

Trent Division eNewsletter – Summer 2018

Foreword from Dr Anand Ramakrishnan, Trent Division Chair



Dear colleagues,

Welcome all to the 2018 Summer edition of the newsletter of Trent division. Earlier in the year we ushered in a New Year 2018 with the hope that this will bring best of luck, success, prosperity, enhanced career prospects and overall positive improvement to all of us. We have had ups and downs. Recently we attended a fantastic International Congress in Birmingham with record number of attendees. At the same time, we mourn our bad luck in World Cup football like others.

This also brings in a new appearance for the newsletter. I was pleased to note that there are many articles for publication this time and our young editor colleagues, Sam and Lesley have been trying hard to include as many as possible in this edition. I hope that this enthusiasm continues so that our newsletter can flourish wonderfully well in the years to come. This is a platform for everyone, trainees to senior consultants and academics to pencil their thoughts, aspirations and fertile imaginations to this fantastic literary contribution that will be read, enjoyed and even contemplated on by everyone.

I wish all the very best to the energetic Trent Executive Committee and its vibrant manager Marie. I wish all success to this editorial committee and wish to thank them for their enthusiastic and sustained effort to bring this newsletter on time.

Dr. Anand Ramakrishnan BSc, MBBS, DPM, MMedSc, MSc, FRCPsych

Chair, Trent Division, Royal College of Psychiatrists

Editorial from Dr Samuel Tromans and Lesley Thoms

Dear Colleagues

It's been a while since we last brought to you the latest from the Division, but we are certain this jam-packed edition makes up for the delay.

Find out:

- What Alex Mitchell thinks about road rage, cycling and getting published, in his e-interview
- If there is room for spirituality in psychiatry
- How DVLA restrictions may influence the doctor-patient relationship
- What impact singing has for people with dementia
- How Rachel Bannister, the Trent Executive Committee Carer Representative, got on with her questions for Jeremy Hunt
- And plenty more...

We are thankful to each contributor, making this a wholly interesting and inspiring read.

Fancy contributing to the next newsletter? It is easy to contribute and we are happy to consider any article. Examples are below, but this is by no means an exhaustive list:

- Review of recent literature
- Past and upcoming events
- Opinion pieces/reflections
- Creative contributions (i.e. photographs, artwork, poetry)
- Research/Audits/QI projects
- Special interests within Psychiatry

Don't forget that certificates for accepted articles can be made available upon request.

Please send all submissions or any queries to the email addresses below. Also, please feel free to email us with any suggestions for improvement to the newsletter – we would be happy to hear from you.

Best wishes

Sam & Lesley

Co-Editors of the RCPsych Trent Division Newsletter

Please submit your contributions and suggestions to:

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“Disclaimer: The views, information, or opinions expressed in the articles within this newsletter are solely those of the individuals involved and do not necessarily represent those of either the editorial team or the Royal College of Psychiatrists.”



Sam Tromans,

Specialist Registrar in Psychiatry of Intellectual Disability



Lesley Thoms,

Core Psychiatry Trainee

Dear Health Secretary, what are you doing to help my daughter?

The NHS's failures in treating eating disorders drove Rachel Bannister to write an open letter to Jeremy Hunt. Her subsequent meeting with him gave her some hope that her concerns might be taken on board



Rachel Bannister met Jeremy Hunt after writing an open letter.

Many people, journalists included, told me it would never happen. That if I were lucky, a junior minister might agree to a meeting. And to be honest, it hasn't been easy trying to organise an appointment with the man soon to be the longest-serving secretary of state for health. Jeremy Hunt is a busy man, overseeing an NHS that no one could deny is in crisis, so I knew getting to see him would be a challenge.

There have been many phone calls and attempts to get in touch with my MP. Finally, in despair, I wrote an open letter. Five weeks later I received a response and an invitation to a meeting. So there we were, my daughter and I, almost three weeks ago — on the day the NHS was facing a crisis over the surge in patients being seen in A&E departments — sitting in the Department of Health with a list of questions and hoping, really hoping, that we'd finally get some answers. I was extremely nervous about meeting him and genuinely surprised by my daughter's keenness to join me. We frequently see him in the media with his figures and statistics and, more recently, softly spoken apologies. But I've never seen him openly debate with ordinary members of the public, and recently he faced down a challenge from the actor Ralf Little alongside ordinary doctors and fact-checkers. So what was he so afraid of, and would he give us enough time to make my points or merely attempt to fob me off with more figures and statistics and empty promises?

We reassured ourselves that at least he'd have all the background information about my daughter's case, and surely at the outset he'd want to offer us not only an apology, but assurances that the situation had improved and other young people would not have to suffer as my daughter had.

Ever since my daughter was sent more than 300 miles away for treatment for an eating disorder in December 2016, I have felt unable to remain silent about what is undoubtedly a deterioration in mental health services that is affecting so many people up and down the country. People have lost their lives as a direct consequence of the underfunding of services, the utter lack of continuity of care, and the inconsistency of eating-disorder treatment. Anyone who watched the Channel 4 documentary by the news presenter Mark Austin and his daughter Maddy (*Wasting Away: The Truth about Anorexia*), in which I was interviewed, could not have failed to have been moved by the tragic story it told of young Lydia, who took her own life at a time when she was very vulnerable and in need of intensive care and support. Yet none was available.

So we know, despite everything, that we are lucky. Our daughter is alive and back home, where she should be. She is, after a struggle, at last receiving a treatment that is more than mere containment. She has also received some of the most excellent care from the highly experienced and talented health professionals that Hunt so often praises.

But our daughter has also been heavily let down. For the first two years in “treatment”, at a dangerously low body mass index, she was given infrequent and erratic appointments and was offered no specialist dietetic support until weeks before her first admission to hospital. We’ve since learnt that even in 2016 there were only 1.3 dietitians for the 613 open referrals to the eating disorder service overseen by less than one full-time psychiatrist. Although clearly all of these 613 young people wouldn’t be in need of dietetic support, surely a high proportion would, and certainly a high number would require assessment by a psychiatrist?

According to Hunt’s standards, even today our daughter would be classed as being “in treatment” simply because her referral had been accepted and she was being “seen” by someone. Our daughter has also been sent far from home to a “specialist eating-disorder unit” that hadn’t even got the facilities to cook the patients fresh food on site. Small wonder, then, that when she was discharged four weeks later she was entirely reliant on an invasive nasogastric feeding programme.

As we finally came face to face with Hunt, we were keen to remain open-minded and hopeful that maybe we, as ordinary citizens with much experience of what is both good and bad in our mental health service, would not only be listened to, but would be able to convince him that action is required without delay.

It was therefore with some disbelief and shock that we discovered that Hunt was not familiar with my daughter’s history. It was necessary to remind him that she had been sent far from home, most recently to Scotland, and, no, it was not the hospital there that was continuing to support her. In fact, as my daughter so politely reminded him, the most fundamental problem with services is the lack of continuity of care. Being shunted between seven different teams across the country is not only inconvenient but extremely detrimental to recovery. After all, it is those all-important therapeutic relationships with mental health staff that enable the best chance of recovery. As the consultant at Great Ormond Street Hospital told us, “continuity of care” is the main aspect of our daughter’s treatment that has been seriously lacking. We were also surprised that Hunt didn’t arrive with details of an investigation into our daughter’s care, and provide us with a copy of the findings. Our MP has kept him informed over the years, and the very fact that our daughter has had to endure out-of-area placements on no fewer than three occasions would surely be something that, if not Hunt, then someone from his department would be keen to investigate.

I increasingly felt during the meeting that Hunt was not expecting us to have come so prepared. Although he certainly gave us time to get our points across, the meeting became progressively rushed and he was unable to provide us with any details with regard to the specific figures he presented. For example, the “500 extra psychiatrists” he believed now to

be working in the NHS, and the “extra 1,400 people being treated each day”. We were — still are — keen to know where these psychiatrists have been deployed (in or out of London?) and whether “being treated” means receiving actual evidence-based treatment or therapy recommended by the National Institute for Health and Care Excellence (Nice), or in reality being “seen” for assessment, then put on an endless waiting list (as per our experience). Of course, an increase in the number of patients being treated is also meaningless when you consider that the population itself has grown and therefore the likelihood of more people needing treatment will have, too.

We were pleased to hear that the figures we had, which show a doubling of referrals to the eating disorder service during Hunt’s five-year period as health secretary, were indeed as unacceptable to him as to us. It was disappointing, however, and extremely worrying to hear that his “extra billion” already in the system was part of what he described as a “slow ramp-up” to improve services. Surely if he is as committed as he says he is to achieving parity of esteem — ie, valuing mental health equally with physical health — then the provision of money and training of nurses, doctors and therapists should have begun in 2012, when he was appointed health secretary? To hear him speak now of “plans” and “commissioning of green papers” as well as “training extra staff” at this late stage is, frankly, alarming. As a carer representative on a Royal College of Psychiatrists committee, I am all too familiar not only with the “recruitment crisis”, but the crisis in retention of doctors and nurses, as many retire or are forced to leave the NHS due to the overwhelming pressures.

