

Eastern Division Psychiatry East



Autumn 2026 Newsletter

Editorial

Contents

Editorial.....	1
Chair's column.....	2
Addressing refugee and migrant mental health.....	4
Perinatal mental health and emotionally unstable personality disorder.....	5
The Griot: social phobia and stigma in Nigeria.....	7
Are we documenting what truly matters? A quantitative and qualitative audit.....	8
Beyond the buzzword: making shared decision-making work in psychiatry.....	10
The illusion of arrival.....	12
A recipe for being a better psychiatrist: what I hope to learn by taking time out.....	14
An East Anglian.....	15
Eastern Division Spring Conference 2026 report.....	17
Vacancies and information.....	19

Welcome to the Autumn 2026 edition of *Psychiatry East*. This is our only edition for this year and is packed full of interesting articles. In addition to the Chair's column, you will find articles on the following themes:

Global and transcultural perspectives: Dr Kayani discusses the barriers faced by traumatised refugees and migrants. Drs Amamasi and Sule analyse *The Griot* and its portrayal of social phobia and stigma in Nigeria.

Clinical excellence and quality improvement: Dr Fayyaz examines the interplay of EUPD and perinatal mental health. Drs Sundus and Walker share an inpatient audit on ReSPECT forms for the elderly, while Dr Benesh evaluates the use of the BRAN framework on shared decision-making in a community setting.

Personal reflections: Dr Ashraf reflects on uncertainty and transition in higher training, while Dr Kuo shares on her plans with taking time out of training to study at Le Cordon Bleu.

Arts and events: With her winning article Kate King MBE reflects on the life and poetry of the Fenland poet John Clare. With our Eastern Division Spring Conference 2026 report, we celebrate the success of this event and its focus on 'Innovation in Psychiatry'.

It has been an absolute privilege serving as the Editor of this publication for the past few years. As I bid farewell, I extend my warmest wishes to my successor as they take on this role. I will continue as Vice Chair and so hope to see many of you soon at an upcoming regional event.

Dr Sepehr Hafizi

Eastern Division Newsletter Editor and Vice Chair

Chair's column



It is a pleasure to welcome you to the Autumn 2026 edition of *Psychiatry East*. As we approach the end of another busy year for the Eastern Division, I would like to take this opportunity to reflect on some of the work we have undertaken and, importantly, to look ahead to what we hope to achieve together in 2027.

As we look back over the year so far, there is a lot for us to be proud of across our Division. It has been a busy and productive year, with opportunities to come together, share ideas and think about how we can continue to support our members and contribute to the wider mental health agenda across our region.

Our Spring Conference in Cambridge in April was a particular highlight. With the theme of 'Innovation in Psychiatry', we explored a fascinating range of topics including psychedelics, psychotherapy, artificial intelligence, ketamine and addiction, leadership, clinical supervision and TMS. It was a great opportunity to step away from our busy clinical roles, learn from one another and have some of the conversations that we do not always have time for in our day-to-day working lives. We are now looking forward to our Autumn Conference in November and to another opportunity to learn, connect and share ideas.

Our Executive Committee has also had a very active year. We have had some constructive and important conversations about the issues facing our members,

our services and the people we care for. Our discussions around Neighbourhood Mental Health Services have highlighted the importance of understanding how services are developing and how we can engage effectively with key stakeholders. We recognise that changes of this scale present both opportunities and challenges, and we want the Division to provide a meaningful professional voice in these conversations.

In May we held a Strategy and Business Planning meeting, which generated a great deal of enthusiasm and many interesting ideas about the future direction of the Division. These discussions have fed directly into our Business Plan for 2027, which we have now finalised. I am particularly pleased that this plan includes an exciting programme of events and activities, with new topics and opportunities for members to engage, learn and share ideas. We hope that our programme will continue to reflect the diverse interests and needs of psychiatrists across the Eastern region.

We are also seeking to strengthen our Division's role beyond education and professional networking. An important part of our work has been looking beyond our own professional networks. As psychiatrists, we have an important contribution to make to conversations about mental health policy and the priorities for our region. As part of this work, we have written to our local Members of Parliament to begin developing a dialogue about the mental health issues affecting our communities. This is an important step in our ambition to influence and help shape key mental health policies and priorities across the Division.

Equally important is our engagement with NHS leadership. Over the last year, we have been working to strengthen engagement with medical leaders across the region. We are in the process of arranging meetings with Medical Directors across the Division. These meetings will provide an opportunity to understand the challenges facing local services, share the perspectives of our members and explore how the College and the Eastern Division can support improvements in psychiatric care and the wider workforce.

Ultimately, we want the Eastern Division to be a strong, supportive and relevant voice for our members. Our role is not simply about organising conferences and educational events, important though these are. It is

also about creating opportunities for colleagues to connect, supporting professional development, engaging with our local health systems and ensuring that the experience and expertise of psychiatrists contribute to the wider conversation about mental health.

None of this work happens without the contribution of our members. I would like to thank everyone who has contributed to our events, attended our meetings, shared ideas, written for this newsletter or supported the work of the Division in other ways. The strength of the Eastern Division comes from the breadth of experience, expertise and enthusiasm within our membership, spanning Essex, Hertfordshire, Cambridgeshire, Bedfordshire, Norfolk and Suffolk.

There is plenty more to enjoy in this edition of *Psychiatry East*, and I hope you find it interesting and useful. I would also encourage you to continue sharing your ideas, experiences and suggestions with us. The Division is strongest when it reflects the people who make up our membership.

There is a great deal to look forward to as we move towards 2027, and I look forward to us continuing this work together.

With best wishes,

Dr Kapil Bakshi

Chair, Eastern Division

Spring conference 2026 poster winners

Medical student category

1st prize: Yuxi Wang and Muzaffer Kaser: Analysis of Anonymous Feedback for a Dedicated Mental Health Service for Healthcare Workers: Review of Treatment Experience and Outcomes

2nd prize: Matilda Black and Margaret Westwater-Wozniak: The Comorbidity Between Eating Disorders and Functional Gastrointestinal Disorders

Foundation doctor category

1st prize: Nathanael Leaf: Flagging the Forgotten: Improving Physical Health Monitoring of a Psychiatric Rehabilitation Ward

2nd prize: Zainab Alkheyr, Bahaa Hassan and Leia Penfold: Documentation of Mental Capacity Assessment on an Older Adult Psychiatry Ward: A Clinical Audit

General medical category

1st prize: Mathew Madhu, Adem Polat and Venkata Gudi: Violence against staff across the NHS: results of a national survey and trends in a mental health trust

2nd prize: Bahaa Hassan: Fluency without understanding: The risks of large language models in mental health care

Eastern Division new members and roles 2026

Dr Hesham Abdelkhalek – Finance Officer

Dr Fatma Swilem - Leadership and Management Committee Representative

Dr Katherine Smart – Perinatal Regional Specialty Representative

Dr Shimrit Ziv – CPD Lead

Dr Felix Clay – Old Age Regional Specialty Representative

Addressing refugee and migrant mental health



By Dr Ahmed Hasham Kayani

For people who are forced to leave their homes due to conflict, persecution or instability, the journey to a new life is fraught with peril and profound psychological strain. While the physical challenges of displacement are often visible, the toll on mental health is an invisible yet pervasive crisis that demands greater global attention.

