

Royal College of Psychiatrists

Psychiatry-East

The Eastern Division e-Newsletter



Editorial

Hello! A warm welcome to this summer newsletter.

And here I am excited, releasing my first newsletter as an editor. I would welcome any feedback you can give. Although I have to say it would not have been possible without the support from my editing team including Shevonne and Moinul. So a huge thank you to them both.

It's an important time and year for the Royal College of Psychiatrists, with a few members joining and leaving the Council. We would like to say goodbye and thank you to Dr Wendy Burn for her 3 years of unshakable hard work as our college president. And congratulations and welcome to Dr Adrian James.

2020 – what is it that you don't know about. We certainly will remember this year differently. But let's think of this year as a year of 'HOPE'. Let's remember fondly of the people who have fought and lost the battle but also those who have fought and survived. Let's think about what we have learned during the pandemic and how can we make use of our learnings to look after each other.

We have many articles in this edition and I will highlight a few to give you a flavour. As 'grief' cannot be ignored at this time, Dr Xu through her article gives you an understanding of grief in the phase of the COVID-19 crisis breaking it into a series of predictable stages. Looking at the impacts this pandemic have on people Dr Shinde gives you a few tips on how can you promote staff mental wellbeing within your organisations. And then there is a fascinating outlook from Dr Ustun towards the current situation where he is wondering 'Could Music be an answer to

Covid-19 related problems'. We also have a look at the current trend of virtual meetings from Dr Morris and you will find tips from her on how to use online meetings.

It is delightful to read from Dr Shanmugam how psychiatry chose her, making you also #choosepsychiatry possibly? Like mine your heart strings too will be pulled reading what happens when Dr Amin told her children "I am going to look after someone who is sick". Dr Menon then talks about our role as a psychiatrist and what it is to be a psychiatrist. Later in the edition we have actor Joaquin Phoenix's Oscar winning performance in the psychological thriller 'Joker'. Dr Apetroae has beautifully captured people's dilemma around the mental health difficulties depicted in the character Joker. Another interesting article I am excited about is 'This is your Brain on Chocolate'. And a few more to check out, including the report on our exciting Eastern Division Medical Student Event at the beginning of the year.

I hope you enjoy reading this edition. And please look after yourself during this difficult time.



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Chair's Column

By Dr Abdul Raof

Let me start by thanking all of you on behalf of the exec committee for everything you have been doing during this challenging time. Please look after yourself and support each other; as it has been said, this is a marathon not a sprint!

College staff have been doing an excellent job to keep the College business as usual as far as possible and to support our members and trainees working tirelessly behind the scenes.

I am pleased to see our Summer Newsletter being released though a little bit later than usual, well done to our editorial team of Nita, Shevonne and Moinul!

We started the year – though it looks like a while ago - with a brand new event being the Medical Student Event in association with Cambridge Psychiatry Society and helped by our Psych Star. The event included workshops, panel discussions and keynote lectures (see Owen's article later in the edition). The event was a success with fantastic feedback. We had over 40 delegates who thoroughly enjoyed the day and the Pizza on offer.

We also launched our new AC Induction Course for the Division in March. This was an addition to the already successful Section 12 Course we have been running since 2017. The course was held in Hughes Hall, Cambridge and was attended by 17 delegates, a good number considering the time of the year and it being offered by many competitors. The course went extremely well and received great feedback. You can read more about it in the article later in the Newsletter.

Our Section 12 Induction Course was scheduled to run on the 23 and 24th of April and was sold out. Unfortunately it had to be cancelled due to the crisis but we are hopeful we can run this again next year.

The College cancelled all live physical courses for the year due to the pandemic and there is now a drive for online and virtual events such as webinars and cpd online type courses. Please let me know if you have any suggestions on how we can organise virtual events.

A big thank you to outgoing exec members last year and congratulations on incoming exec members. Congratulations also to Dr Regi Alexander who was appointed as Assoc Dean for CALC (Centre for Advanced Learning and Conferences). I am pleased to say that I was also appointed Lead for member Training at CALC.

One of the first major projects I had work on in my new role was to develop Mental Health Act approval courses to ensure our trainees and others have opportunities to

gain approval and there is a steady supply of suitable qualified professionals despite cancellation of face to face approval courses.

As you might have heard, the Online Sec 12 and AC Induction Courses were launched recently. Thanks to some incredible work by the CALC team and other contributors the courses were developed within a very short period of time. I am pleased to say it has been a huge success, with over 270 and 170 delegates signing up so far for the respective courses. It has already received great feedback. I am particularly proud of our Eastern Divisions contribution to this central project. I am grateful to many members and trainees from the region who helped us develop the module and top tip videos. I want to thank Kate King MBE, Anna Conway Morris and Anagha Sardesai, amongst many others for their contribution.

As we move forward we are aiming to run live webinars in place of our usual physical events in the Division. As our Academic Secretary Kallur Suresh outlines in the next article we hope to run our StartWell and Autumn Conference in the autumn. Details are still being finalised so keep an eye out for more information. The College has developed a lot of material to support us through this difficult time which are available on line at: <https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians>

Stay safe and try to have some relaxing time during the summer, we all need that!



Dr Abdul Raof, Chair, Eastern Division

Division Conferences during and after the COVID pandemic

By Dr Kallur Suresh

By the end of February 2020, we were all set to go ahead with our spring and autumn conferences of this year as usual in early June and mid-November. Then something unexpected happened. By the middle of March 2020, things were looking more uncertain than at any time I could remember. Our entire world had been turned upside down and we had to make the difficult decision to cancel the spring conference scheduled for June this year.

As academic secretary of the Division, my role is to organise the spring and autumn conferences each year and I have done that for the last five years. Each year we have seen greater numbers of delegates registering to attend and the quality of academic content improve continuously. We have consistently received excellent feedback for the organisation, academic quality of talks and the venue where the conferences were held. Wellcome Genome Campus in Cambridge had become the unofficial home of our bi-annual conferences.

We had to also cancel the Section 12 Induction Course (23-24 April) and we had sold out on this one. We did manage to hold our new Approved Clinician (AC) Induction Course as scheduled on 5th and 6th March, just before the Coronavirus restrictions were announced.

The College has recently launched the Online Section 12 and AC Induction Courses, which was a central college project with a large project team including ourselves amongst other contributors from the Eastern Division.

The College has already announced the cancellation of all physical conferences until at least the end of 2020. However, given the popularity of our conferences and their place in the Division's events calendar, we have made a provisional decision to go ahead with our autumn conference, scheduled for 13th November this year. It will be in the form of a webinar and I am determined to ensure we maintain the high quality of the academic programme.

Very soon, we will be publicising the details of the online autumn conference through the usual channels (Emails, Division website and Division Twitter account). It will be an exciting programme with renowned speakers and very topical for today's psychiatric practice. It will be interactive and you will be able to join in from anywhere. The power of technology will enable more of us to join the meeting and we are trying to replicate as much of the physical conference experience as possible. We will provide some time at the end for networking. Our trainee colleagues have found this time especially valuable in the past.

We keep hearing about 'Reset' and 'the New Normal' in the context of COVID-19. There is significant appetite to maintain some of the changes we have had to rapidly adopt during the pandemic in spring this year, including virtual meetings and conferences. Online conferences might well be here to stay. It will be more environmentally friendly, more efficient and enable us to hear from speakers from anywhere in the world. We can overcome the physical restrictions of traffic, parking and full rooms. Please look out for more publicity about our autumn conference in the coming weeks.

In addition to these conferences, the Division has a busy academic meetings calendar. The Section 12 and Approved Clinician Courses happen in the spring and the StartWell event in October. Both these events are very popular and are often oversubscribed. Please visit the Division webpage for more details at <https://www.rcpsych.ac.uk/members/england/eastern/events> or follow our twitter account @rcpsychEastern.

Finally, I would like to invite each and every one of you to take part in the Division's activities. It's your Division and you make it what it is. Get in touch, share your ideas and experiences, and let us know how things are for you in your neck of the woods. We would love to hear from you and offer any support you might need with some of the challenges you might be facing. We need to acknowledge that this is a difficult time to work in the NHS frontline and we need all the support we can get.

Stay safe, stay positive and I look forward to seeing you at the next conference/webinar.



Dr Kallur Suresh, Academic Secretary, Eastern Division
Follow me @Kallur_Suresh

How Psychiatry Chose Me

By Dr Sridevi Shanmugam

Hello all, my name is Dr Shanmugam. Let me start by saying how gleeful and excited I am, for receiving the Core Psychiatry training offer and I will be starting my training in August. I am writing this at a time when the world is encountering a grievous pandemic and almost everyone is arguably under a certain amount of distress. The entire world's attention is focused on a rapid discovery of vaccines and the effective ways to control the spread of disease. However, what is alarming for me is the mental stress it has brought upon with it inevitably and how the issue of mental health has always been dealt with at the tip of the iceberg, like it is has always been.

