



Special Edition:
**'Reflections on Covid-19 -
what has it meant for society,
our practice and us?'**



The Psychiatric Eye

The London Division e-Newsletter

The year 2020 has impacted everyone in different ways. As the year nears its end this edition offers a reflection on the effect the pandemic has had; not only on the world around us, but also on us as individuals, professionals, and on our patients. It is striking how many have seen opportunities for innovation and positivity despite the challenges.

Perhaps unsurprisingly, we had a large number of submissions to the PsychEye this time round and too many to mention individual here but we do hope you enjoy reading through the articles. Congratulations to the winner of the best article, Dr Naila Saleem, who reflects on moving forward after loss.

We have three offerings from child and adolescent mental health teams. The Lewisham CAMHS ADHD Team updated us how they have adapted the service, and how opportunities for innovation arose. Dr Mamas Pipis offers a more personal reflection on navigating the emotional and practical issues associated with working through the pandemic. We also have a service development evaluation from Dr Tania Saour, describing positive changes to care in the A&E setting.

The benefits of remote medico-legal assessments are considered in an article by Dr Nikki de Taranto. The positivity continues when the therapeutic benefits of music are considered in an article by Dr Sitki Anil Ustunn and culture in mental health is further when Dr Emmeline Lagunes-Cordoba assesses the role of the arts in coping with a crisis.

Whilst the COVID show is far from over, it feels as though the initial anxious panic is dissipating and maybe being replaced by a cautious optimism for progress and powerful resilience. Look after each other and stay safe!

Chris and Rory

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Chair's message

*Dr Peter Hughes
Chair of the London Division*

I hoped that by our next newsletter the situation with the pandemic would be better, but unfortunately that is not the case. We face a tough time ahead of us professionally and personally.

We have seen that what was predicted, has happened, with an increase in mental health cases of depression, anxiety, social isolation and domestic violence. It is likely to continue. I hope that you had a chance to view our London COVID webinar and see what we can learn from the first surge. Messages I took away, were that online work does indeed work, our services did continue, and we have been flexible. Perhaps the message that I liked the most, was the need for all of us to stand together and be kind to each other. It is certain that we will be stretched ourselves over the coming months. We must look after ourselves so we can look after our patients.

We have devoted this edition to COVID. We hoped it would be the epilogue, but it seems to be mid-chapter instead.

I thank the newsletter team for collecting these articles so we can make the best use of a variety of learning at this difficult time.

The London Division is ready to help its London members in any way we can, so please reach out to us if there is anything you think we should be doing, or indeed if you just want to connect.

I wish that all our members remain safe mentally, and physically at this difficult time.



Reflecting on Loss in the Time of COVID-19: Challenges and Opportunities

Dr Naila Saleem

The COVID-19 pandemic has affected the world in unique ways; from cancelling of the Olympics to complete lock-down to shortages of paracetamol. On one hand this pandemic has left us paralysed by taking away our freedom and ability to act in a certain way. On the other hand, we have learnt new skills and have found new ways to survive and continue to function with limited resources and in relatively restrictive conditions. Transition to work from home, use of technology, digital media, online consultations are just few examples of how we have had to cope.

Abraham Maslow⁽¹⁾ discussed the universal needs of societies as he saw them in 1943; stressing the importance of meeting physiological and psychological needs before maximizing human potential. Although more recent research suggests that these needs are not necessarily in the order originally suggested, the COVID-19 pandemic had the potential to put all our needs at risk. Many around the world, especially in developing countries, suffer significant financial impact and struggle to feed their families. Social distancing, although should be understood as physical distancing, has led people to feel lonely and isolated, making them susceptible to psychological distress.



Mental health services have started seeing the aftermath of COVID-19 pandemic and how it has changed people's lives and ways of thinking. Young people with mental illnesses are considered as vulnerable and have struggled significantly during lockdown. However, COVID-19 pandemic has particularly impacted patients with Autism Spectrum Disorder (ASD), and those with Intellectual disability or with high support needs (2). Whilst the aim is to protect them from catching COVID-19, physical distancing measures have inadvertently caused high stress and have impacted the mental health of children with ASD. Children and adolescents with ASD are overly sensitive to change in routine and lack of structure in their routine can have detrimental effects leading to behavioural problems and emotional dysregulation. This population is at risk of further deterioration due to inability to understand some of the restrictions put on them to protect them from getting physically unwell.

This emotional impact of the pandemic has not only affected people suffering from mental health problems but has also affected all individuals, especially those delivering care and health interventions. Burnout amongst health care professionals has been extensively studied and documented. Research has shown the prevalence of burnout to be more than 40%, with highest rates in frontline healthcare providers (3). Health care professionals are found to be least insightful into their fatigue hence more vulnerable to the physical and psychological effects of burnout.

We all have experienced some sort of loss in our life. The pain of loss can be overwhelming; but uncertainties of a pandemic multiply the impact and make the experience even more devastating.

I lost a close family member during pandemic. It was crippling to be in a position where nothing was in my control; not being able to fly back home due to travel restrictions, not being able to be with my family due to distance, not being able to participate in funeral arrangements or even say 'goodbye'. These factors made it extremely hard to accept the reality and come to terms with the loss or process grief smoothly. Although staying connected through digital technology helped me, to some extent, to cope but nothing made emotional pain less intense. Nothing gave me sense of closure, which, I believe, is incredibly important when dealing with grief.

Grief is an inevitable part of our life. During this pandemic we all have gone through the stages of grief (denial, anger, bargaining, sadness, acceptance) as proposed by Elisabeth Kübler-Ross (4). Most people are facing grief related to loss in general (and not only death). This involves, but is not limited to, loss of control over their lives, loss of freedom, inability to take decisions, uncertainty, fear of catching infection, fear of putting family/ loved one at risk, drastic changes in routine, losing stability and comfort and fear of losing loved ones etc. Anxiety experienced during a pandemic can also lead to anticipatory grief. Anticipatory grief is when you imagine the worst for the future (5). To calm yourself, you must come (back) into the present; this is where meditation and mindfulness comes in. It is important to understand which stage of grief you are in and move towards acceptance. Acceptance gives us control and helps us move forward.

The effects and experience of this pandemic on society are far reaching – which I believe is impossible to fully describe on paper. People with low resilience and underlying mental health problems are at greater risk of being affected. However, there are many positives to be gained from this experience; for example, improvised interventions offered at the right time have dramatically improved the quality of life for patients and changed their trajectory. There is a need to prioritise and focus on helping and supporting vulnerable groups of our society. To rebuild our lives shattered by COVID-19, I believe, we need to continue to build upon the gains

achieved in this period and maintain the positives we have learnt. The hustle and bustle of our busy lives will continue, our grief will subside.

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Reflections on COVID-19 and its impact on CAMHS practice

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Background

In addition to the mortality associated with the COVID-19 pandemic¹, daily life stresses have also increased. These stem from concerns about acquiring the COVID infection, economic difficulties from job losses and social isolation from having to quarantine or shield². These may even be more so for individuals with pre-existing mental health conditions for whom these additional worries may exacerbate their mental health, while access to treatment may be restricted.

In this write-up, we reflect on the impacts on the pandemic on the outpatient care of children with ADHD at the Lewisham CAMHS – a community service. We briefly review the pathway of care prior to the COVID pandemic, the disruptions to service provision, steps taken to mitigate these, and the opportunities and challenges presented by the pandemic as we navigate life beyond the pandemic.

Pre-COVID treatment pathway

Prior to the pandemic, children with suspected ADHD were typically referred by health or other practitioners including general practitioners, paediatricians or school staff or other teams within Lewisham CAMHS. This was followed by a preliminary screening to determine whether the symptoms met the threshold for a possible ADHD diagnosis. Children who met the threshold were then assessed via a combination of clinical interviews, standardised questionnaires completed by teachers, parents and the child where possible and school observations. Results of the assessment were then fed back to the children and their families who, where a diagnosis of ADHD was confirmed, were informed about medical and non-pharmaceutical approaches to treatment. Families opting for

medications were then transferred to the ADHD team who organised ADHD and medication workshops for further information. The team which comprises 5 clinicians who each work 1-2 days per week in the team had an average of sixty-four referrals in the past year. Consequently, there is often a long waiting list for medication initiation. At the start of the lockdown in February, 2020; there were almost thirty children waiting to be initiated with waiting times ranging from 2-6 months. After initiation, the medications are titrated at weekly review clinics and referred to the general practitioners (GPs) for continued prescription once an optimal dose has been reached.

