Winter Edition, 2021/22

Psychiatry-Trent

The Trent Division eNewsletter

Contents

Dr Sidra Chaudhry and Dr Kris Roberts Co-editors, Psychiatry Trent

Editorial

Dr Sidra Chaudhry

Dr Kris Roberts

Time continues to fly; even more so in recent months. The training years seem to pass by quickly like the underground tubes in London leaving the platform with me standing behind in a gust of strong wind trying to find my bearings.

It's been a significant year to say the least. The world seems to have shrunk to fit onto our phone and tablet screens. Events around the world have had a magnanimous impact on not just the international economy and politics, but also on our hearts and minds. With travel restrictions easing, I had the chance to visit family back home in Pakistan after two long years, which gave me a much-needed morale and energy booster. I sincerely wish for everyone away from family to be reunited soon in happiness and health!

There have also been significant events within Psychiatry. The COP-26 conference highlighted the Mental Health impacts of climate change, which we wanted to recognize in the current issue. The pandemic continues to stretch services and individuals.

It would be wrong not to also acknowledge the passing of Aaron Beck, the Godfather of CBT, in November, especially after all his contributions to Psychiatry and the ways in which we continue to work because of his influence.

In the spirit of appreciating and acknowledging the efforts of all mental health staff, we initiated the Trent Division Hall of Fame earlier this year. More details can be found within this edition. We take great pride in all the nominees and are very grateful for their contributions within the region. We would like to encourage you to nominate your colleagues for the wonderful work they're doing in the field of psychiatry.

Last, but not the least, a huge thank you to each one of you for your valuable contributions. We have received some very interesting and thought-provoking articles this time and value your continued support and involvement.

Hoping this edition of the E-Newsletter finds you in good health and spirits!

Enjoy*!*

Best wishes*,*

Sidra and Kris*.*

Get Involved!

If you would like to submit an article for inclusion in the next edition, please send it to (Trent@rcpsych.ac.uk).

The division welcomes articles of local interest relating to psychiatry. We encourage trainees to get involved as well as patients and carers.

Submissions could be along the following lines:

Interest articles
Are you personally involved in any local work that you would like to increase awareness of? Is there a topic in mental health which you find interesting and would like to share with your colleagues? Do you have a personal experience within psychiatry you'd like to share?

Event articles
Would you like to share a review/feedback from a conference or other mental health related event that you've attended?

Opinion pieces/blog articles
Are there any issues in mental health that you are passionate about and wish to discuss with a wider audience?

Cultural contributions
This could be in the form of artwork, photography, poetry or an article relating to your insights, interpretations and observations of
relevant popular culture, the arts and theatre.

Research/audits
Have you been involved in any innovative and noteworthy projects that you'd like to share with a wider audience?

Patient and carer reflections
This should be a few paragraphs detailing a patient or carer's journey - you may have a patient whose story you would encourage to share; or it could be a case study including a patient's perspective. Confidentiality and Data Protection would need to be upheld.

Instruction to Authors
Please consider your articles to be as precise as possible. As a guideline, articles on interesting topics, research/audits, good practice and opinion pieces may be up to 1000-word limit which may include up to around 5 essential references. Articles on events or conferences should be within 500 words. Please follow Instructions for Authors of BJPsych for reference style. Authors must obtain written permission from the original publisher if they intend to use tables or figures from other sources, and due acknowledgement should be made in the legend.

Authors are expected to be aware of and comply with best practice in publication ethics. Please declare any conflict of interest related to the article.

Disclaimer:

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

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Chair's Column by Dr Shahid Latif

Dr Shahid Latif
Trent Division Chair

Welcome to the winter newsletter of our Division. This is my first Chairs Welcome in my role as Division Chair. I'd like to thank Dr Anand Ramakrishnan for his dedication and contributions to the division as the previous Chair.

We are keen to hear from our members please email us with your suggestions for future events, topics and how we can get more members involved in our divisional activities to Marie Phelps, Trent and West Midlands Division Manager at Trent@rcpsych.ac.uk

I encourage you to use our Twitter account @rcpsychTrent to communicate with your peers, share best practices and raise the profile of psychiatry in the Trent region, currently with 1052 members.

Thank you to our joint e-newsletter editors, Dr Kris Roberts and Dr Sidra Chaudhry for their input and for putting together this edition in partnership with our members and the division staff, Marie Phelps and Daljinder Waterhouse.

Events

College face to face events continue to be cancelled for 2021 and into spring 2022, due to the Covid-19 pandemic. The College is however continuing to provide online content and webinars, which I hope that you have been able to join.

Spring Webinar

Thank you to our Executive Committee Members for arranging our first ever spring webinar. The event was very successful with 7 speakers, including Professor Tim Kendall and Professor Sir Simon Wessely, giving talks on a range of topics.

We hope to provide a joint spring webinar with our neighbours in the West Midlands Division in 2022. Further information will be provided in the new year.

Mental Health Act Section 12 and Approved Clinician Courses

Bookings are open to book your place please visit our website.

Executive Committee

Committee Meetings

All committee meetings are being held remotely until further notice. The next meeting date is 27 April 2022.

2022 Elected Positions

- Financial Officer: Dr Navjot Ahluwalia

Current Vacancies

There are currently the following vacancies within the Trent Division Executive Committee:

- General Adult Regional Representative
- Neuropsychiatry Regional Representative
- Rehabilitation and Social Psychiatry Regional Representative
- Specialty Doctors Committee Representative

Find out more about our Regional Advisors and Specialty Representatives roles, including full job descriptions (PDF). The closing date is **31 March 2022**. Further information is available on the College website.

Student/Foundation Doctor Associate

Please also invite your foundation doctors and medical students to sign up to associate status, which is free via the College website.

Applying for Fellowship

We award Fellowship as a mark of distinction and recognition of contributions to psychiatry. You're eligible if you've been a Member for 10 continuous years or more and can demonstrate significant contributions to the core purposes of the College:

- setting standards and promoting excellence in mental health care
- leading, representing and supporting psychiatrists
- working with patients, carers and their organisations.

Fellowship is open to both UK and Overseas Members, but unfortunately Affiliates and Associates can't apply.

If successful, Fellows can use the title FRCPsych once they've paid the prescribed registration fee. Find out about how to apply. Please email trent@rcpsych.ac.uk for further information.

Please email trent@rcpsych.ac.uk for further information.

Personal resilience in Psychiatrists: It is about developing and maintaining it throughout our career graph by Dr Deepak N Swamy

Dr Deepak N Swamy
Associate Specialist in Autism & Neurodevelopment

Personal resilience in psychiatrists: Resilience can be described as 'bouncing back despite odds' which we say in common parlays. Resilience is where a person excels despite adversity. It is not a 'static concept' and should be considered as a 'dynamic concept'. This is because we need to imbibe and practice active cognitive processes in our minds and develop positive behaviours to maintain Resilience. There are positive and negative factors that influence the well-being and resilience in Psychiatrists. As Psychiatrists imparting care and being mental health providers to patients, it becomes all the more important to maintain our own well-being and resilience. As the common saying goes 'Please take care of yourself before you take care of others'. 'Please wear your Oxygen mask first before assisting others'. It is important to gain insight regarding the interventions that are needed for resilience and to imbibe helpful suggestions to put this into our career practice.

In my view, it is important to build Resilience in Psychiatrists from the initial training days so that it can be developed into full fledged part of work life. This is especially needed when we finish the training and progress in our career graph to last for our full career time period. There are various ways of building Resilience in Psychiatrists. I have found that inculcating Mindfulness for self-awareness and concentrating on small but pleasurable things in day to day life helps. These are the "things" that we usually ignore or consider not relevant in our hustle and bustle of our work lives. These are important if we consider the larger perspective and holistic view of life. This makes me more focused and to concentrate on completing tasks in my work. It also helps me to remain target orientated and to understand things from the patient's perspective.

An important aspect for resilience that I have found with self-journey is by attending events that are related or unrelated to health discipline. There are two paths to partake in this aspect. One is that you can attend events related to health that adds knowledge and skills to your clinical practice, but not directly your own sub-speciality or speciality. Another is that you can attend events that are outside health discipline but still adds to your communication skills, leadership and management skills. Recently I attended an event about How to improve confidence in Public Speaking skills. Although I attended this event as a participant and not as a speaker, I was asked to speak about a topic impromptu. The topic is chosen by picking up from a lot. I felt that as there was no time to prepare, it actually helped me to speak well and increased my confidence. Attending a health event not related to my sub-speciality or speciality gives me knowledge about how other health professionals perform in their disciplines. At the same time, it made me self-aware about the positives or hardships of my own sub-speciality or speciality and gave me a relative perspective for my own clinical practice.

In summary, I would consider Resilience as a life-long concept that should be practised and maintained by us as we progress through our career graph. It is definitely not a one-day concept. There will be highs and lows in our career and personal lives, but if we have the inbuilt resilience that we develop from our training days, then that should sail us through our professional life as a Psychiatrist.

Author
Dr Deepak N Swamy, Associate Specialist in Autism & Neurodevelopment, Sheffield Adult Autism and Neurodevelopmental Service (SAANS), Sheffield Health & Social Care NHS Foundation Trust

The Nottingham Psychiatric Archive by John Cooper

Aspects of Psychiatric Research in Nottingham, and the Legacy of Duncan Macmillan. Dedicated to the memory of Dr Duncan Macmillan, O.B.E., B.Sc., M. D. FRCP (Ed).

In 1930, at the age of 28, Duncan Macmillan was appointed as Deputy Medical Superintendent of Mapperley Hospital, becoming Superintendent in 1940. He retired aged 65 in 1967, and died suddenly aged 67 in 1969 while on holiday. He thus spent 37 years at Mapperley Hospital, 27 as Medical Superintendent.
Professor John E. Cooper was appointed in 1971, and retired in 1991. He started preparation of this Archive in the 1990s, for many years with the help of Dr Ian Medley, and latterly with the support of Dr Stuart Leask who created these pages. Dr Leask is currently designated as Keeper of the Archive; any enquiries should be addressed to him at stuart.leask@nottingham.ac.uk. The ultimate responsibility for the Archive rests with whoever is Head of the Department of Psychiatry, currently (2021) Professor Martin Orrell.

This Archive contains the following:-

1. A bibliography of research done in Nottingham that follows on from the interests of Dr Duncan Macmillan on the design of mental health services and the epidemiology of severe mental disorders. The Archive does not cover the wide variety of studies carried out in Nottingham on other topics by other researchers.

2. A hard copy section that includes Professor Cooper's personal collection of rating scales and interviewing schedules by a variety of authors that reflect his interest in the classification and epidemiology of mental disorders, structured interviewing and case registers. Some of these were developed during the course of studies with the World Health Organization.

3. Two aspects of the US/UK Diagnostic Project with which Professor Cooper was concerned before being appointed to Nottingham (I) a note on the history of the first five years of the Project (1965 – 1970) and (ii) the personal memories and reflections of surviving members of the Project written in 2020 (50 Years later). JEC 7 May 2021

Author
John Cooper, Emeritus Foundation Professor of Psychiatry, University of Nottingham

Climate Change and Mental Health by Dr Kris Roberts

The recent United Nations Climate Change Conference, known as COP26, in Glasgow has drawn global attention to climate change. The Royal College of Psychiatrists were invited as part of the focus on health outcomes in relation to it, and the message was clear: climate change is a mental health emergency. This article aims to add context to the dangers faced by climate change.

"Climate change is the biggest global health threat of the 21st century" was the statement that book-ended the 2009 report generated by the joint Commission for Climate Change between The Lancet and the Institute for Global Health at University College London[1]. An ecological klaxon for the wider public, environmental awareness has steadily evolved into mainstream consciousness.

In May 2019, the UK government declared a climate emergency, acknowledging the risks to global health outcomes and human life[2]. Disease states could surge as a result of the current climate trajectory; the overlapping potential disruption to global health care delivery adds to a bleak portrait of our current future.

Amongst the major health issues stemming from the loss of our environmental integrity are the significant psychological complications and the disorders of our mental health that derive from them. The security offered by our wider environment is under-appreciated; a transition from a familiar and bountiful external milieu to a hostile and unforgiving one will inevitably provoke a range of negative emotions and forced adaptations that can act as a fertile nursery for mental disorder.

The insidious nature of climate change in the temperate environs of the UK might subvert comprehension around this prospect, but in global regions that are familiar with extreme weather conditions or that have experienced climate-mediated disaster, evidence for the increasing burden of mental ill-health to both individuals and vulnerable groups abounds.