Looking back, I have always been extremely curious about how the human mind functions and how subtle disturbances in it imposes huge amount of disability in people's lives. I vividly remember when I often used to visit the children with disability in our school to spend some time with them and this question of what we as humans, especially medical health practitioners, can do to make their lives better, to help them lead a life as normal as their peers, sparked in my mind. That could have sown seeds to my current passion.

I was eagerly waiting for my Psychiatry rotation but I only had two weeks of internship experience in the Psychiatry department. I found the placement fascinating and was left wanting more, yet so perplexed to choose it as my masters as I was repeatedly told by the peer group not to choose Psychiatry. Such is the stigma attached to the Psychiatry that people tend to stay away from it mostly. Someone like me who always had passion for Psychiatry chose to ignore my interest because of society's way of portraying it. As I finished my medical school, I started working in different specialties (unfortunately not in Psychiatry as Inpatient setting is not so common in India) and finally ended up in A&E. I cleared my Emergency medicine membership exams and moved to the UK to get into a training programme.

My first impression of working in the UK as a Trust grade Doctor made me realise where my passion lay. To put it more clearly, I have learnt a lot working in the Emergency department. It taught me to be confident, to think swiftly, to be a good team leader, and above all to fight for your patients even if they stopped breathing. However, I felt I was not utilising my full potential, and the only time I felt deeply content was whilst attending patients with Mental health illness. My passion for Psychiatry further grew by seeing varied presentations and psychiatric emergencies. Notably, whilst I was seeing a ten year old with a hanging attempt, he was initially reluctant to reveal anything. But when I made him comfortable and established a good rapport, he disclosed that he has been bullied at school. Despite the hectic work environment at A&E, I found

time to spend with the patient and used active listening skills. Having seen many patients with suicidal ideation, I realised the therapeutic value of active listening. Every year, around 800,000 people die by suicide globally, and in the UK alone there were approximately 6500 deaths by suicide.

Moreover, the challenging fact about Psychiatry is that a therapist has to arrive at a diagnosis solely based on symptoms with little to no supporting investigations. To add to it there is enormous hope for carrying out research activities which made me rethink my career choice. Hence, I made up my mind to pursue Psychiatry and only this time I did not ask for other people's opinion.

To gain more insight towards Psychiatry, I applied for clinical attachment in the Psychiatry department. I observed ward rounds and MDT meetings. I went on to attend Psychiatry summer school and Conferences to reinforce my interest in Psychiatry. I did a good number of e-learning sessions to improve my knowledge. I have to mention, Psychiatry Consultants and trainees were massively helpful with the interview process. At last I attended the interview for Psychiatry training all equipped and crossed fingers. Few weeks after my interview, I received a Core Psychiatry training offer and I cannot wait to start in August. I take this opportunity to thank them all for being a part of this wonderful journey.

Finally, if you ever had/have interest in Psychiatry, now is the time. Why? Because flattening the mental health curve might be the next biggest Coronavirus challenge. Please Choose Psychiatry and make a difference.



Dr Sridevi Shanmugam, Clinical Fellow A&E Northwest Anglia NHS Foundation Trust

We will meet again..

How to use online meetings to improve working relationships

By Dr Anna Conway Morris

Since March online meetings have become a reality for all of us. Love them or hate them – they are here to stay.

While they have obvious advantages such as working from home and avoiding the daily commute, online meetings also bring challenges. It can be difficult to know when it is one's turn to speak and it is easy to get distracted. Digital working can be time consuming and if the technology isn't up to scratch, intensely frustrating. Including everyone and hearing everyone's voice can be challenging, especially in time of crisis when decisions have to be made quickly and trusts have moved to a command and control structure.

Over the last weeks I have gathered some tips from veterans of online meetings from health and social care and the world of business to help us on our journey to better online communication and decision making.

Here is a summary of their advice:

The skills needed to chair a fruitful online meeting are no different from chairing a meeting in person.

1. Preparation is key – set your agenda and be clear what you are asking of people. Find out who the participants are and identify a co-chair to assist you with the meeting.
2. Get participants to introduce themselves and explain the rules of the meeting. Engage with people by their names and encourage others to follow your example. Ask people to turn their video and microphone off. Only the chair and the person speaking should have their microphone on.
3. Invite people to speak and ask them to use the “raise hand” option if they would like to speak. Encourage participants to use the chat box to contribute and ask your co-chair to monitor the chat. Some people find it easier to write in the chat box then to speak – accept that people behave differently.
4. Work to include everyone but don't try to do too much in one meeting. It may be useful to limit the time people can speak to 1 or 2 minutes to give everyone their say. As the chair you can mute people if they exceed their time limit (if you dare!).
5. In order to aid decision making it is beneficial to present binary options for people to think about rather than making things too complicated.
6. Start and finish on time and don't bring up complex issues at the end of the meeting. If there are things

left to discuss, schedule another meeting.

Top tips are one thing – but what about the impact on working relationships of remote working during a national crisis? “The shift to command and control leadership has damaged collaborative working and team relationships” writes Allison Trimble in a blog for The King's Fund. While for some leaders this has “brought the exhilaration of power and an opportunity to get things done quickly, others are left feeling frustrated, undermined and voiceless.” As well as impacting on people's productivity, the situation of feeling sidelined and excluded from decision making can lead to low mood, anxiety and irritability which impacts on staff wellbeing and patient care. How can we include people in decision making and give them back their stake in our services? How can we create inclusive conversations in online meetings?

Rachel Watson, chair of the Institute of Family Therapy, London, explains: Setting clear concepts for action is key to creating inclusive conversations. Those with the most power (through experience, status or any other social difference) need to use their authority to create spaces for those who feel less entitled to speak to do so. We need to be deliberate on this. Ask yourself the following questions:

What kind of organisational culture do we want to encourage?

How do we benefit and our patients benefit when all voices are heard?

How do conversations that include different voices make us more effective?

She advises leaders to explicitly state their intention to be inclusive at the beginning of meetings, as an invitation for all to participate.

She also encourages creativity in making space for different kinds of conversations, for example:

- Inviting people to take different positions – some listeners, some speakers, mute those listening and invite two people to discuss a particular issue, then mute the speakers and ask the listeners to reflect on what they have heard. Go around each person and ask for one idea each.

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- Rather than presenting what is already known, ask one person to “interview” the person who is bringing an issue for discussion, then invite reflections from listeners. Choose different areas of practice that need to be addressed, create specific questions about these and invite people into pairs or smaller groups. Create online spaces that they can enter for short periods and then feed back to the bigger group.
- Invite different people to chair and practice using their authority.
- Help people understand that by slowing down the process can enable quicker, more effective planning leading to shorter, not longer meetings.

I hope this short introduction to improving online communication to be more inclusive inspires you to experiment in your meetings and keep in mind the cost of colleagues feeling excluded.

I am grateful to everyone who has contributed to this article including Rachel Watson, Kate Lovett, Tulika Jha, Subodh Dave, Mehdi Veisi, Jon Goldin and Billy Boland.



*Dr Anna Conway Morris,
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'DEANERY-WIDE ONLINE PLATFORM FOR TRAINEES'

As part of an RCPsych pilot, Eastern and Northern Ireland regions piloted the use of Workplace App for all the trainees in the region as an online platform to share trainee-relevant opportunities, news, non-clinical issues and to improve engagement with the College. This was started in August 2019 and we will soon have the end-of-year evaluation.

It was led by current PTC Reps of Eastern Region with immense support from our Head of School Dr Chris O'Loughlin who is also kindly on the platform and sharing useful information and tips regularly. We will send out further updates via TPDs for those who haven't managed to get onto the platform yet. With lesser face to face meetings and networking due to COVID, it has become even more important for us to have other ways of networking across Trusts in the region.

*Dr Shevonne Matheiken
PTC Rep, Eastern Division Exec Committee*

Life after Coronavirus: Grief in the Face of a Pandemic

By Betty Xu

'Life changes in an instant. An ordinary instance. You sit down for dinner and life as you know it ends.' Those were the words that author Joan Didion uses to describe the sudden death of her husband. However those words may also resonate with thousands of people in the UK, on the evening of March 23rd 2020, when the country announced a nationwide shutdown unprecedented during times of peace. All 'non-essential' businesses were ordered to shut, and whole families and communities asked to isolate so that the spread of the deadly coronavirus could be slowed down, the NHS would not become overwhelmed, and lives would be saved. During that instant, life as we knew it ground to a halt.

Over the next few weeks (as well as the coming months) – we experienced shock, denial, guilt, anger, sadness and anxiety, as we gradually acclimatised to the new changes. Many people are experiencing devastating personal losses, including the deaths of loved ones, or loss of employment and security due to the economic upheaval. However, even those who have not lost anything as concrete may be deeply affected by a sense of 'communal grief.'

In 1917, Freud described grief as a conscious process of 'breaking ties with the deceased and readjusting to new life circumstances.' Following from this, psychologist Kubler-Ross expanded this theory to conceptualise grief into a series of predictable stages – namely shock and denial, anger, bargaining, depression and finally acceptance. Perhaps one way to gain a better understanding of grief in the face of the COVID-19 crisis is to break down our feelings into these stages.