Both my daughter and I believe strongly that to make the “transformation of services” happen, it is imperative that the health secretary engage with those like us with lived experience of the mental health system. It was therefore interesting to hear from him that he does this “the whole time” and it is “why he agreed to this meeting”. He believes that meetings such as these are “what have informed his whole approach as health secretary”. We were delighted that he has agreed to consider a role for us, so we can do our bit to offer ideas and experience directly from real-life scenarios that have been both good and bad. We await Hunt’s confirmation of what this might be. We were extremely keen to ask him the question that journalists — including both Victoria Macdonald of Channel 4 News, and Mark Austin — have posed: why does Hunt continue to refuse to ring-fence funding? I am an ambassador for Beat (the UK eating-disorder charity), and know the organisation is also keen to receive a response. For those of us battling with the system or working on the frontline on a daily basis, the argument that Hunt offered us that to ring-fence one area would then raise the question as to why not other areas, too, makes no sense. Our response was, and remains, that as eating-disorder services are undoubtedly the ones most struggling — or as we believe, virtually on their knees — then it makes absolute sense that this should be ringfenced, with immediate effect.

Surely the inconsistency in treatment and what is, in fact, a postcode lottery (as Maddy Austin suggested to Hunt during the documentary) is at least partly a consequence of Clinical Commissioning Groups (CCGs) across the country using their funding in many different ways — often not as it is intended. The most alarming example as highlighted by Beat was the CCG that spent the funding on a new IT system. Again, we could not reach an agreement here with Hunt, but he has promised detailed figures from our CCG so we can try to make sense of why our service is so lacking, compared with, for example, the eating-disorder service in Lincolnshire. I have no idea if the 30 minutes or so set aside for our meeting was standard. Clearly, however, it was not long enough for Hunt to provide us with the detailed responses we need. I’m not sure how often he meets other people like us, but I sincerely hope he will give serious consideration to our suggestion of being involved directly in the shaping of services. He did offer an apology to my daughter, as requested in my open letter, though to have been greeted with this at the start of the meeting would have felt more genuine and heartfelt.

It was good, however, to hear him take full responsibility for the appalling lack of continuity and inconsistency of treatment, as well as the dreadful and damaging long waits for treatment, most recently resulting in the 300-mile out-of-area placement. It remains to be seen if he really has taken our concerns on board and will at the very least begin his “revolution” by ring-fencing the funding for what is a very fragmented and dangerously underfunded eating-disorder service.

One thing, though, is certain: people like us with first-hand experience, and the courageous frontline staff, will not and cannot be silenced. Until our voices are heard and our views taken into account by those with the power to enact change, people will continue to be failed and, tragically, more will lose their lives. Surely this is not the NHS that any of us ordinary people want or deserve.

Rachel Bannister, Trent Executive Committee Carer Representative
Originally published: The Sunday Times, 21 January 2018 (with permission)

Group Singing for People with Dementia: An Observational Study

Introduction

The benefits of group singing on the wellbeing of people with dementia (PWD) have been studied for two decades and are well documented. Most studies interview the PWD-carer dyad together, yet many PWD have memory and communication difficulties. Carers therefore may dominate discussion and as a result, the views of PWD can be underrepresented. To the researcher’s knowledge, observation has not been used as the main form of qualitative data in studies of singing groups for PWD. However it is useful in the “natural setting” (Mays & Pope, 1995, p.182) of a singing group. Direct observation has been described as a “gold standard” (Murphy & Dingwall 2007, p.21) qualitative data collection technique that is currently “underused” (Morgan et al., 2017, p.1060) in healthcare research.

The aims of this study were:

- To assess how participants engaged with singing
- To explore what effects singing had on participants
- To evaluate changes in interactions over time, particularly between people with dementia and their carers



Method

The researcher acted as a participant-observer and attended 10 weekly group singing sessions. After each session, observations were recorded alongside a reflection/interpretation. Observations were thematically analysed using the framework set out by Braun & Clarke (2006).

This study ran alongside PhD researcher Becky Dowson's (BD) study evaluating the CHORD (Chorus Research in Dementia) manual. BD therefore recruited participants and determined the group's location.

Participants were diagnosed with dementia or had self-reported memory problems and most attended the singing group with a carer/supporter. Ethical approval was granted in August 2017 by the Research Ethics Committee of the Division of Psychiatry and Applied Psychology, University of Nottingham (reference number: 311).

Results

There were 24 participants. They can be split into 3 subgroups, each given a letter:

- 1) People with dementia, of which there are 10 (D)
- 2) People who identify as having memory problems, of which there are 5 (M)
- 3) People who identify as a carer or supporter, of which there are 9 (C)

Participants were then numbered to identify them individually. In terms of participants who had a carer or supporter there were:

- 5 spousal couples (1-10)
- 3 mother-daughter pairs (11-16)
- 1 pair of friends (17 and 18)

Also 6 women (19-24) came without carers/supporters from the sheltered housing where the group was held.

Observations of participants, handwritten after each session, totalled 21 A4 pages comprising 182 observations. Thematic analysis produced 29 codes which were grouped into 7 themes.

Theme 1: Increased confidence

The most coded theme described how the group's confidence and engagement increased over 10 weeks. C1 stated 'After the 3rd and 4th visit they're more relaxed in themselves... having confidence in joining in.' D4 was sleepy during the first two sessions but during the 4th session danced very enthusiastically which represented a vast change. C3 described 'I really felt [D4] got more and more involved as time went by, the last session was probably the best really.'

Theme 2: Dependence versus independence

Carers tended to write name labels, chose where to sit, hold the songbook and pick percussion instruments for the dyad. However, from the 4th week onwards there were more instances where PWD demonstrated independence. This was illustrated when D4 was struggling to zip his coat up. Usually C3 would do it for him but at the last session she said, 'we'll let him have a go' before stepping in.

Theme 3: Relationship imbalance

Sometimes carers could unwittingly limit the choices of PWD. If extra songbooks were handed out carers often declined on behalf of PWD. C1 stated 'D2 won't sing if you don't share'. Yet, when D2 was asked if she would like her own book, she took one and used it appropriately. Similarly, when D6 was offered a plate of biscuits C5 quickly reached over and chose one for him saying 'he doesn't mind'.

Theme 4: Cognitive effects of singing

The second most coded theme related to the cognitive deficits observed in PWD and their improvements while singing. Singing evoked memories of the past, for example D16 described that 'You Are My Sunshine' reminded her of when her 'children were babies'. The

group always ended with a farewell song 'shalom'. Participants had not known it upon starting the group but had all learnt it by the final week.

Theme 5: Emotional effects of singing

The most common emotion observed was enjoyment, when participants smiled and commented on their pleasure. C1 described the 4th session as 'paradise' and commented 'the singing makes you feel as though you're at home'. C3 explained 'I think P4 felt at home' and 'it makes you feel more cheerful, your spirits are lifted.'

Theme 6: Communication improvements

There was evidence of PWD having improved communication after singing. D4 mumbled and gave one-word answers in conversation before the session. However, afterwards he spoke more clearly and answered questions. When asked if C3 took sugar, he replied, 'I don't think so'. Although a short phrase, it appeared to demonstrate an understanding of the question and the ability to provide an answer.

Theme 7: Supportive aspects of the group

As participants were going through the same experiences, they were able to support one another. Initially carers' conversation was 'small talk', for example about television shows, but as they got to know one another they discussed dementia and caring. C5 said to C3 'I know exactly what you mean...it's better for them as they don't know what's going on...don't know they're ill'.

Discussion

Although confidence was the most coded theme in this study, previous studies into singing groups have reported similar effects, but not as a key finding (Montgomery-Smith, 2006; Camic et al., 2011; Unadkat et al., 2016). In this study, building confidence appears to be an important function of singing groups which may have contributed to the observations of increasing independence. Moyle et al (2015) identified maintaining independence as an important aspect of quality of life for PWD. Interviewing PWD revealed that lack of choice and power contributed to them feeling they were losing their independence. This finding is reinforced by Bamford & Bruce (2000) who described that maintaining autonomy was cited by PWD as an important outcome measure of good community care. It is well documented that dementia changes the spousal relationship, as the PWD becomes more dependent on their carer (O'Shaughnessy et al., 2010; Evans & Lee, 2014; Wadham et al., 2016). It seemed that during the singing group the relationship imbalance was somewhat redressed, a finding supported by Unadkat et al (2016).

Themes regarding the cognitive and emotional effects of singing are well described in the literature (El Haj et al., 2012; Irish et al., 2006; McDermott et al., 2013), as are the social benefits of these groups (Daly et al., 2013; Hara, 2011), particularly in supporting carers. The changes in communication observed are less widely reported. Schall et al (2015) analysed videos of music therapy sessions for PWD using the CODEM instrument, which assesses communication behaviours in dementia. They evaluated participants' communication pre- and post- therapy and concluded that music therapy had a statistically significant positive impact on communication. Therefore, more research needs to be done to establish if similar benefits are seen following group singing.