New Orleans, Louisiana, USA

The devastating impact of the tropical Atlantic cyclone, Hurricane Katrina, saw over 500,000 people displaced from their homes in the US state of Louisiana. Over 1,800 people lost their lives. As well as the hurricane itself, the population experienced bereavement, loss of personal and financial security and reduced access to food, water and clothing. They were exposed to significant amounts of violence in the early wake of the disaster and, ultimately, many undertook forced migration.

In the aftermath, suicide rates doubled. Of those exposed to the hurricane, 30% of adults subsequently met the criteria for Post-Traumatic Stress Disorder (PTSD), whilst experiencing a more persistent course of the illness[3]. Hurricane Katrina was consistent with findings after the Asian Tsunami of 2004; exposure to situations that threaten life during the course of a natural disaster are associated with an escalation in the burden of long-term psychopathology[4].

Nunavut, Northern Canada

The cultural identity of the indigenous Inuit population of the circumpolar north of Canada is fiercely demarcated by their connection with the land, but they are faced with a rapid destabilisation of their environment. Temperatures are rising at twice the global rate, and the resultant deviations from established precipitation regimes are increasing the duration and severity of extreme weather events[5]. Their working patterns are interrupted; the ice is unstable. They are experiencing first-hand the psychiatric sequelae that result from progressive degradation of the environment: the distress from a reduction in cultural identity and activities; poverty; and decreased access to healthcare are all leading to an increase in addiction and suicide. In the young male Inuit population, the rate of suicide is forty times the Canadian average.

New South Wales, Australia

Seventeen million hectares of land burnt in the Black Summer of 2019-2020 in New South Wales and its bordering regions in a set of unprecedented bush-fires[6]. At least 34 people died. One billion animals perished, with some species forced to extinction.

The mental health impacts of exposure to this disaster have included post-traumatic stress disorder (PTSD), depression, anxiety and alcohol dependence. A further risk comes from a second wave of complications, including domestic violence. In children, regression of neuro-developmental arcs will have impacts far into the future.

United Kingdom

These events occurring in disparate regions of the globe may undermine the impact of the contemporary psychological terms that recognise the burden of mental ill-health relating to the environment. Increasingly, however, the mental health impact of climate change is being recognised at home. Heavier rainfall, higher temperatures and storms are all increasing in frequency and intensity and flooding is now the most common of the devastating weather events in Europe.

The Environment Agency launched a campaign in January 2020 to highlight the negative impacts of flooding on mental health[7]. It underlined the need for preparation against future events and provided some simple tips for those living in areas at risk of flooding to protect themselves and their belongings, and, in turn, reduce the potential impact of the experience. Mental ill-health is experienced by more than 50% of those that experience flooding and complicated by the long term repercussions to security, work and, as above, as a result of forced migration. For those affected, the experience extends beyond the short term; 25% of flooding victims are still living with the direct consequences of their experiences two years after the event.

Furthermore, the campaign recognised the disproportionate impact of climate change and adverse extreme weather events on low-income households. Those with low income are eight times more likely to live in areas at high risk of flooding and in addition, 61% are unlikely to have home or contents insurance that could cover the impact to their lives and home. This financial stress is an important factor in managing the mental-health burden of disaster events.

A recent survey by the Royal College of Psychiatrists also highlighted the impact on younger generations[8]. Over half - 57% - of Child and Adolescent Psychiatrists in England have seen children and young people distressed by climate change and its associated repercussions. The Royal College recognises “eco-distress”, a sub-clinical term that encompasses a range of negative emotions and reactions to the climate crisis; young people who feel powerless against the rising risks and confused as to how it has happened and what their role is in correcting it.

The impact of isolation, the disruption of our normal work routines and the threat of unemployment and financial burden are obvious triggers for mental torque. In this way, the current COVID-19 pandemic has rightly, and very directly, raised the issue of the nations’ mental health on a scale that climate change, so far, has not. The fine line between mental and physical health has never been so clear and the sudden deformity in our social fabric has brought our collective wellbeing into focus.

The impact of climate change, however, will have effects that extend beyond our current predicament. Perhaps this is why it has so far provoked our most basic defence: denial. However, this isn’t a crisis of the future. This is a crisis of the present.

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Author

Dr Kris Roberts, Core Trainee, Leicestershire Partnership NHS Trust

Mental Health as a Medical Student: Spreading the Word About Mental Health Careers by Lénie Zézé

Lénie Zézé, Third year medical student at the University of Leicester

Mental health is an immense part of medicine, however it is sometimes neglected compared to physical health conditions. As we all know, in the past few years there has been lots of increasing awareness, especially on social media to try and normalise mental health and promote services available for people struggling. This is an amazing step forward and hopefully this continues until *everyone* recognises the importance of everyone's mental health.

I studied psychology at A-level which is what sparked my interest in psychiatry and mental health. I find it engrossing learning about the brain and mental processes happening within it, therefore it's something that I'd love to understand more about

I recently did a hip history and examination on a patient, which diverged into talking about how much their condition affected them mentally, through jeopardising their quality of life. In the past, unfortunately I don't think I would have thought to ask a patient, who I was seeing about a hip condition, about this aspect of their life. However, I am now extremely grateful to my medical school for emphasising that we must ask about social history in every single history, as poor mental health is often a consequence of physical health conditions. Acknowledging this and checking for it can make such a difference as it allows them to open up about it and be directed to the appropriate help, rather than them keeping their struggles to themselves. This often happens due to their false perception that their 'worry', 'sadness' or 'anxiety' isn't important.

I think that this patient did unfortunately hold this false perception, as they only mentioned their depression like symptoms when I specifically asked about their quality of life and mental health. They were very emotional, but I think that they really enjoyed talking to me as a medical student as I had the time to listen. They thanked me at the end for bringing this up and allowing them to acknowledge it and consider seeking support, rather than dismissing it as they previously had. It was extremely rewarding to see how much just a small conversation can have a huge effect on someone.

Psychiatry seems like a specialty that is full of rewarding, complex and individually different situations and so I recently helped facilitate workshops for Medicine Calling - a day where year 10s to 13s who are interested in psychiatry can explore the career and gain insight on whether it is for them or not. I loved sharing my interest and introducing others to this enthralling career, a journey which I am only just beginning. Being able to get first-hand teaching directly from a variety of people in the profession was an amazing way for them to build a better understanding of the importance of mental health, whilst also giving them a flavour of what it would be like to go into a job in this domain. It was the first time that I was involved in Medicine Calling but I am eager to do it again as it was extremely fascinating, especially when anonymised stories of real patients were shared with us. Knowing that they were real made it so much more touching and made me want to be able to contribute more to making those momentous differences to people's lives.

At the moment, due to the pandemic mental health is more important than ever which was demonstrated in Medicine Calling by them having COVID-19 themed workshops. These focused on getting the students to try and notice the many subtle effects the pandemic has had on different people. This is a perfect example of how to spread awareness of mental health within and outside the medical profession and more events like this would benefit the community greatly.

Author
Lénie Zézé, Third year medical student, University of Leicester

An exploration into the field of Psychiatry - a Junior Doctor's perspective by Naveen Pillai

The specialism of psychiatry has been an area of persistent interest to me throughout my time in higher education. My first exposure of the science of mind and behaviour was first sparked during my A level education whist studying psychology. Here, I came to learn how human behaviours and mental processes may be described, explained, predicted and even altered through findings from empirical research. This initial insight combined with my passion for understanding the pathophysiology underlying such cognitive impairments in addition to mental disorders, stirred my decision to pursue an undergraduate degree in neuroscience.

Through my undergraduate studies I was able to broaden my scope of cellular pathologies and changes in brain architecture which contribute to behavioural changes amongst individuals through choosing to focus my final year in the field of neuropsychology. It was during the final year of my undergraduate education where I came to learn my particular interest in the value of pharmacology and combined use of psychotherapy to treat individuals with mental health disorders.

These cumulative experiences inspired my choice to read medicine. Whilst studying psychiatry during my medical degree, I was able to gain further insight into the medical, scientific and interpersonal skills required to manage individuals with complex mental health disorders spanning a wide age range and from different walks of life.

These academic experiences were subsequently utilised on a practical basis during my first job as a junior doctor within the field of old age psychiatry. Here, I was able to clerk patients, perform mental state examinations and also contribute to the management of these patients, working amongst allied healthcare professionals to treat, limit disease progression and also optimise patients for rehabilitation into the community. Additionally I was able to join memory clinics and also learn the impact of age related psychiatric conditions on a patient's family and friends.

Whilst progressing through my training as a foundation doctor in a multitude of subspecialties, I have come to appreciate the significance of psychiatry as a specialty and the presentation of mental health disorders in a number of acute settings. I have also been able to appreciate the necessity to identify and explore mental health disturbances as an underlying cause for certain acute presentations such as patients with self harm on a background of substance abuse, severe depression or bi-polar disorder, factitious disorder and personality disorders. I have also come to realise how many mental health disorders are overlooked in fast turn-around medical settings and the underlying cause of a patient's presentation is frequently overlooked, resulting in many instances of repeat presentations or in some circumstances, death.

In order to gain further insight into the various sub specialities of psychiatry, I undertook a number of taster days within different centres managing different psychiatric subspecialties. These included; forensic psychiatry, general adult psychiatry, neuropsychiatry and also spending some time observing the management of psychiatric conditions refractory to traditional pharmacological therapies through the use of ECT.

During these taster days, I was able to explore the multitude of presentations within different settings and also the different approaches to managing such patients. I also came to learn the close affiliation of psychiatry with a number of different specialties to co-manage patients, such as neurology and medical genetics to manage patients with Huntington's disease and their families, in addition to medical specialties in the hospital setting within the field of liaison psychiatry.

An important insight I have gained from working as a junior doctor and also through my taster days is the non-academic skill set that is required from a psychiatrist, which I previously overlooked in my studies. I have come to learn the empathy and compassion required to treat individuals who are often extremely vulnerable, in addition to an initiative to work often within challenging environments and the requirement of a psychiatrist to exhibit strong emotional resilience due to the sensitive nature of topics often discussed during assessment and management of patients.

Through my cumulative experiences learning about the academic and professional commitments required to become a psychiatrist, I remain committed to undertaking a core training programme within psychiatry. I feel my experiences to date have provided a rounded view of the commitments required, but also perhaps more importantly, how a career in psychiatry offers the prospect of providing a positive difference to an individual's quality of life.

Author
Naveen Pillai FY2 Doctor

Service evaluation of Rockbox in a Mental Health Inpatient Unit by Nicole Freeman

Nicole Freeman, Medical Student at the University of Sheffield

Introduction

The World Health Organisation (WHO) recommend that adults aged over 18 years old should do at least 150 minutes of moderate intensity or 75 minutes of vigorous intensity aerobic physical activity (PA) per week. For additional health benefits, it is recommended that people do muscle-strengthening sessions of at least moderate intensity for 2 or more days per week[1]. METS (Metabolic equivalents) are the ratio of a person's working metabolic rate to their resting metabolic rate; one MET is equivalent to the caloric consumption of 1 kcal/kg/hour. The WHO estimate that moderate activity is equivalent to 4 METS and vigorous activity equivalent to 8 METS. Throughout the week, adults should achieve at least 600 MET-minutes through moderate and vigorous PA[2]. It is estimated that 28% of adults are insufficiently physically active[1], but metanalysis shows that 54.7% of people with severe mental illness do not meet the WHO recommended amount of moderate PA and significantly less than the general population meet the WHO guidance for vigorous PA[3]. Many studies researching the correlation between mental illness and PA are in the community, but a pilot study of an inpatient exercise programme showed that the programme improved patients' symptoms of their mental illness[4]. In this project, a mental health inpatient unit ran Rockbox sessions every week over 2 years for both inpatients and staff. Rockbox is a fitness session that incorporates boxercise-style moves with upbeat rock music[5]. This project aimed to analyse the baseline levels of PA amongst patients and staff against the WHO guidelines, alongside their attitudes and experiences of the Rockbox sessions.

Method

Patients and staff who had taken part in at least one Rockbox session were given feedback forms. In total 16 feedback forms were collected. The feedback forms asked participants to provide their age, gender and whether they were a patient or member of staff. Each participant was asked, over the last 7 days, what activity they had taken part in (lasting over 10 minutes), how long for, and how many times. All participants were asked if they felt they did enough exercise. Each participant was provided a list of reasons for why they had not done more PA in the past and were asked to tick all reasons that applied to them with space to write any additional reasons. Twelve participants were given a scale on which to rate the session overall from 'very enjoyable' to 'I did not enjoy it at all'. All participants were given space to write comments on why they tried the session, what had been the best thing about the session, and any additional comments.