When the lockdown was first announced, shock was possibly the best way to describe how most people were feeling. Of course, we had seen the situation in Wuhan, China, where the pandemic was thought to originate. We had also seen the situation in Bergamo, Italy, where hospitals became labelled by the media as 'apocalyptic wards,' and doctors struggled with the huge waves of patients coming into hospital. We read reports of how their intensive care capacity became overwhelmed as doctors were forced to choose which patients went on a ventilator. At this point, of course we were shocked, but we were also in denial. We searched desperately for reasons why other countries could experience such a high death rate.

Perhaps as a final act of denial, the week after a lockdown was announced in Italy, the UK discussed

policies such as herd immunity. Nevertheless, the rise in cases and deaths seen in hospital that week, along with the Imperial Study published, possibly shattered our ability to continue living in denial.

After denial comes anger. Anger is where the individuals start to direct (or misdirect) frustration towards a particular source or target. During the COVID-19 pandemic, anger has been directed at multiple sources. We have seen anger directed towards China, with claims that the country had covered up the severity of the pandemic, especially in its initial stages. We have also seen anger directed more locally – the government has come under criticism by some people for responding too late, whilst others criticised it for overreacting to the situation. Private companies have also come under fire, and even supermarkets are criticised for not preventing the mass stockpiling at the start of the lockdown.

Following anger, many report a stage of bargaining. When people get ill, they bargain, giving almost anything to be the ones who get better. As we realised the harm of the pandemic within the UK, we began to close all non-essential services, enforce social distancing, and watched whilst some of the busiest streets in London stood empty. The government had a tough decision – as lockdown continues, we risk increased unemployment and damage to the economy, as well as a rise in domestic abuse and deterioration in mental health. On the other hand; lifting the lockdown measures too early risks overwhelming the NHS, and more lives would be lost. An Economist article explains the stark series of decisions facing the government, as they are forced to bargain between life, death and the economy, choosing the least harmful way to proceed.

As we struggle through the shock, anger and bargaining during the first few weeks of lockdown, we start to look ahead at the weeks to come. As a mental health professional, I can already see the effect of the pandemic on our patient cohort. I am therefore worried about the mental health consequence of this pandemic. There is likely to be an increased prevalence of depression, anxiety, as well as post-traumatic stress disorder in the weeks, months, and possibly years to come. We will struggle through losing a loved one perhaps, or losing our jobs, or possibly losing faith in the systems we have previously depended upon. We are likely to be fearful about the future and what changes this will bring.

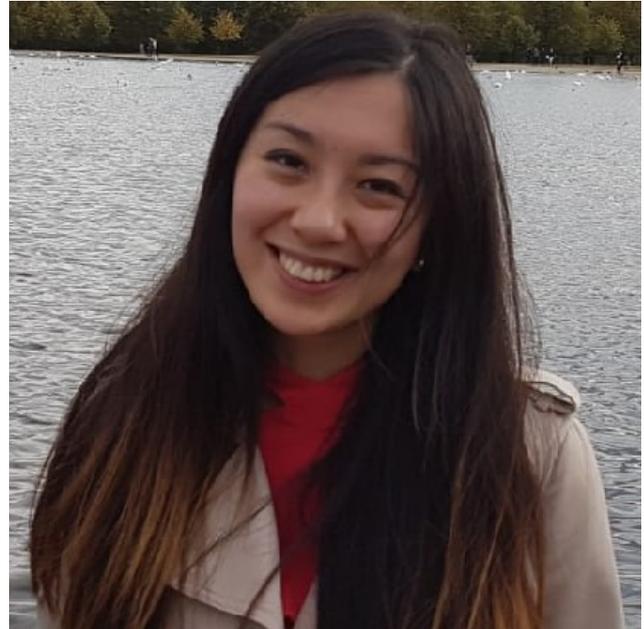
It is important to note that grief is not linear. Most

Life after Coronavirus: Grief in the Face of a Pandemic

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people do not transition smoothly between the various stages. However, eventually, Kubler-Ross' model comes to a stage of acceptance, the concluding stage of the process.

I appreciate that I am fortunate, as I have yet to face the grief experienced by some during this pandemic. However the sense of loss comes from a complete separation from 'normal life,' which at times I will find difficult to accept. In addition, acceptance is about finding new ways to move on. In the face of a pandemic, we question whether we can truly move on from such an event, and whether life can truly return to the way it was before. What sort of changes need to be in place for the future, we would ask. Each individual life lost in this pandemic is a tragedy, and will be grieved by many. Therefore as a society, perhaps the only way to accept and continue from this crisis is to learn from any mistakes we made this time, and to ensure we are better prepared for the future.



*Dr Betty Xu, CT1
Central and North West London NHS Foundation Trust*

RCPSYCH PSYCHIATRISTS SUPPORT SERVICE

The Psychiatrists' Support Service provides free, rapid, high quality peer support by telephone to psychiatrists of all grades who may be experiencing personal or work-related difficulties.

Our service is totally confidential and delivered by trained Doctor Advisor College members.

For information about the Coronavirus, please visit our [information hub](#), you can also find specific [guidance for clinicians here](#).

Get in touch with the support service

Call our dedicated telephone helpline on 020 7245 0412
Email us in confidence at pss@rcpsych.ac.uk

The service is available during office hours Monday to Friday

The Juggling act of Motherhood in Training

By Dr Parsa S Amin

When I became a doctor in 2013 – I was convinced that it had to be the hardest job in the world. The long work hours at work, the huge academic pressures and the emotional toll it took was nothing like I had ever experienced. However, I was proven wrong when I became a mother in 2015 - as I found it infinitely harder than medicine in every possible way.

While a doctor has a set time limit to working, a mother's job never ends. Whilst a doctor's job is somewhat streamlined – doing our basic procedures, following guidelines and practicing evidence based medicine. A child – does not come with any guideline (Gina Ford does not work for everyone, by the way). The unpredictable nature of those little beings, as cute as they are, can be very unsettling for someone who has a type A personality, like me (and my colleagues).

Whilst in medicine – the amount of effort I put in was directly proportional to the outcome. I quickly learnt that the same rule did not apply to motherhood. Before my first baby was born – I prepared meticulously – however, after she was born – all the plans went up the air. She was nothing like I had imagined, but perfect in her imperfect way. I thought working night shifts as a doctor would prepare me for this, but there was no such thing as “post call rest period” with this sort of night shift. I soon learnt to survive on as little sleep as humanly possible – fuelled by copious amount of coffee, of course.

During my maternity leave – I learnt useful lessons in patience, empathy and non-verbal communication. Little did I know – these were some of the most useful transferable skills that would shape my journey as a doctor. With time, she taught me to relax my self-imposed rule surrounding perfection that stifled my creativity and taught me to - just be myself. I started to show up, do my best and be more grateful. Before having my daughter, I would have never considered taking a “gap year” out of medicine – but that is exactly what I did. I decided to not go back to work after my 6 months of maternity leave was up. Inspired by my daughter, I decided to pursue a Master's Degree in Child Psychiatry and sit my PLAB exams.

Fast forward to August 2017 – I had moved halfway across the world to London (from Singapore) - I was then, a mother of two kids under the age of two and a “mature” FY2 doctor in A&E. Leaving my children to work odd twilight and night shifts – felt like my heart was being pulled out of my chest, every single time. As I heard them wailing as I walked out the door, I wiped my own tears and really questioned why I am even going to work.

At times, I felt inadequate as a mother when my daughters did anything less than ideal – poor eater, tantrums, you name it. Other times, I questioned if I was good enough as a doctor - as I constantly ruminated over the decisions I made at work.

I looked forward to being a homemaker on my days off – cooking, laundry, childcare etc., whilst my alter ego “Dr. Parsa” would take over on my days at work. Going into each role, was a break from the other – and it felt like a good balance.

Sometimes I felt insecure that I was not able to progress as fast (or as well) in my career compared to my colleagues and other times I felt like motherhood gave me this intense focus and purpose that I lacked before kids. I was never going to use motherhood (my choice) as an excuse to not pull my weight.

The years went by so quick, and I find it hard to believe it's 2020. My children grew into their own little individuals - who are (genuinely) my biggest fans (I know this phase will not last for long). While my kids don't cry for me anymore – they still feel sad when I am working all weekend or leaving to go for my night shifts. I tell them “I am going to look after someone who is sick” and they ask me “why don't you look after us instead?”

I could wallow in self-pity and guilt – but I choose (try) not to. I chose to have a profession, like I had chosen to be a mother. Both these jobs give me immense joy and satisfaction - and I will continue to give them both my 100%. While the balance is never perfect – I feel immense amount of gratitude towards my life as a working mother, and for now, I wouldn't have it any other way.



Dr Parsa S Amin, CT2
Hertfordshire Partnership University NHS Foundation Trust

What it is to be a psychiatrist, and their role in the #MeToo era

By Hannah P Mémon

I was an ordinary person before I became a Psychiatrist. I had the privilege of having strong views on a topic. Now I no longer do.

