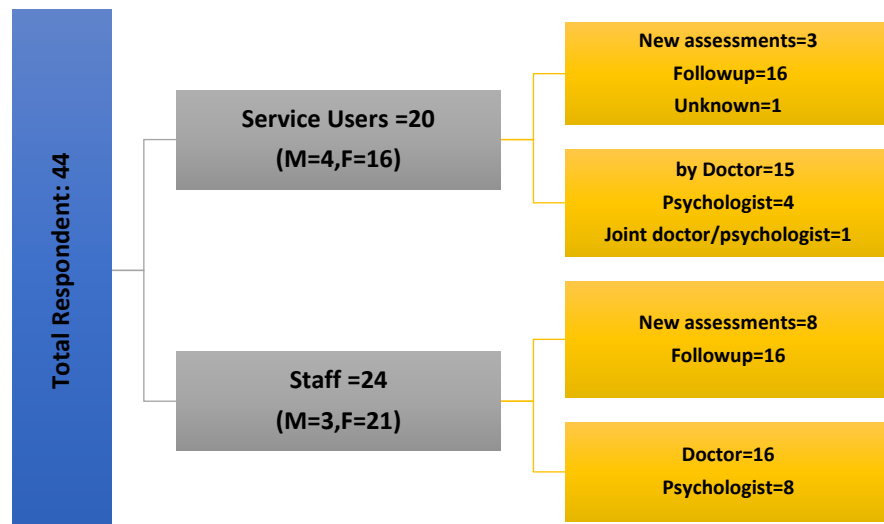


Figure 1: Horizontal Multi-level Hierarchy depicts the number and type of responses received from both groups.

1. For Service Users:

Out of 20 service users, with an age range of 19 to 62 years, 80% were female. Three consultations were new patient assessments and the rest were follow-up reviews. About half of the service users had previous contact with staff. 15 consultations were carried out by doctors, 4 by psychologists and 1 was a joint doctor - psychologist consultation (figure 1).

15 out of the 20 reported their overall experience to be very good and 4 as good. 90% of them found it easy to use: 95% said they would use it again (figure 2).

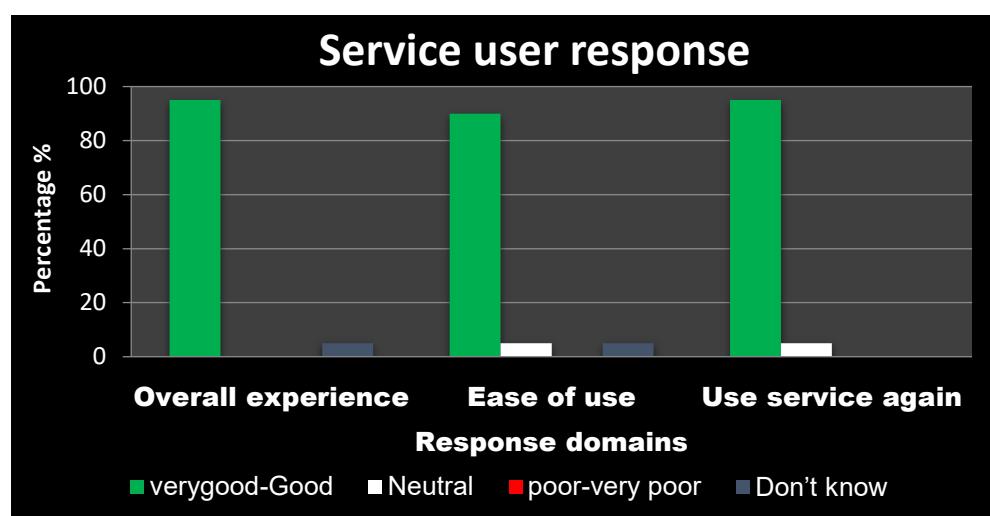


Figure 2: 'Service users' overall response to their experience of an Attend Anywhere video consultation in percentages (x-axis) against the domains (y-axis), based on a Likert scale (see below with colour distribution).

2: For Staff:

Out of 24 staff, with an age range of 30 to 50 years, 87% were females. 16 respondents were doctors and 8 psychologists. One-third of the consultations were new assessments, the rest being follow-ups. 42% had had no previous meetings with the service users, while 58% had (figure 1).