There were 24 participants, all Caucasians from a relatively wealthy suburb, so the sample will not be generalisable to the UK population. As a participant-observer no notes were made during sessions, so important data could have been missed, as it is "impossible" (Mays & Pope, 1995, p.183) to observe everyone. Video footage would have been helpful to add detail and support observations.

Conclusion

A novel hypothesis to emerge from this study is that as the confidence of PWD increased, they appeared to gain independence as they and their carers recognised their capabilities. This helped redress a relationship imbalance that may be caused by dementia. Being less dependent, even for just two hours a week, could improve quality of life for PWD whilst reducing carer burden. Future research could further explore these effects and their clinical implications.

Acknowledgements

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Eloise de Sousa (3rd Year Medical Student), University of Nottingham

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Psychiatry – Putting Spirituality to work



Debate and angst surround the introduction of a religious dimension into psychiatric care: witness ferocious debates that can arise when doctors “do God”¹. Similarly, the introduction of psychological theory into Christian ministry is not without controversy. The Clinical Theology movement has had its detractors since it was founded in the 1950s by the eminent Christian psychiatrist, Frank Lake². Lake sought to bring Christian ministers up to speed with psychological theory and techniques. He imported an

eclectic mix of psychological therapies into his theological work and teaching. He viewed some manifestations of religious zeal as psychologically dysfunctional – e.g. the neurosis that can result from striving for perfection. His views have resonance with the Compassion-focussed Therapy movement and its emphasis on selfcompassion being the foundation of healing. However, the undoubted core of Clinical Theology is acknowledgement of the divine spark within all human beings – a spark that becomes dimmed by our deviance from God’s plan. This amalgam of Christian belief and psychiatry became popular within the Church of England in the 1960s and 70s but Lake’s more controversial ideas, including using LSD in therapy, alienated the mainstream of the Church and his early death in 1982 has further blunted the popularity of his ideas.

It is hard to put spirituality to work in the process of healing the sick mind without a structure. Psychiatry/psychology has its superstructure of evidence-based therapies and procedures but equally well the spiritual dimension of care needs to be embedded in a convincing and believable nexus. The modern culture of individualism and its corollary of quirky, self-centred spirituality can make working with spirituality feel nebulous and tokenistic. Where can the spiritually-oriented psychiatrist gain something more specific and move beyond the isolation that an exclusively individualistic, person-centred focus can generate?

Integrating religious ideas with clinical practice

Integration is more than a current trend; it has been the watchword of community psychiatry for half a century³. Progress has been made but different strands of service remain in silos. The very existence of chaplaincy within the NHS has been questioned⁴. Some organisations encourage the chaplain to put entries in the clinical notes but more often than not chaplaincy input is seen as outside of the multi-professional team. Balancing hard-nosed, scientific evidence against the preferences, ideas and ambitions of the individual patient is the crucial task for the clinician⁵. The Buddhist inspired practice of mindfulness has been integrated into Western psychiatry but can psychiatrists also learn from other faiths?

What can Psychiatry do to bridge the clinical-theological divide?

The Anglican Church is the most widespread theological network in the UK and might be a good place to start this work. Its links with other faiths can provide an entry point into more diverse faith

communities whilst allowing faith-based scrutiny of some of psychiatry's potential extravagances (the medicalisation of grief and sexual desire for example). The potential allegation of a psychiatric mission to bring scientific reductionism into unreceptive cultures has to be taken seriously⁶. Challenge against spiritually bereft models of psychiatry by the Church can only empower other faiths in a vigorous dialogue with the psychiatric establishment. The strength of any profession lies in a willingness not to stand still whilst upholding core values.

Relevant themes for a clerical-clinical discussion could include:

- Dementia – Living and dying with dementia. What is the approach of ministers of the Church?
- Delirium – How does acute confusion present and affect the work of ministry to the sick?
- Depression – Sad, lonely, lost, discouraged or something more? What can ministers teach psychiatrists and vice versa?
- Psychosis – Culturally appropriate beliefs, individual quirkiness or madness. What are the minister's guidelines? Who defines acceptable beliefs? When do unacceptable beliefs form part of mental illness?
- Addiction – Asking for help from that Higher Power versus taking responsibility for one's own wellbeing. Can a balance be struck?
- Prayer and praise – When are they not enough to get you out of a tight corner? Can medical or psychiatric services help? How can one keep well in the face of so much pain?

Such questions are at the heart of modern living and impinge on us all whether we hold to a faith or have no faith. Wrestling with these issues can be part of continuing professional development for psychiatrists and ministers alike. Why not do this in a joint forum and learn more about the roles we each have? Some psychiatrists might view this as selling one's professional soul to religion. In fact, by agreeing a tight agenda on specific issues and questions, inveiglement into evangelism can be avoided in favour of focus on clinical/pastoral scenarios, real-life problems and practical solutions.

The work of Frank Lake was flawed but demonstrated a collaborative way forward for religion and psychiatry. Faith communities of all brands could benefit from reconsidering his work and working with psychiatric colleagues to adapt it for modern challenges.

Dr Simon Thacker, Consultant in Liaison Psychiatry, Derbyshire Healthcare NHS Foundation Trust

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The importance of personal experience



Our life experiences influence our norms, values and assumptions. We carry these around with us and view the world through our own unique lens. Instead of relying on fact or evidence we often base our understanding of new situations and people on expectations, emotions, hopes and beliefs. I will share with you some of my thoughts with the hope it stimulates some of your own.

My name is Dr Jaimee Wylam. I am a current leadership fellow on The Future Leaders

Programme undertaking a project focusing on foundation doctor resilience and well-being. I am a psychiatric core trainee on out of programme experience. I am also a patient of the NHS.

Being a patient before becoming a doctor gave me an awareness of how it felt to try to navigate a confusing health care system. Being a patient helps me to remember that each person we see is facing possibly the worst situation they have been in. Our personal experiences as patients, and we will all have been one at some point, can allow us to show compassion to those we care for.

My own experiences have made me passionate about staff well-being. When preparing to interview for my current role I considered the strengths in what I perceived to be a weakness for the first time. Experiencing ill health as a newly qualified doctor has allowed me to understand, within my own context, the impact personal difficulties can have on staff and I have no doubt that this personal experience helped me to be working to support junior doctors. My experiences have allowed me to show compassion to my colleagues and myself.

Our experiences can be a source of positive contribution, but how can our experiences and assumptions impact negatively? How many of you have been referred a patient and assumed the diagnoses written by the colleague before you are correct? How many of you have viewed a patient through the lens of a diagnosis? How many of you can think of mistakes involving assumptions?

So, what should we do with our assumptions? You could choose to leave them alone. You could offer evidence to support or disprove them. You could change them. We challenge assumptions in clinical practice with ease. For example, in a patient you assume has a viral illness you might supply evidence in the form of a detailed history and observations. With the evidence collected you can assess your initial assumption. But, what if we challenged assumptions on an individual level? For example, I assumed I would not get a leadership post because I was too junior and would not be a good enough leader. In applying for my current post, I challenged my assumptions; providing evidence in the form of the application process and interview. Being a leadership fellow has been an incredibly powerful experience so far and without challenging my assumptions I would not be in this position. With that in mind I ask you to challenge your assumptions, find strength where you perceive weakness and consider the impact of your personal experiences!

Dr Jaimee Wylam, Core Psychiatry Trainee and current Leadership Fellow of the Future Leaders Programme, Health Education England across Yorkshire and the Humber

e-Interview with Professor Alex Mitchell

Professor Alex Mitchell is an honorary professor of liaison psychiatry at University of Leicester and also consultant at Leicestershire Partnership Trust. He was recently ranked among the top 1% most cited scientists worldwide (<https://clarivate.com/hcr/worlds-influential-scientific-minds/>), which is even more remarkable as he remains a full time clinician. He is well known for his work in psycho-oncology, mood disorders, parity of esteem and also for his meta-analytic and screening research.



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

Not many people know I run a modestly successful cycling channel on YouTube called Fastfitnesstips. Through this I developed a lot of resources for training and performance testing. Few people know I am also an excellent five-a-side footballer: ok truth be told, nobody actually knows this, especially my team mates! I also run; (mainly park runs and 10ks) but my times are constantly hampered by injuries. That's my excuse and I am sticking to it!

2. What trait do you deplore in others?

I dislike road rage directed towards cyclists, as I often commute by bike and its regular occurrence due to the absence of cycling lanes in the UK. I don't like people who cheat the system at the expense of others for example moonlighting in private practice during NHS time. But even more than this I hate abuse of power, which unfortunately I have seen many times in the NHS, largely directed against whistle-blowers who dare to speak up against the status quo or question management directives. I attend a number of events at the CQC aimed at reforming the NHS following the Francis report. I was amazed at the mistreatment of clinicians across the NHS who tried to stand up for high quality care namely David Drew, Sharmila Chowdhury, and Kim Holt. In fact, I ended up writing a book on this topic which will hopefully be released in the near future when the time is right.

