



# Trent Division Newsletter

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Autumn 2020

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## Editorial

Dr Sidra Chaudhry and Dr Kris Roberts, Co-Editors



### Dear Colleagues,

What a year this has been! We hope the Autumn 2020 edition of the Trent Division e-newsletter finds you safe and well and that you enjoy the great range of articles included.

Thank you to contributing authors throughout the Trent region, this edition would be far from complete without your valuable time and efforts.

We have a great spectrum of writers this time out, from medical students to specialty doctors and consultant colleagues. Dr Avinash Hiremath, the new Medical Director of LPT, kindly gave his time to answer our questions for an interview; I'd encourage you to give it a read.

If you are interested in contributing to the next edition of the e-newsletter, please email Marie Phelps on [Trent@rcpsych.ac.uk](mailto:Trent@rcpsych.ac.uk). Articles that are considered include:

- Review of recent literature
- Past and upcoming events
- Opinion pieces/reflections
- Creative contributions (i.e. photographs, artwork, poetry)

- Research/Audits/QI projects
- Special interests within Psychiatry

However, these article types are by no means exhaustive, and if you have any ideas for articles that do not neatly fit into the above categories, please still get in touch!

Additionally, don't forget that certificates for accepted articles can be made available upon request.

Submitting a piece of writing is a great way of engaging with Psychiatry in the region, sharing your work and enhancing your portfolio. We also welcome suggestions on what you want to see in future editions.

We look forward to reading your next submissions.

### Best wishes,

Sidra and Kris

*Co-Editors of the RCPsych Trent Division Newsletter*

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## Welcome

### Dr Anand Ramakrishnan, Trent Division Chair



Dear members

I am writing this with a heavy heart in the midst of a pandemic which has affected everybody in this country. Two of my close friends died of COVID-19. I also share the grief of all our friends, colleagues, patients and their family and relatives who lost their loved ones due to this corona infection and also share the joy of those people who were fortunate to recover from, COVID-19. It has been a bad year for everyone including the members of Trent Division of Royal College of psychiatrists due to the pandemic. All face-to-face meetings have been cancelled until January 2021 which is quite unprecedented. Hence our annual conference in November, the Medical Students' Conference and the Old Age Psychiatry Conference, were all sadly cancelled. Thanks to many of my colleagues, Prof Scott Weich, who organised most of the annual conference and Dr Niraj Singh and Dr Shahid Latif who enthusiastically tried to organise the medical students' conference and also Dr Simon Thacker and Dr Hari Subramaniam, who were arranging the Trent Old Age Psychiatry conference.

All of us have had to adapt, change and adopt new ways of working with less face-to-face meetings with the patients, relatives and even with our own colleagues as many are working remotely

with audio and video interviews and online conferences/webinars using various tech mediums like Zoom, Go meeting and Microsoft teams. Although we are not meeting people face-to-face due to the lock-down and social distancing measures, there have been plenty of phone/video contact with friends and their relatives, when not working. Many people have utilised this time for improving family interactions and spending time with members of their own family on a much more positive way. Although there have been few face to face meetings/conferences, there have been plenty of webinars and CPD virtual meetings - regionally, nationally and internationally.

Dr Kris Roberts and Dr Sidra Chaudhry, the new and enthusiastic co-editors of the Trent Division Newsletter are doing a splendid job to collate all submissions and bringing out a new edition of the newsletter. I hope that this newsletter will bring some cheers to many of our colleagues and bring some happiness to our dear members of the Trent division. I sincerely wish that there will be a reprieve from this horrible infection, and our members and their families will have a better time. Hope you all will be able to enjoy the holidays properly without fear of getting infected with COVID-19.

Enjoy this latest edition of the Trent Division Newsletter.

Yours sincerely

**Dr Anand Ramakrishnan**

BSc, MBBS, DPM, MMedSc, MSc, FRCPsych  
Chair, Trent Division, RCPsych

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## Elderly Offenders at Wathwood Hospital – Perspectives and Practicalities

by Dr Sidra Chaudhry, CT3- Wathwood Hospital, Nottingham Healthcare NHS Trust, Yorkshire and Humber Deanery



As highlighted in the College report titled "Caring for the whole person", elderly people have needs very different from others' due to multiple physical health co-morbidities, frailty and increased prevalence of cognitive difficulties and dementia <sup>(1)</sup>. This can often lead to unique presentations of mental illness, making it very challenging for multidisciplinary teams to assess and manage these individuals. It is therefore crucial that services work together to cater to the needs of the older population. Joining my CT3 placement at Wathwood Hospital, a medium secure forensic unit under Nottingham Healthcare NHS Trust, gave me the exciting opportunity to conduct a very interesting service evaluation project aimed at provision of care for elderly offenders in a medium secure hospital.