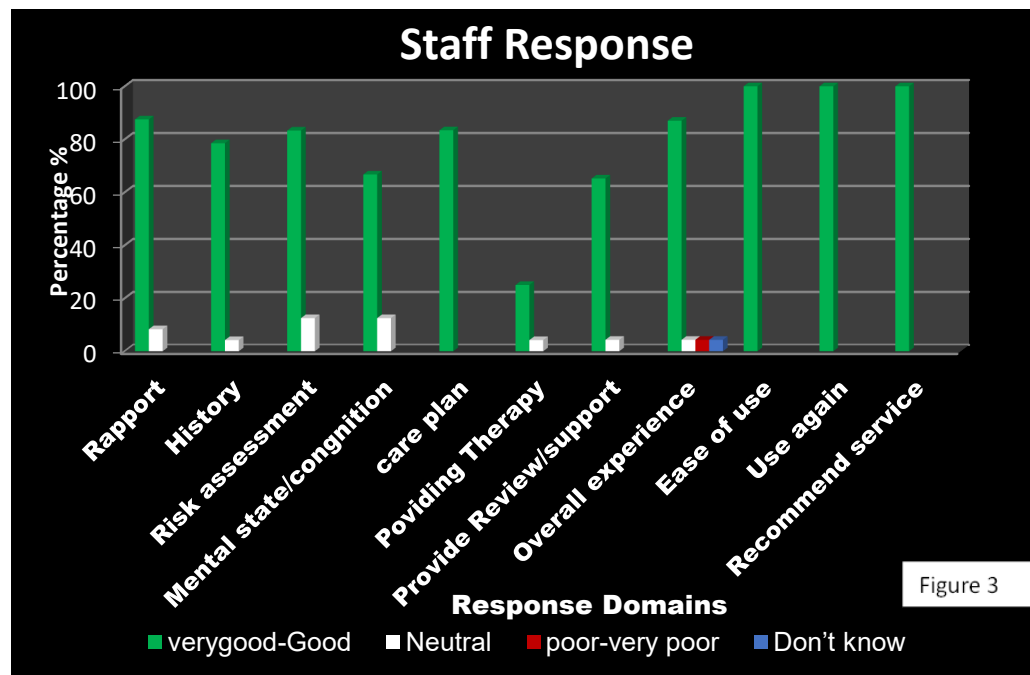


Figure 3

Figure 3: 'staff' overall response of their experience of an Attend Anywhere video consultation in percentages (x-axis) against the domains (y-axis), based on a Likert scale (See below with colour distribution).

Regarding overall experience, 83% (20/24) reported it as very good or good, one third reported that the video consultation saved time and 100% reported the technology easy to use and would re-use it and recommend it to other colleagues (Figure 3).

Further questions asked the staff about the effectiveness of the clinical questioning. The responses were very good-good at 87% for *rapport*; 83% for *risk assessment*, and *care plan*; 78% for *history-taking*; 66% for *mental state/cognition*, and 65% for *providing support*. The remaining responses were either neutral or not applicable (Figure3).

Conclusion

Overall, both service users and staff working at an Adult CMHT found video consultations easy to use and showed a readiness to use them again. Video consultations offer several advantages over telephone reviews, e.g. for developing rapport, assessing mental state, etc. However, we observed that some service users declined video consultation at the time of the appointment booking; we need to examine this information in future evaluations.

This data is limited to the pilot project and a detailed review is planned for a qualitative information data collection with a larger cohort. Following this successful pilot and the promising results, video consultations have been rolled out to all other clinics in the area. We believe video consultations offer several advantages and will be used more frequently, even post-COVID.

Acknowledgement: Thanks to Kerri Mason from R&D team for supporting this pilot project.

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'To take us lands away'- 'Psychiatry and the Arts' group for core trainees during the Covid-19 pandemic

By Dr Ellen Williams, CT3, Black Country Partnership NHS Foundation Trust



Dr Ellen Williams

Throughout medical school and the following foundation and core training years I heard many of my colleagues speak of an insidious loss of interest and time for their passion in the arts. Between clinical workload, exams and portfolio there seems to be little room for reading for enjoyment, let alone trips to exhibitions, theatre or concerts. And yet the importance of the arts in relation to our specialty is well known, as Freud himself once wrote: "The creative writer cannot evade the psychiatrist nor the psychiatrist the creative writer."¹ As clinicians the arts help us to understand and empathise with our patients, they break down stigma, and they can even provide treatment in the form of art, drama and music therapy. Outside the clinical setting they offer a way for psychiatrists to process the complexities and stressors of work, allowing us to recuperate and reignite our passion for the speciality.

In February 2020 as I rotated to a new job I began planning to form a group for trainees interested in the arts and their interaction with mental health, happily envisaging monthly meetings for theatre and gallery trips, lectures, films or book clubs. Alas a month later the Covid-19 pandemic had taken hold in earnest and new restrictions meant that these meetings were not to be. Nonetheless in a fit of optimism I sent information about the group to all West Midlands core trainees and was pleasantly surprised by the number and enthusiasm of our

new members (now totalling over 30 core trainees across all grades). We could not have foreseen, as the group began to take shape in March, what a valuable escape the arts would provide in the following months of lockdown.