A continuum of trauma

Mental health struggles among refugees and migrants are a direct consequence of a continuum of trauma that begins before displacement, continues during the journey and persists long after arrival in the host country (1):

- **Pre-migration trauma:** Before leaving their home country, many refugees are exposed to potentially traumatic events including war, violence, persecution, torture, abuse, human trafficking, or the loss of family and friends (2).
- **Migration stressors:** The journey itself often presents severe stressors, such as dangerous and prolonged travel, exploitation, detention, violence, intense uncertainty and fear.
- **Post-migration stressors:** Upon arrival, the stress does not end. Integration and life in the host

country present new challenges that can worsen psychological distress (3). Challenges include insecure legal status and prolonged asylum procedures, social isolation and loss of cultural identity and support networks, difficulties accessing basic needs like secure housing, employment and food, discrimination, racism and exclusion from the host community, and language barriers that inhibit access to services.

Common mental health conditions include PTSD, depression and anxiety disorders. Children are particularly vulnerable with trauma affecting their development, learning and long-term wellbeing.

Addressing the gap in care

The need for mental health and psychological support is substantial, yet access to appropriate care involves numerous barriers (4):

- Services are often lacking, overstretched or have long waiting times, and legal status can sometimes restrict access to secondary care.
- Lack of culturally competent care and professional interpreters makes it difficult for individuals to express their distress and engage in effective therapy.
- Fear that a mental health diagnosis could negatively impact their asylum application or visa status, combined with cultural stigma surrounding mental illness prevent many from seeking help.

Providing comprehensive support

Effective mental health support for refugees and migrants must be holistic, culturally sensitive, and integrated into broader resettlement efforts:

- Prioritising basic needs, such as stable housing, legal status, employment and education.
- Ensuring mental health support is available at all stages of the migration process.
- Training healthcare professionals to understand how trauma and distress are expressed across different cultures and providing support in native languages.
- Developing programmes that facilitate social connection, mutual support groups and the strengthening of existing community to foster resilience and belonging.

References

1. United Nations High Commissioner for Refugees. UNHCR's Mental Health and Psychosocial Support for Persons of Concern: Global Review [Internet]. Geneva: UNHCR; 2013 [cited 2025 Nov 1]. Available from: <https://www.unhcr.org/media/unhcrs-mental-health-and-psychosocial-support-persons-concern-global-review>
2. Euro-Med Human Rights Monitor. Israel's war on Gaza children: the mental health crisis [Internet]. Geneva: Euro-Med Human Rights Monitor; 2024 [cited 2025 Nov 1]. Available from: <https://euromedmonitor.org/en/article/6284/Israels-war-on-Gaza-children-The-mental-health-crisis>
3. World Health Organization. Mental health of refugees and migrants: risk and protective factors [Internet]. Geneva: World Health Organization; 2018 [cited 2025 Nov 1]. Available from: <https://www.who.int/publications/i/item/9789241514220>
4. Kirmayer LJ, Narasiah L, Munoz M, Rashid M, Ryder AG, Guzder J, et al. Common mental health problems in immigrants and refugees: general approach in primary care. CMAJ. 2011;183(12):E959–E967. <https://doi.org/10.1503/cmaj.090292>

Author

Dr Ahmed Hasham Kayani

Specialty Doctor, Cambridgeshire and Peterborough NHS Foundation Trust

Perinatal mental health and emotionally unstable personality disorder



Dr Arooj Fayyaz

The journey into parenthood is often painted with images of serene joy, yet for many, this perinatal period is one of significant upheaval. When this transition intersects with a pre-existing mental health condition like emotionally unstable personality disorder (EUPD), the challenges can be profoundly intensified. Understanding this complex intersection is vital for providing effective, compassionate and specialist care.

Understanding emotionally unstable personality disorder

EUPD is characterised by pervasive patterns of emotional instability, heightened sensitivity, disturbed patterns of thinking, impulsive behaviour and intense but often volatile interpersonal relationships (1). The core feature is affective dysregulation, meaning a difficulty in effectively managing emotional states, leading to labile mood and high emotional intensity (2).

The perinatal period

For individuals with EUPD, the significant hormonal, physical and psychological changes can act as major stressors and triggers, exacerbating core symptoms. Hormonal fluctuations during pregnancy and childbirth can intensify emotional dysregulation. There

is a need for constant care and support during pregnancy, and after birth there can be increased fears of abandonment – conversely, the dependency of an infant can feel overwhelming. The transition to a new identity as a mother can destabilise an already unstable sense of self leading to distress. The stress of a newborn can impact interpersonal relationships leading to an increase in instability and conflict.

Impact on mother-infant bonding

Mothers with EUPD may struggle with recognising and responding to infant cues. Emotional instability and cognitive distortions can interfere with the mother's ability to respond sensitively to the baby's emotional and physical needs (3). Parenting styles may oscillate between being intensely attached and becoming hostile, critical or withdrawn, reflecting the disorganised attachment styles associated with EUPD.

The role of specialist perinatal mental health services

Managing EUPD during the perinatal period requires a multidisciplinary and highly specialised approach.

- **Early detection and referral:** Women with a diagnosis of EUPD or complex trauma history should be referred to perinatal mental health services as early as possible in the pregnancy for joint planning.
- **Dialectical behaviour therapy:** This is the most established and evidence-based psychological treatment for EUPD. Dialectical behaviour therapy can provide crucial skills in mindfulness, emotional regulation, distress tolerance and interpersonal effectiveness to support the demands of parenting.
- **Mother-infant interaction interventions:** Therapies specifically designed to enhance mother-infant bonding, such as parent-infant psychotherapy, can help mothers understand their baby's communication and improve bonding.
- **Medication management:** Any psychotropic medications must be carefully reviewed by perinatal psychiatrists, balancing the risk to the baby against the significant risk of maternal relapse or crisis.