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

Growing up I always loved popular science, especially Richard Dawkins (Selfish-gene, The Blind Watchmaker) and Jared Diamond (The Third Chimpanzee; Guns Germs and Steel). I recommend everyone catches up on their whole back catalogue. Films? To be honest it must be Cowspiracy on Netflix. I became pescetarian after watching the disturbing practices of the western meat industry. Not to mention meat production takes up around 77% of all the agricultural land worldwide and is responsible for about 18% of greenhouse gases.

4. When not being a psychiatrist, what do you enjoy?

As I am getting older it is mainly health and fitness specifically cycling, football and running. I use GPS tools like Strava but these are humbling when you realize how poor you are compared to the professionals. For those without a GPS device get down to your local park run and you will receive an age graded time for free. I also love photography; previously old school 35mm film and now digital photography especially landscapes and aerial photography. I have a mini-studio at home and have used it for a large scale project to help cancer patients after their diagnosis by using peer based first-hand accounts. I have recorded over 500 videos of patients & families telling their story for the benefit of others (www.cancerstories.info).

5. Which people have influenced you the most?

My mum was my biggest influence, as she was a single parent and I was an only child. When I didn't want to go to school as a child, she would say it's up to you, go for yourself, not for me, not for the school. Needless to say I would always go! I have also met some amazing psychiatrists over the years but what impresses me most are those with great humanity. I was attached to Fuad Hussanyah at St Nicholas hospital in Newcastle as a 3rd year medical student. I was shocked when he spoke to me like an everyday person and took me for lunch in the canteen. I was indoctrinated in those big hierarchical medical teams at the time. As an SHO on the Cambridge scheme Veronica O'Keane left a big impression on me in the liaison psychiatry team. She didn't mind me asking difficult questions and applied evidence based medicine to patients in the real world. Pratibha Nirodi in Harrogate is also an amazing old age psychiatrist who can never help her patients enough. Finally, as a consultant in Leicester I became good friends with Steve Frost, who was one of the most dedicated yet approachable clinicians I have ever met. Sadly, Steve passed away from prostate cancer three years ago.

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

As a fantasy? A professional tennis player or footballer! More realistically I think I could have had a good shot as a professional photographer or film director. Or maybe a cycling coach. In fact, if I wanted a new career I could certainly transition to a personal fitness trainer role as my knowledge of health and fitness is probably better than my psychiatry knowledge at the moment!

7. How would you like to be remembered?

As someone not afraid to stand up for injustice and speak up when needed. This is not an easy task, especially when working in an institution like the NHS, when managers desperately try to protect their institutions reputation regardless of the facts. I urge everyone to read the Speak Up Report (freedomtospeakup.org.uk) and David Drew's book Little Stories of Life and Death. I initially thought I was badly treated when I was issued with 13 redundancy notices over 2.5 years but this is nothing compared with the mistreatment of some of my colleagues from mid-Staffs and many other NHS trusts. Many such cases never

come to light. I would also like to be remembered as a clinician who managed to do worthwhile research on essential clinical questions. I am constantly amazed how little we actually know in mental health. If you really try and look for large scale studies you usually find even basic questions have not been satisfactorily answered, but hopefully this is changing, one high quality study at a time.

8. Finally, can we ask you if you have advice for colleagues how to get published?

I am afraid there is no substitute for hard work but you can do things the very hard way or the regular hard way! For about half of my publications I have done literally everything from start to finish. This is a really high risk approach compared to joining a larger research group from the start. By joining an existing group you benefit from shared expertise, motivation and possibly access to pre-existing data. Journal editors actively dislike single author submissions, indeed I have been asked by editors to add random authors after the paper was submitted for appearances sake. I have also been asked by journal editors to add more citations to the reference list specifically from their journal in order to bump up their journal's impact factor. Most trainees think they should start small and write up a case report. Case reports have a place but are not well cited and hence are not popular with journals. In my opinion, trainees should think big about small questions. In other words, collect as much data as possible about a very specific research question. Choose an idea that you are passionate about and don't give up. I have had papers rejected ten times before they were finally accepted only to become citation classics. Indeed, a quirk of science is that the more innovative your research the higher the chances of rejection by peer reviewers, who generally only want to hear what they already believe to be true. So next time you receive a rejection email about your research, think to yourself you may actually be onto something important!

Survey on Transition for Patients Growing Older with Enduring or Relapsing Mental Illness



Background

The College Report (CR153) 'Links not boundaries: service transitions for people growing older with enduring or relapsing mental illness' was published in 2009. It provides guidance on the transition of people from General and Community or Rehabilitation psychiatry to Older Adult psychiatry services. As part of reviewing CR153, an online survey was conducted in January 2016. The questions were based on the recommendations of CR153 to collect information of

existing protocol or local arrangements for transitioning patients.

Results of the survey

Four hundred and eleven psychiatrists responded and 75% were consultant psychiatrists. Of these 217 were from Old Age, 201 from General Adult, 37 from Rehabilitation, 30 from Crisis and 55 from other areas such as Early Interventions, Hearing Impaired, Learning Disabilities, and Eating Disorders.

Only 54% of respondents reported that they were aware of a local transition protocol within their Trust. The remaining 46% were not aware of such a transition protocol and the comments suggested that transition was more of an ad-hoc process with wide variation within Trusts, or that they had transformed to ageless services. Whilst majority respondents reported their transitions were needs led, 46% indicated that age is still a deciding factor. Only 33% of respondents have said that their protocol is easily available or accessible with

comments such as 'one of the hardest transitions', 'closely guarded secret'. Only 47% respondents reported that their protocols offer a clear focus on the needs of the individual and their family. Comments included "resource management" and "Team's caseload seem more relevant than the needs of the patients or family" and "Tight resources colours everything. There is focus on moving on demanding/difficult patients. It is easy to set criteria and define need but almost impossible to link resources to follow the patients". Many triggers were identified at the time of initiation of transitions. However only 28% respondents indicated that their protocol have standardised triggers. A reoccurring comment was about the lack of clarity in the definition of frailty.

Fifty five percent of the respondents reported that joint case reviews/CPA meetings did take place at the time of transitions. They happen "when the transitions take place in the community" and "only in cases where it is not clear cut" Only 3% of respondents have indicated that monitoring of the protocol is taking place. Only 11% were aware of a local process in which lessons learnt from the transition process are disseminated locally. Responses suggested that this was usually carried out informally, through discussion in consultant groups and usually when a complaint arises.

Fifty percent of the respondents indicated that there were resource issues in relation to the transition arrangements. The comments were "massive", "we have no day hospital, vastly fewer beds, fewer social workers, human resources always go to Working Age". "Money doesn't move with the patient" and "tension can cause conflicts between services". There were also comments about understaffing / excessive workload in all areas involved in the transition process lead to the absence of proper transition CPA meetings.

Sixty percent of respondents talked about issues and concerns in arranging the transitions. Vague criteria leading to frequent disputes, delays in transferring care and clear frustration between both teams make people feel that they should stop referring. There were comments that there is no older adult expertise available to their team due to service restructuring and creation of ageless service.

Twenty one percent of the respondents were aware of mental health relapse during the transition process. Anxiety about change can provoke a relapse. Patients, having been consulted on and informed of plans for transition can find the delay and uncertainty stressful, particularly if ambivalent about transfer in first place.

Conclusions

Feedback from 411 respondents generated a wide range of views on the transition issues. Their detailed comments were used to elaborate and modify the existing College Report on transition. It may be convenient to understand the themes emerging from this feedback:

1. Only 54% of the respondents have said that their services have an agreed protocol and 33% have said that it is easily available or accessible.
2. Reports of resource shortfall in General Adult, Rehabilitation and Social and Old Age Psychiatry services affecting smooth transition.
3. Expressions of clinical frustration and delayed care as a result of poor transitional procedures.
4. An overwhelming majority of the respondents request for the College to provide clarity/description on the criteria of transition.
5. Only 3% of the respondents reported an active monitoring of the use of the protocol which in turn will lead to inadequate data collection of resource issues.

Dr Velusamy Sivakumar, Consultant in Old Age Psychiatry and Executive Committee Member, RCPsych Faculty of Old Age Psychiatry, Sheffield Health and Social Care NHS Foundation Trust, Sheffield.

Dr Edward Dimelow, Consultant in Old Age Psychiatry, Rotherham Doncaster and South Humber NJHS Foundation Trust, Rotherham.

Dr Swarupa Shinde, Consultant in Old Age Psychiatry, South West Yorkshire Partnership NHS Foundation Trust, Halifax.

Confidentiality: patients' fitness to drive and reporting concerns to the DVLA (April 2017). Implications as a result of the guidance: perspective of a Psychiatrist



According to General Medical Council (GMC) guidance, doctors should explain to patients deemed unfit to drive that their condition may affect their ability to drive and that the patients have a legal obligation to inform the Driver and Vehicle Licensing Agency (DVLA) about their condition. If the patient continues to drive, the GMC advises that “you should make every reasonable effort to persuade them to stop.” If persuasion fails or the doctor discovers that the patient is

continuing to drive, the doctor should contact the DVLA to disclose the medical information.