Impact of COVID on the service

One first impact was that face-to-face reviews had to be postponed till further notice. This necessitated alternative arrangements for prescriptions. Where the children were stable, GPs were contacted to continue with prescription and the measurement of physical parameters including weight, height and blood pressure where possible. Over time, review for children who still required continued follow-up were carried out via telephone and video calls. This facilitated the possibility of working from home which became necessary as members of the team initially had to shield and later as government policy shifted to reduce the number of staff present in the clinic. Initially, both ADHD assessments and medication initiations were put on hold; however, as the lockdown continued, families called in to report deteriorations in their children's ADHD symptoms. This may have resulted from families having to spend more time in confined spaces and little respite for parents and children at work and school respectively.

The increased psychological stress from the COVID pandemic may have also resulted in diminished mental resources for coping in the parents, some of whom may have had pre-existing mental health difficulties including subthreshold ADHD symptoms.

The ADHD team's response

The team considered evidence on transmission and prevention at the times and decided to recommence face-to-face ADHD medication initiation clinics. A protocol was established which consisted of screening families on the waiting list via telephone interviews for the presence of COVID symptoms, exposure to persons with COVID symptoms or infection, personal and/or family history of comorbid cardiovascular conditions and severity of ADHD symptoms. Of the twenty-eight families screened, two were shielding while the remainder were willing to attend an initial face to face review in which baseline physical parameters were assessed, further medication information provided and reinforced and ADHD medications initiated. The building management provided personal protective equipment and approved five slots were approved one day in a week to limit the number of people in the building at any point in time. Following initiations, families were contacted once every 1-2 weeks to monitor therapeutic and unwanted effects and to review medication dosages. Between May and August 2020, the team saw between 2-4 children per clinic day and had successfully initiated twenty-six patients, effectively clearing the waiting list.

Opportunities and challenges

Although the pandemic and lockdown was a generally stressful period, it provided the team with an opportunity to trim the waiting list. Many parents were grateful for accelerated access to medication and the opportunity for their children to engage more meaningfully - functionally and socially. The pandemic also provided new

members of the team with an opportunity to broaden their experience with ADHD pharmacotherapy.

While the decision to recommence medication initiation during this period was innovative, we experienced several challenges. Firstly, there was difficulty reaching some families consistently via email or telephone possibly due to COVID-related disruptions in personal schedules, exacerbation of pre-existing chaotic family environments or personal choice. This meant a few families could not be screened or adequately monitored during the follow-up. Caregivers with reservations about pharmacotherapy may find the physical presence of the traditional face-to-face weekly reviews more reassuring which may aid adherence. In one situation, a mother discontinued treatment because her reservations persisted and she did not feel telephone reviews were sufficient to address them. Furthermore, though reachable, shielding families could not have their children attend the interview which meant the children could not benefit from this opportunity. Finally, as several children were no longer attending school, it was difficult to obtain information about changes in ADHD symptoms following medication initiation and to evaluate how compatible the dosage regimens will be with the children's routines.

Recommendations

Our experience highlights the need for collaborations with other health professionals; for example, we were only able to reach one of the mothers through her son's care coordinator. Similarly, we may need to depend on the GPs to assess the baseline physical parameters for children in shielding families. For example, rather than have shielding families come to the clinic, the children can have their physical parameters assessed by the GPs and this information subsequently relayed to us while other assessments could be via video calls.

Schools will also need to be contacted after academic activities resume to assess the efficacy of the ADHD medications. It will also be important to investigate other characteristics of hard-to-reach families and determine facilities that need to be set up to enhance their access to mental health support for their children.

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COVID-19: Reflections of a child and adolescent psychiatry trainee*Dr Mamas Pipis*

The Coronavirus pandemic, an ongoing health crisis which has managed to reshape our lives both in and out of work in a matter of a few months.

From being completely naïve to what constitutes a pandemic, to trying to tackle the challenges of working in the NHS under a state of full lockdown practising and training child psychiatry in a way which I never thought I would (or could).

I can definitely say that in the first weeks or so I was in a state of disbelief. 'Is this really happening?', 'are we not going back to how we were pre-COVID?', 'how does this change things?' etc. A lot of questions that were only getting more and more as days were progressing, a sign that we were far from close to the end.

As this was unfolding, the way we engaged with patients and colleagues also evolved. Initially only the bare minimum and only children and adolescents in crisis were seen in person. Everyone else was assessed and reviewed from a distance using teleconferencing applications for the safety of both patients and professionals. As the pandemic progressed and the number of active cases started slowly going down (at least in London) services were equally moving back to increasing number of face-to-face contacts with the strict use of PPE (where we are at the moment).

This has been-and still is- a once in a lifetime experience for everyone including myself. An experience full of ambivalence, trepidation, confusion and fear but also with newfound feelings of camaraderie, creativity, resourcefulness and 'coming together' (although from a distance).



How do I continue my practise and training in child psychiatry in a way that still retains its core values and goals? Is it really possible to assess anyone, let alone a mentally unwell young person, via an electronic device? Questions kept creeping in, bringing with them uneasiness and doubt.

As we are all in this together, what really helped was sharing and being open about these feelings. Whenever obstacles appeared, asking around or extending a helping hand or even sharing my half-digested understanding of how the teleconference application worked seemed to do the trick: 'Why don't you try this?', 'Have you spoke to [name], I've heard she's good at it' etc.

Patients and their families also showed understanding, willingness and readiness to quickly adapt to this new way of engaging with them. This was essential in moving into this new reality. Despite the initial –mainly technical– challenges, I successfully managed to complete reviews, assessments both in and out of hours with everything these entailed. It wasn't exactly the same as the face-to-face ones but I'm now confident enough to say that they can be good enough to inform my practise and offer containment and a safe space for my young people and their families.

Of course, clinical work was not the only part of work being turned upside down; research and training were also greatly affected. These were moved into the virtual world in a matter of a few weeks after full lockdown was put in place.

Similar feelings of confusion and mistrust on how well this can be done and how well I could engage and follow through. Once again, my concerns were proven inaccurate and through coming together and thinking on the spot in a creative and open-minded way everything was rearranged in a way that helped continuity and quality of our training sessions. Still, not exactly the same as being in the same room with other colleagues, but good enough and most importantly safe enough for everyone involved.

As this unprecedented health crisis developed, I found myself struggling to catch up with all the demands and changes that were taking place in the NHS. Balancing worries for my family's safety as well as mine with maintaining a headspace at work which allows flexibility and resourcefulness was my main challenge. Having gone through the initial and most terrifying part of this pandemic I can now safely say that I feel confident enough in working/training under these exceptional circumstances expecting nothing less than a new normality to slowly emerge. There's no turning back to how things were pre-COVID and this has now properly sunk in.

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The development and set up of a CAMHS Mental Health Emergency Assessment Service (EAS) during the Covid-19 crisis

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Service description

The COVID-19 pandemic has caused an unprecedented challenge for healthcare systems worldwide due to the increasing demand for care of people with COVID-19 while trying to maintain the delivery of essential services and also routine health services. The care of patients seeking or referred for emergency psychiatric evaluation has also been impacted by the present pandemic (Bojdani et al 2020).

During the initial stage of the COVID-19 pandemic the CAMHS Mental Health Emergency Assessment Service (EAS) was developed to support the existing CAMHS service provision. The purpose of the service was to allow children and young people presenting in an emergency, to be diverted away from A&E departments in order to reduce exposure to potential infection, where this was possible and appropriate.

The CAMHS Emergency Assessment Service (EAS) provided a 24/7 triage and out of hours mental health emergency assessment function (see figure 1 for the core functions of the service), which had not previously existed and covered five of the North West London Boroughs: Westminster, Kensington and Chelsea, Hillingdon, Harrow, and Brent.

Setting up of the service

2.1 CAMHS EAS Operational Group

The CAMHS EAS Operational Group (OG) was set up to oversee and ensure the successful mobilisation, delivery and continuous development of the CAMHS EAS. Ongoing review of the service was required throughout the COVID-19 Public Health Emergency to align with changes to local and national guidance.

The EAS OG remained responsible for monitoring and reporting on the performance of the EAS against performance measures set. They were responsible for escalating and managing service risks. Through regular meetings the CAMHS EAS OG monitored and provided assurance on all workforce matters including recruitment and retention, rota and scheduling as well as training compliance.

A role of the EAS OG was also to engage and communicate with internal and external stakeholders, as well as patients and their families whilst also monitoring spend of the service.