Integrating mental healthcare with maternity services is paramount. By establishing a safe and stable framework of care, specialist services can help mothers with EUPD to navigate this challenging period—fostering positive maternal mental health while laying the foundation for a secure, nurturing parent-child relationship.

References

1. NHS. Borderline personality disorder: symptoms [Internet]. NHS; 2022 [cited 2025 Oct 29]. Available from: <https://www.nhs.uk/mental-health/conditions/borderline-personality-disorder/symptoms/>
2. NHS. Borderline personality disorder: overview [Internet]. NHS; 2022 [cited 2025 Oct 29]. Available from: <https://www.nhs.uk/mental-health/conditions/borderline-personality-disorder/overview/>
3. Centre of Perinatal Excellence. Borderline personality disorder (BPD) in the perinatal period [Internet]. Heatherton (VIC): Centre of Perinatal Excellence; [date unknown] [cited 2025 Oct 29]. Available from: <https://www.cope.org.au/new-parents/postnatal-mental-health-conditions/borderline-personality-disorder-bpd-in-the-perinatal-period>

Author

Dr Arooj Fayyaz

Specialty Doctor, Cambridgeshire and Peterborough NHS Foundation Trust

The Griot: social phobia and stigma in Nigeria



Dr Ezinne Amamasi and Dr Akeem Sule

Lay summary

We analysed *The Griot* (2021) and its movie representation of mental health. The protagonist storyteller Lakunle is severely hampered by social phobia. He is affected by stigma, betrayal and cultural isolation until therapy helps him through. The movie highlights anxiety's burdens and the need for efforts to combat stigma.

Background

Pop culture is becoming an easy and accessible way to understand the intricate relationship between society and mental health. *The Griot* is a fictional movie on Netflix directed by Adeoluwa Owu (1) and produced by Africa's largest movie industry, Nollywood. *The Griot* illustrates the stigma experienced by people living with social phobia in Nigeria and highlights both ICD-11 diagnosis and treatments.

Methods

Drs EA and AS had detailed discussions together on *The Griot* to correlate and examine themes, social factors and determinants, as well as psychiatric relevance.

Results

The Griot nicely tells the story of a young adult with mental health issues, shedding light on stigma, rejection, the broader impact on patients and society, and the success of therapy.

Social phobia is an obstacle in society. This obstacle is even more pronounced in communal societies such as those in Nigeria. *The Griot* illustrates this in the story of Lakunle, a gifted storyteller who is terrified of speaking and performing in public. Lakunle's fear means that a vital aspect of culture – transfer of folklore and history amongst generations – is under threat of being lost. He is worried he will embarrass himself, and so decides he cannot tell his stories, and keeps away from all social functions. He also avoids speaking with people and does not attend the regular youth gathering at the village square. Published research suggests that infrequent interaction with friends is a predictor for anxiety (2).

The impact on Lakunle includes an inability to express his love interest to Temi, a young female songstress. This is a theme relatable to people who suffer from anxiety all over the world. Anxiety disorders are as prevalent in the local environment in Nigeria as reported elsewhere in Africa and worldwide, with social phobia being the most prevalent (2).

Lakunle is perceived as an undesirable and is rejected by both the unmarried women and the village families. He trusts his stories to Sanmi—a manipulative and deceptive man. Sanmi exploits this situation and claims all the praise from the King and community. Sanmi is aware of Lakunle's shame and encourages Lakunle to hide his mental health to avoid being disgraced. This mirrors findings in the literature showing a strong association between anxiety disorders and impaired peer relations (2).

Calvary comes to Lakunle when he tells Temi of his problems. She takes him through relaxation techniques and sessions of CBT. They work together on graded exposure, to the point where Lakunle feels able to perform at the King's party.

Conclusion

The essential features of social phobia remain the same across various populations, yet its negative impact on productivity and progress is particularly evident in the Nigerian context. *The Griot* illustrates the connection between mental health stigma, the increase in public health burden, and the resulting loss in social, cultural and economic productivity.

References

1. Owu A, director. The griot [streaming video on Netflix]. Lagos: Degzy Films; 2021 [cited 2025 Nov 14]. Available from: <https://www.netflix.com/title/81591166>
2. Nzeakah CW, DadeMatthews AO, Onofa UO, DadeMatthews OD, Ogundare T. Crippled by fear: anxiety disorders among adolescents in Nigeria. *Int J Psychiatry*. 2022;7(2):103-115.

Authors

Dr Ezinne Amamasi

ST4, Essex Partnership University NHS Foundation Trust

Dr Akeem Sule

Consultant Psychiatrist, Essex Partnership NHS Foundation Trust

Are we documenting what truly matters? A quantitative and qualitative audit of ReSPECT form completion in elderly psychiatry inpatient settings



By Dr Omaima Sundus and Dr Michael Walker

Introduction

The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) form enables

personalised emergency care planning through structured conversations about individual preferences, values, and priorities. A ReSPECT form should capture not just clinical decisions but also the person behind the patient: their fears, values, and what makes their life meaningful.

Completing a ReSPECT form is not synonymous with capturing what genuinely matters. Are we ticking boxes or sincerely listening to voices? Quality documentation requires moving beyond generic entries to specific, personalised narratives that enable truly individualised care during critical moments.

Aim

To conduct a mixed-methods evaluation of ReSPECT form documentation in dementia care, with the following objectives (1,2):

- **Quantitatively** assess completion rates and determine whether completed forms meet the minimum standards set out by Resuscitation Council UK.
- **Qualitatively** evaluate the quality of documentation to determine whether person-centred information is being captured in sufficient detail to guide individualised care decisions.

Method

A retrospective audit was conducted in a dementia inpatient setting across four wards. Thirty ReSPECT forms completed between August and September 2025 were reviewed. Quantitative assessment measured compliance with Resuscitation UK minimal resuscitation council standards. Additionally, a qualitative thematic analysis was performed to explore documentation quality, focusing on how well service users' fears and values were recorded.