As of now, the only dedicated medium secure unit for male patients above the age of 55 years in England is Cranford Ward in St. Andrews, located in

Northampton. Cranford ward is a 17-bed unit, which is a very small number considering it is the only dedicated male medium secure unit in the entire country. This, along with the struggle to find beds within the catchment area, causes other medium secure units to start accepting patients in this age bracket, leading us to question whether the needs of these patients can be appropriately met in units that have not been specifically designed to care for them.

Keeping this in view, our project aimed to identify patients above the age of 55 years, who had been referred and subsequently admitted to Wathwood Hospital from 2012 onwards. On search of the Wathwood Hospital database, it was identified that a total of 220 referrals had been made to the service with only 9 patients above the age of 55 years amounting to approximately 5 % of total referrals. Index offences, mental disorder diagnoses, physical co-morbidities including cognitive assessments in the form of memory tests and brain imaging were also collated for identified patients from electronic patient records.

Index offences included violence against the person, homicide, robbery, threatening behaviour, dangerous driving and affray. These patients presented with a variety of mental disorders such as learning disability, delusional disorder, paranoid schizophrenia, bipolar affective disorder, alcohol dependence, personality disorder and depressive disorder.

Physical health profiles of all patients were gathered, which showed multiple co-morbidities such as diabetes, COPD, hypertension, coronary artery disease and musculoskeletal problems. Out of the nine admitted patients, only six had an Addenbrookes Cognitive Examination with an average score of 70.83. Five patients had brain imaging studies, with two normal results and the others showing some degree of atrophy and ischemic changes. With the advantage of a primary health centre based within the hospital premises, it has been easier to manage physical health related issues in a timely and efficient manner. Our services don't have access to specialist medical advice from on-site geriatricians, however such advice can be sought from acute hospitals over phone or letters if need be.

In tracing patients' journeys through admission, out of the nine patients, one was discharged to another medium secure unit, two were stepped down to a low secure unit and one was transferred back to prison. One patient unfortunately died during admission and four are still inpatients.

A staff survey was conducted to find their perspective on the challenges in managing elderly patients and whether they felt Wathwood Hospital had the appropriate resources for them to work with elderly offenders in their area of work. On examination of the feedback received from multidisciplinary professionals working at Wathwood Hospital, the key challenges highlighted were increasing frailty, co-morbidities and lack of training to manage physical health problems in the elderly. Other difficulties were in engaging elderly patients in psychological work as it was observed they are more reluctant to talk openly about their mental health. Elderly patients may also find it difficult to engage in certain occupational activities due to mobility problems. Staff also noted that

elderly patients can be more vulnerable in comparison to their younger peers on the ward as the culture on the ward was driven by young males, which often led to issues with noise levels and daily routines. It was also noted that logistical difficulties such as stairs and accessible shower rooms were not available as the hospital was designed for independent patients.

In conclusion, it is evident that there are a variety of challenges in managing elderly patients in units that are not specifically designed to manage their various needs. This is due to the lack of elderly-friendly training and resources available to allied health care professionals such as nurses, health care assistants, psychologists and occupational therapists in a forensic medium secure setting to carry out their respective work. It is therefore crucial that we talk more openly about these challenges and formulate more inclusive strategies to work through these. At Wathwood Hospital, the introduction of the Bite Size Teaching programme has worked very well in educating staff about various common physical and mental health issues that can occur on the wards. This can be extended to include sessions aimed at care of the elderly patient to ensure that we as a service are able to manage this very important and growing part of the patient population.

**Acknowledgements:** Special thanks to Dr Gwilym Hayes and Dr Darran Bloye for their help and support in completing this project.

**REFERENCES:**

1. Rcpsych.ac.uk. (2019). Caring for the whole person. [online] Available at: <https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr222.pdf> [Accessed 24 Dec. 2019].

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# Psychiatric Care of Patients with Parkinson's Disease – Is There Room for Improvement?