2.2 Core functions for the service

- The EAS is set up to ensure that all CAMHS referrals for urgent care receive a mental health triage and appropriate signposting and assessment 24 hours a day 7 days a week.

- Through the triage process this service ensured that all potential admissions met the threshold for an admission.

- During the COVID-19 Critical stage it was important to alleviate pressures on the A&E department. The EAS would enable CAMHS patients who would otherwise go to A&E for a mental health assessment to be seen in an alternative setting.

- Face to face assessment would be offered and a standardised admission threshold agreed with CAMHS home treatment team intervention as first point of consideration for inpatient treatment.

- To reduce the number of staff required in A&E by completing gatekeeping assessments in an alternative location.

- To provide an emergency assessment space for a maximum of three young people in the centre at one time and for a maximum of 24 hours.

2.3 Referrals in hours

Between the hours of 9am to 2pm, assessments were carried out at the relevant CAMHS team sites. New referrals were triaged by the EAS practitioner in the centre and those who did not meet criteria for A&E pathway were seen for an assessment away from A&E. If a referral was received after 2pm a triage assessment was completed and a decision made if the child or young person could be seen at the EAS or would need to remain in A&E for an assessment by the CAMHS Urgent Care Team.

2.4 Referrals out of hours (5pm – 9am)

A triage practitioner would triage any new referrals received. Where appropriate, the child or young person would be received directly from A&E to the EAS for assessment. Where deemed necessary and appropriate, a child or young person would remain in the centre overnight.

2.5 Inclusion/Exclusion Criteria

The following, whilst not an exhaustive list, sets out the exclusion criteria for children and young people seen at the EAS. If any of these criteria were met they would be more suitable to be seen at A&E.

- Confirmed or suspected overdose
- Self-harm with injuries requiring medical attention
- Acute psychotic episode
- Drug and alcohol intoxication
- High risk of absconding (ASD/LD/LAC)
- Severe agitation/aggression
- Eating disorders requiring medical intervention
- Section 136 of the MHA
- Primary need is related to break down of a social care placement
- Aged over 18
- Child or Young Person with medically unexplained symptoms

2.6 Psychiatric input

There was a rota of all non-consultant grade doctors across five boroughs (CTS, STs and speciality doctors) organised to cover the centre during the daytime.

The CAMHS EAS had a dedicated consultant psychiatry lead, who was the primary contact where consultant input was required. However, the day to day consultant cover was provided by a duty consultant on the rota that included all consultant child and adolescent psychiatrists from the five boroughs covered by this service.

Results

The EAS went live on Wednesday 8th April 2020. Over a two-month period, from 8th April 2020 to 8th June 2020, a total of 90 young people presented to A&E within Central North West London NHS Trust requiring an emergency CAMHS psychiatric assessment. Of these, 19 (21%) met the criteria to be diverted to the EAS located at Northwick Park Hospital.

Of the 19 young people who were seen at the EAS Suite, 4 were out of borough and 15 were within the 5 CNWL boroughs: Westminster, Kensington and Chelsea, Hillingdon, Harrow, and Brent.

12 were female and seven were male. The majority of assessments were for young people aged 16 (6 cases). The ages ranged from 13 to 17- one young person was 13 years of age, five were 14 years of age, three were 15 years of age and four were 17 years of age.

The majority of referrals to the EAS suite came from St Marys Hospital (42%), followed by Northwick Park Hospital (32%), Chelsea & Westminster Hospital (21%) and lastly Hillingdon Hospital (5%).

Furthermore, the majority of cases (52.6%) were not previously known to CAMHS. Only 9 (47.4%) were open to their local CAMHS. Fifteen cases (78.9%) were seen out of hours (between 5pm and 9am). In these cases, 68% were seen between midnight and 9am. 4 cases (21.5%) were seen within office hours.

The main reason for referral from A&E to the EAS Suite was suicidal thoughts and low mood (42%). Overdose contributed to 21% of referrals where the young person was diverted once medically cleared. Anxiety contributed to 26% of referrals and active self-harm contributed to 11% of referrals. Of those who were reviewed at the EAS unit during the allocated time frame all but one young person (who required inpatient adolescent admission) were discharged to be followed up by either their local community CAMHS teams or the Urgent Care Teams.

Discussion

During the Covid-19 critical phase we set up the EAS, which allowed children and young people presenting in an emergency to be diverted from A&E departments where this was possible and appropriate. Data has shown that only a small proportion of children and young people were able to be diverted to the EAS (17%). This meant that in majority of cases young people needed to remain and be assessed within A&E Departments.

The provision of this alternative service had several advantages. Firstly, it improved patient and staff safety by minimising exposure to infection risk associated with busy A&E departments. Secondly, it provided young people presenting with acute distress, a calmer and less stimulating environment. Thirdly, there was a reduction in delays to the assessment and discharge of young people and reduced emergency department workload. In addition, with the new structure of the out of hours services in CNWL, this meant that in certain situations clinicians did not have to travel to different A&E departments to complete assessments but instead completed assessments in one place improving time management and efficiency. Nevertheless, the service was set up to meet an urgent clinical need without time for a detailed evaluation of its potential cost-effectiveness.

Several areas of improvement need were highlighted. There were a small number of patients who needed to be transported from their local A&E to the location of the EAS. This meant that they had to travel further away from home for an assessment. Review of the data highlighted that the majority of the referrals needed to remain in A&E for assessment. Finally, it was felt that having this service could lead to further division between the mental health and physical health services and a potential increase in the stigmatisation of mental illness.

This service is currently closed but the experience was valuable and could help in setting up other services in crisis situations. The learning from this experience could also help us in further development of CAMHS crisis and emergency services.

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What we have learned from COVID?

Dr Mark Salter

Early on in the pandemic, many prisoners were glad to learn of their early discharge. Not long after they reached the imagined freedom of their homes they found themselves in another prison, their incarceration now managed by an invisible viral cloud. We can learn much from this.

In March I saw a newly released 33-year-old drug dealer. Via video, his daytime flat looked as dark as a cell. He reported anxiety, but his nightmares were worse - he dreaded return to the time he left his cousin to bleed out in a car park, calling the ambulance before he ran. That was five years ago, he said, *but why is this coming back to me now?*



Over months, peering into the homes of patients like never before, I saw how, denied of their routine contacts with the world, long-managed trauma and abuse was reappearing everywhere. COVID reminds us that all of daily life is an adaptive coping strategy; Palmer (2005) dryly calculated that even a patient seeing their GP fortnightly for a year spends 99.95053272% of their life beyond the medical gaze. We should ask patients less about their symptoms and much more about what they actually do all day.

My drug dealer wasn't hemmed in by fear of some bug. He was responding to social imperatives described by Durkheim over 100 years ago: the sharing of any strong emotion causes predictable changes in that group;

consider the Nation's behaviour after Diana's death. My patient was kept under house arrest by the weekly banging of pots and the sudden ubiquity of fear-linked stimuli; what Daniel Kahneman describes as an 'availability avalanche'. We were entranced by Boris at six, exhorting us to 'stay home, stay safe'. We hurried back to an elderly couple of wise institutions: the NHS and BBC, which only months earlier Boris had considered cutting. We can discern another lesson here, at a social scale. We should spend less time exploring our patient's heads and pay more attention to the world around them. We have, after all, chosen to treat the only organ in the body that can vote.

Our sudden distance from our patients was no mere social distancing. Unlike the rest of medicine, psychiatry has almost no tests or devices to refine its efforts. Instead, we rely on our ears, our eyes and sometimes our noses. We started looking and listening from behind a screen. The bravest had only a mask. How odd it felt to be suddenly deprived of - and made to appreciate - those countless tiny cues, the sighs, the diverted gaze and its flinching return, and most of all, the silences. It was not easy to gauge the pain and poignance of those quiet moments that are the stock of our trade. Like musicians, so much of our work goes on in between the notes. How do you assure someone of your understanding when you have unleashed waves of grief and tears four miles away?

For all the optimistic talk of 'virtual clinics' in the future, psychiatrists must be wary. Our work is not like the rest of medicine. Distance deprives us of our most important tool, a potent mix of knowledge, interest, empathy and proximity. Without this, we cannot properly grasp the thoughts, feelings and hopes of our patients.

If medical science has taught us one thing over the past hundred years, it is that human suffering is incredibly complex. Many of our responses; our resort to explanatory biological myths and diagnoses of questionable validity (Parker 2018) or the shrinking of our discharge summaries, all are signs of our instinctive retreat from the bewilderment we feel when confronted by complexity. Psychiatry is stigmatised for its apparent inability to match the 'precision' of our more bodily focussed colleagues.