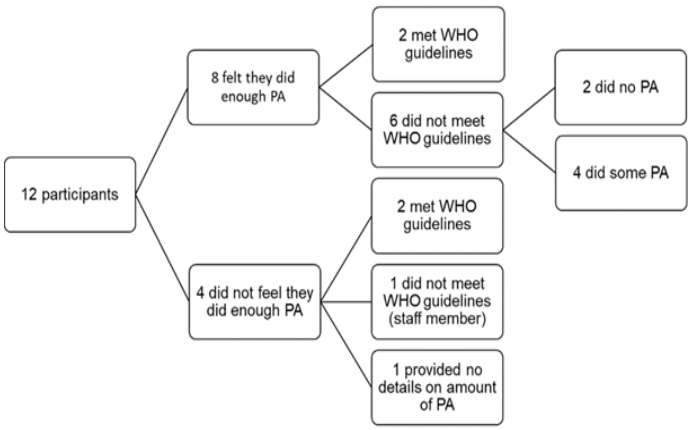
Each exercise mentioned by a participant was classified as 'moderate' or 'vigorous'. Rockbox sessions were excluded from the analysis. It was decided that walking would be classified as moderate PA, as the WHO Global Physical Activity Questionnaire state that walking is equivalent to 4 METS[2]. Going to the gym was classified as vigorous PA: although it has its limitations, it can be assumed that going to the gym is a hard physical effort and causes a large increase of heart rate and breathing, so is in-keeping with the WHO definition of vigorous PA [2]. Furthermore, going to the gym was categorised as a muscle-strengthening session. The number of MET-minutes per week was calculated by multiplying the MET value of each activity with the duration of the activity in minutes and then adding the total MET-minutes per week together, in line with WHO guidance[2]. Microsoft Excel was used for calculations and for analysis of all data, and to make the figures.

Results

Physical activity per week. Two feedback forms were omitted due to not providing answers and illegibility, so 14 feedback forms were analysed. The age range was 25 to 74 years, with the mean age being 44.7 years old. There were 6 males and 8 females, including 2 female staff members and 14 patients. Of the 12 patients, 41.6% (n=5) exceeded 600 MET-minutes per week: 16.6% (n=2) of patients exceeded 75 minutes of vigorous PA per week, 8.3% (n=1) of patients exceeded 150 minutes of moderate PA per week, and 16.6% (n=2) met 600 MET-minutes per week through a combination of moderate and vigorous PA. The remaining 58.3% (n=7) of patients did not meet 600 MET-minutes per week, with 25% (n=3) of patients doing no PA at all and 25% (n=3) doing some PA per week. Additionally, 25% (n=3) of patients did 2 or more muscle-strengthening sessions in the last 7 days. Both staff members did not meet 600 MET-minutes per week and did zero minutes of PA. The mean number of MET-minutes per week was 550 minutes and median 210 minutes including staff members. Excluding staff members, the mean was 641.7 minutes and the median 360 minutes.

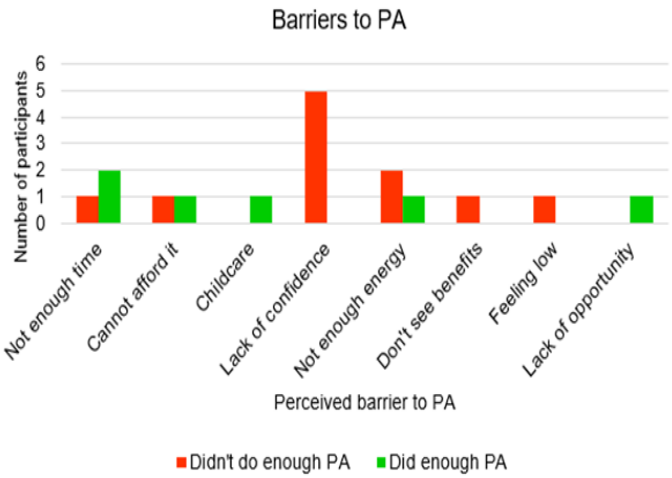
Attitudes towards physical activity

Twelve participants answered whether or not they felt they did enough PA, including 11 patients and 1 staff member. Both patients included in this analysis who did no PA in the last week felt that they had done enough.



Barriers to physical activity

Seven participants did not state their perceived barriers towards PA. One staff member and 8 patients reported their barriers towards PA, 3 of whom exceeded 600 MET-minutes per week of PA and 6 who did not. The table below shows the perceived barriers in these 2 groups. In those who felt they did enough exercise, lack of confidence was the most common (n=5) barrier towards PA. Not enough time was the most common barrier (n=3) in those who felt they needed to do more PA.



Patient experience of Rockbox and comments

All (n=12) participants who were provided with a rating scale on the feedback form rated the Rockbox session as 'Very enjoyable'. All participants (n=16) provided reasons for deciding to try Rockbox, with common reasons being to improve fitness (n=3), lose weight (n=2) and being told about it by others (n=3), including one patient who was encouraged by a staff member.

This patient named motivation when feeling low and lack of energy as barriers to taking more PA, but as a result of the session they felt "like they used to feel" and wanted to attend another session.

When asked what the best aspects of the session were, "fun" was the most commonly stated reason (n=3) out of all (n=16) participants who answered. One staff member and one patient described having patients and staff exercising together as a highlight of the session. A patient who didn't meet WHO guidelines for PA and perceived confidence as a barrier to PA, stated that the highlight of the session was being "allowed to take part within my limitations".

Of the patients who provided additional comments on the session (n=15), all were positive. One patient commented that they wish the sessions had started when they first arrived at the unit and another commented that the session made them feel happier with more energy, and it had allowed them to release their energy and feel calmer after. A different patient, who felt they didn't do enough PA and perceived not having enough time or energy for PA, indicated that the session changed their attitude towards future PA by stating that were interested in attending Rockbox in the future outside of the unit.

Conclusions

In this cohort of mental health inpatients, 41.6% met the WHO recommendations for PA through walking or going to the gym. This is lower than the WHO estimate that 72% of adults globally do sufficient PA[1], and similar to figures cited in previous studies[2]. Lack of confidence was the most common barrier towards PA in those who did not do enough PA, and Rockbox sessions addressed this by allowing people to take part within their limitations. A different set of barriers were faced by those who felt they did enough PA in comparison to those who felt they did not do enough PA. Although, 75% of patients who felt they did enough PA did not meet WHO guidelines. All participants found Rockbox a positive experience, and, although a small sample size, patient comments show that such sessions have the potential to change their views on PA.

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Mindfulness and Obsessive Compulsive Disorder

by Harish Coonjobeeharry

Introduction

Obsessive compulsive disorder has long been thought to be a lifelong treatment resistant disorder, and it is only in the last two decades that effective treatment options have become available. These first-line treatments are SSRI's and/or cognitive behavioural therapies in the form of exposure prevention therapy. Only 60 percent of sufferers report these treatments to be beneficial[1].

Incorporating teachings of mindfulness into psychotherapy for OCD is a relatively recent concept. Mindfulness is a concept that has existed for thousands of years- though its rapid emergence in the West has really only become apparent relatively recently. Despite its roots originating from spiritual traditions- its premise can be transferred easily into secular settings and therapeutic interventions within healthcare[2]. Its role in treating anxiety related disorders is where I believe it holds the greatest promise.

Neurology of OCD and Exposure Response Prevention.

Obsessions and compulsions arise in everyone. The difference sufferers experience lies in the intensity and persistence of these obsessions/compulsions. The neurological basis behind the intense feeling of fear a sufferer experiences over obsessions and the repetitive nature in which they perform compulsions, is linked to the overactivity and strong links between certain brain regions that are associated with fear, anxiety, error detection, and coordination of thoughts/ emotions[3]. During exposure prevention therapy (the most commonly used behavioural therapy for treatment of OCD), a person is often encouraged to refocus their attentions towards another activity while exposure to their obsessions occurs. Overactivity and abnormal connections between specific regions in the brain, produce a feedback loop which is reinforced the more a compulsion is performed. During exposure response prevention, one begins engaging in another activity to replace their compulsion. In so doing, the effects of operant conditioning are being used to rewire this faulty circuitry by refusing to perform compulsions[4].

The Gap

Simply put, mindfulness is the bringing of one's attention to the present moment without judgement[1]. When someone is not exercising this ability- it is very hard to differentiate thoughts/emotions from reality. However, in being truly mindful, a person distances themselves from the content of their mind. They are observing the inner workings of their mind as it receives information from the brain- but they don't identify with this By doing this, they create a gap between their will and their intrusive urges. Suffering with OCD is an experience of being very much out of control of your mind. You don't feel yourself as being separate from your mind, you feel you are doing whatever your mind is. As the ability to be mindful develops, the perceived gap between rational self and intrusive thoughts grows. You begin to shift from the 'what if' that OCD lives in, to the 'what is'- the present.

Automaticity

Many sufferers are deeply aware of the irrationality of the compulsions they perform-hence the embarrassment that unfortunately accompanies this disorder[5]. The trouble comes when a sufferer immediately reacts to the fearful feelings that arise with whatever ritual they attribute to be the antidote to this. They react they don't respond. However, with an increasing distance between the sufferer's perceived will and their fearful feelings (that develop as a consequence of building a skill of mindful observation), the tendency to automatically react diminishes. If they get past the stage of automatically reacting- by nature of the disorder, these intrusions will persist. The error detection system in the brain continues to fire and the impending feeling of doom remains[4]. It is the skill of being present- observing these bizarre intrusions for what they are, without identifying and subsequently reacting to them- that is an indispensable tool when refusing to give in.

Focusing Attention and Cognitive Appraisal

Where can I possibly redirect my attention? At times there may not seem to be any obvious attention-demanding activity in front of you. The mere fact that it is possible to believe this, demonstrates how accustomed we have become to having the mind leave the present. There are countless phenomena occurring for anyone in any given moment: the sensation of breath in the nostrils, the physical sensations occurring in your body, the visual and auditory sensations you experience while receiving information from your environment. Thoughts and feelings are also present moment phenomena. During moments of experiencing obsessions these feelings will most probably be fear/ anxiety and the thoughts being the dreadful consequences that will occur if immediate rituals are not performed. Being mindful, we observe all these things with the sole intention of remaining anchored to reality. It is when a sufferer gives the OCD the respect of identifying with these urges that they become lost, and it is when they become lost that they perform compulsions. Developing a skill in mindfulness provides an increased ability to redirect attention towards other phenomena, whilst also appraising the cognitive distortion sufferers often face whilst experiencing intrusive urges[6]. It is only the cognitive appraisal of this fault that allows sufferers to truly understand the dissociation between their urges and themselves.

Taking Responsibility

One tool sufferer's always have in their arsenal is the ability to discriminate truths. By nature, OCD is not a psychotic disorder- and sufferers are able to identify these intrusive thoughts as false[5]. Obsessions can never take over a sufferer's will, and one can always control one's response to obsessions. However, the ability to redirect attention, identify and challenge cognitive distortions, and create the gap between one's rational self and intrusive urges, all require an accomplished ability to remain mindful. This skill is only indirectly taught while engaging in the current gold standard therapies for OCD[4] and this is why I truly believe that the beneficial effects of this current approach are underwhelming.

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Physician Associates in Mental Health: Who, What, Why and How has it gone Recruiting Physician Associates in MHS in Sheffield? by Dr Pranav Mahajan

Who are Physician Associates?

Physician associates are 'medically trained, generalist healthcare professionals who work alongside doctors and provide medical care as an integral part of the multidisciplinary team. Physician associates are able to work autonomously with appropriate support.'[1] All physician associates hold a bachelor's degree in science or health related subjects prior to undertaking the 2 year (90 weeks) postgraduate master's course. Physician associates have been a part of the UK workforce since 2003[1] however they have been a mainstay of healthcare workforces in the United States of America since the 1960s.

Why are Physician Associates working in Mental Health?

Despite having been working in the NHS for the best part of twenty years, the role is still relatively new in mental health. The Royal College of Psychiatrists estimate that there are around eighty physician associates working in mental health services in England. This figure is likely to continue rising over the next few years due to the need for organisations to address long term workforce difficulties. The NHS Long Term Plan[2] published in 2019 detailed a commitment to investment in mental health services to meet current and anticipated future demand in England. Health Education England's workforce plan[3] suggested recruiting 5,000 people into 'new roles' of which physician associates were one. The NHS Mental Health Implementation Plan 2019/20 – 2023/24[4] stated an aim to recruit 140 physician associates to work in mental health in addition to those recruited as part of the Health Education England workforce plan. The Royal College of Psychiatrists has called for 10 percent of all new physician associate graduates to work in mental health[5].