Results and implications

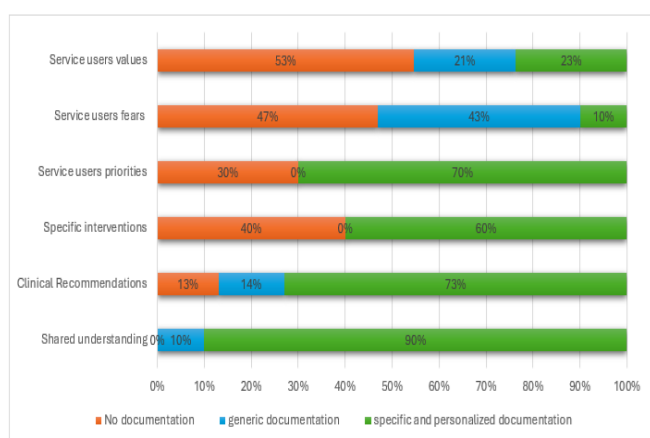
Out of all patients admitted to the dementia wards, only **44%** had a completed ReSPECT form, highlighting a lack of consistent documentation. Among all admissions, only **3%** of patients had a ReSPECT form in place prior to admission, all completed during earlier hospital stays, with none originating from the community. This suggests that

ReSPECT discussions are typically initiated only during hospital admissions, or later in the disease course when patients are admitted to dementia wards with advanced dementia.

Additionally, **87%** of service users lacked capacity at the time the ReSPECT form was completed, suggesting that these important conversations are often taking place too late in the course of dementia.

Altogether **81%** of forms met minimum Resuscitation Council UK standards, however, quality of documentation varied markedly across form sections: clinical elements (shared understanding of health and clinical recommendations) were specific and personalised in **83%** of forms, while person-centred elements (service users' fears and priorities) achieved specificity in only **16%**. These findings reveal that baseline compliance is achieved but quality remains suboptimal.

Documentation quality across all sections



Recommendations

1. Early involvement of GPs in ReSPECT discussions

ReSPECT conversations should be initiated at the point of dementia diagnosis within primary care to ensure that these discussions occur while patients still have decision-making capacity. Early engagement of GPs and community teams can help establish individualised care preferences and avoid delayed documentation that often

occurs when patients reach advanced stages of dementia or are admitted in crisis.

2. Targeted staff training on person-centred documentation

Training programmes should be developed to enhance clinicians' skills in eliciting and recording person-centred information, including patients' values, fears, and individual priorities for care. This will promote more meaningful and holistic ReSPECT forms, moving beyond medical decisions to reflect what truly matters to the patient.

3. Formal allocation of protected time for ReSPECT discussions

Staff should be given dedicated and protected time within their clinical schedules to conduct comprehensive ReSPECT discussions with patients and their families. This will ensure that these sensitive conversations are not rushed or overlooked due to workload pressures and will support a more collaborative, compassionate approach to advance care planning.

4. Re-audit to assess progress and sustainability

A re-audit is recommended in six months to evaluate the impact of these interventions on both the quality of documentation and the timing of ReSPECT discussions. Monitoring improvements over time will help assess whether early community-based engagement and staff training lead to more proactive and patient-centred advance care planning.

References

1. Resuscitation Council UK. The ReSPECT process: a guide for clinicians completing the plan [Internet]. London: Resuscitation Council UK; 2023 [cited 2025 Nov 10]. Available from: https://www.resus.org.uk/sites/default/files/2023-02/ReSPECT%20Guide%20for%20Clinicians_FIN_AL.pdf

2. Healthcare Quality Improvement Partnership. Best practice in clinical audit [Internet]. London: HQIP; 2020 [cited 2025 Nov 10]. Available from: <https://www.hqip.org.uk/wp-content/uploads/2020/05/FINAL-Best-Practice-in-Clinical-Audit-2020.pdf>

Authors

Dr Omaira Sundus

GP Trainee, Hertfordshire Partnership NHS Foundation Trust

Dr Michael Walker

Consultant Psychiatrist, Hertfordshire Partnership NHS Foundation Trust

Beyond the buzzword: making shared decision-making work in psychiatry



By Dr Naveena Benesh

Shared decision-making (SDM) has become something of a mantra in modern healthcare. From NICE guidance to the NHS Long Term Plan, the expectation is clear: decisions about care should be made with patients, not for them (1,2). The King's Fund report, *Patients' Preferences Matter* (2012), highlights the ethical and economic benefits of engaging patients in decisions—warning against the 'silent misdiagnosis' that occurs when clinicians identify

medical problems but neglect to recognise patient preferences (3). Yet in psychiatry, where fluctuating insight, decisional capacity and risk are part of everyday practice, translating the rhetoric of SDM into meaningful clinical reality is more challenging than it may initially appear.

The case for SDM is strong. A national Care Quality Commission survey has shown that many inpatients want to be more involved in decisions about their care: 45% of inpatients and over 30% of primary care patients (4). Specifically, to mental health, a community mental health survey of service user experience in Hertfordshire Partnership University NHS Foundation Trust (HPFT) in 2024 showed that only 45% of service users feel in control of their care and about half of the service users felt supported by the mental health team in making decisions (5). Legally, *Montgomery v Lanarkshire* (2015) changed our obligations by requiring clinicians to take reasonable care to ensure that patients understand any material risks and reasonable alternatives associated with treatment (6). Importantly, what constitutes a reasonable risk is defined not by professional consensus but by what a reasonable person in the patient's position would consider as significant. Therefore, SDM is not merely best practice but also a legal duty.



Source of image: 'It's Ok to Ask' HPFT leaflet

I conducted a retrospective audit of GP letters within Adult Community Mental Health Services in Welwyn Garden City, to understand how well SDM is reflected in routine psychiatric practice. The BRAN framework (Benefits, Risks, Alternatives and doing Nothing) was used to examine how medication decisions were documented. BRAN provides a structured method for promoting SDM and has been endorsed by initiatives such as Choosing Wisely and Scotland's Realistic Medicine reports (7).

Twenty-five letters documenting medication reviews were purposively sampled. Each was scored from 0–4 based on the number of BRAN elements documented, with scoring independently verified to reduce bias. Findings showed that while ‘Benefits’ (72%) and ‘Risks’ (68%) were frequently recorded, ‘Alternatives’ were mentioned in only 20% of letters, and the option of ‘doing Nothing’ was never documented. These results suggest that although clinicians discuss treatment benefits, documentation of a truly shared decision process is inconsistent, particularly regarding alternatives and non-intervention. Barriers may include time pressure, uncertainty around evidencing deliberation, or hesitation about presenting non-treatment as a legitimate option. Simple improvements, such as adding BRAN prompts to electronic templates could help embed SDM principles more reliably into correspondence and facilitate ongoing evaluation. At HPFT, we have launched the ‘It’s OK to Ask’ campaign, encouraging service users to engage with their clinicians using BRAN-style questions.