Although we claim to give equal weight to the biological and the psychosocial elements of our assessments, the truth is that we are drawn to the former, because they seem less challenging (Ventriglio et al 2018). COVID's lesson for psychiatry is clear: psychiatry must face the true complexity of mental illness head-on. If we are seen to do this by the rest of the medical profession, our uncertainty in the face of it can become psychiatry's touchstone rather than its millstone.

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Article notes:

"The author confirms the clinical details in this article are not representative of any particular person. Any resemblance to actual persons, living or dead, or actual events is purely coincidental."

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Positive aspects of conducting psychiatric assessments in medico-legal post-traumatic cases remotely

Dr Nikki de Taranto

I am a forensic psychiatrist who acts as an expert witness, areas of interest including personal injury cases involving trauma, historical child abuse and clinical negligence. In such cases the examination process can be challenging or even deeply distressing for the client.

For years, I have offered a few examinations over remote platforms, in cases where the person cannot physically get to a meeting, because of distance or disability. However, my default arrangement has been seeing the client in person.

At the start of lockdown in the UK I moved my medico-legal practice entirely online, using Skype, FaceTime or (more recently, after some security issues were sorted out) Zoom.



I conduct the interviews from my locked study at home, using a headset so the client's voice is not being broadcast over speakers. Prior to the interview I ask the solicitor to explain this to the client to reassure them.

I had a fairly neutral attitude to this change initially, although I realised early on that the lack of travel had immediate benefits. I was saving hours of time, was never late for a meeting, and was always in a calm and focused mental state, not having had to negotiate roads or trains, look for

parking or worry about finding the venue. The case was completely fresh in my mind as I had been reading the paperwork in the comfort of my own study, directly before the start of the interview.

As time went on, I started hearing from clients directly how they too were finding this way of working to be positive. The most common starts to interviews in the pre-COVID era were the client saying, "Doctor, I very nearly didn't come", or "I was so scared about coming". What I now started to hear was, "I was so relieved when my solicitor told me I could do the meeting by Skype".

The experience of working in this way has continued to be a positive one for both me and most of the clients. From a financial and environmental point of view the benefits are obvious, as they have been to everyone in the world now adjusting to increased remote working.

I have however, with the aid of feedback from the clients, found that there are for many of them definite psychological and mental well-being benefits:

- a) They feel that they are less anxious in the run up to the remote meeting than they would have been before a face-to-face meeting.
- b) None of the stress of travel, finding the venue or worrying about being late.
- c) No sitting in a waiting room in an anxious state, and the meeting always starts on time.
- d) They are in the comfort of their own space (one lady was in bed, hugging a pillow).

- e) They can have unlimited refreshments with them or go to fetch them at any time.
- f) They can smoke during the interview. This has been an unexpected one. I have had several clients smoke through the interview to manage their stress level. Clients could of course, in face-to-face interviews, ask for a cigarette break, but that is not the same as being able to smoke at leisure.
- g) They can ask for a short break, or to resume later in the day, which would not be possible when working in the old way, with a booked consulting room and travel involved. Of course clients have always had the opportunity to discontinue a meeting if they cannot cope, but this would then mean having to come back, with all the stress of travel etc, perhaps weeks later. Now the meeting can easily be broken into as many parts as the client requires (and a number have requested this).
- h) If an interview runs over time and I have another commitment directly afterwards, I no longer have the difficult choice between letting the next commitment (which may well be another anxious client) wait, or requiring the current client to travel to come back again another time.
- i) The nature of these interviews means that clients frequently become distressed, and this cannot always be avoided where you are addressing post-traumatic issues. Of course I would always try to ensure that the client is reassured, and to allow them time to compose themselves, but this is not always possible in face-to-face interviews, when the next client may be waiting outside, or the room may be booked for someone else. This means that sometimes a client who is visibly

upset or crying has had to walk through a waiting room and then drive, or travel on public transport, to get to the solace of their own home. All of this is avoided now.

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Coping with Covid-19: A Perinatal Newsletter in South West London and St Georges NHS Trust

Dr Holly Kirwin, Dr Thomas Prew, Dr Mireia Pujol

Due to the COVID-19 pandemic, many of our perinatal patients were becoming increasingly isolated due to the lockdown measures in place, at an already high-risk time for these women. Many services had been reduced including GP, health visitors, midwives, and children's centres, adding to the sense of isolation. In addition, some of the perinatal staff in our service were re-deployed to other newly opened mental health emergency services to support the demand. As a result, we had a reduced number of staff to manage our caseloads, all whilst the circumstances and information regarding the pandemic were changing rapidly.

To help address this we developed a weekly COVID-19 perinatal newsletter covering a number of topics and signposting to alternative sources of support.



The aims were to support women in our perinatal service to remain psychologically and physically healthy through the COVID crisis considering this reduction in services, along with keeping them engaged and to hear them share their mental health perinatal journey with others as a way of peer support. We sent out a survey to all the women receiving the newsletter at the beginning and the end of the project, covering

questions using a Likert scale about their psychological and physical wellbeing along with any suggestions for change.

We completed a total of 14 newsletters which were sent out on a weekly basis from 20/3/20-22/7/20 covering the following topics: Introduction to the newsletter – general information; Anxiety; Antenatal and postnatal depression; Maternity mental health awareness week; OCD; Domestic Violence; Kindness; Eating disorders; Substance misuse; Relationships; Tocophobia; Contraception; Sleep; and Postpartum Psychosis.

We also included 7 testimonials from our service users and one service user with a background in editing assisted us in re-developing the newsletter template. It was a true co-production project.

Some of the service user feedback about what they found most helpful from the newsletters included;

- *'Information of services and advice on how to adjust'*
- *'The informative articles'*
- *'Knowing there are people who are spending time doing this newsletter willing to help and support who is in need'*
- *'Knowing that there is always somebody there to help but also the little tips'*
- *'Stories by other service users.'*

Although it was a small cohort who responded to both surveys and we cannot say any improvements were solely due to the newsletters, the results were positive .

For example;

- Confidence in managing physical health increased from 43% feeling 'quite confident' to 80% by the end of the project.
- Confidence in managing mental health increased from 7% feeling 'quite confident' to 80%.
- Service users' ability to access the right support during a crisis also increased from 28% 'a great deal' to 40% by the end of the project, and 28% 'quite a lot' to 60%.

Further benefits from developing the newsletters also included fostering closer relationships with other services due to a number of experts contributing, including from sexual health services, eating disorders, OCD, substance misuse, maternity services, father's projects and the safeguarding team.

We are currently considering continuing the newsletter on a monthly basis for a trial period and creating a booklet of all the newsletters that can be given to service users in the future.

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Being an International Medical Graduate in the times of COVID

Prof. Subodh Dave and Dr Emmeline Lagunes-Cordoba

"We are all in the same storm but not in the same boat." - Damien Barr



The cruel and pervasive claw of the COVID-19 pandemic has touched us all, affecting every aspect of our lives. It has also exposed health inequalities in our societies. People of BAME origin were up to twice as likely to die of COVID-19 compared to their White peers (1). We healthcare workers are not immune from this statistic. Alarm bells rang when the first ten healthcare workers dying of COVID-19 were all reported to be of BAME origin. Sadly, months later, 95% of the medical staff dying have been from BAME backgrounds (2). Buried in this statistic is the fact that almost 90% of these doctors were International Medical Graduates (IMGs). International staff make up 20% of the NHS workforce (3). While ethnicity and other protected characteristic monitoring is becoming increasingly common, migrant status data is hard to come by. Early reports from HSJ suggest that deaths secondary to COVID-19 are almost twice as high for international workers even when *White* staff are included: 53% of deaths are international healthcare workers (IHCWs) who make up only 20-25% of the workforce (2). Despite this doubling of risk for IHCWs, no official COVID-19 death statistics are available for IMGs/IHCWs.

Identity as an IMG

So, who exactly is an IMG? No two IMGs are the same, of course. SD hails from India and has been a Brummie for over twenty years. ELC, a Londoner, comes from Mexico and has been in the UK for five years, but only one year working in the NHS. But both do share similar stories, being migrants to the UK.

Both have families abroad, are nostalgic about certain foods, and shout at the TV when watching news from their country of origin. London, with the highest concentration of IMGs in the country, must have thousands of similar stories. However, many doctors from Europe who might think of themselves as IMGs are not included in the General Medical Council definition (doctors from outside the EU) (4). The Royal College of Psychiatrists uses country of primary medical qualification in its definition, which means that the growing band of UK-born and schooled students studying in medical schools outside the EU are considered IMGs. The oft-made conflation of IMGs and BAME origin does mean that IMGs of non-BAME origin are often left out of the discourse (and the data) around equality and diversity, despite encountering the same issues as BAME IMGs.