The guidance has implications not only for patients and doctors but also for wider network as discussed in a following manner:

1) Patients

There is a considerable healing power in the doctor-patient alliance. Working together offers the opportunity to significantly improve the patient's quality of life and health status. There are no investigations as such to prove the functional mental health diagnosis. However, reliance on part of the subjective and objective experience of psychiatrists and rapport building, which takes time, subsequently leads to development of trust.

However, this alliance between a Psychiatrist and patient may sometimes become fragile due to lack of insight and subsequent engagement on part of patient and the duty of care involved for psychiatrists in detaining patients under the MHA, including treating them against their will, which often breaks this bond.

On top of this, the guidance above potentially damages the alliance leading to further lack of trust. Patients are more likely to: disengage, hide details, get upset, complain, and worry potentially leading to relapse, seek second opinion or request transfer of care to another psychiatrist. Whilst the latter is in process, the patient would often remain without care of mental health services, further increasing the potential risks both to themselves as well as to general population.

Furthermore, it is unfortunate for those patients who do comply and have their license revoked. Especially for those, who are taxi/ bus/ lorry/ driver and that's their main occupation and livelihood. This could have a huge impact on the patient and his/her family. The doctor

could get the 'blame' on such a tragic occasion. At present, there are no adjustments made/ recognized by the government in terms of offering them alternative source of income/ occupation.

2) Psychiatrists/ doctors/ GPs

There are wide number of disorders often associated with lack of insight and lack of capacity including Dementia but also with potential presence of capacity in disorders such as substance and alcohol misuse, which could come into the remit of this guidance.

It is argued that Psychiatrists/doctors are put in a very difficult position (there is a conflict of interest given that I am a Psychiatrist) by where there are expectations to report to the DVLA when a patient fails to comply and to provide suitable time period for patients to act on the information in relation to driving and informing the DVLA. Unfortunately, there is no clarity provided on how long this period should be and what should, if anything, happen during this period. The guidance heavily relies on the honesty of the patients. They may falsely promise to inform the DVLA and to stop driving and the chances of the doctor discovering that the patient is continuing to drive are slim.

There is also an ongoing expectation on Psychiatrists by the employing Trust to continue to engage and maintain therapeutic relationships with all their patients who come within Psychiatrists' sector. Many a time it is overlooked that patients may be entitled to second opinions or a change of psychiatrist because of conflict caused by the guidance such as above. Should there be a complaint, not only is this included in the Psychiatrist's appraisal folder but one may have to go through the time-consuming process of preparing a report/ going through an investigation in the case of being reported to the GMC.

All the above potentially lead to stress, pressure, worries and sickness on the part of already busy psychiatrists.

3) Hospital Trusts

The guidance also demands that should a patient request a second opinion, this should be provided. Often there is no clear channel/ process/ pathway designed by the Trust who should seek the second opinion/ another psychiatrist. If there is a process, it is a long and strenuous one whereby the Clinical Director comes into the picture and must find another psychiatrist who is willing to take over the care.

4) Wider population

Unfortunately, the general population continues to remain potentially at risk from those drivers who should not drive because of their difficulties affecting driving but continue to do so.

5) Police Officers/ Criminal justice system

May get involved in case of a driving offence however often there is no clear communication between police officers, health services and the DVLA.

6) DVLA

Monitors the process of Licensing but this is often based on the reports submitted by doctors.

7) GMC

The role is to protect patients however the guidance seems to be more directed towards protecting the general population.

8) Department of Health

The government has a duty towards patients who lose their occupation and livelihood because of illness to provide with alternative source of income/ occupation.

Suggestions:

A review of this guidance involving patients, psychiatrists, GPs, hospital Trusts, the DVLA, Department of health, GMC and Police officers, to outline a clear responsibility on each and development of a clear pathway, keeping in mind all above points.

Dr Madhvi Belgamwar, Consultant in General Adult Psychiatry Derbyshire Healthcare NHS Foundation Trust and Trent Division RCPSYCH Vice chair and Regional Advisor,

Reference

Confidentiality: patients' fitness to drive and reporting concerns to the DVLA or DVA (2017): www.gmcuk.org/guidance/ethical_guidance/30653.asp

Engage Your Mind – Fighting for Identity: An evening with Kellie Maloney

In Winter 2015 we ran our first Engage Your Mind event, myself and Dr Charlotte Blewett (both Higher trainees at the time). We started the concept of a series of interactive lectures and seminars aimed at medical students and foundation doctors to promote Psychiatry as both a foundation post and a career. Our first lecture saw Prof. Steve Peters attend and give an interesting and inspiring review of his career at Sheffield University and Undergraduate Tutor to Team GB Cycling Psychiatrist and expert witness to WADA (World Anti-Doping Agency). Following encouraging feedback from attendees we saw Engage Your Mind grow from strength to strength.

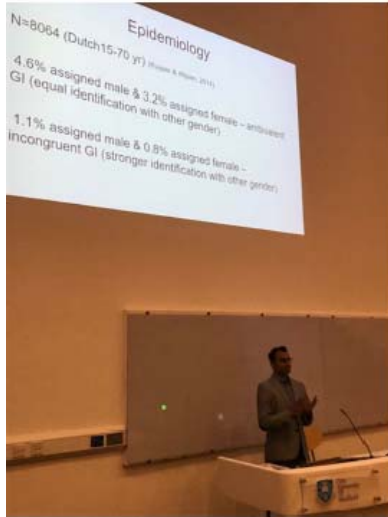
Over the last two years, we have ran events “Speed Dating in Psychiatry” – medical students and foundation doctors were invited to spend the evening circulating around tables manned by consultants in various specialities in Psychiatry and have a chat about what it was like to be a consultant in that particular avenue of Psychiatry. This event was particularly liked by foundation doctors who were deciding about applying for Psychiatry. “In the Mind of a Psychopath” was another well received event where we invited Consultant Forensic Psychiatrist Dr Paul Egleston, Consultant Forensic Medical Psychotherapist Dr Shari Mysorekar and Mr Julian Hendy from Hundred Families talk about offending rates, assessing and treatment of criminals with Psychopathy and the experience of families after experiencing violent crime committed by someone who is mentally unwell. This ended with a lively debate where the floor argued “Should all Doctors be screened for Psychopathy.”

We have also been lucky enough to have Mr Michael Bennett, former Professional Footballer and Head of Player Welfare at the Professional Footballers Association, talk about the importance of mental health management and support in football – in an event which we called “Tough at the Top.”

More recently in March 2018 in our event “Fighting for Identity” - we were lucky enough to welcome Ms. Kellie Maloney, former Boxer and Boxing promotor to Lennox Lewis, talk about her journey becoming a woman. She was able to tell us about her trouble with the media, going on Celebrity Big Brother, her experience of gender reassignment and the impact this has had on her family and her mental health. We were lucky to also have Dr Abhi Shetty (Consultant Liaison Psychiatrist and Sheffield Gender Identity Service) give an informative session of definitions, epidemiology and account of current services available in the country for gender dysphoria.

As Engage Your Mind has grown we have been lucky to have a trustworthy team of Psychiatry core and higher trainees in South Yorkshire who have tirelessly helped in organising and running these events: Dr Charlotte Blewett (Co-Lead), Dr Ryan Dias, Dr Jaimee Wylam, Dr Dasal Abayaratne, and Dr Nicky Combs. Our thanks go to them. Watch this space; we have some great ideas for 2018 to 2019 – you can follow us on Facebook and on Twitter @EymPsychiatry. Please get in touch; we would love to hear what you think!

Dr Madeleine Bonney-Helliwell, Consultant Psychiatrist, Derbyshire Healthcare NHS Foundation Trust



What do higher psychiatry trainees need to best prepare them for their consultant career?



In my perspective, one of the most important aspects to develop as higher psychiatry trainees is resilience. StartWell, the Royal College of Psychiatrists Consultant-led initiative for Psychiatrists in their first five years as a Consultant focusses on six supporting elements: Making connections, continuous learning, using support effectively, personal resilience, career development and clinical leadership.

While the other five elements are either clearly defined or easily interpreted, the concept of personal resilience (maintaining a work-life balance, accessing personal therapy and maintaining boundaries) and in consequence, the way of supporting its development has missed the point.

This is understandable as the concept of resilience is contextual. There are definitions of resilience in metallurgy, biology, ecology, psychology, organizational theory, economics, IT, aeronautics, sociology, and national security (1).

Although the concepts have communalities, before trying to create, promote or enhance it, we need to be clear on what it is.

The psychological concept was introduced in child psychiatry by Garmezy and continued being developed by others later on as “a dynamic process encompassing positive adaptation within the context of significant adversity” (2: p.543) and is associated with three factors: (a) attributes of the children themselves, (b) aspects of their families, and (c) characteristics of their wider social environments.

In the French literature, the term was introduced by Cyrulnik as the capacity to carry on regardless in environments that ought to lead to breakdown. As Francart put it, it seems to be “a psychological quality that affords those who possess it a conscious or unconscious return to normality without lasting injury.” (1: p.1)

If this is a psychological quality, and in recent investigations it has been discovered that it is genetically determined (3), is there any way to assist “susceptible individuals” to help them to increase their resilience?