Our first meetings took the form of a virtual book club, examining Laura Imai Messina's 'The Phone Booth at the End of the World', Virginia Woolf's 'Mrs Dalloway' and Ayòbámi Adébáyò's 'Stay with Me'. Discussions were enjoyable and insightful, covering wide ranging topics such as grief, PTSD, psychosis and motherhood. Perhaps more significantly it has been a setting to 'meet' and form links with core trainees from all localities, at a time when the usual opportunities such as induction and teaching have not been possible. Hopefully the group has provided an opportunity for trainees to take time for themselves, putting aside work and training commitments to focus on their own wellbeing. On my part it has been rewarding to hear from several trainees that they have started reading for enjoyment again.

As various forms of lockdown rumble on, the group are beginning to look at other ways to engage with the arts, including virtual viewings of films, plays and concerts and socially distanced visits to the newly reopened Ikon Gallery, BMAG and Hippodrome exhibitions. We look forward to a time in the future when the group can meet face to face, and we plan to form a committee to sustain the group beyond the pandemic, for trainees to enjoy in years to come. In the meantime, we must be content with our virtual gatherings and take comfort in the wise words of Emily Dickinson, who wrote 'There is no frigate like a book, to take us lands away'.²

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An Evaluation of Dudley CAMHS Medical Consultation Service

By Dr Catherine Stevens, ST6 CAMHS, Black Country Healthcare NHS Foundation Trust

Acknowledgment: the project was supervised by Dr Michael Slowik, Consultant Child and Adolescent Psychiatrist

CAMHS services have an established structure of multidisciplinary team working, utilising the skills and experience of all clinicians working within it. Dudley CAMHS, in line with many other CAMHS services throughout the UK, utilise the Choice and Partnership approach (CAPA)¹ which aims to link children and family in partnership working with those clinicians who have the relevant experience and skill mix to offer the highest quality and most effective care. In practice, there will be times when a clinician working with a child or young person feels that another professional's input is required. When this input is sought from a medic, this can often centre around issues of risk, diagnostic clarity, or the need for pharmacological treatment.

Dudley CAMHS introduced their Medical Consultation Service in April 2018 which runs weekly and is attended by the core CAMHS consultant group, and sometimes psychiatric trainees. Slots are booked for discussion by the young person's keyworker through the team secretary. The keyworker attends the meeting and a collaborative conversation is had, leading to an agreed management plan, which may or may not include scheduling a medical review for the patient. Prior to the meeting, the lead consultant consults the clinical notes and records the main issues plus demographic details on a running spreadsheet. This creates a complete and auditable record of the work of the meeting.

Method

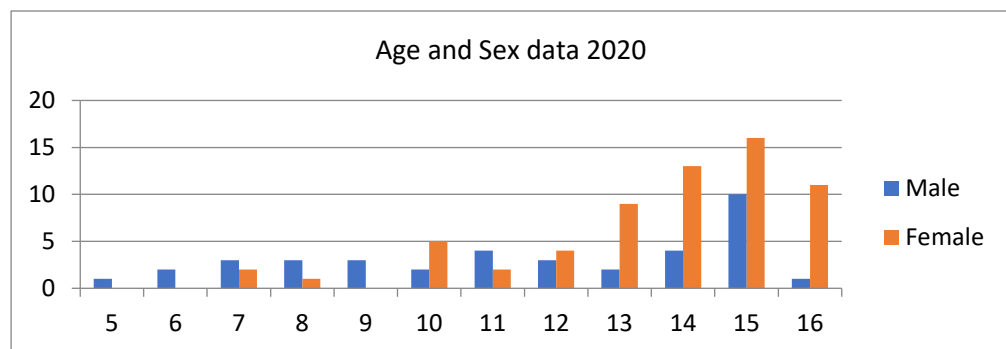
The aforementioned data was analysed at one, and two years after the Medical Consultation clinic started, and are referred to as '2019 data' and '2020 data' respectively.

Results

The baseline data was gathered:

	2020 data	2019 data
Time Span	1 April 2019 to 31 March 2020	1 April 2018 to 31 March 2019
Duration studied	12 months	12 months
Number of sessions offered	44 sessions	40 sessions
Number of consultations	111	101

The age and Sex data for 2020 was plotted to show the demographics of patients being brought to consultation.