Am I saying Psychiatrists are extraordinary? No. But we are out of the ordinary.

Why? Because we are not just doctors who are treating patients with a mental illness. We are not just friends to our patients, whom they can be vulnerable in front of. We are not just colleagues to our team, from whom advice can be sought, histories of patients discussed, and eventually, when the right comfort level is reached, life stories be shared.

We are more than that. We have to be more than that.

The changes that occur in your personality all come about so slowly that you don't realise it. Each day you learn how to listen better, how to invite people's confidence better. And you don't realise that people are more willing to trust you, based on your profession too. When I met people outside the medical background, and they heard I am a 'Psychiatrist', they began to share their own stories with me, or bring up a controversial topic to hear my view on. They wanted to hear my opinion on their mental health and their personality. They wanted to hear my opinion on whether they did the 'right thing when that happened' or not.

Over time, however much I refrained from being in that position, or accepting that responsibility, society has unintentionally put us in that position, and we have unknowingly accepted it, by choosing this career path.

Whether we like it or not, we do carry the weight of being individuals whom society can look upon, to be caring and responsible; we are looked upon to make difficult decisions, and be the friend to the angry family member who needs someone to blame, and then be questioned by a coroner for why we did what we did. We are the 'eldest child' of society: looking after the younger, more vulnerable siblings, and being answerable to the parents in society: the law.

And so, whether we like it or not, we need to have opinions on societal issues. From gender identity, to sexual harassment, being a psychiatrist means that we understand the impact on the sufferer, and the doctrines of the persecutor. And due to the burden of this responsibility, I felt my role has to be, to have a balanced perspective: to apprehend both points of view, to understand both sides of the coin and what contributes to their make-up.

Psychiatrists use a technique called 'normalising' whereby you subtly and calmly open a discussion with a patient who may be shy to talk on a subject, for fear of being criticised, judged or looked down on. Once the topic is broached and with the right tone and manner the subject is normalised, patients start to trust you and are open to telling you things that they wouldn't share with anyone else. Psychiatrists commonly use this technique when talking about the sexual side effects of psychiatric medication. Needless to say, being 'easy to talk to' is a must-have quality in a psychiatrist.

The #MeToo movement showed us the powers of the 'normalisation technique' on a global level. What was once embarrassing, humiliating and a 'dirty secret' to take to your grave, suddenly became a channel to express your repressed anger and shame, to connect with people on a matter so sensitive, that typing the words '#MeToo' lead to a powerful release of emotion for many: 'You are not alone, I am not alone'. Women started to realise their 'dirty secret' wasn't dirty, nor a secret. It has happened to so many women that it was almost statistically more likely for a woman to have been sexually abused, than not. Each woman's story of sexual trauma, shame, self-blame and anger was held to her chest, with an oath made to oneself that it was too shameful to share, and had to be taken to the grave, until the movement unleashed her: to speak out, yell, scream, write about or make public. The shock for men and women worldwide was catastrophic. Women and men were angry, many people chagrined, saddened by the state of western society, and the dichotomies that still exist within it, despite lauding itself for making no difference between the sexes.

The more people talked about it, the more conscious society became of what is appropriate, and what isn't, in terms of jokes with women, comments made about women, and expectations from women, in and outside the work place.

The #MeToo movement made people think and talk about a topic which was avoided, and it made something that was an 'unconscious' part of people's behaviour towards women, conscious. People started to make a conscious effort to think about what the #MeToo movement meant for them, and whether their jokes and comments were appropriate at all times. It made people conscious of how women have been treated in every industry, and how they have borne it for decades.

There was another longer-term consequence to the movement, one perhaps that no one foresaw. It was that some men started to get nervous about approaching

What it is to be a psychiatrist, and their role in the #MeToo era

By Hannah P Mémon

women at all, and risking being perceived as 'harassing them' for simply complimenting them on their attire in an office space, or lightly touching them on the elbow to get their attention. A study carried out in 2019 to determine the views of men and women in wake of the #MeToo movement found that 27% of men would now avoid meeting alone with women for work reasons, and a similar percentage of men would avoid hiring attractive women (<https://hbr.org/2019/09/the-metoo-backlash>). Is this because they have developed insight, and felt they were at risk of acting inappropriately, or because he were afraid of being attacked for something they felt they hadn't done?

And yet, there was an even more unexpected outcome. Dr. Arin Reeves, president of a U.S. employment advisory firm Nextions and known to be a leading researcher in 'Workplace Leadership' stated she had noted in her research that it was sometimes "men who aren't doing anything wrong who are feeling needlessly nervous" after the #MeToo movement, in regards to their interactions with women. For Psychiatrists, this would explain the narrative of men who suffer from Generalized Anxiety Disorder or Social Phobias, who now have something new preoccupying their mind, and making it even harder for them to talk in front of half the population.

What is the role of the psychiatrist in the #Metoo Era? As far as I am concerned, it is to uphold the law, and encourage women and men who have suffered sexual abuse to step forward and vocalize their suffering. It is to help them find justice for what they suffered, if not practically, then emotionally, which can be a longer (but sometimes more fulfilling) journey than the justice offered by law. Our role is to make men who have become nervous, talk about their feelings and why they feel so self-conscious. It is to help women who are still brushing sexual harassment under the carpet, slowly see how it is something that they have become so used to, that it is their 'new normal'.

But, above all, our role is to never be quick to judge. It is to always observe, and be a listener. It is to always be a friend to the person sitting in front of us, whomever that may be. It is to be a supporter, and never the critic.



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'JOKER'- What is the Psychiatric Diagnosis?

By Dr Meda Apetroae



'Joker' is a 2019 American psychological thriller directed by Todd Phillips, starring the great actor Joaquin Phoenix. The film is based on the DC Comics series, and follows Arthur Fleck, a mentally ill aspiring stand-up comedian on his journey to becoming the iconic 'Joker'. The movie was a big hit when first released in October 2019, and Phoenix's performance won him an Oscar at the Academy Awards in 2020. The attention also came with a lot of criticism, for example Robbie Collings for the Telegraph stated "a part of me found Todd Phillips' radical rethinking of the Batman villain Joker thrillingly uncompromising and hair-raisingly timely. Another thinks it should be locked in a strongbox then dropped in the ocean and never released."

I chose Joker for the topic of this article because, when I saw the movie, I was completely captured by the story and it got me interested in attempting a psychiatric assessment of Arthur Fleck. Phillips does a great job of giving us valuable information about Arthur's upbringing and personal history. For me, as I am sure for most of those who watched the movie, Arthur's life is extremely sad - he was unfortunate to have been born and raised in poverty, being subjected to physical abuse from his mother's partner and neglect from his mentally ill adoptive mother as a child. In later life he is clearly struggling with mental illness for which he is receiving minimal, and by the end of the movie, no support with, whilst having to deal with the hardship of a decaying society that disregards the poor and mentally ill. In Arthur's words, "the worst part about having a mental illness is people expect you to behave as if you don't." This describes, in a nutshell, what people with mental illness go through in our society, and this film appears to

attempt to raise awareness on the stigma around mental health in a very powerful way.

And so I want to talk about what everyone who has seen this movie has been asking themselves: what is Joker's mental health diagnosis? As a psychiatrist, after seeing the movie twice, I have come up with a few possible diagnoses which I will be explaining below. For those of you who have not watched the movie yet, I apologise- this article comes with a big spoiler alert!

The first possible diagnosis that Arthur could be suffering from is depression, and this is portrayed in the opening scene of the movie. Here we see Arthur Fleck, a man in his 30s, sitting at his dressing table, painting his face for work- he is an advertising clown for a talent agency. He appears as if he had been crying as the paint on his face is dripping from under his right eye. He also looks flat in affect and the most striking moment in the scene is when Arthur is pushing up the corners of his mouth with his fingers to force a smile. Later, in the movie, Arthur continues to give clues that he might be suffering from a depressive illness by saying, "I haven't been happy one minute of my entire [...] life". His adoptive mother, Penny, also comments on his significant weight loss, which could be interpreted as a biological sign of depression, but also the poor conditions they were living in.

The next scene of potential diagnostic importance is when Arthur is having a routine appointment with his social worker. The scene starts with him laughing uncontrollably, which is a recurrent scene throughout the movie and is indicative of pseudobulbar affect - we later find out that in childhood he sustained a severe

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brain injury secondary to the physical abuse he was subjected to by his mother’s partner.



During the film we are invited to take part in Arthur’s romantic life as well, where he forms a relationship with one of the neighbours in his building. Later in the movie we learn that part of this episode in Arthur’s life was a figment of his imagination, and can be classed as a symptom of a psychotic illness. A more specific diagnosis of psychosis cannot be made, as we are not told of any other psychotic symptoms that Arthur might be experiencing.