In here, I would like to introduce the concept of orchids and dandelions in child psychology (4). A “dandelion child, refers to the capacity of some children to survive and even thrive in whatever circumstances they encounter, in much the same way that dandelions seem to prosper irrespective of soil, sun, drought, or rain” (4: p.184). The contrasting “orchid child describe the context-sensitive individual, whose survival and flourishing is intimately tied, like that of the orchid, to the nurturing or neglectful character of the environment. In conditions of neglect, the orchid promptly declines, while in conditions of support and nurture, it is a flower of unusual beauty” (4:p.184). This means that an increased biological sensitivity to context that orchid children may have, would result in potential negative effects under conditions of adversity and positive effects under conditions of support and protection.

If we were to generalise the above concepts to the higher trainees, some “dandelion trainees” may be naturally resilient and may respond with that quality to the challenges, while “orchid trainees” would need to be supported to enhance the quality in preparation for

many circumstances that will challenge us as Consultant Psychiatrists. However, it would not be appropriate to think that “dandelions” would not require support. Resilience is not a quality that is static, but affected by the specific challenges. I imagine resilience as a savings account for any type of critical circumstances. Even for the most resilient people, those savings have a bottom line under which the recovery after the crisis would be more challenging and long.

There are articles proposing how to increase resilience in adults, i.e. personally (practice optimism; rewrite your story, don't personalise it, remember your comebacks, support others, take stress breaks, go out of your comfort zone) (5) or organizationally (training in mindfulness or breathing meditation, reflection, self-awareness exercises, and shared experience) (6). If Deaneries and Trusts were to take a leading role in enhancing higher trainees' resilience, it is possible that the monthly academic sessions could be halved to have a parallel running programme. It is very likely that you would have a group of more satisfied well-resourced higher trainees ready to face the challenges of the consultant posts.

In addition to this, Deaneries may promote the Professional Support Unit as the place to enhance your savings account of resilience, and not as a “punitive” place to which you are referred due to particular personal or clinical shortcoming.

In summary, resilience is not a simple concept; there are many variations that may lead to confusion if this is not carefully analysed. As Psychiatrists, we need this quality because, unlike other specialties, the challenges faced with patients and carers may more frequently touch our professional and personal lives. While some higher trainees may be dandelions and others orchids, we all need strategies to enhance our resilience to face the challenges of being a consultant. The Professional Support Unit at the Deanery is best placed to organise a programme that could run in parallel to the monthly academic sessions.

Dr Sandra Reyes-Beaman, ST4 in Psychiatry of Learning Disability, East London Foundation NHS Trust, former Core Trainee in the East Midlands Deanery.

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Psychiatry at the end of life: From reflection to recommendation



I am a Higher Trainee in Old Age Psychiatry and thought I was fully subscribed to the idea that care is at least as important as cure. My specialist interest session in Palliative Care Medicine has developed my thinking further. Dementia is a neurodegenerative disease, with a poor prognosis, which can span several years. People with advanced dementia don't get to make many decisions themselves. They

often develop infections and are sent to hospital, where they are at risk of developing more infections and becoming delirious. They may become disorientated in a new environment. An unfamiliar environment may make them fearful and potentially aggressive. Aggression which doesn't respond to conservative measures, and puts themselves or others at risk, may lead to a person being sedated. There are then the risks associated with sedation, especially in an older adult, with multiple co-morbidities.

In palliative care, I have witnessed many frank conversations with patients regarding what they would like to happen if they lose capacity and develop an infection towards the end of their life. More often than not, they don't wish to receive anything which would prolong life, when they already have a life limiting illness. However if receiving antibiotics meant it could improve their quality of life (e.g. improve pain control) even for a short time, they would want them. Another topic is artificial feeding. When people with dementia reach the end of their lives, they often stop eating and drinking. This causes problems for the medics, and they are often referred to the mental health liaison team. If we don't know what the patient's wishes are, we may need to rely on family to make these difficult decisions, at a time of high emotions for them.

The prognosis of people with cancer is a lot better understood, and it is often easier to recognise dying. There is an uncertainty about the prognosis of people with dementia, and it can be difficult to know when the end is looming. Research shows that our predictions of remaining lifespan in advanced dementia are generally too optimistic. This means that discussions regarding end of life care are often avoided until the immediately terminal stages. Those with dementia don't often get the option of going to a hospice at the end of life, unlike patients with cancer.

An 89 year old man who advanced Alzheimer's disease was brought to hospital with new confusion. He was diagnosed with delirium secondary to constipation. When he got to A&E (one of the most deliriogenic environments known to man), he became physical aggressive to staff members. He was given IM medication in the department. He was later moved to the assessment unit, and became aggressive again. Security were called, he was restrained and given further IM medication. He died a week later.

If these discussions surrounding the end of life, however difficult, happened early on when a person is diagnosed with dementia, it could prevent unnecessary admissions to hospital. Would you want to be restrained and sedated at the end of life? I certainly wouldn't.

In my role as a member of a mental health liaison team, I see frequent referrals of frail, older adults, who don't want to go on anymore. It is too often, perceived by non-psychiatrists as mental illness. I have seen many people in their late 80s and older, who are plagued with multiple co-morbidities, often their partners have died, and they don't leave the house anymore. They feel they have nothing to live for and are just waiting to die. The medics want

us to wave a magic wand. What do we do for these people? There are befriending services; however this is often not enough to help the lonely. Invoking palliative care for frailty and loneliness could be perceived as highly sinister but conversely the assumption that an antidepressant is a game-changer fosters a myth of a cheap, chemical cure. The palliative principle of comfort over cure is very helpful in these circumstances. As psychiatrists, we need to be energised as much about spiritual and social interventions as by the pills we have at our disposal. "To cure sometimes, relieve often and care always".

Older adult psychiatrists could learn a lot from palliative care physicians. When a person is diagnosed with a terminal illness related to cancer, lots of discussions regarding end of life happen; before a person loses capacity. What does the person want at the end? Where do they want to die? Would they want life prolonging treatment? Talking about death needs to happen more often, especially when we are diagnosing patients with neurodegenerative illnesses, which potentially will shorten their life.

Not everybody wants to talk about death, but we at least need to give everyone the option, before it is too late to have these conversations.

Dr Daisy Yates, Old Age Psychiatry Trainee (ST4), Liaison Team, Royal Derby Hospital, Derbyshire Healthcare Foundation Trust.

Uganda: My Trip to Gulu, Mental Health services, Northern Uganda with the Gulu Sheffield Mental Health Partnership

Dr Paul McCormick, Consultant in Old Age Psychiatry in Sheffield, is interviewed about his experiences in Gulu, Uganda, as part of his work on behalf of the Gulu Sheffield Mental Health Partnership.

What is The Gulu Sheffield Mental Health Partnership?

In 2012 the Sheffield Health and Social Care NHS Foundation Trust, together with Gulu Regional Referral Hospital (GRRH) and the Gulu Branch of Mental Health Uganda (GBMHU) formed the "Gulu Sheffield Mental Health Partnership".

The Partnership works with the Ministry of Health in Uganda and the Uganda UK Health Alliance to ensure that together we work within Ugandan priorities. It also works with Health Education England and other NHS Trusts operating in Uganda.

How as an Old Age Psychiatrist did I get the opportunity to go to Africa?

Paul says "In 2015, one of my core trainees at SHSC, Nicola Coombs travelled to Gulu with the partnership. She had such an amazing time and produced a collection of unique and excellent audits and poster presentations from her experience that won several local and regional prizes for her portfolio.

Such was the level of her enthusiasm Nicola managed to persuade (bully!) me to run the Berlin Marathon in 2015 to raise funds for the area.

The project identified for fundraising was the village of Abwoch. A village one hour drive outside of the main town of Gulu in Northern Uganda. This village was significantly affected during the conflict and terror inflicted by the Lord's Resistance Army (LRA) led by the now outlawed Joseph Kony.

At present, there is no central meeting building other than a tiny church within the village. The local community meet under a tree central to the village. The nearest source of clean water is 2km away and there is no toilet in the village of 10,000 people. The idea was to start to raise funds to construct a multipurpose building for the villages to meet and support each other.

I was amazed that I managed to raise £2000.”



My Trip to Gulu 2017

In November 2017, Paul was excited and honoured to be invited by the partnership to travel to Gulu, to visit the actual village of Abwoch. This was a unique experience as it is not often that runners, who raise money for charities, actually get to personally meet the people for whom they run.



“The highlight of my whole trip was meeting the villagers in Abwoch.

On arrival I was briefed that I would be expected to give a speech to the villagers, on who I was and why I was there. Daunting to say the least.

Fortunately, on the drive up some of the local team taught me a few words in Acholi, the local tribal language.

So, I was able to address the meeting in their local language. This went down really well and then through an interpreter I was able to tell the story of the marathon, even down to the effect on my feet. It was quite an emotional day and experience.

I am pleased to say that through this visit we are now more aware of what the villagers actually want and need for their village from the money raised. We have made local contacts to supply materials, so the villages can get a team together to construct the building themselves.”

Why Gulu, Uganda?