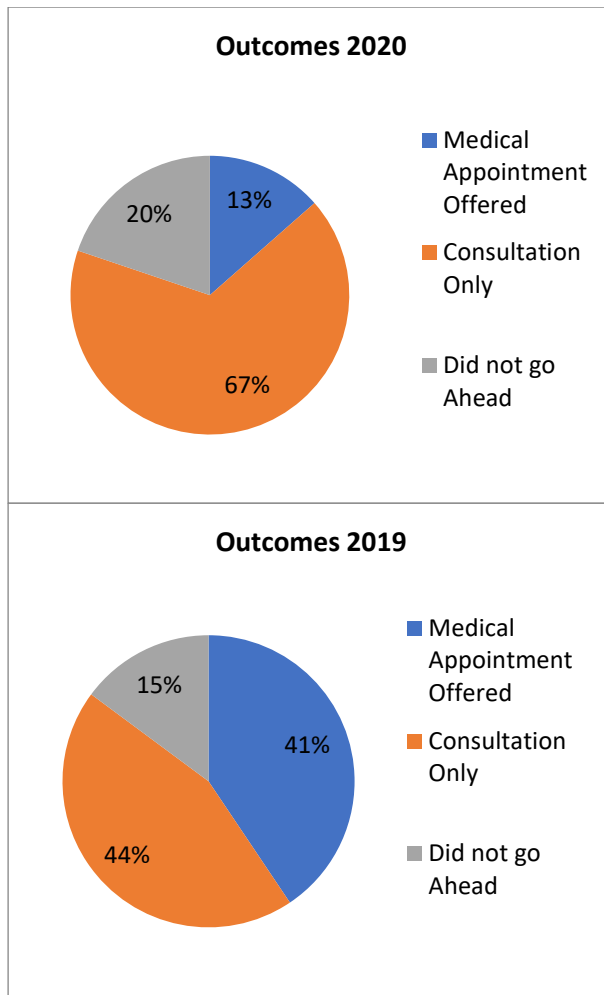


The types of clinicians accessing the service were identified. These were predominantly OTs, CPNs and CAMHS Locum Practitioners. The groups less likely to attend consultation include psychotherapy, family therapy and iCAMHS (crisis team).

The diagnoses or difficulties of young people brought for discussion were also looked into. In 2020, 'additional factors' were also recorded such as social services involvement, parental mental illness or abuse, which featured frequently in the group of patients brought for consultation. The top three most frequently brought issues were as follows:

2020 data	2019 data
1. Anxiety	1. Insomnia
2. Difficulties associated with ASD	2. ASD
3. Low Mood	3. Anxiety

Finally, the outcomes of the consultations were analysed.



Conclusion

- There has been a 23% increase in the number of cases managed through consultation only.
- Clinicians not attending planned appointments has increased from 15% to 20%.
- The difficulties brought, are in most cases, multifactorial. The most frequent issue in 2019 was insomnia, and in 2020, anxiety. Cases involving ASD, anxiety and low mood have been consistently frequently brought.
- The cases brought have many markers of complexity, including social services involvement, parental mental and physical ill health, history of abuse and neglect, substance misuse and school refusal.

Discussion

Analysis identified that older girls present more often, despite there being more males overall in the service. With further data analysis, presentations could be mapped to age and gender, which may identify that

some presenting issues arise for consultation more frequently in certain age/gender groups, like emotional dysregulation in older girls or neurodevelopmental issues in younger boys.

The number of medical appointments offered dropped in the last year (41% in 2019, 13% in 2020). In 2020, several medical reviews offered were for low mood and self-harm. This could be in part due to the medics capacity to potentially diagnose a depressive disorder, risk assess and offer pharmacological intervention within that consultation making it particularly efficient. With complex cases, sometimes medics taking a supervisory role, where they are able to see 'blind spots' in the dynamics, is more effective than becoming involved as an additional clinician.

There is an increase in cases being managed by consultation only (44% in 2019 to 67% in 2020) We have seen that the *types* of cases are slightly different, with anxiety and ASD high on the list in 2020, which may be better managed non-medically (consultation only), in comparison to insomnia in 2019, which often led to medication review for melatonin. With the addition of recording 'additional factors' in 2020, it has become clearer that the complexities of the cases are high; although we cannot directly compare this to 2019, it could offer some explanation as to the increase in consultation only appointments, in terms of the need for supervision as described above.

The fact that the service is no longer in its first year may be another factor in why the number of medical appointments offered has dropped; there could have been an early expectation of referrers that the consultation was simply a way to secure a medical review, paired with a drive within the medical team to clearly demonstrate the work and effectiveness of the new service. As the service has become established, it follows that the expectations of the referrers and the medics have changed. In fact, the data could suggest that the holding and containing function of effective supervision is actually the main factor in reducing the need for direct medical review.

Although the presentations of cases brought nearly always have multiple and complex issues, there are not particular indicators that the patients in general are high

risk. That is, that they are psychiatrically very unwell needing urgent treatment (e.g. first episode psychosis, eating disorder) or that they have significant risks to themselves (suicidality accounted for only 3% of the total presentation factors) or others (conduct disorder accounted for 7%). This could be explained by the fact that the most risky cases would have already been allocated to medics or iCAMHS.

Referrers not attending scheduled appointments have remained a problem in 2020, and rose to 20% from 15%. The reasons for these include forgetting, sickness, other commitments, or cancelling.