What can Physician Associates Offer to a Mental Health Multidisciplinary Team

Physician associates have a varied skillset and are able to take on a number of roles within a multidisciplinary team with appropriate supervision (Box 1)[6].

Physician associates are able to:

- Take psychiatric and medical histories
- Carry out physical and mental state examinations
- Complete risk assessments
- Formulate differential diagnoses and management plans
- Perform diagnostic and therapeutic procedures
- Develop and deliver appropriate treatment and management plans
- Provide health promotion and disease prevention advice for patients
- Carry caseloads under supervision
- Prepare reports and discharge summaries
- Deliver education
- Undertake QI and audit activities
- Liaise with other services

Box 1: Information adapted from Royal College of Psychiatrists[6]

Physical Health and Mental Health

There is vast evidence that people with serious mental illness (SMI) are at an increased risk of developing physical health problems. Those with SMI have a life expectancy that is up to 20 years lower than that of the general population and up to 4 times higher mortality rates[7] largely due to cardiovascular, endocrine and respiratory disease. Physical health issues are also increasingly prevalent amongst those suffering from depression, eating disorders and personality disorders. NHS England[8] estimate that the disparity in life expectancy contributes to roughly 12,000 extra deaths per year from cardiovascular disease. Physician associates have a generalist training background and are therefore well placed to assess and address the physical health needs of service users as part of a wider mental health multidisciplinary team (Box 2).

Physician associates can address physical health concerns by:

- Assessing risk factors associated with poor physical health
- Carry out physical examinations
- Carry out investigations and observations
- Interpret the results of investigations
- Provide health and lifestyle advice
- Liaise with primary care and specialist services to promote integrated care
- Provide health promotion and disease prevention advice
- Deliver physical health education to other members of staff

Box 2

How Has the Experience in Sheffield

Sheffield Health and Social Care NHS Foundation Trust has been providing placements to physician associate students from two local universities for several years. It became clear through supporting student placements that physician associates could add value to mental health multidisciplinary teams and help to address some of the workforce difficulties at the trust. In 2018, the trust recruited it's first two physician associates to inpatient wards. There are now 9 physician associates at the trust working in general adult and older adult inpatient services, community teams and in the learning disabilities service.

Supporting Integration of Physician Associates

Joining a new team can be a daunting experience at the best of times, but entering a pre-existing multidisciplinary team as a new role can pose new challenges which required thought and planning. There was a concerted effort to provide information and education to staff regarding who physician associates are and what their roles would be. The trust sought to understand and address any concerns and questions that arose from the prospect of physician associates joining the teams.

Physician associates are able to work autonomously however do require some clinical supervision. It was important to ensure that there was an enthusiastic named clinical supervisor to offer support and direction for new physician associates joining teams.

During their university course, physician associates receive a minimum of 90 hours/3 weeks of placement time in mental health. As such, the trust organised a physician associate specific educational programme (Inceptorship Programme) to help bridge the gap between leaving university and working in mental health for the first time. This programme aims to cover aetiology, diagnosis and management of common psychiatric problems, communication and history taking skills, reflective practice and personal development.

Lessons Learnt at Sheffield

As one of the first mental health trusts to employ physician associates, there was no blueprint to follow and therefore numerous lessons were learnt along the way.

Physician associates are keen to work in mental health and that the demand has always exceeded the availability of posts. This has led to the trust continuing to develop posts and expand physician associate numbers.

The development of the educational programme had additional benefits not initially considered. It allowed for physician associates to meet each other and form a peer group. It was also a forum to raise any concerns they have in their working environments which is to not uncommon when integrating new roles into pre-existing teams.

Physician associates are generalist practitioners and are required to maintain and develop their physical health competencies. It was quickly understood that a mental health trust was not always best placed to provide this and so links were built with the local acute physical health trusts and primary care organisations to develop a regional educational programme with a much broader scope.

Feedback

Feedback from teams that have worked with physician associates has been overwhelmingly positive with the main positives including continuity in care, responsiveness to physical health needs, support to junior doctors and allowing junior doctors to focus on their mental health training by removing some of the physical health burden.

"I have found the Physician Associates in Psychiatry to be motivated, keen to learn and compassionate working in the sometimes challenging environments of inpatient psychiatric wards. They have developed good relationships with the teams and particularly supported junior doctors in undertaking routine work and helping out when doctors are off the ward for training."

Consultant Psychiatrist, Sheffield Health and Social Care NHS Foundation Trust

Wordcloud of feedback provided regarding Physician Associates. Made using 'worditout'

Conclusions

Physician associates working in mental health is becoming more commonplace. The Royal College of Psychiatrists, Health Education England and NHS England are all putting significant effort into increasing these numbers further to help bolster teams in a time of increasing demand. Physician associates have a skillset which allow them to be an important asset to the mental health multidisciplinary team and are well placed to help deliver integrated physical and mental health care.

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The Role of the Physician Associate in Psychiatric Services- Reflections following a Student Placement by Dom Osborne

I am a Second year Physician Associate Student with an interest in working in mental health, currently on my placement in a Psychiatric Rehab. I also currently work as a Healthcare Assistant on an acute ward, and have done for the past three years. Both on my placement and in the lead up to starting my course, I have aimed to explore how the Physician Associate role fits into the MDT. I have canvassed opinions from a wide range of clinical and management staff, as well as having my own thoughts as to some of the challenges faced by the profession and the teams hoping to integrate this still very new role, but also the opportunities to help and support medical, nursing and psychological teams to enhance patient care and help fill gaps in service provision.

The Royal College of Psychiatrists are evidently ardent supporters of the profession in the specialty- they aim to have 10% of PA graduates working in Psychiatry[1] , and there is a long list of skills, procedures and tasks published, which they aim for the PA to be able to perform[2].

As someone who is considering this as a career path, I find it incredibly heartening that there is becoming a formalised pathway for the profession. Additionally, almost without exception, the staff, across all services that I have encountered have been enthusiastic, knowledgeable and supportive at the idea of the role and working with them.

I do however, believe that there are some challenges that both the profession as a whole, and specific professionals may face when they start their career. Most of these centre around the role not yet being properly established, boundaries regarding scope of practice, and tasks and roles that PAs are not currently allowed to perform under the law.

One of the things I find concerning is the lack of exposure and training as part of the degree currently that we as PA students undertake. On my part, the exposure is 3 weeks on placement and 3 days of lectures, with one assignment. For many of my peers, this will be the entirety of their exposure to Psychiatry before graduating, at which point they could potentially get a role at a Band 7 level of responsibility. Physician Associates are highly capable, motivated graduates and the degree prepares for them for intense learning which they would be expected to continue when employed in a speciality. However, employers and supervisors must be mindful of the potential for a new graduate to be incredibly “green” when starting. Whilst this may not be a problem if they accept that, I do feel there should be robust training, support and supervision available, especially in the early part of a career.

One of the themes that we are often “warned” of as PA students is hostility from other professions, be that from Medics, Advanced practitioners, or others. I personally have yet to experience this in Psychiatry, and speaking to colleagues and course mates, their experiences are largely extremely positive. I fully accept that there might be concerns, especially amongst junior doctors, that learning opportunities may be taken away etc. However in practice, if we (PAs) are able to help cover the ward so others can attend training, to alleviate some of the pressures of day-to-day ward jobs, and to ease the burden of managing physical health conditions in inpatients, then we will be seen as a way to enhance learning as opposed to being a barrier to it. Initially as other roles trained to the medical model perfuse through the health system, there is naturally a feeling of resistance, both to change, and to feeling though scopes of practice are being encroached on.

However given staff shortages across the country and the medical world, the feeling is that any increase in capacity is more and more being welcomed with open arms. With nursing staff, I do feel the situation is slightly more delicate- if I were an RMN who has studied Mental Health nursing specifically for three years, with years of experience working at Band 5, the presence of a new graduate with minimal specific experience starting 2 bands above would certainly bother me. It is an awkward and uncomfortable situation, and to be frank one I struggle with myself. I think, justifying it to myself, the scope of practice and responsibility (when experienced) for a PA does justify these rates, though I do still feel exceptionally uncomfortable with the disparity between wages and experiences, especially if and when a PA is virtually brand new to Mental Health. I would fully expect some hostility initially in this situation, and it is down to the individual to show they are engaging, willing to learn, and to show how they can add value to a team.

It seems every single article relating to PAs brings up the current lack of prescribing rights. Whilst not wanting to echo my colleagues too loudly on this, I do think that this could be a real barrier for some employers, both in terms of reducing Doctor’s workloads, and also the attractiveness of the role in general compared to other Advanced Practice roles. In other specialities, PAs have made a “niche” for themselves by becoming highly competent on a procedural and practical level, and there may be less scope for these to take place in a Psychiatric setting. This could be a barrier for PAs, with regards to worries becoming de-skilled, and not “finding a place” within the team as readily as in other specialities. Regarding this last point, the guidance provided by the Royal College does give some reassurance.

I could write reams over the minutiae of how the role can help with regards to physical health monitoring, to obstacles they face regarding where they fit in with the law, where scope of practice overlaps with RMNs, RGNs and Advanced practitioners and Junior Doctors. Overall however, my experiences of people's perceptions to role have been overwhelmingly positive. I do have my concerns regarding whether or not "fresh" PA graduates would be truly ready to step up to this role, though with the right support and mentoring, I honestly believe Physician Associates have the potential to bring a valuable contribution to a team across a variety of services.

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De-prescribing in Psychiatry: Reflections and Implications for Clinical Practice by Dr Anne Wisdom

Polypharmacy and over-reliance on pharmacological treatments is of increasing concern within the field of psychiatry. In the UK, 17% of the population is prescribed an antidepressant and 5% is prescribed either a benzodiazepine or z-drug.[1] The reasons for polypharmacy and over-reliance on psychotropic medications are multi-factorial and include long waiting lists for psycho-social interventions and concern from both patients and professionals about withdrawal symptoms, escalating risk issues and possible relapse on dose reductions or medication discontinuation. In my role as a Higher Trainee in an Assessment and Formulation Team, I assess patients between the age of 18-65 who are referred into secondary mental health services.

Many patients referred have been under the care of secondary mental health services in the past and are prescribed a complex array of psychotropic medications. It is not uncommon for these patients to have been prescribed these medications for many months, years or even decades. My work within the team has given me reason to reflect on the implications of long-term psychotropic use and how to tackle the extent of polypharmacy and overreliance on psychotropic medication in psychiatry. Until very recently, there has been an underestimation of the severity and chronicity of discontinuation symptoms from psychotropics, especially antidepressants and antipsychotics. This is reflected in the vast array of guidelines available to clinicians to support decision making around prescribing and the relative scarcity of guidelines helping to inform decisions about how we reduce and discontinue medications safely.

It was then with great interest I watched the presentation, 'The Art and Science of Deprescribing Psychotropic Medication' at The Royal College of Psychiatrists International Congress in June 2021. The presenters explained that the de-prescribing of psychotropic medication, with a particular focus on antidepressants and antipsychotics, is an expanding area of interest where research and clinical knowledge is only now starting to catch up with patient experience.

The Royal College of Psychiatrists took an interest in the evolving evidence base relating to a protracted withdrawal syndrome from antidepressants in around 2018 and published a position statement the following year. It acknowledged that antidepressant withdrawal, in some situations, can be severe and take a prolonged course.[2] NICE guidance was updated to similar effect shortly afterwards.[3] These changes were supported by the results of a meta-analyses by Dr James Davies demonstrating that 56% of people experience antidepressant withdrawal symptoms and of those, 46% describe them as severe.[4] The updated guidance is corroborated by thousands of testimonials by patients experiencing disabling physical and mental symptoms as a consequence of abrupt medication discontinuation. The support website www.survivingantidepressants.org was established by a patient struggling with her own journey of problematic medication discontinuation and withdrawal. The purpose of the website is to offer guidance and support to others going through similar experiences; needed by many in the absence of any robust medical guidelines to inform the process. The website attracts more than half a million page views worldwide each month and appears to be a powerful indicator of the power of the patient testimonial in informing change within medical culture and direction of research.[5]

Symptoms of antidepressant and antipsychotic withdrawal are varied. The SSRI 'discontinuation syndrome' is most well-known and includes paraesthesia, 'electric shock' like sensations and affective symptoms. Other antidepressants, including SNRIs, tricyclics and MAOIs can also cause significant withdrawal symptoms. Withdrawal symptoms from antipsychotics are less widely acknowledged but can include somatic, motor and psychological symptoms. Rapid discontinuation of antipsychotics can also cause rebound psychotic symptoms, thought to be related to the upregulation of dopamine receptors.[6] This may lead clinicians to erroneously attribute withdrawal symptoms to relapse. This is of particular clinical relevance in cases where antipsychotics are used in the absence of psychotic illness, for example personality disorder or treatment resistant depression and may lead to diagnostic error.