Dr Sarah Wilson<sup>1</sup> (Consultant Old Age Liaison Psychiatrist), Dr Manisha Ray<sup>1</sup> (Higher Trainee in Old Age Psychiatry), Dr Chia Wei Tan<sup>2</sup> (Higher Trainee in Geriatric and General Medicine), Kayleigh Stafford<sup>1</sup> (Mental Health Liaison Nurse).

<sup>1</sup> Nottinghamshire Healthcare NHS Trust <sup>2</sup> Nottingham University Hospitals NHS Trust

## Introduction

Mental health problems are common in people with Parkinson's disease (PD) and can have a huge impact on people's day to day lives. At the moment, many people with Parkinson's struggle to access mental health support when they need it.

Neuropsychiatric complications in this population vary from functional illnesses such as depression, anxiety and psychosis to organic processes such as delirium and dementia. These complications can arise as a consequence of the Parkinson's, or as co-morbidities. Furthermore the anti-Parkinsonian medications themselves can have psychiatric side effects such as psychotic symptoms (e.g. visual hallucinations) or behavioural disturbances (e.g. impulsive disorder).

Parkinson's UK launched a survey in early 2017 across the UK to find out how mental health problems impact on the day to day lives of people with Parkinson's, as well as people's experiences of accessing mental health support. The results revealed that three quarters of the people with Parkinson's surveyed felt that their mental health problems had an impact on their quality of life. More importantly, around 65% of the people surveyed were not confident that their mental health problems were being addressed by the NHS.

In this survey we attempted to explore the involvement of mental health services among patients with Parkinson's disease

in Nottinghamshire. This survey followed a similar project done by Nottingham University Hospital that emphasized the need for improved access of mental health services among patients with Parkinson's disease.

## Aims and objectives:

Our aims going into this project were to gain an understanding of which patients are referred to psychiatry (MHSOP specifically) from the Movement Disorders Service, via the GP. What diagnoses we are making? Which specialist teams are involved? What interventions are we providing? And what is the level of communication between MHSOP and the Movement Disorders Service (MDS)?

We developed the following Objectives:

- What are the demographic details (age, gender) of patients known to MDS and MHSOP concurrently?
- How much contact do these patients have with MHSOP services?
- Which specialist MHSOP teams are involved with this cohort?
- What diagnoses are we making for this cohort?
- What medications are we prescribing for this cohort?
- Are we copying clinic letters to the MDS to share relevant clinical information?
- Where do the referrals come from (via primary care or direct from secondary care)?

- What are the time frames between MDS requesting a referral and the referral being made, and the referral being received and the patient being assessed?

## Methodology

This survey was done in two parts. An initial pilot study in 2018 included a questionnaire designed to seek mental health clinicians' experiences and thoughts in treating people with a co-morbid diagnosis of Parkinson's disease (Appendix 1). The questionnaire included 10 questions with Likert's scale responses. The results were quantitatively analysed and are outlined below.

The second part of the survey followed an audit project that was designed to check the current practice of treating mental health problems in patients with Parkinson's disease in Nottingham University Hospitals NHS Trust (NUH). In the 2018 pilot we attempted to identify patients known to Nottinghamshire Healthcare NHS Trust (NottsHC) who had a diagnosis of Parkinson's Disease, to compare interventions from the mental health perspective. Unfortunately these patients proved difficult to identify from the mental health electronic patient record system, mostly due to physical illnesses not being routinely coded in mental healthcare records. The pilot therefore only identified 17 patients across Mental Health Services for Older People (MHSOP) in one year who had a diagnosis of Parkinson's Disease, significantly less than expected for the population of Nottingham City, Rushcliffe, Broxtowe and Gedling.

We therefore gained the appropriate permissions and went back to NUH to obtain a list of all the patients seen by the Health Care of Older People (HCOP, geriatricians) consultants in the Movement Disorders Service at Queen's Medical Centre (QMC) from 1<sup>st</sup> July 2017 to 30<sup>th</sup> June 2018. This gave us a list of 224 patients which we then cross-referenced

with NottsHC's electronic patient record and found that 82 patients were known to Mental Health services between 1<sup>st</sup> January 2017 and 31<sup>st</sup> October 2018 (this period was longer to ensure we captured as much concurrent Mental Health intervention as possible).