IMG issues

Moving home is generally considered one of the most stressful life events, and it is significantly more stressful when involving international borders and different medical regulators. Getting a driving license, renting accommodation, and opening bank accounts (try getting one when you don't yet have a billing address) can all become a Kafkaesque Catch-22 nightmare.

The NHS saves £250000, to £500000, per imported doctor, depending on their seniority. Given the large numbers of IMGs, one would think that managing IMG induction and acculturation to NHS practice is carried out with consummate ease. In practice, however, IMGs are expected to deliver the standards of Good Medical Practice while receiving the same Trust induction as any other UK graduate. Add to that the routine microaggressions at work (for example, SD has been mocked for his accent, abused racially and asked “when do you go back home”) that IMGs suffer in disproportionate numbers, and the result is that IMGs often feel that they are set up to fail. No wonder that they are more likely to be referred to the GMC (interestingly, more often by their employers than by patients). One of the main bugbears for IMGs is that their strengths, the rich experience that they bring to the NHS, is almost never utilised or even recognised.

IMGs and COVID-19

COVID-19 has amplified the negative impact of the issues, both personal and systemic, faced by IMGs. The fear of coronavirus infection is a real and present danger for all of us, but for some, the deaths of colleagues and friends has brought that fear closer to home. Many IMGs reported feeling disempowered and unable to raise their concerns about lack of PPE or about the lack of appropriate risk assessments (5).

At a personal level, SD and ELC have both come across colleagues and friends reporting further isolation and burnout, fear for the safety and wellbeing of family members, and guilt for not being able to support them. Travel and visa restrictions have meant that many have been unable to attend the funerals of loved ones. With the advent of the second wave, the prospect of meeting loved ones seems even more remote and that does get dispiriting.

However, while this is the case for IMGs already established in the UK, the pandemic also impacted a large number of IMGs who travel to the UK to undertake their professional examinations. Hundreds of IMGs were left stranded in the UK, with very limited resources and no support, when their exams got cancelled and the borders were closed. ELC has been involved in a humanitarian effort led by a charity to support these stranded IMGs.



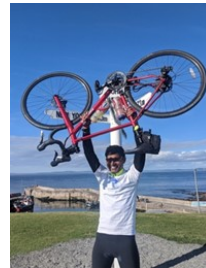
How can you help?

Systemic measures like ensuring IMGs have appropriate PPE based on a personalised risk assessment is clearly important (5). But there are things that we can all do. Reach out, with a simple “how are you?” or acknowledge their “IMGness”: a “Must be hard not being able to travel” may be a good start. Show support and consideration by helping with annual or compassionate leave; IMGs may not have seen their family for a very long time. IMGs like to share their experiences; show compassionate curiosity. Welcome IMGs, especially those new to the country, to your community (at work or outside work). IMGs, like anyone, else need to feel valued, cared for, and connected. Today, more than ever, we need to demonstrate through our actions, and not just words, how much we value the sacrifice of IMGs being separated from their loved ones.

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Changes to the Mental Health Tribunal in response to Covid-19 – what will be the ‘new normal?’

Dr Joan Rutherford and Dr David O’Flynn

The Mental Health Tribunal in collaboration with the Royal College of Psychiatrists’ and South London and Maudsley NHS Foundation Trust would like feedback from clinicians and patients on their experience of remote hearings.

The survey links are:

RC or Doctor feedback questionnaire - <https://bit.ly/38j6m6q>

Patient feedback questionnaire - <https://bit.ly/36gAxdB>

(for a paper version email DCPHESC.MentalHealth@justice.gov.uk).

Introduction

The Covid 19 pandemic led to a rapid adoption of virtual face to face working across mental health services and the judicial system. The Pilot Practice Direction (PPD) issued on 19th March enabled the Mental Health Tribunal to hold hearings remotely, change the panel composition and, during the PPD, proceed without the pre-hearing examination of the patient by the Medical Member. These changes meant the Mental Health Tribunal remains compatible with the Human Rights Articles 6, ‘Right to Liberty and Security’, and ‘Right to a Fair Trial’, and Article 5(4) - the right to a speedy hearing.

Initially, hearings were by phone with one judge; specialist advice from a medical and lay member was available. Ministry of Justice technological investment allowed video conferencing from April and remote three panel members hearings resumed during May.

In this article, we describe the evolving virtual tribunal process and introduce the collaborative study between the Tribunal, the Royal College of Psychiatrists’ and South London and the Maudsley NHS Foundation Trust which aims to understand the patient and clinician experience of the virtual face to face Tribunal.

The hearing set-up

The tribunal guidance prescribes a system that is Ministry of Justice approved and secure. Once the hearing participants are in the virtual hearing room it is locked; further entry is only permitted by the Judge.

All participants can join the virtual hearing from different rooms or locations and on different devices, with a nurse in the room with the patient with social distancing and face coverings, so significantly reducing transmission risk.

Remote hearings require a different way of working which professionals are learning by necessity. Guidance for Tribunal Members in the COVID-19 Bench Book advises:

- Keeping questions focussed and relevant to the statutory criteria
- Encouraging patients to give evidence first
- Making any adjustments suggested by the clinical team
- Offering breaks
- Whole day hearings for specific cases (CAMHS, or when interpretation is required)

The experience so far

Anecdotal experience from patients aged 18 and under is that they prefer virtual face-to-face than facing three adult strangers in the hearing. Clinicians have reported that giving evidence from home can feel intrusive with particularly combative hearings. Others welcome more efficient use of time.

Challenging technological issues

Lack of laptops, problems with connectivity, access to Chrome (essential for cloudroom access) and some hospital firewalls blocking access to cloudrooms are widely reported. The tribunal service is working with Trusts on the technology essential to virtual working.

Reasonable adjustments

To facilitate participation in the hearing, there is now information for CAMHS patients and patients with Intellectual Disabilities [2] about remote hearings. Sharing of good practice is crucial.

Obtaining feedback about remote hearings

a) from patients

Patients are willing to give feedback even when the outcome is not what they wanted, as shown by a pilot feedback study by the Tribunal of face-to-face hearings in October 2019.

The anonymised on-line survey can be completed on a mobile phone, iPad, laptop or paper, and includes sociodemographic data (see link above) or paper (obtain from

DCPHESC.MentalHealth@justice.gov.uk – scan and return)

Sociodemographic data is vital so we understand the experience from the point of view of different populations; patients from our BAME communities are more likely to be detained under the MHA, and are more at risk of Covid-19 transmission.

Trainees in the SLAM pilot reported that assisting patients to access either the on-line or paper survey was a useful exercise particularly when the patient has not been discharged.

b. from clinicians

This is the first ever feedback opportunity. In addition to the practical and technological issues we are keen to obtain clinicians' opinions – all grades including trainees - on their experience of giving evidence. The link to the survey is given at the start of this article.

What could be the 'new normal' Mental Health Hearing after Covid-19?

It is not planned to substitute all face-to-face hearings at hospitals with remote hearings in the longer term. However, whilst the risk of a resurgence, second wave and local lockdowns continue, Tribunal Panels must avoid the risk of passing on the virus as they travel between up to ten hospitals over the course of a working week.

The Tribunal Senior Management have discussed that remote hearings have avoided adjournments in areas where it has been historically difficult to ensure panel member attendance (Cornwall, Northumberland and the Isle of Wight). Also noted is less clinical and administrative time spent escorting tribunal members through security in High Secure Units.

Virtual face to face tribunal may be preferable for different patient populations and may remain an option. With such as rapid rollout of such a fundamental change in Tribunal ways of working , so important to protect the Human Rights of our patients – it is vital we work together to listen and learn from all parties. This project is a first step.

Thanks to:

Dr Gabrielle Milner, Deputy to CMM First Tier Tribunal (Mental Health) West Midlands Division and Deputy Chamber President Judge Sarah Johnston

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COVID-19 pandemic – we have passed through this way before!

Dr Olusegun Claudius-Adeniyi



The novel coronavirus pandemic gained notoriety on the dark side of world history by its peculiar characteristics – sudden onset and speed of global transmission, mistakes in recognition and management and deep political divisions in management approaches. For society, the burden has been enormous with severe and damaging socio-economic consequences and public health impact. As family units and individuals, this pandemic allowed a significant intrusion into our lives with government imposed sanctions to curtail spread and limit catastrophes. The concept of social distancing which was later enlarged to social isolation and eventually lockdown became the norm – cancelling large gatherings of people; avoiding indoor crowds; quarantining individuals exposed to the virus and the wearing of face masks. Consequently, whole communities and cities have faced lockdown measures.