Dr Mark Horowitz and colleagues offer a means to more safely reduce psychotropics in their article, 'A Method for Tapering Antipsychotic Treatment that may Minimise Risk of Relapse'[7]; that of hyperbolic tapering. In hyperbolic tapering, the dose of psychotropic is reduced by a percentage of the previous dose, rather than in fixed set increments as is the case in linear tapering. They recommend this is done slowly, over a period of months or in some cases, years. The rationale for this is that there is evidence supported by PET scanning of the hyperbolic relationship between doses of antipsychotic and D_2 receptor blockade. Reducing the dose in a hyperbolic fashion is thought to allow for a more 'equal' reduction in D_2 blockade, reducing the likelihood of withdrawal effects.

Prescribers in the Netherlands have used the principle of hyperbolic tapering to develop tapering strips which represent a simple and effective method of achieving gradual dose reductions using a hyperbolic tapering technique.[8] Unfortunately, tapering strips are not at present available for use in the NHS. Recent guidance published by The Royal College of Psychiatrists do however provide practical advice on the use of hyperbolic tapering for antidepressants,[9] and the recent edition of The Maudsley Prescribing Guidelines also incorporates the use of hyperbolic tapering in discontinuing both antidepressants and antipsychotics.[10]

In conclusion, whilst the use of psychotropic medication plays a central role in psychiatric practice, clinicians should be mindful about its judicious use and seek to limit complications of withdrawal when a decision has been made to discontinue medications when benefits no longer outweigh risks. Consideration should be given to the concept of hyperbolic dose tapering over several months or longer in some cases which is supported by recent research in the field.

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Trainee Wellbeing and Morale – A Snapshot Survey by Dr Kirsty Ward

There is increasing awareness with respect to trainee health and wellbeing, particular given the workload and additional pressures presented during the Covid-19 pandemic. In 2019, the BMA published the results of their well-being survey from 2018. This revealed that 80% of doctors were at high/very high risk of burnout[1]. Furthermore, 4 in 10 doctors suffered from a mental health condition with junior colleagues, those working more hours and women being at the highest risk of experiencing a mental health problem[1].

In October 2021 we held our annual TIF (Trainee Improvement Forum) for the core and higher psychiatry trainees in South Yorkshire. This is an annual event during which we able to explore current issues and address training needs within the South Yorkshire training rotation. One of the focus groups was regarding trainee and workforce well-being and morale.

Due to the ongoing Covid-19 social distancing guidance, the event was held via video call conferencing. We identified that this may present a barrier in terms of trainee engagement and quality of feedback. Therefore we asked attendees to partake in an anonymous snapshot survey using Mentimeter interactive presentation software. We received complete responses from 27 trainees with two more trainees' choosing to partially complete the survey. The survey included questions around work-life balance, support and mental health needs.

Results of Survey

Figure 1. Likert scale feedback regarding trainee experience

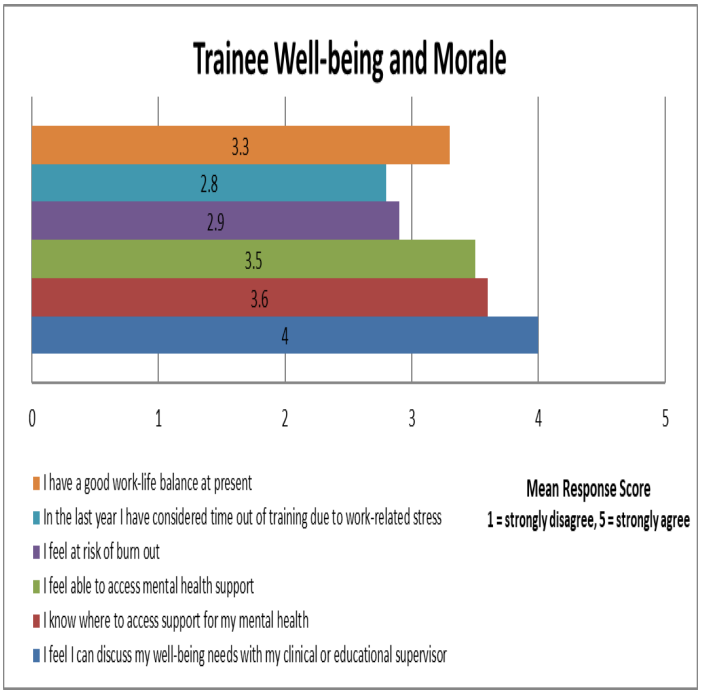


Figure 2. Days taken off work

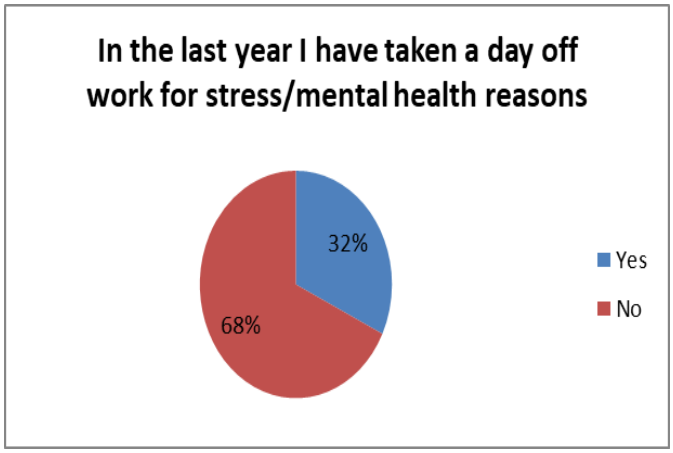
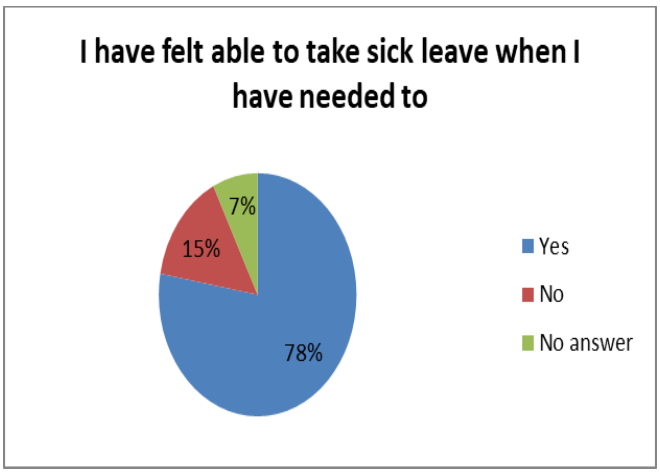


Figure 3. Taking sick leave from work



Discussion of results – is it just us?

Reassuringly, trainees identified that they generally agreed (mean score >2.5) with statements regarding work/life balance, being able to access mental health support, knowing how to access the support and being able to discuss their well-being needs with their clinical or educational supervisors. However the responses regarding burnout risk and considering time out of training were more concerning. Upon reviewing the breakdown of results 31% of trainees slightly or strongly agreed that they had considered time out of psychiatric training in the last year. Furthermore 28% of trainees slightly or strongly agreed with feeling at risk of burnout.

As a profession, doctors are less likely to prioritise their own health needs[2]. During the initial wave of the Covid -19 pandemic, a tertiary London trust explored Covid-19's impact on doctor well-being and training. More than two thirds of survey respondents reported sleep disturbance during the initial Covid-19 and 40% expressed concern that the pandemic would have a lasting impact on training

Despite these concerns, 82% felt supported clinically with 39% reported that the level of support had increased during the pandemic[2]. However reassuring the latter of those figures may be, it's vital to consider how vastly different our clinical workload is at present, almost 2 years on since the first Covid-19 lockdown.

From our survey, 32% of respondents had taken a day off work due to mental health or stress problems in the last year and 15% felt unable to take leave when they have needed to. Similarly, data from the 2017 NHS staff survey showed that 36% of doctors-in-training reported feeling unwell due to work-related stress in the previous 12 months and that sickness presenteeism among doctors is particularly high with 38% of doctors working whilst sick in the previous three months[3]. The pressure to be present may have also been effected by the Covid-19 pandemic with departments adapting on-call rotas and implementing buddy systems to ensure that departments are appropriately staffed. More than ever, doctors have felt pressured to support their colleagues and care for their patients in these unprecedented circumstances.

Morale boost – what can we do as trainees?

During the TIF discussions trainees identified a number of ways in which wellbeing and morale may be improved. Much of the discussions revolved around a need for return to face-to-face teaching and meetings in order to tackle isolation and loneliness. Another key theme was around junior trainees feeling empowered within their teams and encouraging them to take on leadership roles in order to reduce frustration and helplessness in relation to their clinical role.

A West Midlands higher psychiatry trainee group explored the benefits of a trainee away day pre-Covid-19. From the attendee surveys, 81% said the event reduced stress levels, 90% said it increased their sense of well-being and 86% felt an increased sense of belonging as a trainee[4].

In South Yorkshire we have reintroduced trainee socials to help tackle isolation and create a sense of belonging. We hope to work towards a return to face-to-face teaching when safe to do so and continue to foster a culture of support and openness regarding trainee wellbeing needs.

Although it doesn't feel like we are out of the woods just yet in terms of the additional Covid-19 pressures, we know that morale was an issue before Covid-19 and morale and wellbeing will be of increasing relevance and importance in the future if we are to develop sustainable working patterns. Regardless of our role or level of training, where possible, it's important to consider how our attitudes and ethics can empower and support others.

Acknowledgement

Special thanks for everyone who took part in the survey. For anyone wishing to discuss issues around well-being, stress or burn out, please consider your clinical or educational supervisor as the first point of contact. Otherwise there are alternative avenues of support including your GP, BMA Counselling or Doctors for Doctors Service (0330 123 1245) or the Doctors Support Network (https://www.dsn.org.uk/contact)

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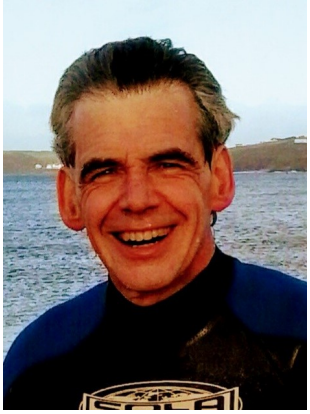
Why are ADHD drivers at greater risk of accidents? A narrative review by Dr Simon J. Taylor



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Abstract

Purpose: ADHD has appeared to attract a disproportionate amount of attention concerning driving risk, presumably because of the concentration and impulse issues that define it. This review examines the validity of this assumption and the association with risk to lay out a framework to guide assessment of driving risk. **Methods:** Using PsychINFO, Medline and EMBASE to April 2016 the search terms of "driving" AND "ADHD" were used. Additional cross references were taken from these articles. **Results:** The relative risk is at least partly explained by overall greater miles driven by drivers with ADHD. Comorbidity, especially for antisocial behaviours and alcohol misuse are strong associations with risk. In addition it seems that ADHD drivers spend more time doing distracting tasks and this may have greater impact on their driving. There is an increased risk of sleep related accidents. Medication reduces risk. **Conclusion:** The risks associated with ADHD are multifactorial and are probably associated with comorbidity more than comorbidity per se. Strategies to reduce driving risk are suggested.

Implications for Rehabilitation

Introduction

Studies of drivers with ADHD have identified that they are at higher risk of being involved in road traffic accidents than drivers without ADHD. An early, and a much referenced, publication suggested up to a four fold increase of risk [1]. The most recent meta-analysis gives a lower relative risk of 1.24 once controlled for confounders such as miles travelled and publication bias [2]. It appears that the relative increase of risk of accidents resulting in personal injury is higher than those resulting in property damage only.