From a personality point of view, Arthur exhibits traits of dissocial, narcissistic and emotionally unstable personality disorder, as he lacks feelings of guilt for the violent acts against others, craves “to be seen”, to be in the centre of attention, has a history of childhood abuse

and has a marked tendency to act impulsively - evidenced by the dramatic murders he commits throughout the movie.

All in all, I believe ‘Joker’ is a cinematic masterpiece that is trying to portray what is wrong with our society today: the rich rule the world while society disregards the poor and the mentally ill. And although I can sympathise with Arthur and understand what pushed him to commit horrible crimes, I by no means agree with his choice of making his own justice through violence, but I can’t help thinking his last words in the movie are painfully true: “What do you get when you cross a mentally ill loner with a society that abandons him and treats him like trash?- I’ll tell you what you get, you get what you [...] deserve!” It is everyone’s responsibility to look after the most vulnerable, and as mental health professionals for us to be the voices of our patients and do our best to help and support them.

And as the great Robin Williams, another one of my favourite actors, used to say “everyone you meet is fighting a battle that you know nothing about. Be kind. ALWAYS!”



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Could Music Be An Answer to COVID-19 Related Problems?

By Dr Sitki Anil Ustun

Quarantine life has caught almost all of us so unprepared. Now we have absorbed the news and accepted this very new fact of our lives, we have been trying to adapt to the new circumstances. In response to the pandemic, various public health strategies such as isolation of infected or at-risk persons, reduction of social contact, have been advised to reduce the risk of infection. Although these measures have been successful with a significant decrease in growth rate and increased doubling time of cases, reduced access to family, friends, and other social support systems causes loneliness and increasing mental health issues like anxiety, depression as well as increase in substance use. (1) But what if most of these problems could be solved or eased with one significant factor and that was music?

Music has been used for treatment purposes since the earliest times. Over the centuries there have been many concepts regarding its functional mode, like ancient concepts, and recently influencing the physiological functions of organisms. A scientific basis for music therapy only emerged after World War II and the term "music therapy" was introduced in about 1950. It complements pharmacotherapy as a part of complex treatment, together with other forms of art therapy, psychotherapy and physiotherapy. (2)

The way music has been practised since the pandemic has evolved in many ways. Excitingly awaited concerts and events had to be cancelled, consequently, some have been performed in remote settings. Although these have given a sense of artificiality, it has become accessible to so many people across the world which also enhanced the audience of the performances and therefore the bond by the music. Despite these changes, music has still been very accessible to everyone across the globe and that could be utilized to address the problems occurred and aggravated by pandemic circumstances.

Initially public emotional response to any pandemic is of extreme fear and uncertainty which usually drives towards negative societal behaviors and can involve public mental health concerns like anxiety, insomnia, depression aggression, frustration and hysteria (3)

Furthermore, exposure to situations capable of generating post-traumatic stress disorders, such as natural disasters (earthquakes, pandemics) or accidents, has been associated with increased rates of alcohol abuse and dependence in some studies (4). Research conducted by Alcohol Change UK revealed that Around one in five drinkers (21%) told us that they have been drinking more frequently since the lock-down.

This suggests that around 8.6 million UK adults are drinking more frequently under lock-down. (5)

Parents and caregivers are attempting to work remotely or unable to work, while caring for children, with no clarity on how long the situation will last. For many people, just keeping children busy and safe at home is a daunting prospect, especially when living with increased stress, media hype, and fear, all of which are challenging our capacity for tolerance and long-term thinking.(6)

Evidence shows that violence and vulnerability increase for children during periods of school closures associated with health emergencies. Rates of reported child abuse rise during school closures. For many, the economic impact of the crisis increases parenting stress, abuse, and violence against children. (6)

The music experiences used in music therapy may be varied and can range from listening to music to playing or singing songs to free improvisation.

When the outcomes of studies in music therapy were analysed, many promising results addressing the problems exacerbated in the pandemic circumstances are seen. In a randomised controlled study, participants receiving music therapy plus standard care showed greater improvement than those receiving standard care only in depression symptoms, anxiety symptoms and general functioning at 3-month follow-up. (7) Moreover, another study addressing more severe anxiety disorders; in patients with OCD, music therapy, as an adjunct to standard care, seems to be effective in reducing obsessions, as well as co-morbid anxiety and depressive symptoms. (8)

In a study comparing the effects of music therapy interventions on depression, anxiety, anger and stress specifically in a group with alcohol use disorder; participants' scores in depression, anxiety, anger, and stress were significantly reduced after participating in the music therapy sessions.(9) Furthermore, other study results indicate that personally pleasing music might have a role in augmenting substance use disorder treatment via craving reduction. (10)

Musical activities were used to promote positive parent-child relationships and children's behavioural, communicative and social development. Significant improvements were found for therapist-observed parent and child behaviours, and parent-reported irritable parenting, educational activities in the home, parent mental health and child communication and social play skills. (11)

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The relationship between music and social bonding has been an interest of research. Although there is as yet no consensus about the mechanisms, two main theories of synchronization and EOS (the endogenous opioid system) have been widely accepted. Synchronization is often cited as an important mechanism by which social bonding can occur. (12) Endorphins (and the EOS in general) are involved in social bonding across primate species, and are associated with a number of human social behaviors (e.g., laughter, synchronized sports), as well as musical activities (e.g., singing and dancing).

It is well known that passively listening to music engages the EOS(12), In a recent study analysing the audience and a violinist in a violin performance concluded that it is highly possible that neural synchronization between performer and audience occurs when they are engaged in the same music performance. Furthermore, the popularity of the performance and music appreciation were also correlated with the left-temporal inter-brain coherence (IBC) between the audience and the violinist. (13) Those research data suggest that the EOS and synchronisation are important in the social bonding effects of music which could be experienced in the music events and performances.

In conclusion; music stands as an inexpensive and widely accessible tool for everyone who has been mentally affected by the pandemic. In the pandemic circumstances music and music events have evolved in the positive way. Therefore music remain as a perfect aid and even solution for not only to the exacerbated problems by the pandemic, but in our daily lives.

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Staff Wellbeing During the Covid-19 Pandemic

By Dr Ekta Shinde

The Covid-19 pandemic is having a significant impact on the mental wellbeing of NHS staff, with rates of anxiety and burnout running far higher than usual. As per a recent YouGov poll, half of health workers questioned across the UK reported suffering mental health problems such as stress and trauma as a result of dealing with Covid-19.

It is important during this time that staff take time to prioritise their own mental health and wellbeing, recognising that it is more difficult to provide outstanding care for others when they are not adequately cared for yourself.

With staff adapting to the various changes in their work environment, the need for organisations to look after their staff's mental wellbeing is paramount. Some suggestions for promoting staff wellbeing during the pandemic:

1. Embedding discussions about wellbeing into meetings and supervision

The more we normalise check-in questions, the more likely it is for someone struggling with their mental health to speak up for support.

2. Giving managers access to mental health resources

Line managers will often be the first to respond to staff seeking additional support, so ensuring managers have access to the right training and resources to support their team is an important step.

3. Encouraging team work

Working in healthcare during a pandemic can be overwhelming and staff need extra support from their teams to cope with the new challenges. Many staff will be juggling work alongside looking after children, elderly family members or vulnerable neighbours. Offering flexibility around their working hours and workload within the team is crucial.

4. Regular communication

While events continue to unfold, one of the biggest causes of anxiety is mixed messages from different social media and news sources. Frequent communication is important so staff are not left

uncertain about what to do. It is important for staff to know about the updated policies and information on things like sick leave, procedures and protocols to follow, and remote working practices.

5. Surveys to assess staff wellbeing

It would be difficult to tackle the issue of staff wellbeing based on assumptions only. It's important to find out from staff what their wellbeing concerns are. A good way to assess this would be to ask staff to undertake an anonymous wellbeing survey and provide a suggestion box for them to give their feedback.

6. Promoting good work-life balance

It's important to encourage staff to engage in hobbies and activities, to be able to cultivate a life outside of work and foster a positive work-life balance. Engaging in daily exercise and maintaining a healthy lifestyle is known to have an uplifting effect on general wellbeing. Daily breathing exercises and mindfulness can also help combat stress.

7. Virtual social activities

Considering the social distancing measures, virtual social events have become the norm during the pandemic for informal 'catching up'. There are a range of social activities that could be incorporated, including: staff quizzes, lunchtime video calls, yoga sessions, healthy cooking classes, team coffee mornings, meditation groups, book club or an arts group.

Conclusion

The ongoing Covid-19 pandemic is a constantly changing situation with many uncertainties. Staff are understandably experiencing increased anxiety about the future, in terms of both personal and work life. Being mindful about this anxiety and showing support for not only staff's physical wellbeing but also of any increased mental stress is crucial during these times.

Staff Wellbeing During the Covid-19 Pandemic

By Dr Ekta Shinde

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This is your Brain on Chocolate

...and why I have opted out of “Choxit” during the COVID pandemic...

By Joanne Lowe

That there is an interaction between food, health and the mind is not a new concept. Burgeoning scientific knowledge has brought, for some, a more intellectual and rational dimension to the approach to food. It is not unusual, for example, to see fellow supermarket shoppers studying the labels on packaging learning of macro- and micronutrients and the health effects, beneficial or otherwise, of what is on offer.