It is also important to acknowledge that SDM is not a uniform process and does not always occur in the same way. In mental healthcare, preferences vary with symptom burden, risk, capacity and therapeutic relationship. Consider Sara, a 35-year-old teacher with recurrent depression, who is weighing antidepressants against psychological therapy. Using BRAN supports an honest and values-based discussion: medication might bring faster symptom relief but comes with side-effects; therapy is effective but may involve waiting; and doing nothing might lead to deterioration. Sara can then align decisions with her priorities, such as wanting a quicker return to work or a lower side-effect burden. By contrast, James, a 22-year-old patient with psychosis detained under the Mental Health Act, lacks capacity and poses significant risk. Full SDM is not possible, yet its’ principles remain relevant. Explaining decisions, offering choices where possible (e.g. oral vs injectable medication) and reinforcing that his views will continue to matter still promote dignity, autonomy and trust. These examples highlight that SDM in psychiatry is not a binary task but a spectrum requiring contextual and compassionate judgement.

Thus, SDM in psychiatry must move beyond policy rhetoric and become a practical clinical skill. This means recognising fluctuating preferences, insight and capacity and adapting our approach accordingly. The results of the BRAN audit reveal that while

elements of SDM are present, opportunities to discuss alternatives and non-treatment are often missed. Empowering our patients to ask informed questions and viewing SDM as a dynamic and relational process is a meaningful step toward care that is both legally robust and person-centred. Ultimately, effective SDM is not about handing responsibility to patients, but about sharing it with clarity, respect and partnership.

References

1. National Institute for Health and Care Excellence. Shared decision making: guidance and learning package. London: NICE; 2021.
2. NHS England. Universal personalised care: implementing the comprehensive model. London: NHS England; 2019.
3. The King's Fund. Patients' preferences matter: stop the silent misdiagnosis. London: The King's Fund; 2012.
4. Care Quality Commission. Inpatient survey 2019: statistical release. London: CQC; 2019.
5. Hertfordshire Partnership University NHS Foundation Trust. Community mental health survey: service user experience results. Hertfordshire: HPFT; 2024.
6. Montgomery v Lanarkshire Health Board [2015] UKSC 11.
7. Chief Medical Officer for Scotland. Annual report 2020–2021: realistic medicine. Edinburgh: Scottish Government; 2021.

Author

Dr Naveena Benesh

ST6 General Adult Psychiatry, Hertfordshire Partnership University NHS Foundation Trust (HPFT)

The illusion of arrival



By Dr Farhana Ashraf

What I wish I had known before starting higher training

There is a moment in every doctor's journey when a milestone feels like a destination. For me, that moment seemed clear. I had completed postgraduate psychiatric training in Pakistan and had navigated the responsibilities that come with independent clinical practice. I then undertook the challenge of securing a place in Higher Training in General Adult Psychiatry in the UK.

I believed I had finally arrived.

What I discovered instead was that higher training was not the destination, but the beginning of a different journey—one that would challenge not only my clinical knowledge but also my assumptions about expertise, leadership, identity, and growth. Looking back, there are several things I wish I had known before starting higher training.

Expertise is not the same as certainty

One of the biggest misconceptions I had was that experience would eventually eliminate uncertainty. After years of training and clinical practice, I expected seniority to bring a sense of confidence that would make difficult decisions easier. Instead, I found that uncertainty remained a constant companion. Complex presentations, overlapping diagnoses, difficult risk

assessments, ethical dilemmas, and decisions with no perfect answers continue to be part of everyday psychiatric practice. What changes is not the amount of uncertainty we face, but our relationship with it. The most experienced psychiatrists I have worked with are often those most comfortable saying, 'I'm not sure.' Not because they know less, but because they understand the complexity of human experience more deeply. Higher training taught me that expertise is not about having all the answers. It is about remaining thoughtful, curious, and compassionate when the answers are not immediately obvious.

The humility of starting again

Being an IMG brought a unique challenge. Before joining UK higher training, I was accustomed to making independent decisions and carrying significant responsibility as a consultant psychiatrist in Pakistan. Yet, entering a new healthcare system meant becoming a learner again. There is something deeply humbling about being experienced and inexperienced at the same time. You know enough to recognise complexity, yet you are still learning new systems, processes, legislation, and ways of working. At times, this can feel uncomfortable. However, I have come to appreciate that discomfort is as an essential part of growth—medicine evolves, healthcare systems differ, and cultures shape practice. Remaining open to learning may be one of the most important professional skills we can develop.

Leadership begins earlier than you think

Before starting higher training, I viewed leadership as something that happened later in a career. In reality, higher trainees are leaders from the moment they begin. Whether supervising junior colleagues, contributing to service development, leading multidisciplinary discussions, representing trainees, or managing complex clinical situations, opportunities for leadership arise daily. What surprised me most was discovering that effective leadership rarely looks dramatic. It is often found in quieter actions: listening carefully, supporting colleagues, encouraging others, and helping teams work together towards a common goal. Some of the best leaders I have met in psychiatry are not necessarily the most authoritative people in the room; they are those who make others feel heard.

Relationships matter more than I expected

Psychiatry revolves around people. This may seem obvious, but I did not fully appreciate how central

relationships would become to my professional satisfaction and development. Our work involves building therapeutic relationships with patients, collaborative relationships with multidisciplinary teams, supportive relationships with supervisors, and respectful relationships with carers and families. Many of the most valuable lessons I have learned have not come from textbooks or examinations. Rather, they have emerged from conversations with colleagues, observations of experienced clinicians, and encounters with patients who have shared their stories with remarkable honesty and courage. Working across different healthcare systems has reinforced one particularly powerful lesson: while services and structures may vary, people's needs remain remarkably similar. Patients everywhere want to be understood, respected, and given hope.

Confidence and competence are not the same thing

Early in training, it is easy to assume that confident people must also be the most competent. Over time, I learned that these qualities are not always linked. Competence often involves recognising one's limitations and asking for help when needed. Confidence may fluctuate depending on circumstances, whereas competence is built gradually through reflection, experience, and continuous learning. Some of the safest clinicians I have met are those who are willing to seek advice, challenge their assumptions, and remain open to alternative perspectives. Higher training taught me that asking for help is not a sign of weakness. It is a hallmark of professionalism.