Most of these studies have not been without significant methodological issues such as non-representative samples, for example, attending tertiary specialist centres or selected via advertising. Many of these problems have been addressed by Chang [3] using Swedish National Registers for ADHD and serious traffic accidents resulting in injury or death. The relative risks for men and women were 1.47 and 1.45 respectively once multiple confounders were taken into account but this study was unable to control for exposure, in terms of miles travelled. ADHD drivers tend to drive on average further than non-ADHD drivers with reported differences ranging from 8.5% to 135% [4,5].

This, however, is not helpful for assessing an individuals risk, and it does seem that some drivers are more accident prone than others. In Berkley's [1] original study a disproportionate number of crashes occurred to a minority of drivers. Sobanski [5] found that more than 60% of the accidents occurred in just a third of the ADHD group, with 28% occurring in just 11% of the group. Aduen [6] found that the relative risk for one accident for ADHD drivers was 1.25 (0.87-1.78), i.e. not significantly different from the controls, but the relative risk for multiple accidents was 2.21 (1.31-3.74), again suggesting that the ADHD population is not homogeneous with regard to risk. This purpose of this paper is to review the features that may explain these differences within ADHD drivers and may help predict individual risk.

Method

A literature search was undertaken. The search terms "driving" AND "ADHD" were used using PsychINFO, Medline and EMBASE to April 2016. Results were restricted as being published after May 2012. Article were selected that reported the relative risk of road traffic accidents in ADHD drivers and associations with risk. Additional cross references were then examined from these papers.

Results

Off the 200 abstracts examined, 26 articles were selected. An additional 27 articles arising from cross references were also examined. Studies were varied, ranging from naturalistic recordings of driving behaviour, cohort studies, questionnaire studies and simulator studies. The heterogeneous nature of these studies allowed only for a narrative examination of what factors within the ADHD driving population that contribute to driving risk. The evidence for the contribution of each of these factors is discussed individually.

Severity of symptoms

It seems likely that severity will be an important variable with regard to driving impairment but findings are inconsistent. Thompson [7] using a combined outcome variable of accidents and violations found that this was associated with hyperactivity/impulsivity severity but not attention problems.

Jerome [8] found that scoring on the attention items on a ADHD rating scale was associated with driving violations but not collisions. Garner [9], in a small number of patients diagnosed in childhood, found at follow up that both inattention and hyperactivity/impulsivity score were associated with accidents and speeding violations. Unfortunately, all these studies seem to have combined cases and controls within their analyses so associations with severity will be inevitable.

In a study of those attending a casualty department following a road traffic accident and who screened for positive for ADHD, increased mind wandering, which is increasingly identified to be part of inattentive problems in ADHD, was associated with responsibility for the index accident [10].

Simulator studies may be more sensitive to attentional problems and other core symptoms because the driving task is removed from its social context and therefore will be less influenced perhaps by antisocial behavioural problems and substance misuse. Graefe [11] found that inattention was associated with not stopping at stop lights, delay in setting off if stop occurred and driving faster on straight roads. Hyperactivity/impulsivity was associated with faster driving on curved roads and not stopping at lights. Groom [12] reported inattention and hyperactivity/impulsivity was associated with less vehicle control and speeding on simulated motorways and hyperactivity/inattention was associated with greater anger and frustration.

Distractions

In a small naturalistic driving study of ADHD drivers with a previous crash history Merkel [13] reports that the ADHD group experienced 2.74 times more sudden car movements and had more accidents, although as most of these were minor. Short video recording was triggered by these sudden car movements. In total twice as many incidents of inattentiveness were recorded in the ADHD group. More than twice as many (2.57) cell phone events were recorded and 6.1 times as many “adjusting car device” occurred for the ADHD group. The two most expensive to repair accidents occurred whilst the driver was texting.

The 100-car naturalistic study highlighted the importance of attention and distraction in accidents. Dingus [14] examined the results of 4 naturalistic studies, concluding that a range activities including cell phone use, especially texting, reaching for objects and eating markedly increased risk of accidents. Philip [15] reports higher levels of these activities in drivers screening positive for ADHD who spent 53% more time on the phone and 150% more time texting than controls.

Simulator studies examining the effects of secondary activities while driving are of interest. Both Narad [16] and Slavrinos [17] report a non surprising decline in driving performance whilst texting, but there were no differences between ADHD and control groups. Reimer [18] reported the same for a simulated high stimulus urban environment but found that in a low stimulus simulated driving environment the ADHD group performed much worse than controls leading them to conclude that ADHD drivers may be particularly prone to the effects of distraction in low stimulus driving settings. These observations may explain the strong interaction between ADHD symptoms and driving distractions [19], such that the estimated proportion of accident risk for those so exposed was 68%. It seems, combining the findings from naturalistic studies and simulator studies, that ADHD drivers may spend more time pursuing distracting activities and under some circumstances, at least, this may have greater impact on safe driving.

Comorbidity and rule breaking.

Although there are increased rates of affective disorders and anxiety in patients with ADHD the most common comorbidity considered is to do with conduct and oppositional defiant disorders in adolescents (CD/ODD) and antisocial personality in adults (ASPD). As Vaa [2] points out, in Berkley's original paper [1], the symptom severity scores for CD/ODD seemed to contribute much more to accident risk than the ADHD severity in a regression analysis. Redelmeier [20] found that following up driving outcomes for those with an earlier diagnosis, that the ADHD group had a non-significant increase of accident risk of 1.2, but those with CD/ODD and combined ADHD and CD/ODD had significant risk increments of 1.3 and 1.4 respectively. When separating out studies in which more than 50% of the ADHD group also had CD/ODD, antisocial personality disorder or other conduct problems from those that did not, Vaa [2] noted a significant increase relative risk for the former of 1.86 (1.22-2.75) but for the latter the 1.36 (ns).

The problems of CD/ODD and ASPD are characterised by rule breaking. ADHD groups seem to have a greater propensity for all motor vehicle violations. Speeding violations in particular are associated with increase accident risk in general and could partly explain increased risk in this group. Other violations such as reckless driving may do so as well, either directly or by association. Clearly violations such as non-payment of fines in themselves will not directly increase risk but will be a marker for rule breaking. Olazagasti [21] found a significant relationship between frequency of all traffic violations and being judged at fault in two or more accidents and concluded that 51% of the variance for risky driving was associated with the development of ASPD and that probands without this had not engaged in more risky behaviour. This is concordant with a meta-analysis of laboratory based risk taking behaviour in ADHD that concluded that although increased in ADHD, risk taking was markedly moderated by antisocial personality features [22]. This is also consistent with studies in the offender population that show greater social deviance is associated with car accidents and that this is partly associated with driving violations [23].

Comorbid conduct disorder and ASPD seem to significantly contribute to accident risk in ADHD drivers. A history of driving violations and, perhaps, any antisocial behaviour could be a valid marker for future accident risk.

Anger and emotional lability

Emotional lability and especially anger are not diagnostic features of ADHD (DSM V) but are common associations. The preliminary findings of the Second Strategic Highway Research Program Naturalistic Driving Study suggests that periods of anger increase accident risk ten fold in the general driving population [24]. ADHD has been associated with driving anger, particularly with comorbid ODD [25]. Surprisingly there are no findings yet that directly link anger in the ADHD group with increases risk of collision.

Cognitive deficits

ADHD is associated with a number of cognitive deficits including executive dysfunction and working memory. Berkley [26] found no association between these and adverse driving outcomes. Those with executive dysfunction have more accidents but this is not specific to ADHD [27]. There is evidence that there are many other areas of neuropsychological test performance deficits but the impact of these on driving is unclear.

Sleepiness

Many patients with sleep disorders may show features of ADHD and equally many more ADHD patients than controls may complain of day time sleepiness [28]. Philip [29], reported on an internet survey of drivers. Drivers were screened for symptoms of ADHD and sleepiness. Higher levels of day time sleepiness in the ADHD symptom group were confirmed (adjusted OR= 3.01(2.54-3.57)) and 20.5% of the ADHD group reported more sleepiness at the wheel compared with 7.3% of controls (adjusted OR=1.4(1.21-1.60)). Sleepiness has been strongly associated with traffic accidents [30], so it is of no surprise that sleep-related accidents occurred more often in the ADHD group in univariate analysis. Numbers were small, with 125 sleep related accidents occurring, in which 12 were in the ADHD group. Day time sleepiness, or at least that experienced at the wheel, may be important in contributing to accident risk in the ADHD group.

Substance misuse

Patients with ADHD have a higher rate of substance misuse. The meta-analyses of Vaa [2] and Jerome [31] are inconsistent, with a relative risk of self reported drink driving of 1.55 in the latter, but no difference in the former. A four fold greater rate was reported especially in males [32] and eight times as many drink driving citations. Farouki [19] reported that at the point of injury related accidents, those who screened positive for ADHD were 2.38 times more likely to have used alcohol. Thompson [7] did not find adolescent ADHD to predict drink driving although both the development of comorbid conduct problems and impulsivity at 18 years did. Woodward [4] found that the statistical significance of higher rates of self report drink driving and alcohol driving offences disappeared once gender and conduct problems were accounted for. Koisari [32] noted that, although in a small sample, drink driving convictions were closely_associated with other convictions, including 57% violent crime convictions. It is likely that ASPD may be, at least in part, a mediating factor increasing risk of drink driving. Different proportions of those with conduct problems in different studies may possibly explain the differences in findings reported here. This is further compounded by the growing evidence that those with ADHD may be more impaired by the same level of intoxication and that their recovery from this may be slower [33,34].

There is also an increased risk of substance misuse in ADHD. Substance misuse is increasingly being recognised as important in road traffic accidents [35]. There appears to be no specific studies looking at this but it is unlikely that substance misuse driving in this group would not increase accident risk.

Choice of vehicle

In the cohort study of ADHD patients [32], it is striking that the first two premature deaths were motorcycle accidents. The ADHD group also suffered one tetra-paresis in similar circumstances. The authors conclude that ADHD drivers may have a predisposition to choosing high performance motorcycles. There is no other suggestion that ADHD drivers may seek high performance vehicles with the exception of the Pittsburgh ADHD Longitudinal Study that found that those diagnosed with ADHD as children were three times more likely to take up some sort of motor sport [36]. The authors included in this auto racing, four wheeling, trial biking and all-terrain vehicle driving. Motor sport involvement seemed to have a significant association with increased risk of road collisions. Although the numbers are small, involvement in motor sport seems to be an important predictor of accidents. Indeed, the relative risk of accidents for motor sport involvement is 1.51 whereas the relative risk for ADHD in this study is 1.05 with there being a fraction fewer accidents in the “infrequent motor sport” ADHD group than in “infrequent motor sport” controls. Persistence of_impulsivity, alcohol misuse and development of comorbid ASPD were associated with attraction into motor sport, the three variables that have the greatest evidence for increasing accident risk in ADHD. It may be that involvement in motor sport is an additional important behavioural marker for these factors and the associated increased road accident risk.

Other associations

In general ADHD drivers tend to drive faster. Vaa [2] suggesting that this is a strategy to escape the boredom of a relatively unchallenging task. Merkel [13] reports that the ADHD group were more than two and a half times more likely not to be wearing a seatbelt. This would certainly partly explain the higher relative risk reported above for personal injury accidents with respect to property damage accidents.

There is evidence that more ADHD patients have difficulty getting a licence [7,32] than the general population, and therefore there may be a component of self selection excluding those perhaps who are most disabled.

Medication

It is perhaps unsurprising that medication shows improvements in driving performance in simulator settings [37]. Sustained release stimulants seemed to be better. Real world driving assessments are fewer, Jerome [38] finding that spouses reported improved driving performance in parallel to other symptoms and Cox [39] finding inattentive errors were reduced in a dose dependant way in a single blind cross over study. Randell [40] found, on a driving licence procedure test, that medicated patients were similar to controls. Verster [41] found lapses were reduced on a double blind crossover study on a 100km dual carriage way. It appears that the increased lapses that occurred over the duration of the monotonous journey (constant speed slow lane driving on dual carriage way) did not occur in the medication group. Chang [3] probably has produced the most convincing evidence with regard to accidents with a record linkage study. This covered both stimulant and non-stimulant medication. A within-individual comparison showed that medication potentially reduced accident rate by 58%. In a meta-analysis long acting preparations seemed to be better than short acting preparations [42].

Conclusions

Many of these studies are of poor design with issues of non-representative samples such as convenience samples attending tertiary specialist centres or selected via media advertising. Control groups have potentially not controlled for confounders, such as being selected from employees of the same institutions. Cohort studies often follow up into adulthood those diagnosed in teenage but for which current diagnosis is not confirmed. This also generates potential biases as diagnostic practices have evolved over time with wider definitions of ADHD with progressive editions of DSM. In addition, often population studies define based on screening tools cannot produce diagnosis as neither presence from childhood and absence of comorbidity such as depression, which is also often associated with concentration problems, can be confirmed. The record linkage study by Cheng [3] possibly addresses these issues best, however, could not control for exposure i.e. distance driven, which tends to be more in “ADHD” groups [2].