Living in the developed world bestows on us the privilege of being able to appraise and select the food we buy for its nutritional value, if we choose to. Advances in food technology mean that novel vegetables such as purple carrots and red Brussels sprouts need not only be found in a child's colouring book. Furthermore, the world of 'nutritional genomics' has introduced us to the idea that food can interact with our genome (our DNA) at a molecular and cellular level, affect gene expression (via the proteins that our DNA makes) and play a role in preventing or treating disease.

Now, herein lies the tension our relationship to food is also physical, emotional, sensual, cultural, ethical and social. We not only need food to keep us alive in the most basic sense, we need it to experience closeness, cohesion, community and our culture. We cannot reduce this relationship to one of nutrition and health alone.

The Coronavirus pandemic has restricted our ability to commune with friends over food (in pubs, cafes, restaurants, street markets and the likes) and we are now ever more dependent on sourcing our food from our own food cupboard (via the supermarket). It is chocolate which highlights to me personally, the profound complexity of our response to food. During the pandemic I find myself wondering, “Why is my concern about not having chocolate in the cupboard, no less disturbing to me than the threat of temporarily having to use tortilla wraps as loo roll?” “Why, as a health-conscious person, do I plan chocolate-eating into every day, when this is the food, of all that I eat, which is arguably most likely to contribute to obesity, type 2 Diabetes (with all its sequelae) and migraine?” “Why do I crave chocolate even when I have eaten a full meal?”. I am clearly not the only one; chocolate is the most “craved” food in the population at large ⁽¹⁾. Let's find out more

What is chocolate?

Chocolate is a preparation of cacao seeds which originate from the fruits of the *Theobroma* (literally “food of the Gods”) Cacao tree. The seeds are fermented, dried, roasted, shelled and ground into

cocoa mass (a paste). This is melted to chocolate liquor which can be separated into cocoa solids and cocoa butter. Solid chocolate is a combination of cocoa solids, cocoa butter, sugar and milk, in varying proportions.

What are the major psychoactive components of chocolate?

Flavanols: these are natural compounds which abound in the plant kingdom. We also consume them in tea, red wine, grapes and apples.

Caffeine: the world's favourite stimulant, from the methylxanthine chemical family. It is widely accepted that caffeine, amongst other things, helps a sluggish brain become more alert.

Theobromine: related to caffeine and specific to chocolate. This readily dissolves in fat and peaks in the bloodstream 1-2 hours after chocolate consumption.

Carbohydrates: the ubiquitous human fuel molecules, which literally keep us ticking over. Obviously not specific to chocolate, but play a role in craving.

Number one in the craved food charts – why?

Despite much research on the individual psychoactive components of chocolate, the prevailing view appears to be that we crave chocolate due to its orosensory qualities, or “mouthfeel” ⁽²⁾. It is very sweet, highly palatable and has a unique flavour. In chocolate we find the optimal synergistic relationship between its many constituents – in other words, the whole is mouth-wateringly better than the sum of its parts. Individual factors also have a role in craving, namely our gender, age, dietary habits and hormonal fluctuations.

Chocolate and mood

There is reliable research data to suggest that chocolate causes an elevation of mood. This is the case when there is either a pre-existing negative mood state, or when a negative mood is induced by the experimenters, e.g. by giving people an impossible task to solve, or a grim film to watch before a dose of chocolate ⁽³⁾. The jury appears to be out about whether the mood elevation lasts about the short time it takes to get up from the sofa and guiltily replace the chocolate leftovers back in the cupboard, or whether it lasts for 1-2 hours. ^(3,4)

Of all components, it seems that caffeine may be the largest contributor to this effect,⁽²⁾ which is likely to involve activation of the brain's reward pathways.

This is your Brain on Chocolate

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By Joanne Lowe

Chocolate and cognitive function

Cocoa flavanols (CF) have been shown to improve our cognitive function. Both long-term and short-term intake of CF enhances attentiveness, reaction times and working memory.^(5,6) CF peak in our blood at two hours post ingestion, and may well achieve their effect through enhancement of cerebral blood flow (improving blood flow to all areas of the brain thereby increasing supplies of oxygen and nutrients to our grey and white cells)⁽⁷⁾. Evidence also suggests that long-term CF consumption can improve our sensitivity to insulin (this is reduced in type 2 Diabetes) which can also improve our brain function.⁽⁸⁾

A caffeine/theobromine combo may also produce a similar effect.⁽²⁾

Conclusion

Any research normally highlights to us what we still need to learn and just how much we don't yet know. Chocolate research is no exception. In light of the above findings I am opting out of “Choxit” (the carefully considered long-term withdrawal of chocolate from my diet) and sticking by my grandmother's adage “a LITTLE bit of what you fancy does you good!”

“There is nothing better than a friend, unless it is a friend with chocolate...”⁽⁹⁾ With special thanks to my Consultant Clinical Supervisor, Dr Ajay Wagle, for his inspiration, encouragement and chocolate cake!

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Quality Improvement by Introduction of 72-hour admission pathway in FHAU for Young People in Crisis

By Dr Linda Zirinsky and Dr Sadaf Mufti

Background:

Three-day Crisis admission was introduced in 2018 in Forest House Adolescent Inpatient Unit as a need was felt for a brief admission pathway to provide treatment for patients suffering from EUPD traits in keeping with NICE guidelines(i). NICE guidelines suggest that people with Borderline Personality disorder should be considered for acute psychiatric inpatient admission only for the management of crises involving significant risk to self or others that cannot be managed by other services.

The guidelines also recommend ensuring that the decision is based on an explicit and joint understanding of the potential benefits and likely harm that may result from admission and agreeing to the length and purpose of the admission in advance.

Aim:

The specific aim of the proposed intervention was to facilitate the most appropriate treatment for patients with EUPD and prevent the iatrogenic harm caused by prolonged stay in hospital. Receiving the correct treatment in adolescence is vital as the neural pathways still show plasticity and positive changes can be made in reducing the development of this personality disorder at this stage of life.

Who, what changes triggered the decision and why now:

The inpatient consultant psychiatrist, also the clinical lead of CAMHS, championed this change.

It is now well known that prolonged hospital stay can be harmful for youngsters suffering from EUPD and not be effective as treatment. According to Linehan(ii), the attentive responsiveness to reported suicidal ideation or self-injury that characterizes hospitalization can act as an unintended reinforcement of self-harmful behaviours.

A large number of Hertfordshire inpatients were found to require treatment out of area in an audit carried out in 2017. Out of a total of 45 inpatients, 30 were treated out of area, 8 of these in acute units. There were high numbers of EUPD patients in the cohort, 15 of the 45. The majority of EUPD patients were not receiving appropriate treatment and their stays were lengthy.

Rationale/Main interventions of the Crisis admission:

1. Immediate risk management.
2. Help the family as a whole; enable both the patient and the parents to understand the difficulties.
3. A time to think, away from stressful environment for the patient. Respite to both the patient and the family.
4. Safety plan enlisting details about triggers of risky behaviour provides coping skills to the young person and skills to parents to support the patient. Self-help tools based on DBT skills.
5. Diagnosis confirmation and psycho-education about the condition. Management advice emphasising the most appropriate treatment.
6. Linkage with community team for continuation of treatment.

Method:

1. The referrals were mainly received from CCATT - Children Crisis Team who carry out assessments of young people presenting to A&E's and as emergencies under Section 136.

2. Prior to the referral, the young person and family are encouraged to sign a contract in agreement of the inpatient stay to last for 3 days.

3. The patient is nursed on general observation and observed for any risky behaviours. The young person is offered a set of self-help DBT tools devised by the psychology team. A senior member of the nursing team meets the patient to discuss various risky thoughts and the triggers for such thoughts. A detailed personalised Safety plan is devised from this discussion. Meetings are held with parents to educate them about the Safety plan. A Hospital to Home Care Plan is prepared from this Safety plan which is offered to the family at the time of discharge.

4. The discharge meeting is one of the main interventions in the Crisis admissions. This meeting can be quite challenging and requires up to 1.5 to 2 hours.

Quality Improvement by Introduction of 72-hour admission pathway in FHAU for Young People in Crisis

By Dr Linda Zirinsky and Dr Sadaf Mufti

There may be no major change in the suicidal risk of the patient since the time of admission. The families; as a result, may be reluctant regarding the plan of discharge.

The meeting is attended by the senior consultant, the most experienced nurse on the shift, the unit social worker if required, Care-coordinator and High-Risk nurse from the community team. The Consultant Psychiatrist who attends all of these meetings, listens to the concerns of the patient and the family, validates their anxieties and advises about a different way of understanding the symptoms and treatment.