The viral pandemic has challenged the social order, creating upsets in many areas. Jobs have been lost and millions have been pushed into poverty, especially in developing countries. Worldwide lockdown measures have disrupted socio-economic activities and infringed on age old and cultures with resultant frustration and anger – all these in the face of helplessness at the hands of a merciless and ravaging viral invader.

The pandemic has also continued to pose a humongous challenge to science with multidisciplinary approaches to solutions, involving health care providers, scientists, epidemiologists, computer models and worldwide information integration. A great deal has been learnt in less than a year of its onset but with still much to learn. The COVID-19 genome has been completely sequenced with documented mutations noted. The mode of transmission is still being studied but it is known that it is quite different depending on the length of time since an individual becomes infected and how symptomatic the individuals are. The length of immunity conferred by antibodies created by viral exposure is still uncertain.

Infection with COVID-19, serious illness and/or death of a loved one infected by COVID-19, loneliness, financial distress, job loss, isolation and lingering medical/psychiatric symptoms after recovery from acute COVID-19 infection have led to an increase in cases of anxiety, depression, trauma-related symptoms, substance abuse and suicidality. Other collateral issues have been identified that can worsen or add to individual and societal pressures and thus increase the risk of psychiatric symptoms including continued social isolation and the merry-go-round of opening—closing—reopening—reclosing of cities and towns as COVID-19 quietens down and then surges in unpredictable manners. Mental health issues are also not helped by the uncertainties related to unemployment and financial distress, childcare, online versus in-classroom education and relationship stress. Indeed, the Li & Wang study revealed the following about impact of COVID-19 on the UK population:

- Over one-fourth have general psychiatric disorders during COVID-19.
- Over one-third sometimes or often feel lonely during COVID-19.
- People with COVID-19 symptoms have more psychiatric disorders and are lonelier.
- Women and young people are risky for psychiatric disorders and loneliness.

The challenges posed by this novel virus may be the stimulus required to overhaul many areas of clinical practice in the months and years to come. From the initial struggle at developing appropriate and affordable test kits, current approaches include identifying COVID-19 antibodies in recovered patients (whether symptomatic or asymptomatic), using antibody treatment in managing new cases, development of medications to treat the illness (controversial and has involved the trial of different medications including hydroxychloroquine), the recently launched mass testing and contact tracing approach with the development of a tracing app and efforts at developing an effective vaccine.

Vaccine development appears to be the icing on the cake and has also brought in its wake political divisions with Russia launching a vaccine that was yet to fully complete the trial phases. It is widely believed that an effective vaccine is still months away.

Thus COVID-19 has seriously challenged not only every line of protection and management installed by governments and public health authorities around the globe, but also (and fundamentally) the human, clinical, and practical resources of mental health service agencies.

COVID-19 has drastically changed the face of psychiatry. The changing face of psychiatry is marked by innovative adaptations. There have been palpable changes in the modus operandi of day to day psychiatry practice. In an era where healthcare workers had to shield and/or work from

home, the use of technology has been deployed extensively. The use of virtual resources in many areas of practice is gradually becoming the norm with extensive use in psychiatric consultations and meetings (CPA reviews, professional meetings). The Department of Health and Social Care (DHSC), in emergency amendments to sections of the mental health act, also approved the widespread use of videos in mental health act assessments and tribunal hearings. Overall, the pandemic has provided opportunities to put psychiatry at par with other medical specialties, creating opportunities for telemedicine and delivery of mental health services via virtual resources, reducing unwarranted variations in clinical practice and ensuring effective spread of resources.

As society and individual and professionals, the pandemic has taught us how to do things differently. It has also brought to the fore the deep message of our frailties and vulnerabilities. The question remains whether life as we used to know it can ever be the same again. COVID-19 is a natural cataclysm that has evoked repressed survival instincts and has challenged us almost on all frontiers of existence. Though it brought deaths and sorrows in its path, on the other hand, it also brought innovations and improvements. We are suddenly awaking to a deeper meaning of life and society in the context of our interdependence as human beings, our embodied vulnerabilities and the fact that we need each other for life itself.

Though the Great Influenza pandemic ended approximately 100 years ago, it serves as a reminder that humanity has faced similar challenges in the past – we have indeed passed through this way before. Thus, the primal message of COVID-19 should not be lost - our society can be modelled along a more liberal line without compromising efficiency, value or excellence.

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

Dr Sitki Anil Ustun

Quarantine life has caught almost all of us so unprepared. Now that 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, and 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, the reduced access to family, friends, and other social support systems has caused loneliness and increasing mental issues like anxiety, depression as well as an increase in substance use.

But what if most of these problems could be solved or eased with one significant factor and that this 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; some are ancient and some are more recent- 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 compliments pharmacotherapy as a part of complex treatment, together with other forms of art therapy, psychotherapy and physiotherapy.

The way music has been practised since the pandemic has evolved in many ways. Excitingly awaited concerts and events have 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 enhances the audience and therefore the bond by music. Despite these changes, music has still been very accessible to everyone across the globe and could be utilised 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 behaviours and can involve public mental health concerns like anxiety, insomnia, depression aggression, frustration and hysteria.

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. Research conducted by Alcohol Change UK revealed that around one in five drinkers (21%) stated 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.

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.

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.

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 are analysed, many promising results addressing the problems exacerbated in the pandemic 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. 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.

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. Furthermore, other study results indicate that personally pleasing music might have a role

in augmenting substance use disorder treatment via craving reduction.

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.

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. Endorphins (and the EOS in general) are involved in social bonding across primate species, and are associated with a number of human social behaviours (e.g: laughter, synchronized sports), as well as musical activities (e.g: singing and dancing).

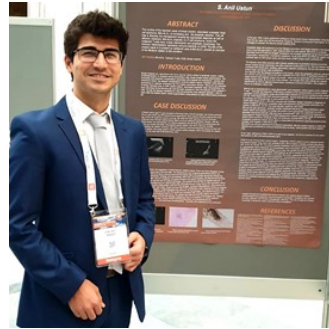
It is well known that passively listening to music engages the EOS. In a recent study analysing the audience and a violinist in a violin performance, it concluded that it is highly possible that neural synchronisation between performer and audience occurs when they are engaged in the same music performance. 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. 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, music and music events have evolved in a positive way. Therefore music remains a perfect aid and even a solution, for not only the problems of the pandemic, but in our daily lives.

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Lockdown in London: A patient/carer perspective

Rachel Braverman

Our family's mental health was on the up as Coronavirus descended on the world. I was coming out of a serious relapse of the binge eating disorder that has plagued my life since early childhood, been discharged from the Eating Disorders Unit, and was slowly, slowly losing the 7 stone I'd gained (always takes at least twice as long to take off as it took to put on). I was less anxious and depressed. I'd started working with a trauma therapist. My partner's anxiety and depression were at bay. We were both doing jobs we enjoyed, and were getting on with each other, family, friends, neighbours and colleagues.

Our 16-year-old adopted son has complex mental health problems and learning disabilities. After years of extremely challenging behaviour, he was managing well in a trauma informed special school. He had just completed six-month's Independent Travel Training and was proudly taking the bus to school by himself. Most encouraging, he had referred himself to CAMHS, via school, for help with OCD – the first time he'd engaged with services for himself.

On 16th March 2020, everything collapsed. The country went into lockdown.

My weight and my partner's other health conditions put us in the 'vulnerable' category. I work from home anyway and my partner was, thankfully, put on furlough. Although T's school, being special, remained open for a while, we decided to keep him home. Our monthly overnight respite break and 8 hours' weekly respite stopped. Our son's Tuesday forest camp was suspended. We retreated into our tiny flat and closed the doors.

The sudden change affected all our mental health. We all have anxiety diagnoses, and they went through the roof. Our sleep patterns were all over the place.

My partner worried about catching COVID-19, while I (typical foodie) spent hours and hours sorting out deliveries. We both agonised about T. We held endless, draining councils of war, until we realised we were just feeding our anxieties and set time limits.