There are certain groups more and less likely to access the service. Family therapists and Psychotherapists, who use the consultation at low rates, work within a culture of regular structured reflective supervision with colleagues. iCAMHS, who tend not to use the service, manage riskier clients who need urgent care, and therefore medical advice tends to be sought primarily through the urgent duty medic system on any particular day.

Overall, one could conclude from the current data that the Medical Consultation service is a well-used service, accessed by a range of clinicians. It provides an accessibility to the support and advice of consultant medical colleagues whilst keeping this structured and optimising efficiency. It has grown in its rates of consultation and an increasing number of cases, despite them being of high complexity, are able to be managed without a direct medical review. This is likely to have some relation to the containing, reflecting and supervisory role that the service offers.

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Assessing fitness to drive in general adult and old age mental health inpatients: A Service Audit

By Dr Divyanish, CT3, Black Country Healthcare NHS Foundation Trust



Dr Divyanish

Audit team: Dr Nneamaka Asiodu, Dr Ismail Khan.

Background

Studies have suggested that drivers with mental health conditions have a higher risk of being involved in a crash.¹ It has been observed that the vast majority of patients are often admitted and discharged without the assessment of their fitness to drive. Both the nature of their illness and the medication they require can affect their judgment and decision-making skills, which in turn can affect their ability to drive. This led to the conclusion that clinicians should take the responsibility in supporting patients to make safe driving decisions, after an inpatient stay, as part of the duty of care underlined in good medical practice.⁴

According to the Driver and Vehicle Licencing Authority (DVLA), advice for medical professionals to assess fitness to drive in common psychiatric conditions,² in mild to moderate illness patients may be fit to drive. However, in severe and progressive illness or prolonged admission, or when starting a new medication that may affect patients' alertness or judgement, the DVLA would need to be notified.³

It was decided to perform an audit regarding assessment of fitness to drive amongst inpatients in various sites of Dudley and Walsall Mental Health Trust.

Aims

The aim of this audit was to determine if fitness to drive was assessed on admission and discharge, and for this to be documented during clerking and on discharge notes. Additionally, it was necessary to know if patients were being educated about the impact of their mental illness on the ability to drive and if they were unfit to drive whether they were aware of the need to inform the DVLA.

Methodology

This retrospective audit was a trust wide audit, carried out in various sites in Dudley and Walsall, Dorothy Pattison Hospital (DPH), Bushey Fields Hospital (BFH) and Bloxwich hospital, involving 71 discharged inpatients within general adult and old age psychiatric specialities. 4 cases were taken from each Consultant team. Data was collected over a period of 4 weeks from October 2019 to December 2019.

Results

	DUDLEY BFH (n=21) (%)	WALSALL DPH (n=35) Bloxwich (n= 15) (%)
Informal	42.3	76.0
Mental capacity	66.7	74.0
Driving Status specified	0.0	28.0
Diagnostic categories		DPH BLOXWICH
F 00-F09	0.0	0.0 46.7
F 10-F19	21.8	28.6 6.7
F 20-F29	26.1	28.6 0.0
F 30-F39	13.4	8.6 53.3
F40-F49	9.5	14.3 6.7
F 60.3	29.8	20.0 0.0
Dual diagnosis	18.0	11.5 13.4
Not advisable to drive as per diagnosis	0.0	60.0
Medication as a contraindication to drive	42.9	18.0
Driving advice on admission	4.8	2.0
Driving advice on discharge	4.8	10.0
DVLA notified	4.8	0.0

As can be seen from the above table, higher proportions of patients were informal (76% at Walsall and 42.3% at Dudley) and had mental capacity to consent to treatment (74% at Walsall and 66.7% at Dudley).

Additionally, driving status was only specified at the Walsall sites in 28% of cases (n=14 in which 7 actually drove). The most common diagnoses at BFH were Emotionally Unstable Personality Disorder (29.8%) and Schizophrenic disorders (26.1%). At DPH, these 2 diagnoses were also common as was Mental and Behavioural disorder due to multiple substance misuse (28.6%). At Bloxwich hospital organic mental disorders such as Alzheimer's Dementia (46.7%) and affective disorders (53.3%) were most common. At BFH only 4.8% of patients were given driving advice on admission and discharge, as opposed to 2% on admission in Walsall and 10% on discharge in Walsall. The DVLA was notified in only 1.4 % of the total 71 patients who were discharged between October and December 2019 from Dudley and Walsall sites respectively.

Recommendations

1. To update clinicians on DVLA guidelines for fitness to drive through postgraduate educational meeting.
2. Clerking proforma to be updated to prompt clinicians to assess fitness to drive on admission, therefore ensuring driving (as an important aspects of a patient's social life or occupation) is considered during the patient's treatment as an inpatient.
3. Discharge notification forms to be updated to ensure fitness to drive assessment is performed on discharge.
4. Patients to be educated about driving safety and their conditions through a patient information leaflet.