Your career is bigger than your job description

One of the joys of higher training is discovering opportunities beyond direct clinical work. Research, teaching, psychotherapy, quality improvement, leadership, service development, medical education, and academic writing all offer ways to grow professionally and contribute to the wider field of psychiatry. These activities not only strengthen a portfolio but also enrich one's career. They provide opportunities to develop new skills, meet inspiring colleagues, and maintain curiosity throughout training. Importantly, they remind us that being a psychiatrist involves much more than seeing patients, however central that remains.

Wellbeing is not a luxury

Perhaps the most important lesson has been the importance of protecting one's own wellbeing. Psychiatry attracts compassionate individuals who invest deeply in the welfare of others. Yet, meaningful compassion can only be sustained when we also care for ourselves. Higher training brings responsibility, expectations, examinations, and competing demands. It can be tempting to believe that wellbeing should come after everything else. In reality, it should come alongside everything else. Rest, supervision, friendships, family, hobbies, exercise, and time away from work are not signs of reduced commitment. They are essential foundations for a long and fulfilling career.

The goal is not arrival

Finally, I wish I had known that it is perfectly acceptable not to have everything mapped out. Many trainees feel pressure to identify their future subspecialty, consultant role, academic interests, and long-term career plans as early as possible. Yet, careers rarely unfold in a straight line—unexpected opportunities appear, interests evolve and priorities change. Looking back, I realise that much of my professional life has been defined by milestones I once viewed as destinations: postgraduate training, consultant practice, MRCPsych, and UK higher training.

Each achievement felt like arrival.
Each eventually became another starting point.
Perhaps that is the real lesson.

Higher training is not simply about acquiring knowledge or progressing through a curriculum. It is about developing judgement, resilience, leadership, humility, and professional identity. It is about continually becoming, rather than finally arriving. If I could offer one piece of advice to anyone about to begin higher training, it would be:

Focus less on becoming the perfect psychiatrist and more on becoming a reflective one.

The rest tends to follow naturally.

Author

Dr Farhana Ashraf

Specialty Registrar GAP, Essex Partnership University Foundation Trust

A recipe for being a better psychiatrist: what I hope to learn by taking time out of training



By Dr Melissa Kuo

On the first day of my time out of training, I worked a night shift as a locum where a patient died during a cardiac arrest following a suicide attempt. It was a difficult shift, and the timing made it harder. I had stepped away from training expecting to spend the next few months somewhere completely different and instead found myself facing one of the hardest nights of my career before that new chapter had even begun.

What stayed with me afterwards was not just the death, but how different it felt experiencing something like that from outside a team. As a trainee, difficult experiences are usually held collectively—with supervisors, colleagues and established structures to support the doctors involved. The colleagues on shift with me could take sick leave and lean on the support around them. I could not do the same. As a locum taking time out of training, time off meant no income. I had contact from psychology, which I was genuinely grateful for, but there was something isolating about being outside a system that had, until recently, quietly looked after me too.

I'm now several weeks into the strange gap between that shift and the thing I actually took the time out to do. Soon, I start several months at Le Cordon Bleu London—having come second in their annual scholarship—studying Basic Cuisine and building a foundation in classical technique from scratch. It's an

unusual decision for a doctor in postgraduate training, and I've swung between genuine excitement and a nagging feeling that I'm being faintly irresponsible with my career.

There are good reasons to be apprehensive. Training is cumulative, and time away means fewer clinical hours and a gap in the usual rhythm of supervision and appraisal. My colleagues keep moving forward while I step sideways, and I'll inevitably miss things because of it. I've also realised how much of the structure around working life you don't notice until you step outside of it.

This is not an escape from medicine though, or a new interest I've picked up on a whim. I've had a longstanding interest in food and nutrition alongside my medical training, and it has become more serious recently. I've spent time working in professional bakery environments in London and found that I enjoyed the discipline—the early starts, the precision and repetition, and the satisfaction of gradually getting something right. The scholarship is a chance to take something that has sat alongside of medicine for me for many years and to finally give it proper attention.

It also connects to something I think about in psychiatry: what happens when professional identity becomes too tangled up with a person's whole sense of self. I've seen how difficult it can be when a doctor's confidence is shaken by an experience that makes them question their competence. Medicine rewards being knowledgeable, capable and useful, and so it is easy for those qualities to become tied up with our sense of worth.

We spend our working life asking patients about identity, meaning, stress and what makes a life worth living. It seems fair to occasionally turn some of those questions back on to ourselves. Medicine makes it easy to know who you are. You are a doctor, on a rota, working for a team. Take that away and you need to work out what is left.

Cooking might look a long way from psychiatry, but I suspect the overlap is closer than it might first appear. A kitchen demands attention to detail while keeping track of the bigger picture: several things happening at once, usually under pressure, with mistakes that are immediately obvious. You accept correction, try again and carry on. Not so far really from a busy ward round.

What I am most curious about is being a beginner again. Medicine gives you a certain authority almost by default, even early on. There is an expectation that you broadly know what you are doing. I won't have that in a kitchen. I will have to listen carefully, accept that I don't know the answer and get things wrong in front of other people. After several years of training, that feels both uncomfortable and useful.

The simpler reason that food matters to me so much is that it's such an ordinary part of people's lives. We all need to eat but what and how we eat can say a surprising amount about where we come from, who we live with and what is happening in our lives. When someone becomes unwell, eating can be one of the first things to change. These details don't always make it into a psychiatric history, but they can be important in understanding the person sitting in front of you.

I am particularly interested in where food, mental health and public health overlap. I don't expect a cookery course to turn me into a nutrition expert, and I don't think food is any kind of cure-all for mental illness. But I would like to understand it more practically and culturally, and think harder about what routine, pleasure and shared meals contribute to wellbeing.

I don't know yet exactly what I will bring back. I hope for some practical skill, more confidence working under pressure, and a clearer sense of what I need outside medicine to sustain a career within it. More than that, I hope to come back with a broader understanding of health—one that includes the parts of life that never quite make it into a clinical history.

I remain committed to returning to clinical training. The hope is not that I will come back as a different doctor, or that a few months in a kitchen will somehow make me a better one—it is simply that I will return having learned something outside medicine, and with a little more perspective on myself.

Perhaps that's the point of taking time out. Sometimes becoming a better psychiatrist has less to do with learning how to be one, and more to do with spending enough time remembering how to be a person first.