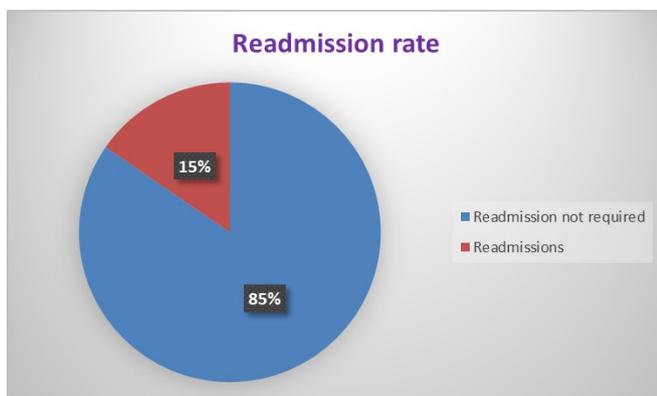
Extensive Psychoeducation about the disorder is provided to the family and advice is offered regarding implementation of the safety plan.

Assessment of the outcomes of the new admission model:

For the entire year of 2018, a total of 20 patients were offered Crisis Admissions(1) for suicidal behaviour. These were patients who presented in crisis related to suicidal risk and who did not have a confirmed diagnosis of EUPD. Some of these patients had previously received inpatient treatment.

Re-admission rate for patients who had been offered Crisis admissions

Out of a total of 20 patients offered 72-hour Crisis admissions in 2018, only 3 of the patients required re-admissions until the end of 2018. One of these 3 re-admissions was for a different diagnosis.

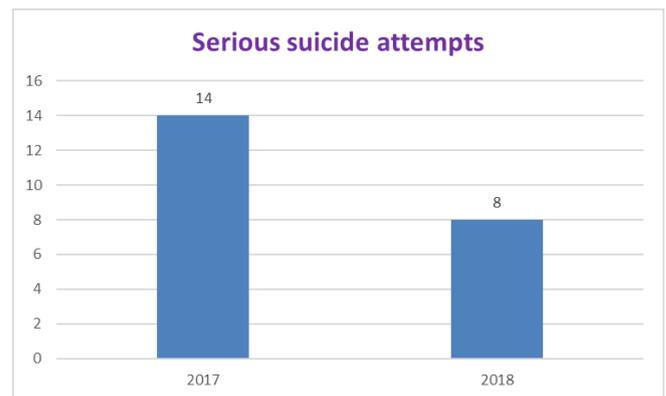


¹ These exclude the patients with established diagnosis of EUPD and patients under the care of Home Treatment Team (Tier 4 service) requiring 3-day admissions as a break from their ongoing treatment under HTT.

These also exclude Eating disorder patients admitted for 3 days for 'top-ups', patients admitted for 3 days but not as planned crisis admissions, CTO recalls. Patients initially admitted for Crisis 72-hour admissions who required an extension of their stay due to wrong initial diagnosis were also not counted.

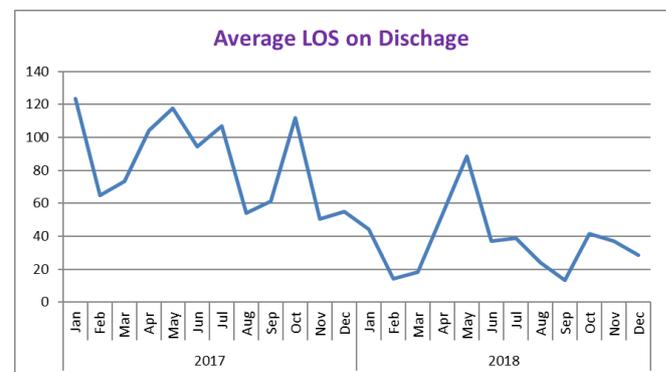
Comparison of serious incidents on the unit:

In year 2018 there were reduced number of suicidal attempts on the unit, 8 as compared to 14 in 2017.



Comparison of length of stay:

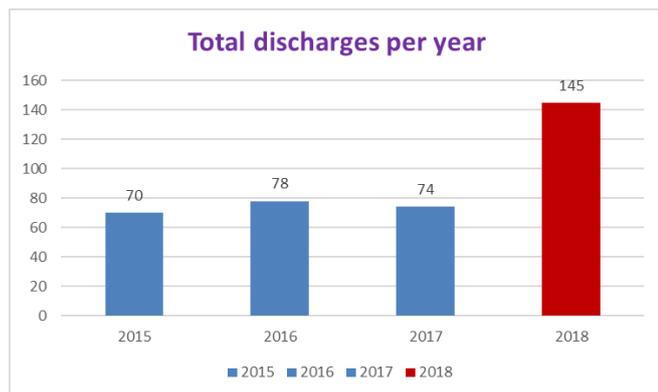
In 2017, there were 74 discharges and an average length of stay of 82 days. In 2018 there were 145 discharges and an average length of stay of 37 days. The trends are shown in figures below.



Quality Improvement by Introduction of 72-hour admission pathway in FHAU for Young People in Crisis

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Comparison of number of discharges:



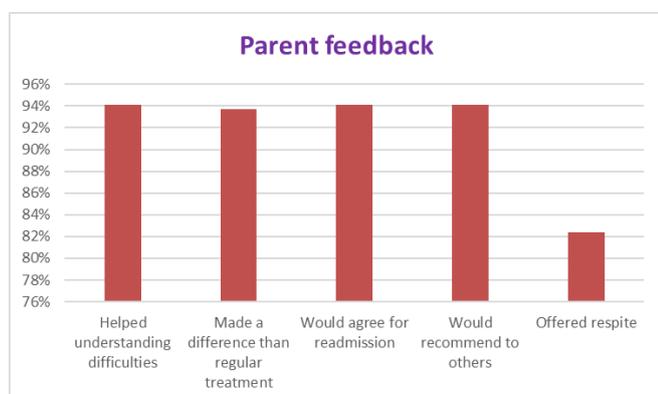
Patient satisfaction survey:

Crisis admissions to FHAU were first started in Jan 2018. A satisfaction survey was started around October 2018 and completed in Jan 2019. Only those cases were included where the crisis admission was offered for suicidal risk.

The questionnaire helped assess:

- effectiveness of the overall intervention
- contributions of the components of the admission
- description of the helpful aspects

Results of this survey:



As shown in the graph; more than 90% of the parents gave positive feedback regarding crisis admissions. They reported that the Crisis admissions had equipped them

to deal with risky behaviour of their children. Most families had found the safety plan quite useful. Some parents commented that the experience of inpatient admission helped their children to turn their life around.

Successes:

The positive feedback from the majority of patients, combined with the very low re-admission rate and reduction in the number of serious suicidal attempts on the Unit indicated that this pathway had been a success.

Data confirmed that a much higher number of young people benefitted from inpatient treatment in FHAU since the introduction of this change in Jan 2018 as compared to previous years due to significant reduction in average length of stay.

The staff seemed to show better satisfaction with this pathway knowing that this was best for the young patients as it prevented them from harms of longer periods of hospitalisation.

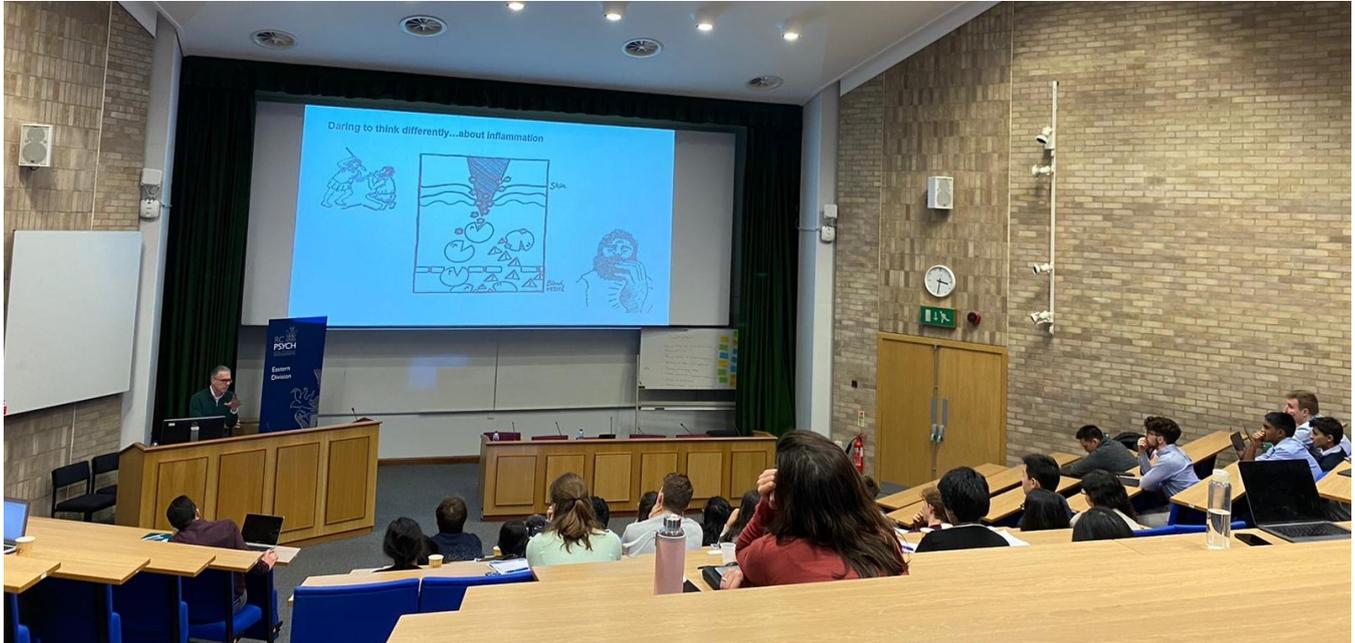
References:

- NICE Guidelines for BPD: Treatment and Management 2009
- Linehan M. Cognitive-Behavioral Treatment of Borderline Personality Disorder. New York: Guilford; 1993



Dr Linda Zirinsky, Clinical Lead
Hertfordshire Partnership University NHS Foundation Trust
Dr Sadaf Mufti, Locum Consultant
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Eastern Division Medical Student Event in Association with Cambridge Psychiatry Society 2020 Conference Report. By Mr Owen Crawford



Saturday 1st February 2020 was the day that Cambridge University Psychiatry Society hosted its first ever medical student conference in collaboration with the RCPsych Eastern Division. It took place at the School of Clinical Medicine next to Addenbrooke's Hospital. After months of planning, the day was highly anticipated by all of us who were keen to make it a successful and memorable event for all.

To allow for Saturday morning lie-ins, registrations opened at 10.30. We had a diverse group of over 40 delegates, most of whom were Cambridge medical students, with others coming from London, Oxford and even Bangladesh! Pastries were available on arrival, as well as tea and coffee. After delegates had stocked up on the latest RCPsych memorabilia, they gathered in the William Harvey Lecture Theatre for an introduction by Chair of the Division Dr Abdul Raouf and the inevitable viewing of the ever-inspiring #ChoosePsychiatry video.

The delegates then rotated through a series of workshops delivered by our excellent regional psychiatrists. Dr Felix Clay and Dr Afef Mahmoud provided students with some clinical scenarios including data interpretation. The scenarios looked at some of the interfaces between mental and physical health. For example, students were asked to interpret an ECG that showed QT prolongation after a patient had been started on an antidepressant. The following discussion explored other considerations when prescribing pharmacological therapies for psychiatric illness.

Dr Rhiannon Newman led a discussion on the objective structured clinical examination (OSCE) and communication skills, which is particularly pertinent to medical students in all three clinical years, as we may have a psychiatric component in each of the end-of-year OSCE examinations. The final workshop was delivered by Dr Paul Wilkinson, who led a case based discussion on child and adolescent psychiatry, which is a subspecialty less commonly experienced on clinical placements at undergraduate level.



Eastern Division Medical Student Event in Association with Cambridge Psychiatry Society 2020 Conference Report. By Mr Owen Crawford

Students and facilitators were so engrossed in their workshops that organising the coordinated rotation of the groups proved challenging. This speaks of the impressive quality of the sessions - many students remarked in subsequent feedback that they would have preferred the workshops to be longer. This was in spite of the fact that pizza was waiting in the common room!

Lunch was a real treat for everyone. Pizza, sandwiches, crisps and fruit were only some of the many items on offer. This was an opportunity for students and doctors to mingle and discuss the morning's workshops, a mutual interest in psychiatry and whatever else people talked about before COVID-19 sent our lives into uncertainty.



The first postprandial session was a careers Q&A session with some esteemed local psychiatrists: Dr Muzaffer Kaser, Dr Felix Clay, Dr Afef Mahmoud, Dr Rhiannon Newman, Dr Anuya Bandekar and Dr Chris O'Loughlin. We discovered their favourite parts of their job, what inspired them to choose psychiatry in the first place, and advice on how to look after one's own mental health, given the potentially challenging emotional impact of a career in psychiatry.

The final part of the conference consisted of a duo of keynote speeches, both of which touched on some really exciting areas of research going on in Cambridge at the moment. After a brief revision of the pathophysiology of Alzheimer's disease, Professor John O'Brien talked about the prospect of using biomarkers in the diagnosis of Alzheimer's and Lewy Body dementia, ending with a



discussion on the primary prevention of dementia.

Professor Ed Bullmore presented his famous work on inflammation and depression. He explored how depression can be thought of more accurately as a syndrome with multiple potential aetiologies, one of which could be a pro-inflammatory state. He talked about an old patient of his who had rheumatoid arthritis, and how her low mood may not just be a cognitive consequence of the physical health burden, but a biological one mediated by the same inflammatory markers present in rheumatoid arthritis.

The day came to an end at 4pm. Feedback from delegates was excellent - each and every session received plenty of praise. We are incredibly grateful to all the psychiatrists involved for giving up their precious time to help inspire the next generation of psychiatrists. It is only thanks to their generosity that events like this can happen. We hope they enjoyed showcasing their career as much as we enjoyed hearing about what it has to offer.

I would finally like to thank Moinul Mannan and Jen Edwards from RCPsych Eastern Division, and our student committee, especially our conference coordinator Dr Ankeet Tanna and our treasurer Heng Chun Wong, for all their hard work and dedication towards this conference.

Mr Owen Crawford, Medical Student and President of Cambridge University Psychiatry Society

Eastern Division AC Induction Course 2020

Course Report. By Moinul Mannan



On the 5th and 6th March 2020 and just a couple of weeks before the unfortunate lockdown, we were proud to launch our first Approved Clinician Induction course.

We had been running the Section 12 Induction Course since 2017 and had been hoping to get the AC Induction Course added to the calendar. The demand for this course had been growing for some time. The Course was held at Hughes Hall, Cambridge and was therefore in a good location for our Eastern region members and other clinicians. After months of planning, the day was highly anticipated by all of us who were keen to make it a successful and memorable course for all.

We had a total of 17 delegates who attended the course over the two days of the required schedule. This was a good number as it made the interaction between the speakers and delegates more engaging given the slightly smaller scale compared to the maximum capacity of 30.

The course was led by our Division Chair Dr Abdul Raouf who was joined by several other speakers throughout the two days. On the first day he was joined by Dr Elizabeth Fistein who spoke on the 'Ethics of Mental Health Practice'. Our Eastern Division Patient Representative Mrs Kate King, gave a personal account and spoke about 'Protecting patients' rights and autonomy'. Delegates were particularly impressed by Kate's presentation which was very powerful and thought provoking.

On the second day we started with a session by lawyer Mr

Simon Lindsay on 'Legal Essentials and Medico-legal challenges'. In the afternoon Dr Anna Conway Morris, a Child & Adolescent Psychiatrist and Eastern Division Representative spoke about 'Part 3 of the Act and Mental Health Law in Specialised areas'. The course was completed by Dr Raouf and Mrs Jo White an Approved Mental Health Professional, who covered areas such as 'Documentation, Administration' and 'Returning to the community'.



Throughout both days delegates also had the chance to network and work interactively with colleagues they may not have met before. The breaks served as a great time to network and lunch was a great time for them to get to know each other. The lunches were served at the venue dining room and delegates thoroughly enjoyed the mixed buffet on offer.

Feedback for the event proved to be very good and given that this was our first AC Induction course it was an excellent reflection. We hope to implement the few suggestions to improve further, during the next course, which we hope will happen sooner than later, despite the current circumstances.

I would like to thank our Eastern Division Chair Dr Abdul Raouf for his lead on this course and for getting the programme together. A huge thanks should also go to all the speakers who made the two days happen.

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

The Eastern Division is made up of members from 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 Medical Student Essay Prize Autumn

The Eastern Division has established this prize in order to raise the profile of the Division and to encourage medical students to pursue further study and professional training in Psychiatry.

Prize: £100

Eligibility: All medical students training in Medical Schools located within the Eastern Division.

Where Presented: Eastern Division Autumn Conference (online event) 13th November 2020

Regulations:

1. Eligible students are invited to submit an original essay of up to 5000 words on any aspect of psychiatry. The essay should be illustrated by a clinical example from medical or psychiatric practice relevant to mental health and should discuss how the student's training and awareness has been influenced as a result. The essay should demonstrate an understanding of the Mental Health issues pertinent to the clinical problem and should include a discussion of the effects and consequences of the condition for the individual, their family and the wider healthcare system.
2. The essay should be supported by a review of relevant literature and should be the candidate's own work.
3. The Eastern Division Executive Committee will appoint three examiners to judge the entries. Criteria for judging merit will include: clarity of expression, understanding of the literature and evidence, cogency of argument and the overall ability to convey enthusiasm and originality. The Division reserves the right not to award the prize if no entry reaching the agreed minimum standard is received.

Closing date: 1st November 2020

Submissions should be made to:

Moinul Mannan

Eastern Division Manager

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Deadline for next edition

Submit your articles for Winter 2020 edition by 1st Nov 2020 at psychiatry.east@rcpsych.ac.uk

Royal College of Psychiatrists - Eastern Division E-Newsletter

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