My son was terrified lockdown would never end, asking continually when it would be over. He finds 'I don't know' hugely difficult to hear. He missed his routines. We read this piece together, and he told me to tell you he was always 'annoyed, bored and sad'. Online learning was a daily battle. Usually, I lost. He hugely resented how curtailed his life had become and sometimes took it out on his parents, as is in the children's job description. I knew intellectually he wasn't able to understand, but emotionally it was hard to bear. My parenting skills were at a low ebb.

I went through some very dark days. The problem of isolation is being well documented. But for me, the problem was constantly being around people. I love my family, but I need time and space for myself to recharge my batteries and to get respite from challenging behaviour. For months, that couldn't happen.

It was the common problem of caring for someone with mental health problems writ large. My son's behaviour and distress impacted my mental health, which meant I had fewer resources to help him. And down we plummeted. I felt deeply ashamed at how poorly I was coping.

Help appeared. I was impressed by how quickly services adapted to online. There's a lot on offer, though how much we can access it varies.

My son hates groups, so much of the help for young people with mental health problems doesn't work for him. He quickly gave up therapy with CAMHS, saying he hadn't got to know the therapist well enough beforehand, and online was too much. On the other hand, he reported that regular sessions with his school's drama therapist were helpful. They are continuing, easing the transition back to school.

Therapy online wasn't for me. Zoom blocks off so much non-verbal communication, although I wonder if that's more of a problem for trauma therapy, rather than CBT or psychotherapy. Not being able to find a private space was another barrier. Even with the door shut, I was always aware of other people in the flat, so it just didn't feel safe. Also, I missed travelling to and from sessions - that bit of space to reflect.

Some online support has been (and is) amazing. Our local carers' organisation quickly arranged virtual coffee mornings and events. They called regularly. I remember one call landing on a particularly difficult day, and the relief to just let it all out. Peer support WhatsApp and Zoom groups are flourishing. Many are international. I can now hop onto a meeting for help with my eating disorder 24/7. If I get a craving in the middle of the night, I can reach out to someone in the middle of their afternoon. We're all saying let's continue, whatever happens. As a result, my eating is better than it has been in years.

And some days and hours were delightful. My son and I discovered metal detecting on our local common and he found an earring with a real diamond. Sometimes the three of us snuggled under the duvet, binge watching *Modern Family*.

Our communal garden became a haven for 15 species of bird – we counted them.



Our lives are getting back to normal. School is starting. My partner is back in the office.

We're thinking of what we can put in place if there's another lockdown. So far, we've decided to stock up on a fortnight's food supplies, continue my son's drama therapy and my online support groups, and hoard a few box sets.

Note from author:

'My son and I read through this piece together and he is happy for it to be published'

Author details:

Rachel Braverman

London Division Patient/Carer Representative

Webinar report: “COVID and London - learning from local experience”*Dr Sachin Shah*

As we have been dealing with a pandemic that has forced us all into varying degrees of isolation, it was good to hear from fellow clinicians who have been going through the same. Over what else but a Zoom call, it was comforting to put a human face to the challenges we have all been going through as healthcare professionals.

Dr Suhana Ahmed, Old Age Psychiatry Consultant in South West London, spoke about the “regular” shop-floor experience of COVID-19 from the inpatient setting. On the ward, the first month of the pandemic was fuelled by panic and adrenaline. There was a reduction in beds on the ward, as rooms were being used for donning and doffing personal protective equipment.

The changes to the ward affected staff. Initially the ward had decided that two staff members would be assigned to the isolation wing each day, but the staff felt that 12 hours on the wing while wearing PPE was too stressful, so they split shifts down to 6 hours. As no visitors were allowed on the ward, this actually increased workload as the ward staff were making more telephone calls to keep family informed.

Dr Ahmed listed things that worked on the ward. She made sure to be present and visible on the ward, while maintaining a structure of having a

handover every morning. She was flexible in terms of time, which in her case meant working longer hours. Advocating for fellow staff, and being more open with praise, helped raise staff morale.

There were also things that worked at home for Dr Ahmed. She made sure to express her emotions, and she gradually found it easier to say when she was feeling upset. She also used the support that was around her. She has [recorded a podcast for LeadersPlus](#) about balancing home life with being a consultant during the COVID-19 pandemic.

Dr Ahmed identified things that didn't go so well. She realised that she had her limitations. She found she couldn't respond to every email, and was even looking at emails as late as 10pm. She sustained “crisis mode” for longer than she feels she should have, without taking leave, and her self-care had reduced.

She's proud of her team, without whom she feels the ward would have never made it through the crisis. She feels she never would have survived without the ward manager, who was a major source of support for her. She also gave credit to her personal support network.

Dr Anil Kumar, Consultant Psychiatrist at Bethlem, gave his experiences from the acute inpatient setting. He noted that the pandemic was a difficult experience for patients and staff on his ward. Support and validation from management was helpful for staff. He commented on the need for support specifically for vulnerable and BME staff: he was asked by his Clinical Director and Assistant Clinical Director if he had any physical health issues and they were very supportive, which he appreciated.

Dr Kumar's ward had a high incidence of female patients with EUPD who were admitted long-term. The ward worked to discharge such patients to appropriate community placements and many have remained well and haven't been re-admitted. The ward worked closely with CMHTs and kept more regular contact.

Six patients on his ward tested positive, most with mild illness. The hospital initially had COVID-positive wings on wards, and then progressed to entire COVID-positive wards. At one point all the patients in the Trust's female PICU [were COVID-positive](#).

Clozapine administration was a difficult challenge, as various effects of COVID-19 overlap with adverse effects of clozapine. But the ward had input from the pharmacy and the National Psychosis Unit to assist with this. The ward had to discuss use of rapid tranquillisation medications with the pharmacy, due to the respiratory adverse effects of medications such as promethazine and benzodiazepines. The ward placed all patients on Vitamin D supplements, as a significant proportion of mental health patients are D3 deficient, and patients deficient in D3 can be at higher risk of acute respiratory infection.

He gave an account of his own illness with COVID-19. When the outbreak started he felt he wouldn't get it, as he does not go out that much, but within a week he experienced severe symptoms that kept him in bed for eight days. He acknowledged that healthcare staff have died due to COVID-19 and he feels fortunate to have recovered. His managers were extremely supportive.

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Dr Gabrielle Pendlebury, Clinical Lead for Forensic Adolescent Services at the Tavistock Trust, discussed how the pandemic has affected Forensic CAMHS at the Portman Clinic.

She said it has been a tough time for adolescents due to uncertainty, loss of education, and reduced social activity, and there has been an increase in suicidality, mood disorders, psychosis and anxiety.

She is proud of what her team has achieved as they've had to change their way of working. They cover a huge area, travelling all over 13 boroughs, but with COVID-19 they have moved to remote consulting with professionals, which in a sense was positive because it increased productivity. But assessment and intervention with young people was more difficult. The hardest task with adolescents can be engagement, so over Zoom it can be even more of a challenge.

Regarding use of technology in the future, she noted that technology is useful for consultation with young peoples' networks and for advice to clinicians. But for consultation with young people that is traditionally done face to face, she found that a lot of the adolescents she sees are very unwell and have communication difficulties, and so while technology is good for a spot-check, she still needs to see them in person. She encouraged viewers to use technology when it is most appropriate, but not to rely on it entirely.

She also identified issues from her perspective as a medico-legal consultant. There were issues of confidentiality, not just in ensuring the young person had a space to talk where they wouldn't be overheard, but also from the point of view of professionals who may be doing consultations from home, where their family may be around. Recording was also an issue: it is easy for young people to record virtual consultations, and the team had to think of pragmatic solutions to this, such as ensuring the young person doesn't post recordings onto social media. However, Dr Pendlebury noted that it could be positively therapeutic for patients to record sessions, so the team took a case-by-case approach regarding this.

The moderator of the webinar, Dr Peter Hughes, Chair of the RCPsych London Division, closed the session by adding that it can be fatiguing working during these times. Bringing in his experience of global psychiatry, he was reminded of working with Ebola patients in West Africa. He emphasised that self-care is important, and that this extends to looking after colleagues. Every part of the team must always be considered, including domestic staff who are often forgotten. We should also always think of how children, both our own and those of patients, may be affected. Children may be experiencing the pandemic in a different way.

He said the pandemic can bring out the worst and best in us and we can see it in ourselves when we are overworked and stressed, and so this is a great time for self-reflection. He raised the principle of “building back better”, noting that this is a terrible time but we’ve learned how to make things better as we move forward. Not just in terms of technology, but also in terms of camaraderie we’ve built within our teams.