Conclusion

This audit demonstrated that fitness to drive, largely, was not being assessed for patients both on admission and at discharge from adult or old age inpatient services in the Dudley and Walsall area. The driving advice was not provided to patients and therefore the DVLA was not notified in the cases where they should have been. This could pose a risk to the safety of the patient and the wider public hence, it is essential that this aspect of treatment is considered for every patient.

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An e-Interview with Dr Hilary Grant, Executive Medical Director, Birmingham and Solihull Mental Health NHS Foundation Trust



Biography

A graduate of University College Cork, Ireland. I completed a degree in Biochemistry, subsequently a Masters in Nutrition before completing my degree in Medicine. I then came to the UK to undertake my house jobs before commencing my career in psychiatry. I trained mostly in Birmingham and the West Midlands. I am dual trained in Forensic and in Child and Adolescent Psychiatry. I was Clinical lead for Forensic CAMHS services in Birmingham from 2004, Clinical Director for Youth Services in Birmingham from 2012 and Executive Medical Director since 2016.

Tell us something about yourself that most people don't know

In order to financially support myself through medical school as a mature student, I became a cheese maker and developer and a member of the Irish National Cheese Tasting panel. This required an appetite for both cheese and Guinness. Latterly while undertaking a WSET (Wine Spirits Education Trust.... very demanding!) course, I discovered I was a "supertaster", a fact I like telling my friends repeatedly, without a hint of hubris, particularly if they're cooking for me! And my first summer job in the UK was in Glenthorne Youth Treatment Centre as a youth worker in the late 80s, coming round full circle in 2003, when I took up my consultant post in Forensic CAMHS, which is located on the old Glenthorne site, now called "Ardenleigh.

What trait do you deplore in others?

I am a fairly "glass half full" person regarding other people but really struggle with indolence in others. I believe in the importance of really engaging with commitment and dedication to "our" work, as we hold such privileged positions in the work we do with service users and their families.

Tell us about either a film or a book that left an impression on you?

"This Thing of Darkness" – Harry Thompson. A novel about the relationship between Darwin and Fitzroy, a naval voyage, invention of weather forecasting and surveying of Tierra del Fuego, natural disasters, relationships, colonisation, relationships, mental illness. I have recommended it to many and they too have done the same... granted it feeds my endless appetite for stories of the ocean.

My daughter and son could respond in chorus as to what my favourite film is : "Pride"; a 2014 historical comedy-drama, which depicts the true story of a group of LGBT London based activists, who raised money for Welsh miners during the 1984 British miner's strike. It's about power in what initially seems as an unlikely union, touches on the impact of HIV and AIDs in the 80s, homophobia, coming of age and class, sexuality and gender boundaries. It makes me realise too, how pleased I am that my son and daughter were born in a different time though not still without its challenges. (I am so, so proud of them both. Fantastic authentic people – both).

More recent reading "White Fragility: Why it's so hard for white people to talk about race" – Robin DiAngelo. This book challenged my perceptions and hopefully moved me from unconscious incompetence to one of relative conscious incompetence.

As recent lead for inequalities within the trust, I recognise the huge challenges but also opportunities to make things better together and my responsibilities are to increase my knowledge and competence in this area, so as to make some small contribution to making a difference.

When not being a psychiatrist, what do you enjoy?

Being with friends and family, having fun, being outside and on the water whether fishing, kayaking, paddle boarding, swimming or sailing, walking up hills and mountains, coming across an iron age fort or stone circle, reading, art....the world is fascinating!

Which people have influenced you the most?

My maternal grandparents, as after my mum died when I was five, they were the key to my resilience. They lived on the cliffs above Tramore, Waterford and sitting on the cliffs with them as a young child and teenager, they taught me about; the sea, seabirds and their "calls", nature, music, history, art and a love of reading and of humanity. They also kindled my interest in psychiatry and the challenges of the stigma of mental illness, as my grandmother and my mum's siblings suffered from mental illness. I remember my grandmother's severe depression so acutely, my own bewilderment and trying to get a sense of understanding, when it was clear it was not to be spoken of!

If you were not a psychiatrist what other profession would you choose?

I would have loved to have followed a creative career, either as a writer or artist but sadly I am not good enough at either but maybe when I retire, I will try harder!

How would you like to be remembered?

For being committed to mental health care and in particular with respect to young people's mental health. Resilient, in the face of adversity and challenges. Compassionate and inclusive in my personal and professional life, adventurous, energetic and hopefully fun with a love of "mischief"!