Author

Dr Melissa Kuo

Resident Doctor, Essex Partnership University Foundation Trust

An East Anglian



By Kate King MBE

John Clare, poet (1793-1864)—you may wonder why I am choosing to write about a 19th-century poet in a division newsletter for psychiatrists. Well, John Clare was a local man, who wrote poems about Fenland life. He also lived with and wrote about mental illness. His life, however, like that of your patients, was so much more than just his illness. As winter approaches when the nights are long and cold, and when a cosy chair is a refuge, I thought you might like to share a little time looking at a man who is arguably England's first nature poet.

Clare was born in 1793 in the village of Helpston, in the flat lands near Peterborough: 'There not a hill in all the view, save that a forked cloud or two upon the verge of distance lies, and into mountains cheats the eyes' (1)^a. His father was the illegitimate son of a travelling musician, and his family were landless, doing whatever casual work was available. Clare worked in the fields from childhood. However, his father deeply valued education and when the family had enough money, Clare was sent to school. He fell in love with poetry aged 13 and devoted the rest of his life to it.

It is almost a miracle that his work has survived. It's partly luck. He was born during a period of rapid change: the old, shared fields, the commons and wasteland that had supported peasant farmers for generations were being enclosed—literally fenced off for rich landowners. Ancient oak trees were chopped down, cash crops of softwood planted instead. New

straight hedgerows and fences marched across the landscape. As Clare said in 'The Moors': 'Inclosure came and trampled on the grave of labours' rights and left the poor a slave...' (1).

At such a time, Clare's poetry spoke to a genuine loss felt by many. He did this through an acute unsentimental recording of the natural world and local people's lives. As an example, 'The Badger' starts: 'The badger grunting on his woodland track, with shaggy hide and sharp nosed scrow'd with black, roots in the bushes and woods and makes a great huge burrow in the ferns and brakes' (1). But this is not a pretty tale. Badgers have always been hunted, and Clare's poem goes on to describe the badger's desperate fight to the death.

Clare was born and lived in poverty. He was just five feet tall, about six inches shorter than average. In polite company, he was ashamed of the sound of his hobnailed boots on fine floors, yet his poems were highly regarded. He was largely self-taught and used local dialect and idiosyncratic punctuation—he thought far too much time and energy was spent arguing about grammar. Once his first book was published in 1820, patrons supported him, but life was always a struggle, working in the fields and writing to earn enough to feed and clothe his growing family. He was aware that he was driving himself too hard, but he had no choice, and his mental health deteriorated.

Some people like to romanticise mental illness as a creative gift—it is not; it gets in the way of art. Clare's poetry exists in spite of his depression not because of it, but I think it does shape his work. When you are depressed, you feel less. People and sensations that sparked intense feelings of connection and emotion no longer do so. What remains is nostalgia, the intense pain of knowing what/who you have lost. In this context, I think we can see Clare's work as a careful laying down of sensation. He describes the natural world in gemlike detail as if he is setting the world in its place so that it can't be forgotten. He wants to save it from the grey blanket of depression, and from the brutal uncaring plough of progress - 'The Moorhen's Nest': 'I pick out pictures from the fields that lie in my mind's heart, like things that cannot die - like picking hopes and making friends with all.' (1).

Clare spent the last 30 years or so of his life in asylums: first Epping and then in a new asylum in Northampton, later to become St Andrew's. At times he thought he was a prize fighter, at times the poet Byron. He

believed he had married his first love Mary and wrote many songs of unrequited love. Because he was respected, much of his later work was saved. One of his asylum poems is 'I Am' circa 1844^b. It seems to me a perfect distillation of the exhaustion and isolation you can feel when you can't see any way forward.

'I Am':

'I am – yet what I am no one cares or knows;
My friends forsake me like a memory lost:
I am the self-consumer of my woes –
They rise and vanish in oblivion's host,
Like shadows in love's frenzied stifled throes
And yet I am, and live – like vapours tossed

Into the nothingness of scorn and noise,
Into the living sea of waking dreams,
Where there is neither sense of life or joys,
But the vast shipwreck of my life's esteems;
Even the dearest that I loved the best
Are strange – nay, rather, stranger than the rest.

I long for scenes where man hath never trod
A place where woman never smiled or wept
There to abide with my Creator, God,
And sleep as I in childhood sweetly slept,
Untroubling and untroubled where I lie
The grass below – above the vaulted sky.' (1)

Clare's use of dialect helped introduce new words to written English. So, I will end with one that seems appropriate for the coming winter: 'crump' that soft squeaky sound you hear when walking in fresh snow. Next time it gets icy cold, think of Clare as a young man heading home, noting each bird—maybe the way they dip their head or twitch their tail, or pluck off ripe berries to swallow whole—tramping in his old boots and green coat beside low trees and bushes along the fen edge:

'Each twig when touched, tho hardly stirred, its white shower litters to the ground, and from the shake of startled bird, the rime like powder puthers round' (1)^c.

Notes

- I have quoted his lines as prose here because I think they may be easier to follow
- If you would like to hear 'I Am' read aloud, here's a YouTube video by Joey Akubeze: <https://youtu.be/eO3StldS2fA?si=BXQakNfB5ZLwbaU6>

- (c) from the poem "Emmonsail's Heath in Winter". 'Rime' is ice that grows on everything when the air is damp and freezing. 'Puther' is what dust does when you disturb it.

References

1. Robinson E, Powell D, eds. John Clare: Major works. Oxford: Oxford University Press; 2008.

Author

Kate King, MBE

Adviser on Lived Experience, Working Group member of Mental Health Act Review 2018

Eastern Division Spring Conference 2026 report

By Dr Afef Mahmoud and Dr Shamima Nargiss



The RCPsych's Eastern Division Spring Conference took place on 24 Apr 2026 in an excellent venue in Cambridge. The programme was focused on transformative advancements in psychiatry. Hence the title of the conference as 'Innovation in Psychiatry'.

The conference delegates were welcomed by Dr Kapil Bakshi, our division chair and Dr Robert Dudas, our academic secretary.

The morning session began with a talk on advances in the use of psychedelics in psychiatric services. Dr Liliana Galindo presented emerging evidence on the therapeutic use of compounds such as psilocybin, particularly in treatment-resistant depression. She also outlined patient selection, safety considerations, and

described the development of a local psychedelic service in Cambridge.

This was followed by another innovation-focused talk on developments in psychotherapy services by Dr James Fitzgerald, a consultant in old age psychiatry. He described his journey in designing and implementing a psychotherapy service for older adults with complex psychological needs, highlighting challenges such as engagement, comorbidity, and adapting therapeutic models to this population.