He gave a shout out to his colleagues, including nurses and OTs who have been working hard during this time. He urges us all to thank our colleagues for how hard they work during this difficult period. The message he wanted everyone to take away from the seminar is one of kindness: compliments, chocolates and biscuits are always a good way to people's hearts!

This message of kindness was supported by Dr Pendlebury, who said we should be kind and have compassion when things don't go how they should go. Dr Ahmed said that we should be kind, and pay it forward if someone does something nice for us. Dr Kumar added that kindness and willingness to help can be reassuring for others, and that in a crisis, people's helpful natures and resilience will emerge. Dr Hughes said that people make mistakes in difficult times.

We are all human. Understanding that, we should be kind and nice to everyone.

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Dr Sachin Shah

General Adult Psychiatrist

Culture Vulture

Culture and arts in the time of COVID: Coping with a crisis or improving our mental health?

Dr Emmeline Lagunes-Cordoba

On the verge of the pandemic, all theatres, cinemas and cultural venues in the UK closed their doors to reduce the spread of COVID-19. Whilst we were going through unprecedented times, there was also an unprecedented effort from theatres, museums and art organisations to keep the arts alive, and, more importantly, to support people shielding and isolating at home, by providing entertainment and allowing us to be transported to other places and times, focusing only on our mental wellbeing. In this article, I would like to highlight not only all the efforts of many art and cultural organisations, but also the relationship we as humans have with the arts and the influence these have on peoples' mental health.

On March 26th, the National Theatre launched their "at home" programme with the acclaimed production of *One Man, Two Guvnors*, followed by *Jane Eyre*, *Frankenstein*, *Coriolanus* and a magnificent *Amadeus*. This was soon followed by other theatre companies, including the Soho Theatre, which screened *Fleabag* by the superb Phoebe Waller-Bridge, along with the Shakespeare's Globe and the Gecko Theatre, which streamed some of their productions for free.

For opera lovers the options were also numerous. The Royal Opera House (ROH), the Metropolitan Opera in New York and the spectacular Vienna State Opera House released an amazing free programme online: *The Barber of Seville*, *La Bohème*, *Fidelio*, *La Traviata*, *Tosca*, *Don Quixote*, *Don Giovanni*, *Salome*, and *Turandot* were among the many options available. The ROH and the Vienna State Opera, along with the English

National Ballet, also streamed brilliant ballet productions: *The Winter's Tale*, *Sleeping Beauty*, *Giselle*, *Coppelia* and *the Nutcracker*; while Sadler's Wells showed *The Rite of Spring* by the amazing Pina Bausch. These sites also released many videos to exercise along to and practice some ballet at home. Other entertainment efforts included live online performances by the London Symphony Orchestra and the Royal Albert Hall: while the Cirque du Soleil streamed weekly online videos of some of their most famous circus acts.

Museums also joined the global effort and developed interactive virtual exhibitions: from the *Mona Lisa* in the Louvre to *Starry Night* in the MoMA. You could even pass by the Rosetta Stone in our own British Museum. One could argue that the experience of admiring La Gioconda on-screen will never be comparable to seeing it face-to-face, yet the former allows an otherwise impossible close-up to admire da Vinci's fine brush strokes. The Uffizi, Hermitage, D'Orsay, Vatican, and the Smithsonian museums joined this online effort, as did even Banksy's murals.

The pandemic enormously impacted people working within the arts, as many artists struggled with galleries and exhibitions closed. To support fellow artists, Matthew Burrows created the Artist Support Pledge initiative, which included asking other artists to sell their artwork for less than £200, and once they reached £1000, they bought another artist's work for £200. This initiative received an immediate and positive response and has now been shared thousands of times.

I did my personal bit by buying a piece of work from one of my favourite artists in London: Tony Blackmore. If you have never done it, this might be a great opportunity to not only support artists during this time but also to own an original art piece.



Figure 1: Colour Tile Number 2 by Tony Blackmore, 2020. This is my COVID soul soother. I find mystery in the way it changes with the light. Go on now and discover your own mysteries in life.

This pandemic has represented a challenge for most of us, but one positive aspect is that it has brought us closer to the arts, reminding us of that special relationship we have with them. Throughout history, the arts have been a fundamental part of human lives. Most of the information we currently have from ancient civilisations can be attributed, to or considered, early artistic expressions. Over the last centuries, the arts have been embedded in almost every part of our lives, whether we see it or not. Our cities are filled with amazing architectural buildings; our walls often showcase paintings or photos; our shelves encase literary masterpieces; and even our phones contain music, books and films; all this showing our deep connection with the arts.

Studies focused on the effects of the arts on both people's physical and mental health have shown

that different types of art therapies and creative artistic expressions tend to have a positive impact on people's wellbeing. Two literature reviews, focused on the effects of art on health, reported that music engagement, visual arts, expressive writing and movement-based creative expression have significantly positive effects on people's health (1) and that engagement and participation in the arts can be used as tools to enhance mental health wellbeing (2). Other studies have also reported a positive impact of the arts on people's mental health. One study evaluating the impact of an art prescription programme suggested this intervention helped reduce anxiety and stress levels, and increased contentment, wakefulness and calmness, which were considered components of psychological wellbeing (3). Another study assessing the significance of art for mental health service users reported that the arts can not only be used as a form of expression but also as escapism, taking people to a different place that allows them to better cope with their current situation (4).

There is no doubt the COVID-19 pandemic has affected the lives of most of us, including the way we work, travel, and communicate with each other. However, this has not changed our need to look for meaning and beauty in our everyday lives. Today, more than ever, the arts have helped us escape and cope with the pandemic and all its negative effects. Being able to be amazed by a powerful voice, a delicate dance, a precise brush stroke or a dangerous circus act, is something that we need to embrace and encourage. As Rene Magritte said, "Art evokes the mystery without which the world would not exist." The pandemic has not only reminded us that art can help us improve our wellbeing but it has also shown us new opportunities to explore and appreciate the arts in novel ways and broadened its reach to so many more people than we ever imagined.

So let's escape and get inspired to solve the mysteries of life, to discover the beauty others witnessed and captured with their lenses and canvases and to be amazed by the human body and its ability to fly across a stage, making us remember we are exceptional and that one day we will be back to create and enjoy those feelings only the arts can evoke in our souls.

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The Great Equaliser

Dr Anju Soni

No human is immune from the Great Equaliser
Dogs puzzle why humans are wearing muzzles
But where there were none
There is now the chirruping of birds

Lo and behold
Nature is king and is having the last laugh

COVID-19 doesn't discriminate
Race, religion, age, class and disposition
No soul, no panacea, nothing innate can guarantee protection

Some call it a war zone
Where heads stuck in their self-delusional sand come out
And global giants reeling under the pressure have their inadequacies shown out

No one is invincible
And everyone is scrambling in this Game of Thrones together

Inside, across corridors of coughing
Doctors and nurses without PPE swim across
Being in a developed part of the world doesn't guarantee you will acquire
The armour you require
Above, white cotton wool balls float silently across the azure skies
As we begin to gasp, the world starts to revive

Humans huddled together in their warrens
Some worry about the number of daily cases
While others about the number of ever-increasing deaths
And their own fate
As they zoom past others
While social distancing goes haywire

We yearn to rise, phoenix-like
From the ashes to surmount our troubles
If only poems could be lifesaving drugs.



Dr Anju Soni

Consultant Forensic Psychiatrist,
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Responding to COVID-19 Different ways the College is supporting members at this time

Psychiatrists' Support Service

The Psychiatrists' Support Service is a free, confidential support and advice service for psychiatrists at all stages of their career who find themselves in difficulty or in need of support.

Telephone: 020 7245 0412

Email: pss@rcpsych.ac.uk

[PSS webpage](#)



CPD Online has released more free modules and podcasts to support members' work at this difficult time.

[Free CPD Online Modules](#)

[Free Podcasts related to Covid-19](#)

Webinars for members

The College has launched a series of free webinars for members.

The webinars will offer a solution-focused approach to the current COVID-19 pandemic and other topics.

[Free Member Webinars](#)

COVID-19: Support for patients and carers

The College has created an area on the website to provide information about managing your own or someone else's mental health during the COVID-19 pandemic.

[For more information please visit the website.](#)

COVID-19: Guidance for clinicians

The College has created a hub on the website to support clinicians at this time. The pages will continue to be updated with relevant information and guidance.

[For more information please visit the website.](#)

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Congratulations!

Congratulations **Dr Naila Saleem** for winning the best article of the Autumn 2020 Edition for her submission

'Reflecting on Loss in the Time of COVID-19: Challenges and Opportunities'

Read all about it on page 3.

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