Despite these reservations there is an increase risk of road traffic accidents in those who have been diagnosed with ADHD in childhood, most of whom will have persistence of problems into adulthood. This increased risk also occurs for those diagnosed in adulthood. The relative risk seems less than that for all mental disorders or alcoholism of 1.72 and 2.0 respectively [35]. Previous crashes will be a marker for future risk, as will demographic factors with many adults with ADHD being graduates from child and adolescent services.

Simulator studies may be more sensitive to attentional problems and other core symptoms since, as argued above, the driving task is removed from its social context and therefore will be less influenced perhaps by antisocial behavioural problems and substance misuse. Certainly there are associations with inattention but the findings are inconsistent [11,12,35]. Similar inconsistency exists in self report of driving studies (Thompson [7] and Garner [9]). Mind wandering, which seems closely linked to attentional problems, increases risk of at fault accidents [10].

Those with ADHD spend more time perusing distracting activities while driving and in some driving conditions at least this has a greater impact on driving and subsequent risk. In addition it has been suggested [2] that speeding may be used as a compensatory strategy to address the boredom of less challenging or low stimulus driving conditions so that increased risk occurs as a result of this. There is a suggestion that increased complexity, and hence stimulus level, of driving with manual gears may enhance driving performance [43]. Sleepiness at the wheel may be important too.

Although core symptoms may play a role, increased risk seems more closely associated with comorbidity. Persistence of hyperactivity/impulsivity may well be linked to expressions of driving anger although there are no clear links as yet in the ADHD population that this increases accident risk. Development of comorbid CD and ASPD seem more far more important factors with their associations to substance misuse, driving violations and other violations. There is a possibility that ADHD drivers are more attracted to high performance vehicles. These are summarised in Table 1.

Advice for drivers has to be tailored to their needs and experiences. Surprisingly there has been no qualitative research on the experiences of ADHD drivers. It is clear that some are aware of concentration issues and have adapted by driving only short journeys or actively excluding all possible distractions, including from passengers, as much as possible. It is unclear why ADHD drivers on average drive more although some report that it is the only time that they can actually concentrate in a satisfactory way. For those who are medication responsive, continuation with this is needed with some clinicians advocating an additional evening dose if evening driving is planned. Additional education and driver awareness may benefit this group [44], particularly with increasing evidence for group based structured behavioural and cognitive interventions benefiting ADHD sufferers in other areas of their lives.

Table 1.Predictors of driving risk and some suggested interventions

Characteristic	Effect	Advice/intervention
Previous crashes	+++	-
Miles driven	++	-
Demographic factors	+++	-
Severity of symptoms	+	-
Distraction behaviour	+++	Awareness and avoidance which may include distraction by passengers
Comorbidity and rule breaking	+++	Education sessions about good driving practice and the consequences of violations.
Anger and emotional lability	? absence of evidence	Education about probable impact. Avoidance of confrontation situations and other frustration provoking situations.
Cognitive/ neuropsychological deficit	?	-
Sleepiness at the wheel	++	Avoid driving when tired
Alcohol and Substance misuse	+++	Education and driver awareness. Avoid
Choice of vehicle	?	-
Driving faster	++	Education and driver awareness
Driving without seatbelt	+	Education and driver awareness
Monotonous driving conditions	+	Take regular breaks
Medication compliance	+++	Remember to take medication, long acting is probably better, consider additional evening dose if driving late.

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Author

Dr Simon J. Taylor Derbyshire Healthcare NHS Foundation Trust.

RCPsych Medical Training Initiative (MTI)

by Charlotte Callaghan

Abstract

The RCPsych Medical Training Initiative (MTI) provides the opportunity for a small number of Psychiatrists from low- and middle-income countries to train in the UK for up to two years before returning to their home country. Employing Bodies can benefit from the diversity and experience that MTI Fellows bring, along with their unique insight into patient care. MTI Fellows can fill vacant CT3 training posts, including converted ST posts, or Trust posts which provide sufficient educational and training content. The RCPsych MTI team provide support throughout the entire process of employing an MTI Fellow and can offer a flexible approach based on the individual needs of the Employing Body.

Full Article Text

The RCPsych Medical Training Initiative (MTI) is coordinated by the RCPsych in collaboration with the Academy of Medical Royal Colleges (AoMRC). A small number of suitable doctors from low- and middle-income countries are selected each year to experience training in the NHS, before returning home to share their newly acquired knowledge and skills. The MTI scheme provides successful International Fellows with a unique opportunity to gain experience in several sub-specialties, gain exposure to the NHS regulatory framework and work in a multidisciplinary team.

MTI Fellows provide valuable contributions to the UK workforce, with the diversity and skills they bring to their workplace. This is in addition to providing unique insight into overseas medical education and patient care for their UK peers.

The RCPsych MTI team provides support to Employing Bodies throughout the MTI application and employment process and will continue to provide holistic support to Fellows throughout their MTI placement. RCPsych will provide the doctor with GMC sponsorship and coordinate the application to the Academy of Medical Royal Colleges (AoMRC) for a Certificate of Sponsorship, for the doctor's Tier 5 visa application to enter the UK.

Employing Bodies can apply to RCPsych to employ an MTI fellow if they have vacant training posts which cannot be filled by UK trainees. MTIs can also fill converted ST posts, or Trust posts which provide sufficient educational and training content. The posts must not disadvantage UK trainees nor adversely affect the training of existing trainees in the location. MTI posts must not disadvantage UK trainees and the local Deanery are asked to confirm this. MTI Fellows should start at CT3 but may progress to ST level after a few months with agreement from the MTI Fellow and Employing Body.

Interested Employing Bodies can read the RCPsych MTI Employer Guidance Document and RCPsych MTI Employer Guidance: An Overview for more information about the scheme. Employing Bodies can apply to employ an MTI doctor by completing an Employing Body Submission Form and submitting this to mti@rcpsych.ac.uk. The MTI team will quality assure the post before matching the Employing Body with a suitable doctor.

The Employing Body application period will be open from January to March 2022 for doctors to start placements from August 2022, however the RCPsych MTI team is happy to provide a more flexible approach, based on the needs of the individual Employing Body.

There is an Employing Body administrative fee of £750 for each doctor RCPsych successfully matches with a post. The fee allows the RCPsych to continue the scheme and provide a high level of support to both Employing Bodies and MTI Fellows from application right through to the end of placement.

If you are interested in the MTI scheme, or have any questions, please contact the team at mti@rcpsych.ac.uk.

Author

Charlotte Callaghan, Medical Training Initiative Coordinator Royal College of Psychiatrists

‘Meet the member’ series by Dr Santoshkumar Mudholkar

Dr Santoshkumar Mudholkar

Our 'Meet the member' series introduces you to members across the Trent region, to learn more about their professional lives and personal histories.

Dr Mudholkar has extensive clinical experience as Psychiatrist and worked in mental health services in U.K. for the last 26 years. Dr Mudholkar has worked as Consultant Forensic Psychiatrist for over 14 years across the spectrum of secure care and Offender Mental Health. Over the last three and half years he works as Consultant Forensic Psychiatrist at Rampton High secure Hospital, Nottinghamshire Healthcare NHS Foundation Trust. Dr Mudholkar’ s clinical interests include complex mental health presentations in mentally disordered offenders including psychiatric co-morbidities, personality disorders, Adult ADHD, assessment and treatment of sex-offenders and cultural aspects of Psychiatry.

Dr Mudholkar graduated in Medicine in Mumbai, India in the early 1990s and completed MD (Psychological Medicine) in Mumbai before moving to U.K. He completed core psychiatry training with Charing Cross General Psychiatric Training scheme, London and higher training in Forensic Psychiatry in London, U.K. Dr Mudholkar completed MSc (Clinical Psychiatry & Research) at Imperial College, London in 2000. He was a Trainee Editor, British Journal of Psychiatry during 2005-2010.

More recently, Dr Mudholkar was Associate Registrar (Membership Engagement), Royal College of Psychiatrists 2016-2021. During this time, he was Clinical Co-Editor, RCPsych Insight (the first College magazine for members). He was conferred Fellowship of the Royal College of Psychiatrists in 2018. Dr Mudholkar was finalist for “*Psychiatrist of the Year RCPsych Award 2020*” by Royal College of Psychiatrists, London.

Dr Mudholkar is sensitive to the issues of International Medical Graduates (IMGs), minority ethnic groups working in frontline NHS. Dr Mudholkar is the immediate past President of British Indian Psychiatric Association (BIPA). He was appointed Equality Champion and CPD Lead for RCPsych Trent Division in 2021.

What made you choose psychiatry?

It would be fair to say that there were several factors which led to me choosing psychiatry.

My interest in medicine was kindled at an early age growing up in a medical family in India. My father was a Consultant Physician specialising in Chest Diseases and my mother was a Geneticist and Professor in Anatomy. Both devoted their professional lives to serve the poor in rural India.

In 1970s I used to accompany my parents to far flung villages and remote areas where they organised free health camps to diagnose and treat Tuberculosis which was a huge public health problem in India. I became aware of health and social inequalities at an early age. This was reinforced when, before joining medicine, I volunteered to collect health census data regarding the uptake of vaccinations in a hard to reach rural communities.

There was also family influence in spirituality and practising yoga as a way of life.

My early experience piqued my interest in community medicine and public health. I was interested in Internal Medicine as a medical student and contemplating specialisation in Neurology or Nuclear Medicine. However, my growing interest in social and cultural aspects of medicine led me to look for a speciality which would fit-in with my diverse academic interests and abstract thinking. In the early 90s, “The Decade of the Brain” there was renewed interest in Psychiatry and Neuroscience in India which was still considered as branch for the future.

I did an elective in Psychiatry during my internship (Foundation Year 1) and, subsequently took the plunge and completed Psychiatry training in India. Although my parents were initially surprised by my choice of Psychiatry as a career, they were quite supportive. I repeated the core psychiatry training and complimented it with higher training in Forensic Psychiatry in London, U.K.

Tell us about your current professional role?

I have been a Consultant Forensic Psychiatrist for the last 14 years in NHS as well as independent sector. For the last 3 years and more I have work full-time in NHS as Consultant Forensic Psychiatrist with Nottinghamshire Healthcare NHS Foundation Trust at Rampton Hospital. I am also involved in medical student teaching with Nottinghamshire Medical School.

What would you say to someone considering a career in psychiatry?

Psychiatry is an intellectually stimulating speciality with a holistic approach to patient care. It will appeal to individuals with a humanistic attitude who are able to "think outside the box" and integrate knowledge in neurosciences, sociology, and psychology in addition to medicine to improve the lives of those who are less privileged than us. In psychiatry more than any speciality, the Psychiatrist must work as part of a multidisciplinary team where there may be divergent views and deal with uncertainty. A psychiatrist must be self -aware and able to communicate effectively across the social and cultural spectrum, particularly, with individuals who are less privileged, have faced adversity and exclusion.

I would like to encourage medical students and Foundation trainees to gain a broader and holistic perspective in Medicine and mental health. It is crucial to take up opportunities for volunteering and Overseas work experience in a different health system than U.K. early on in ones' professional career.

What does your role as Continued Professional Development Lead at the College involve?

I will be assisting the Academic Secretary and Chair of Trent Division in organising educational events for the Division. In this role I will also be liaising with key players from other College Divisions and CALC.

What do you enjoy most about being involved in the work of the College?

First and foremost, I feel proud to be part of the college which belongs to its members and fellows. I started working with College during my higher psychiatry training as Psychiatry Trainees Representative for London Division. This gave me an opportunity to understand the College Management structure and how it works.

As Associate Registrar (Membership Engagement) during 2016-2021 I enjoyed interacting with members from diverse backgrounds from various College Divisions, Devolved nations., faculties and special interest groups (SIGS). This enabled me to listen and understand how members view the College and their expectations. As President of the British Indian Psychiatric Association between 2018-2020 and a member of the RCPsych Diaspora Committee I was uniquely placed to engage the diaspora groups with college activities and liaised regularly with Prof Wendy Burn (then President, RCPsych) and Dr Adrian James ((then RCPsych Registrar and current RCPsych President).