Uganda is a low-income country with an estimated population of 37 million. Its mental health resources have to compete for funding with other preventable diseases with high death rates, e.g. Malaria and HIV/AIDS. Uganda spends 0.7% of the health budget on mental health services compared to 11% in the UK, and there are currently only 26 psychiatrists in Uganda, mainly based in the capital, Kampala.

However, what is unique to Northern Uganda is that it is a region recovering from the devastating impact of the terror campaign from the Lord’s Resistance Army (LRA) led by Joseph Kony. Gulu was at the epicentre of the LRA war and still suffers from the psychological shadow of the conflict.

Several issues are specific to the North of the country, including:

- Child soldiers who are now adults re-integrating into their community
- Young women and girls who were taken as sex slaves and wives for generals who are stigmatised and rejected
- Community issues of land entitlement as a result of the forced movement of local people into internal displacement camps
- A whole generation of people who lost their education, their home, land, livelihood and family life
- Thousands of refugees from South Sudan arriving in the area for the past 12 months fleeing the civil war.

As a result of the conflict in Gulu, Ugandan research now indicates high levels of:

Anxiety, depression, PTSD, epilepsy (considered a mental illness in Uganda) and trauma and the mental effect of reintegrating abducted people back into the communities in which they may have caused harm or been harmed as children.

GRRH has a Mental Health Unit providing both an Inpatient Ward and an Outpatient service that stretches up to and inside South Sudan.

Experiences on the wards



Paul says: "Whilst in Gulu, I also got the chance to meet all members and grades of the mental health team in Gulu, visit the mental health unit, and sit in clinics and ward rounds.

As circumstance allowed, I was even able to sit in the Medical student final exams.

Due to my previous and current roles in medical education, I found this an amazing experience.

I learnt different techniques on how to examine and how to test the extent of the student's knowledge in Psychiatry.

I was amazed how in such a short time the examiners were able to assess a student's knowledge on depression, counselling, giving bad news, admission processes, care planning, risk and most impressively attitudes to mental health in different rural areas of Uganda.

A good technique I observed was when the examiner, Dr Cannon, a Psychiatric Clinical Officer (PCO), first found out where in Uganda the student came from. Using their knowledge of mental health issues in that area, the student was asked to role-play being the lead psychiatrist for that area on the local radio station. They were then asked to talk about issues surrounding a particular mental illness to inform the public.

For example, one student came from an area where the illness "Luc Luc" (a Luo word) was very common. Using this role-play the student was able to comment on the causes of Luc Luc, also known as Nodding syndrome. He was able to discuss that many rural communities still believed it was caused by infected or poisoned maize during the war. He was then asked by the radio interviewer (examiner) how we needed to educate the community on its real cause. The student was then able to discuss that it was actually a form of epilepsy possibly caused by the parasitic worm *Onchocerca volvulus*, which is linked to the black fly and river blindness. It is thought that the illness involves the formation of antibodies against parasite antigen that are deposited in certain parts of the brain causing "nodding" like seizures.

To listen to all this knowledge from medical student in such a short time was eye opening and I got a good lesson in cross cultural psychiatry.”

Paul is one of those who volunteered to go to Uganda in his expertise as a consultant psychiatrist. However most of the work done so far has been done by the Partnership Clinical Leads, Senior Nurse, Kim Parker, Greg Harrison, Partnership Coordinator and Bernard Turner, lead REPECT trainer at SHSC.

“In Gulu, the Partnership has established a course called RESPECT. It has resulted in the reduction of the use of seclusion and rapid tranquilisation. Instead, staffs now have a better understanding on how to interact and communicate with an agitated patient with compassion, using de-escalation techniques and only using restraint if necessary.” Paul says.

Mental health Awareness

Paul is now part of team that goes out to Gulu, Uganda, to support the development of sustainable training at the hospital and local villages. This will help dispel the stigma and discrimination and improve the experience of people with mental health problems and epilepsy.

“The programme has been running for the last 5 years and has made a huge difference to the area. Villagers, patients and carers tell me they received so much more compassion and respect as service users.” Paul says.

“It’s had an enormous impact on tackling mental health stigma in the area.”

The training has also helped to dispel other medical myths, such as the belief that you can catch epilepsy.

“The real life stories of stigma and misconceptions about epilepsy had a huge effect on us. Gloria, a young girl from Abwoch Village, who is well known to the partnership, fell into a fire whilst having a seizure and was badly burned. She was left in the flames longer as bystanders still believed they could “catch” epilepsy if they were to touch her.”

It was 24 hours before her mother, who also has mental health problems, was able to raise the money to get her to hospital 36 km away. Gloria’s mother and Lilly, one of the leaders of Abwoch Village and village mental health coordinator, have both taken part in training provided by the partnership in teaching epilepsy awareness.

Lilly has since said that she once came across a labouring woman having a seizure on the side of the road. “People were afraid and throwing stones at her”. Lilly said. “I now have the knowledge, I knew not be afraid, that I was safe and I helped her.”

This shows a real life example on how this training helps saves lives in the community.

“RESPECT” and other work provided by the Gulu Sheffield health Partnership

Whilst I was in Africa the biggest impact I observed from the partnership was the progress of “Management of violence and aggression courses (Respect)” project.

This began in November 2013. Its impact has been formally evaluated by Sheffield University and SHSC and published in the African Journal of Traumatic Stress (2015). An award from the Tropical Health Education Trust (THET), funded by the UK governments

Department for International Development, has enabled a team of Gulu RESPECT instructors to be trained.

Other Partnership work with the GRRH includes:

- Hosting 23 Gulu colleagues (2012-18) to travel to Sheffield to share knowledge
- This was supported through the Commonwealth Fellowship Programme, funded through the British Council and managed by the Commonwealth Scholarship Commission
- Developing a dedicated space in the mental health unit to create a children's ward
- The creation of a Medical Library and Resource Centre at GRRH, supported by the British Medical Association, Book Aid International (a UK charity) and Sheffield Hallam University.
- Co-development of a Rapid Tranquillisation Protocol with regular audit and feedback of practice
- Supporting the creation and maintenance of an Occupational Therapy service on the Mental Health Ward at GRRH

Service user led groups in Uganda

A lack of community mental health services has resulted in the development of vibrant service user led groups in Uganda and the most active of these in the area is the Gulu Branch of Mental Health Uganda (GBMHU).

The partnership has provided Mental Health Awareness training to GBMHU.

A "Train the Trainers" course was then provided to GBMHU members in November 2013, which has enabled service users to deliver mental health awareness courses themselves to the wider Gulu area.

This was updated in 2016 and they are now providing training to local churches. This will help combat the stigma of mental health in Uganda and by doing so improve the quality of life for communities.

Traditional Healers received Mental Health Awareness training from GBMHU supported by a long-term volunteer who was then a Junior Doctor in Sheffield.

In Sheffield a Registered Charity, the Sheffield Health International Partnerships (SHIP) enables fundraising to be undertaken and to benefit from Gift Aid

The Future

Paul is passionate about his work with SHSC and plans to run another Marathon in Uganda to raise money for the charity.

Knowing that it is compulsory for medical students in Uganda to address issues of mental health has been a great comfort to Paul.

"My trip showed me that the work with the partnership which is helped by the commonwealth links is so important. Like Lilly's example, if we can change one person's attitudes towards mental health, it can save a life, but knowing that mental health is a key part of the medical curriculum in Uganda especially with regards to community awareness of mental illness is far more than I expected to see."

Future trips to Uganda will become part of Dr Paul McCormick's involvement with the work of the Gulu Sheffield Mental Health Partnership. Sheffield Health and social care charity

(SHSC). "Meeting Lilly and knowing Gloria's story, I would really like to build on the earlier work of the partnership and focus on epilepsy awareness"

The UK Cabinet Office has recently produced a short film about the work of the Partnership for screening at the Commonwealth Heads of States summit in London in April 2018.

What about the NHS and the UK

Paul has also had thoughts on how his experience will benefit services in the UK:

"I am now involved with a project to continue links with Gulu and how it can help us in the NHS. I learnt so much in Gulu that I have brought back to the UK, so I would like to set up a project to give psychiatry trainees the same opportunity. We are looking to develop a Trainee Service Development prize in Yorkshire and Humber with Health Education England. The winner will receive funding to travel and work in Gulu for a few weeks. I think this opportunity would be mutually beneficial to Psychiatry in the UK, NHS services, recruitment and to the projects in Uganda.

The People

Paul met some great friends and colleagues from the team in Gulu who he still keeps in contact with via email and Facebook.

"Sister Immaculate Akello, (senior psychiatric nurse from Uganda Gulu hospital) has become a good friend"

She says:

"The aim of this partnership is to improve patients' safety. In Sheffield UK, there is Greg Harrison as the coordinator and Kim Parker as senior clinical lead of this partnership.

The partnership has benefited both the UK and Uganda staff, a total of 23 staff from Gulu hospital have gone to Sheffield and over twenty staff have visited Gulu hospital.

The last UK staff to visit Gulu was a psychiatrist, Paul McCormick, who was very instrumental in discussing the way forward for the partnership, he also observed a hospital examination of the clinical students.