During the mid-morning session, Dr Rajeev Krishnadas gave a talk on a buzz topic 'AI in Psychiatry: Ethnic bias in artificial intelligence and machine learning.' This attracted great audience engagement and curiosity listening to Dr Krishnadas present with an added touch of humour using eye-catching slides and videos. He spoke at length on bias: ethnic bias in AI, sources of bias, consequences of it, how to mitigate biases etc. It was very informative and relatable due to his stories, examples and images that he added in elaborative ways.

SLAM Lead Addiction Psychiatrist Dr Irene Guerrini gave a talk on a major public health and media focal point, which is often dubbed as 'Gen Z's drug of choice' for its low cost and high potency - 'Ketamine addiction: unravelling the intricacies of its pathogenesis, diagnosis, multifaceted mental and physical co-morbidities and treatment pathways'. Among the many things she spoke about, some highlights included aspects on the neurobiology of ketamine, adult substance misuse treatment analysis, Bexley Ketamine Project data analysis, ketamine use disorder in mental health, service user views about treatment provisions, ketamine relapse prevention etc. This talk was an excellent opportunity for the delegates to access the latest information on ketamine addiction.

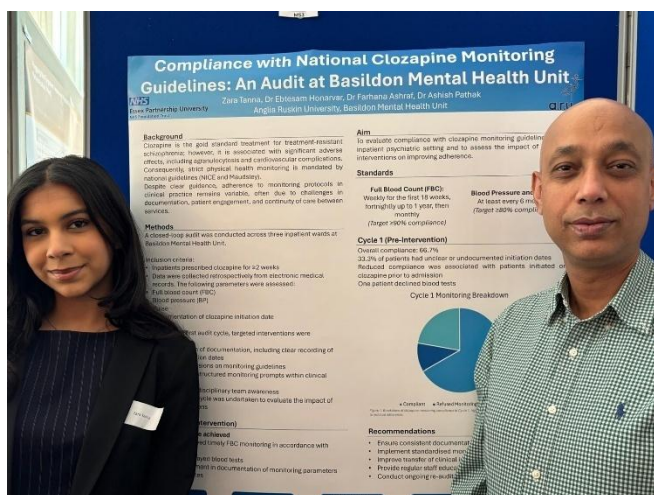
After the lunch break, the breakout sessions included two popular and highly interactive topics on ARCP and leadership.

The leadership in psychiatry session, delivered by Dr Katherine Worley, was particularly engaging. Participants were divided into small groups to explore real-life clinical scenarios, focusing on leadership styles, team dynamics, and decision-making under pressure. The session encouraged reflection on

personal leadership approaches and promoted rich group discussion.

The other session was led by Professor Nandini Chakraborty who spoke on 'ARCP and Clinical Supervision' from her practical experience of being the Clinical Lead for National Recruitment in Psychiatry. She highlighted on the opportunities and challenges in the ecosystem of clinical supervision in psychiatry and presented a framework to help recognise cultural complexities and to offer practical support for supervisors and their supervisees. ARCP for psychiatric trainees was another area where her reflective and insightful delivery was highly enriching for all to understand the core purpose of ARCP and how to ensure good and timely outcomes. It was an excellent scope for trainers and trainees to share reflections, experiences and perspectives.

The final talk of the day focused on transcranial magnetic stimulation and was delivered by Dr Emad Sidhom. He provided a clear explanation of the underlying neurophysiology, practical aspects, and clinical applications, particularly in depression. He also discussed indications, limitations, and future directions for this treatment modality.



The conference also included poster presentation sessions, with two from each of the three categories (medical student; foundation doctor; general), and a final winner in each category was decided upon on the day by the judges. There was an impressive range of work presented by medical students, psychologists, foundation doctors, and core psychiatry trainees, covering clinical audits, research, and quality improvement projects.

Authors: Drs Afef Mahmoud and Shamima Nargiss
CPD Leads, Eastern Division

Upcoming events

Intersection Between Physical and Mental Health - Eastern Division Autumn Conference

Fri 13 Nov 2026

Raddison Blu Hotel, Stansted

Join us this November for the Eastern Division Autumn Conference, where we will explore the theme of the 'intersection between physical and mental health'

Confirmed speakers include:

- Dr Marisa Manning - Menopause and Mental Health
- Dr Sophie Behrman - Premenstrual Dysphoric Disorder (PMDD)
- Prof Fabrizio Schifano - Use of medication such as GLP-1 for weight management in psychiatry
- Dr Ania Crawshaw - Functional Neurological Disorder (FND)
- Dr Jonathan Rogers - 'Psychiatric presentations of encephalitis'

Breakout sessions:

- Dr Anupam Bhardwaj - 'Fourteenfish'
- Dr Vivek Agarwal - Exams

More information and full programme coming soon on our webpage:

[Intersection Between Physical and Mental Health - Eastern Division Autumn Conference 2026](#)

Royal College of Psychiatrists 21 Prescott Street London E1 8BB Phone: 0208 618 4000 Email: moinul.mannan@rcpsych.ac.uk	The Royal College of Psychiatrists is the professional body responsible for education and training and setting and raising standards in psychiatry. The Eastern Division is made up of members from areas including Essex, Hertfordshire, Cambridgeshire, Bedfordshire, Norfolk and Suffolk. We would like to thank all members for their contributions towards Eastern Division activities throughout the year.
--	---

Eastern Division vacancies

The Eastern Division have a number of exciting roles to share. Please see the list of vacancies below:	
Regional Representatives: - Eating Disorders - General Adult - Liaison - Medical Psychotherapy - Neuropsychiatry	- Deputy Regional Advisor <u>Executive Committee</u> - Recruitment Lead For more information on these roles and to apply, please click here: https://www.rcpsych.ac.uk/members/england/eastern/about-the-eastern-division/vacancies
Deadline for next edition: To be confirmed For enquiries email us at: Psychiatry.East@rcpsych.ac.uk	

Psychiatry East - Eastern Division e-newsletter

Editorial team: Dr Sepehr Hafizi, Editor, Cambridgeshire and Peterborough NHS Foundation Trust; Dr Kieran Loughran, Assistant Editor, Essex Partnership University NHS Foundation Trust

Chair: Dr Kapil Bakshi, Norfolk and Suffolk NHS Foundation Trust

Production: Moinul Mannan, Divisions Committee Manager, Royal College of Psychiatrists

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