I worked closely with RCPsych Chief Executive Officer (CEO), Mr Paul Rees and College Communications team in developing the College's membership magazine, RCPsych Insight. It was a privilege to be involved with RCPsych Insight as its founder and Clinical Co-Editor between 2017-2020.

I was keen that the voice of silent majority of Psychiatrists and College members in U.K. and abroad is heard in shaping future College strategy. So, I championed the College's first ever full membership survey for 3 years. I was pleased that this was finally undertaken in 2020. I am grateful to the College Officers and senior management team who supported this initiative.
It is a privilege to serve the College and I am now focusing on my role as CPD Lead and Equality Champion for Trent Division.

Covid 19 has highlighted health inequalities in the general population as well as in medical workforce in the UK. The tragic death of George Floyd in Minneapolis, USA in May 2020 has refocused our attention on the issue of racism and health inequalities closer to home. I would like to work hard in addressing these key issues and represent colleagues who are often excluded or ignored.

Author

Dr Santoshkumar Mudholkar, Consultant Forensic Psychiatrist, Equality Champion and Continuing Professional Development Lead on the RCPsych Trent Division Executive Committee

Work experience in Psychiatry by Alex Randle

I am dyslexic. I have been given the opportunity to write this article after being invited to attend work experience. This was a challenge for me as writing presents a particular problem which I'm only too happy to accept.

I had the amazing opportunity to undertake work experience at Mill Lodge, an inpatient unit for people suffering with Huntington's disease, where I was shadowing healthcare professionals with their role in a clinical practice caring for patients with HD. From first walking into the clinic it was evident how caring and friendly all members of staff were. Taking a brief tour I realised that the patients, as well as family members, needed time and support, being provided with exceptional levels of care. The staff understood the patients on a personal level, doing their best to provide access to maintain existing interests and hobbies.

Before going to Mill Lodge I researched HD as I would be shadowing a clinician caring for patients with this illness. This was extremely helpful as it gave me a general understanding of the condition, symptoms, diagnosis and the types of treatment/support available to people suffering with this. HD is caused by a faulty gene in DNA. A chronically progressive neurodegenerative disease consisting of a triad of cognitive, emotional and physical disability. HD has a 50% chance of being inherited by a child whose parent carries the huntingtin gene. This faulty gene can be detected with a genetic test. If the faulty gene is present, at some stage symptoms will develop usually between the ages of 35 and 45, but can start at any time from childhood to old age. The gene is attached to chromosome 4 and codes for the Huntingtin gene, which produces a vital protein, huntington, needed for the body's development before birth and by nerve cells in the brain. The protein sequence is Cytosine, Adenosine, Guanine, (CAG) and when this is repeated too many times it appears to damage certain parts of the brain. Currently there is no cure but understanding the symptoms can help identify possible ways to manage the illness more effectively resulting in an improvement to quality of life.

Being able to sit in meetings with the whole multidisciplinary team, consisting of an Occupational therapist, Physiotherapist, Speech therapist, Dietician, Psychiatrist, Neurologist and other healthcare professionals, highlighted the importance of collaboration and working together to discuss the patients health and effective communication lead to beneficial changes for each individual. Crucial bedside manners were evident and by actively listening to patient's concerns enabled them to be addressed swiftly, allowing patients the best possible care. Safety was of paramount concern. Bedrooms are fundamentally designed to provide accessibility through the use of handrails, wide openings, fixed toilet seats minimising risk of falling and potential injury.

To enhance relaxation a sensory room is provided to allow additional comfort for patients.

Having completed this work experience I have gained a general understanding of the support required for HD patients. Patients can present multiple conditions and therefore a holistic approach is most important to understand the patient to provide them with the best care. This has been an eye opening experience for me and I am looking forward to carrying out further work placements in other clinics to learn more about the medical field.

In conclusion, I am truly grateful for this opportunity that has given me an excellent introduction. I anticipate many challenges that I may face as a medical student and as always I embrace these and face them head on.

Dyslexia has presented challenges through reading, writing and spelling but using a combination of different learning techniques, visual, auditory, reading and kinesthetic. Personally having a hands-on approach alongside visual and auditory techniques help me to assimilate the information more easily and uses one of my strengths, problem solving skills. Also by immersing myself in whatever I am learning, I am able to focus clearly on that particular problem. Having struggled with spelling throughout my life the use of autocorrect has proven to be very useful and by visually seeing what I spelt incorrectly, I am able to learn and over time, autocorrect is used less often. I find it helps to read on coloured paper as for me it is harder to read on white paper because the words 'jump' and consequently makes it harder to follow and read. To help colleagues with dyslexia within the health service, it would be beneficial to provide coloured paper and use a variety of formats to convey information e.g. audio, drawings and diagrams. Dyslexia has presented many hurdles so far, and I only intend to jump ever higher to reach my goals.

Author
Alex Randle, Student, Mill Lodge Inpatient Unit, Leicestershire Partnership NHS Trust

Hall of Fame Nominations

We are proud to announce the winter 2021/22 nominees in the Trent region.

Purpose

The aim of the nominations are to recognise and appreciate medical students, doctors of all training grades (foundation, core trainees, higher trainees, SAS doctors, consultants and physician associates), managers, nurses, social workers and support workers (or even teams, if not individuals) for their contribution towards psychiatry in the region. This would in turn help us tell people that they are valued and appreciated for the work they do.

Nominations

Dr Madhvi Belgamwar, Derbyshire Healthcare NHS Foundation Trust
I would like to nominate Dr Belgamwar as an excellent Educational Supervisor for Core Psychiatry Trainees.

She is working as a consultant in General Adult Psychiatry in community setting in Derbyshire. I have worked with her to complete a quality Improvement project to Improve Quality of writing clinic letters. She listened to the voice of patients to improve the care.

As an Educational supervisor, Dr Belgamwar gave me an enormous support during my Core Training. She is approachable and flexible. She can recognise individual needs of the trainee and give guidance and support when needed. She went above and beyond to support trainee to achieve maximum professional growth.

Simba Chitsiga - Approved Mental Health Practitioner - Emergency Duty Team - Leicestershire
Simba has one of the best bedside manners for acutely distressed mental health patients that I have ever seen.

He is able to engage with psychotic, depressed, manic and personality disordered patients on a human level which is therapeutic within itself.

He also has a deep understanding of a range of social and religious backgrounds which gives context to the acute presentations.

He has helped every higher trainee in Leicestershire learn and understand mental health better during emergency assessments.

During assessments Simba's calm and empathic demeanour has helped numerous patients during their assessments.

He has also advocated for understanding different cultural backgrounds which may have otherwise resulted in detention under the MHA.

He has also shared his experience and knowledge with the higher trainees and we have hugely benefited from having completed assessments with him.

Dr Lizzie Kershaw, Leicestershire Partnership NHS Trust
Lizzie is always available for her peers and takes an active role in improving engagement across the Trust.

She strives to improve working conditions for her colleagues and as a result, enhances the care offered to patients.

Lizzie is a colleague who takes active interest in improving conditions for her peers and patients. She does this in an inclusive way, and bases this in her own experiences and clinical and professional acumen.

Dr Esther Loganathan, CT3 South Yorkshire
Esther has always been a very hard-working and dedicated trainee. She is very approachable and looks after her junior and senior colleagues. She is involved in several projects and shows the fascinating ability to multitask and do justice to all of her clinical and non-clinical roles.

She has worked tirelessly during the pandemic on projects focusing on trainee wellbeing and training development in South Yorkshire.

Esther has taken the lead to push for trainee support, for example running regular weekly peer support sessions during the pandemic. She is also actively involved in updating the Yorkshire and Humber Psychiatry website and organizing a Leadership and Management course for psychiatry trainees in the region. As one can see, her interests are quite varied and she does not hesitate to go the extra mile to achieve her goals and to support others in the process.

Becky Richmond, Medical Student, Sheffield Medical School
Becky has done a joint audit with my supervision titled 'Audit of ADHD Medications in Transition ADHD Referrals to SAANS Service, Sheffield' as part of SSC Research Project in Sheffield Adult Autism and Neurodevelopmental Service (SAANS), Sheffield Health and Social Care NHS Foundation Trust.

This Audit project has been done in the ADHD Specialist area of practice in the Regional Neurodevelopmental Diagnostic Assessment Service at Sheffield. This has increased awareness and complexities in the transition pathway of ADHD referrals from Children's Services to Adult ADHD Service.

Becky has shown immense interest and motivation in doing the ADHD audit collection, audit analysis and completion of essay report for the SSC Project submitted to the Medical School. She has shown exceptional research skills at her level and has done extensive search of research literature for completing her essay report.

Dr Niraj Singh, Consultant Psychiatrist in Intellectual Disability and Clinical Supervisor, Nottinghamshire Healthcare NHS Foundation Trust
Dr Singh is an excellent clinician who has a holistic approach towards the patients. He has taken responsibility for overall care of the Patients and coordinated and signposted to different specialists and disciplines. He was available to support MDT and he is easily approachable and available for clinical and others matters to support trainees.

Dr Singh is a community consultant who has developed a team to support Patients in the community and he was always available to support the team for the welfare of the patients. He was very particular in safeguarding patients with ID. Dr Singh also communicated the RCPsych developments and guidelines particularly it was very helpful during the pandemic.

Dr Singh has showed particular interest in the quality of the care given to patients and he has been excellent as a clinical and educational supervisor. He has been very keen in organising the conferences and trainings for medical students and Core trainees and he has been supportive in trainees' involvement in leadership and Management.

Chloe Wong, Medical Student, Sheffield Medical School
Chloe has done a joint audit with my supervision titled 'Audit of ADHD Medications in Transition ADHD Referrals to SAANS Service, Sheffield' as part of SSC Research Project in Sheffield Adult Autism and Neurodevelopmental Service (SAANS), Sheffield Health and Social Care NHS Foundation Trust.
This Audit project has been done in the ADHD Specialist area of practice in the Regional Neurodevelopmental Diagnostic Assessment Service at Sheffield. This has increased awareness and complexities in the transition pathway of ADHD referrals from Children's Services to Adult ADHD Service.

Chloe has shown immense interest and motivation in doing the ADHD audit collection, audit analysis and completion of essay report for the SSC Project submitted to the Medical School. She has shown exceptional research skills at her level and has done extensive search of research literature for completing her essay report.

Enhanced Team (West), Kendray Hospital, Barnsley - part of South Yorkshire Training Scheme
Dr Kiran Rele (consultant psychiatrist), Shani Robinson (team manager), Angela Jackson, Laura Midgley, Lesley Wilson and all multidisciplinary staff

The Enhanced Team offers assessment, care management and a range of evidence-based interventions and treatments to improve mental wellbeing and is committed to recovery approaches. Services are provided in accordance with the Care Programme Approach (CPA). Where service users appear to have social care needs dependent upon their eligibility under The Care Act 2014, either social care support is offered through personalisation and self-directed support, or, they will be provided with advice and information on how to meet their social care needs.

The team has been exemplary in all domains. It has worked tirelessly to provide treatment and care to all its clients. It has been extremely welcoming of newcomers from all disciplines. Their work ethic is commendable and they are all very helpful and professional at all times. The Enhanced Team has worked very well to manage patients through FACT - which is the Flexible ACT model to provide intensive support to patients in crisis in the community. This prevents referrals to Crisis Team and inpatient admissions.

Rowan 1 ward nursing and Medical Team, Highbury Hospital
Dr Faizal Seedat (consultant), various junior doctors, Amanda Smillie (ward manager), Campbell Mtetwa (staff nurse), Heather (staff nurse), Angela Akpovi (staff nurse) and various other nursing and HCA staff

The whole team works best together and the flow of work is managed really well by the whole team. The team works to get the best for patients and are able to do it in due course with the right guidance and leadership.

The team has been committed to the best quality and professional growth in terms of services offered to our mental health patients. We have had a recent admission to the ward of a patient who is terminally ill with cancer, he was expertly reviewed initially by the ward team, started on the correct medications and got him back in his community in less than 2 weeks. His physical as well as mental health needs were dealt with promptly. Patient has bene reviewed in community and is doing well.

Royal College of Psychiatrists -Trent Division

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

The Trent Division is made up of members from Leicestershire, Lincolnshire, Derbyshire, Nottinghamshire, South Yorkshire and the Humber.

We would like to thank all members for their contributions towards Trent Division activities throughout the year.

Trent Division

Deadline for next edition
Submit your articles for the Summer edition by 31st May 2022 at trent@rcpsych.ac.uk

Royal College of Psychiatrists - Trent Division E-Newsletter

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