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Meet our West Midlands Division Psychiatric Trainees Committee (PTC) Representatives

Dear fellow West Midlands Trainees

Firstly, we hope that this finds you all keeping safe and well given the current situation. It has been a challenging six months or so to say the very least and now, more than ever, it is so important for us to support each other.

We would like to warmly welcome those of you who are new to core and higher training, and especially those of you who may be new to the deanery itself. We thought that it would be helpful to introduce ourselves to you as your representatives on the Psychiatric Trainees' Committee (PTC) at the Royal College of Psychiatrists (and to recap for those of you who already know us).

Who we are



Dr Laura Stevenson

ST6+ in dual general and older adult psychiatry currently working at North Staffordshire Combined Healthcare NHS Trust

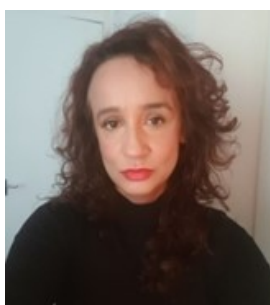
laura.stevenson2@combined.nhs.uk



Dr Huw Evans

ST5 in dual general and older adult (+ liaison) psychiatry currently working at Midlands Partnership NHS Foundation Trust

Huw.evans1@nhs.net



Dr Rehana Kauser

ST5 in dual general adult and old age psychiatry currently working in the community in Birmingham for Birmingham and Solihull Mental Health NHS Foundation Trust

rehana.kauser1@nhs.net

How can we help

The PTC is composed of representatives from each deanery and devolved nation across the entire United Kingdom. It functions to ensure that the views of all psychiatry trainees are heard throughout the Royal College, and to drive improvement in the training experience. All committees across the College have representation from the PTC to enable us, as a collective, to be effective in achieving this. More recently, as you would perhaps expect, a lot of our focus has been on the impact of the COVID-19 pandemic on training and wellbeing. We have been liaising closely with the examinations team along with a host of others, to ensure that the quality of training; progression through training; and completion of training, are maintained with as little disruption as possible. We are fully aware however that this has been a very stressful and uncertain time for some of you. We have also been liaising closely with colleagues in the Psychiatrists' Support Service (PSS) and would like to take this opportunity to encourage you to seek support if you are finding things hard for whatever reason. The PSS offers confidential, free, rapid and high quality peer support via telephone, to psychiatrists of all grades, who may be experiencing personal or work related difficulties. You can access further information about the PSS [here](#).

The representatives of the PTC meet regularly (albeit now only virtually) to share feedback received from the trainees in their area. We would therefore like to ask all of you to kindly make contact with one of us if you have any queries, concerns, questions or comments. There is lots of information available through the PTC pages on the College website, including links to our most recent newsletters and 'The Registrar' (the magazine of the PTC). The editor, Ahmed Hankir, would be happy to consider any work for inclusion so please do not hesitate to get in touch if you have something that may be suitable. If you would like to know more, please click [here](#).

We will aim to ensure that any important information is disseminated to you, predominantly via email. Things do however continue to change quite frequently, and so we would encourage you to also try and keep yourself up to date on relevant training matters. The College and PTC have produced some very helpful information to guide

and support clinicians during the COVID-19 pandemic which can be accessed [here](#). Some of this is specifically for trainees but it covers a wide range of topics, including the increased risk posed by COVID-19 to BAME staff and how to mitigate this. The webinars hosted by the PTC remain the most highly attended of all the College webinars to date.

Engagement is one of our core priorities and if you have any thoughts about how we can be more effective in achieving this we would love to hear from you. Although the three of us cover a large part of the deanery geographically, we are aware that we are all higher trainees. We are therefore especially keen to hear from any core trainees about their experiences, so that we can confidently represent the whole of the West Midlands trainee body.

Sending our warmest wishes

Laura, Rehana and Huw

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Mentoring and Coaching Update

By Dr Geoff Marston, RCPsych West Midlands
Mentoring Lead



From everyone on the mentoring and coaching (M&C) team, we wish you the best and hope that you are all well and surviving/thriving at this difficult time. Like everyone, we have looked for IT solutions to ensure that our regular activities continue and that the college mentoring network has support and development options available. So, what has been going on and what is out there for you?

Our virtual 'Teams' **Support and development group** ran a weekly evening session (mainly in a peer support function) during the first 2 months of lockdown, then 2 weekly for another month. We are currently back to meeting every 2 months in work hours (**next on 24/02/2021 from 2-4pm**). These sessions provide a confidential space for mentors on the scheme to discuss mentoring issues and to talk through any personal concerns. The hope is to start introducing a virtual educational element to further develop skills, if the group feels this is wanted. The sessions can be used as evidence of maintaining skills and quality in your M&C and count towards CPD subject to peer group approval. Please contact Marie and Daljinder at westmidlands@rcpsych.ac.uk for details of the link.