Each staff come back with a project which includes hand overs, and far most beneficial, RESPECT, (tactful management of aggression and violence among mentally disturbed persons). I am proud to say the Ministry of Health has supported some programmes.

RESPECT is a researched accepted programme, aimed at handling aggressive and violence in psychiatric patients.

The Gulu hospital and Sheffield UK have formed a partnership, and they have trained eight instructors, who in turn have trained hospital staff to manage violence with minimal harm to patients and staff.

Many thanks to the funders. THET (tropical health education trust) the UK lead instructor, Bernard Turner, Kim Parker and Greg Harrison for their endeavours in this programme, which has brought fantastic changes in ways of service delivered in Gulu hospital in Uganda."

Further reading

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Hague, B., Thompson, A. R., Sills, J. (2015). An evaluation of the benefits to a UK Health Care Trust of working in a partnership with a hospital in Northern Uganda: International partnership working in health. *Globalization and Health*, 11:52. DOI: 10.1186/s12992-015-0134-8 (IF: 2.25)

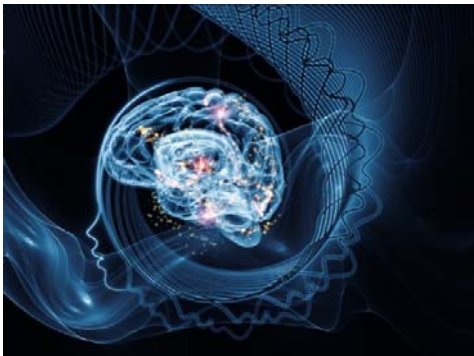
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Hughes, P. (2017). Refugee mental health needs in Uganda. Accessible from:

<http://www.rcpsych.ac.uk/discoverpsychiatry/overseasblogs/uganda.aspx>

Kigozi, F., Ssebunnya, J., Kizza, D., Cooper, S., & Ndyabangi, S. (2010). An overview of Uganda's mental health care system: results from an assessment using the world health organization's assessment instrument for mental health systems (WHO-AIMS). *International journal of mental health systems*, 4(1), 1.

First Regional Neurodevelopment Psychiatry Day 2018



On Friday 15th June, medical students and junior doctors gathered for the first Neurodevelopmental Psychiatry Day, held at the University of Leicester. The regional conference hosted an array of clinicians, covering a wide variety of topics that underlines work in the area of Neurodevelopmental Psychiatry. With the aim of stimulating interest, the conference evidently surpassed this with the level of engagement from delegates and the palpable enthusiasm in the room.

The day opened with an inspirational keynote speech by Dr Pete Miller, Chief Executive Officer of Leicestershire Partnership NHS Trust and Consultant Child Psychiatrist. Dr Miller spoke about the value of considering Neurodevelopmental Psychiatry in everyday clinical encounters and provided an exciting overview of the remainder of the day.

Delegates were fortunate to hear from clinicians from around the East Midlands Deanery who discussed relevant and interesting topics; spanning Autism Spectrum Disorder to Neurodevelopmental Psychiatry in Forensic settings (see box 1). Members of the MDT also took the audience through a patient journey, illustrating the essential contributions of allied health professionals in the care of patients within Neurodevelopment Psychiatry – a valuable insight for students who may otherwise have little exposure to the MDT.



Dr Pete Miller, CEO of Leicestershire Partnership NHS Trust



Dr Mary Barrett, Consultant Psychiatrist

In an interview with the eminent Professor Bhaumik (OBE), delegates gained some insight into a career in Neurodevelopmental Psychiatry and the opportunities available within this area of clinical work. Professor Bhaumik spoke passionately about his experiences as a clinician and the satisfaction gained from working to improve the quality of life for individuals with learning disabilities. He also discussed his experiences as Medical Director, leading on the development of NICE guidelines and authoring several books, which led to particular commendation from the audience.

Further focus on leadership and academia followed, as other clinicians spoke specifically about their journeys and experience in research, leadership and management. Delegates were offered invaluable advice and wisdom from prominent clinicians well known for their work both locally and internationally, as well as from trainees and those with Academic Clinical Lectureships, who spoke about the formal and less formal routes into research and teaching and the exciting research developments in Neurodevelopmental Psychiatry.



Professor Bhaumik interviewed by Dr Chaya Kapugama (ST5)



Christopher Burston (OT), Catrina O'Regan (Community Nurse), Dr Heidi Higgins (Clinical Psychologist) & Jenny Roberts (SALT)

The day concluded with Consultant Psychiatrist and Honorary Associate Professor, Dr Biswas, talking about career pathways into (Neurodevelopmental) Psychiatry and the opportunities available to medical students and junior doctors, including essay prizes and the RCPsych Pathfinder Fellowships.

Overall, delegates were given a taster into the world of Neurodevelopmental Psychiatry, with its clinical challenges that require skilled clinicians to call upon their knowledge of psychiatry and general medicine, combined with sensitive communication, leadership and team-working capabilities. With a day of inspirational stories, clinical knowledge and experience and opportunities for professional development, it is unsurprising that feedback from delegates was very positive.

The success of the Neurodevelopmental Psychiatry Day 2018 makes this regional conference the first of many to come.

For more information on the Neurodevelopmental Psychiatry day, please email: Samuel.Tromans@leicspart.nhs.uk

Dr Lesley Thoms, Core Psychiatry Trainee, Leicestershire Partnership NHS Trust

Box 1: Additional topics covered at the Neurodevelopmental Psychiatry Day

- Introduction to Intellectual Disabilities (Dr Peter Cutajar, Consultant)
- Autism (Dr Mary Barrett, Consultant)
- ADHD (Dr Barbara Houghton, Consultant)
- Epilepsy (Dr Samuel Tromans, ST6, ACL & Dr Chaya Kapugama, ST5)
- Forensics (Dr Abdul Shikh, Consultant)
- Leadership (Dr Richard Welfare, Consultant)
- Research (Dr Regi Alexander, Consultant & Dr Samuel Tromans, ST5, ACL)
- Case Scenarios (Dr Ben Ross, ST5)
- Experience of FY2 in ID (Dr Benjamin Gerrins, FY2)

RCPsych Trent Division Annual Conference *****Friday 7 December 2018*****



The Trent Division Annual Conference will be held on **Friday 7 December 2018**,

at the Double Tree by Hilton Nottingham Gateway Hotel, Nuthall Road, Nottingham, NG8 6AZ.

We have a full and varied [programme](#) featuring Professor Wendy Burn, President of the Royal College of Psychiatrists as a key note speaker, a number of thought provoking talks, a medical student public speaking competition, prize and poster presentations and we conclude the day with an engaging debate.

To book a place please click [here](#). Please note, upon clicking this link you will be directed to a secure webpage where you will need to login using your college account credentials.

Bookings will close on midday Monday 3 December 2018.

This conference is eligible for **1 CPD point per hour** subject to peer group approval.

We will look forward to seeing you there.

Best wishes

Marie Phelps

Trent Division Manager

The Royal College of Psychiatrists

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Divisional Prizes



In 2018 the Trent Division will be offering the following prizes:

Poster Presentation Prizes for Student Associates, FY1-2, CT1-3's and ST4-6's

Prizes will be awarded at the Trent Division Annual Conference. Further details can be found [here](#) or by contacting Gloria Zachariou.

Vacancies

Executive Committee Member (6 Vacancies):

We are looking to appoint enthusiastic and experienced consultants to join the Trent Division Executive Committee and welcome applications for the 6 vacancies listed below.

[Child and Adolescent Psychiatry Regional Specialty Representative](#)

[Academic Psychiatry Regional Specialty Representative](#)

[Perinatal Psychiatry Regional Specialty Representative](#)

[Policy and Public Affairs Committee Representative](#)

General Adult Psychiatry Specialty Representative

Private and Independent Practice Representative

Please click [here](#) for a summary document for your information and click on each link for further details.

Being a committee member provides an opportunity to gain management expertise, get involved in projects and influence policy.

Are you keen to contribute to the psychiatric community, gain invaluable networking opportunities by working on behalf of the Royal College of Psychiatrists AND boost your CV? Would you like to get involved?

If you are interested in applying for this post please e-mail your CV, including the names and contact details of two referees, to mariej.phelps@rcpsych.ac.uk

The closing date for all applications: **midnight on 30 September 2018** Further information about the roles is available [here](#).

Trent Division Executive Committee

The Trent Division Executive Committee meets four times a year at different venues within the region.

The next meeting date is;

Wednesday 7 November 2018 Sheffield

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

Current Consultations

The Division regularly seeks the views of its membership on [consultations](#).

If you would like to contribute to the Division's response please email Marie Phelps.

Get Involved!

If you would like to submit an article for inclusion in the next edition of the newsletter please send it to Samuel Tromans and Lesley Thoms with a copy to Marie Phelps.

Contact us with any additional comments, views and opinions on this topic for inclusion in the next edition of the newsletter.

Contact Us

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Further details about the Division, its Executive Committee, future meetings and events can be obtained from Marie Phelps.

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