After 7 years of training events our first '**Virtual introduction to mentoring and coaching training day**' took place on the 13 November and was attended by 45 psychiatrists from around the 4 nations. The course was hosted by Geoff Marston (WM M&C lead) Jan Birtle (National college lead for M&C) and Andrew Leahy (WM M&C team). We aimed to recreate the didactic learning, group interaction and individual coaching exercises possible in previous years face to face meetings. With a mix of pre-recorded video modules to watch in advance, with suggested reflective and practical exercises to work

on before 2 live webinar modules:- featuring Q&A sessions and 3 person '*practicing skills*' break out rooms on the day (thanks to Marie Phelps and Karen Morgan for their help and advice on putting this together, along with the rest of the College team providing support on the day).

These introductory courses are suitable for all Consultants new to mentoring, Consultants who mentor but have not received training, Consultants thinking of becoming mentors, Specialty Doctors / Associate Specialists (SAS grade) and higher trainees interested in becoming a mentor.

The **Psychiatric Trainees Committee guide to M&C** is in its final stages before publication. This resource will provide a useful overview of M&C and information on where trainees (and others) can find support/further training.

The **M&C team is working with trainees** to identify and support mentoring champions, covering all the regional MH trusts, to develop trickle down peer mentoring structures. We hope to offer regional training and reflective practice support groups.

The **National mentoring and coaching network** chaired by Jan Birtle is looking to work with other college bodies and Trust Medical Directors, to promote a M&C culture within MH trusts in line with staff wellbeing needs; to support recruitment and retention; as part of addressing differential attainment issues; also seeing it linked with appraisal systems (especially given the current GMC guidance on being more wellbeing centric).

The [**Medical Training Initiative \(MTI\)**](#) enables international psychiatry graduates to enter the UK to experience CT3 training in the NHS for up to two years, before returning to their home country. The RCPsych MTI Team is looking for mentors to pair with incoming MTI Fellows to support their transition to the NHS and to the UK in general.

The current climate will put more strain on these incoming overseas doctors, so any additional support that can be provided will be very much appreciated. Incoming MTI Fellows will be required to self-isolate for 14 days on entering the UK, consequently, the isolation we all feel when moving to a new country, starting a new job, being away from our families will be even more significant. Pairing Fellows with mentors will alleviate some of the

difficulties they encounter and help to strengthen their UK networks.

There are still a number of MTI's who require a mentor and as our division runs a RCPsych mentoring scheme, we ask if any of our current mentors would consider mentoring an RCPsych MTI Fellow.

If you would like some further information, please contact Agnes and Sarah at mti@rcpsych.ac.uk

We wish you well and hope that you will consider becoming a regional mentor (if not already one) by contacting Marie and Daljinder in the regional office at westmidlands@rcpsych.ac.uk

If there is anything you would like to ask the team, or if there are any suggestions around further training you would like or ways to further enhance M&C in the West Midlands please contact us via the regional office westmidlands@rcpsych.ac.uk

Thanks again for all your support

Geoff Marston, Jan Birtle and Andrew Leahy (WM C&M team)

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Executive Committee

The West Midlands Division Executive Committee meets three times a year.

Approved [minutes](#) from previous meetings can be accessed online (member login required).

The committee's next meeting takes place virtually on Friday 26 February, 9-11.30am

Find out more information about the Divisions

Our eight Divisions play a central role in the delivery of services to the 12,000 members in England. The Divisions support members via core activities which are coordinated locally by each Division's Executive Committee and staff.

[Read our Dynamic Divisions booklet](#) (PDF) to find out more about the work of our Divisions.

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Section 12(2) and Approved Clinician Training Courses

Refresher courses

If your Approved Clinician or Section 12 approval period is due to expire before 31 March 2021, you will be granted a 12-month extension period. Read further details on the [temporary extension](#).

We are hoping to run online refresher courses early in 2021. Please [register your interest](#) to receive updates on future courses.

Induction courses

Bookings are open for our upcoming Section 12 (2) and Approved Clinician Induction courses, taking place online throughout November and December 2020.

Section 12 (2) Induction: [Find out more about the online course and book your place](#)

Approved Clinician Induction: [Find out more about the online course and book your place](#)

Please note: Attending one of these courses is only part of the process to becoming accredited.

We would strongly advise you to check with your local [NHS Specialist Mental Health Approvals Lead](#) (PDF) for information on the criteria for approval/re-approval, and to confirm which course is suitable for your requirements before registering for a course.

If you have any queries, please read our [Approved Clinician FAQs](#) or [Section 12 FAQs](#). If you can't find the answer to your question there, please contact S12ACtraining@rcpsych.ac.uk

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Get Involved!

If you would like to submit an article for inclusion in the next edition, please email it to Dr Nilamadhab Kar (westmidlands@rcpsych.ac.uk), Editor.

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 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

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