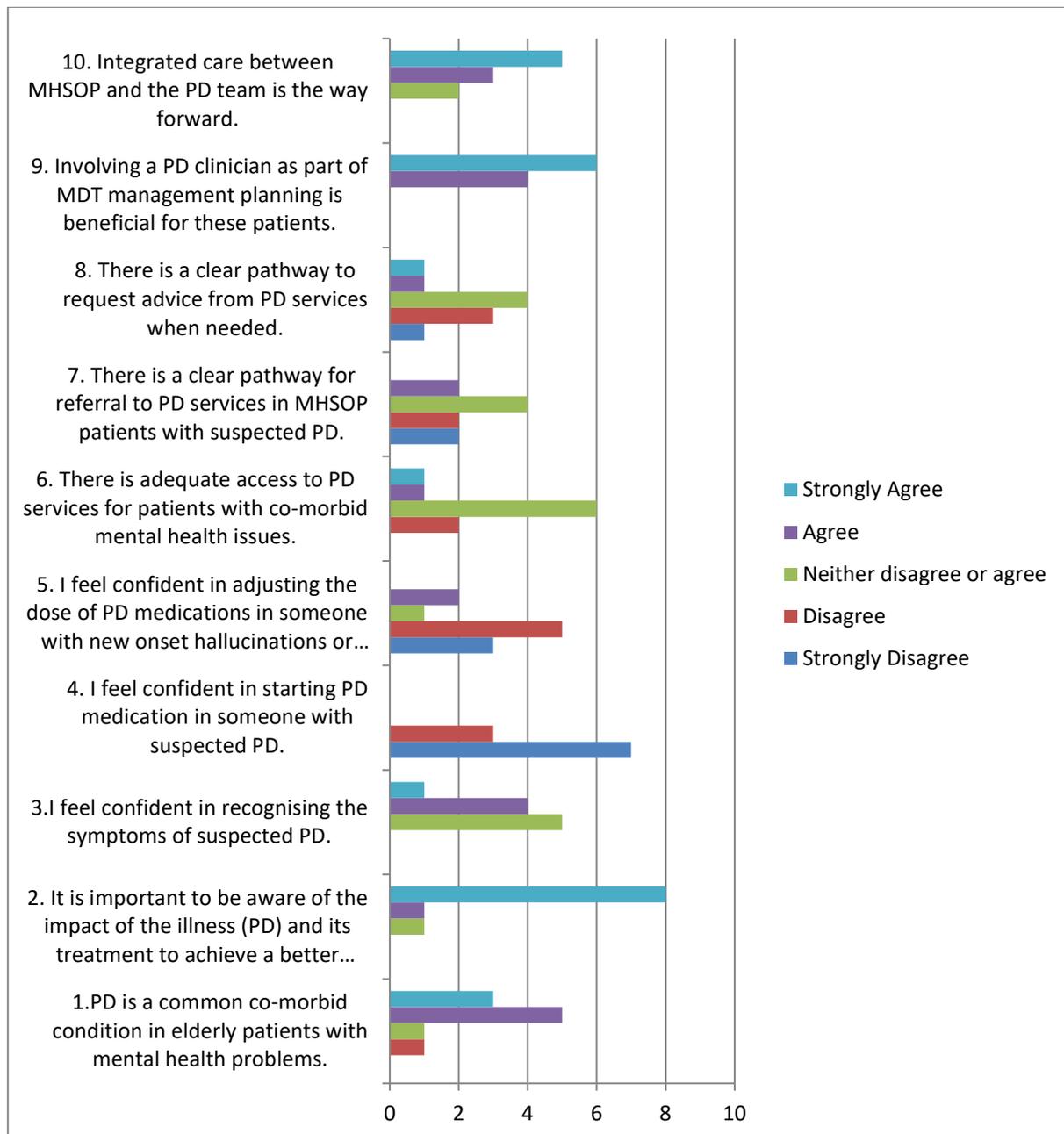
A data collection tool (Appendix 2) was designed to collect data on the demographics of these patients, which services and healthcare professionals they had seen, what diagnoses were made, what medication was prescribed and how many contacts these patients had with Mental Health services. We also compared physical and mental health diagnoses recorded in the Movement Disorders Clinic with those recorded in the Mental Health records, and looked for any evidence of any communication between the two services.

The results of the data collection are summarised and discussed below.

**Results:**

**Part One (responses to the clinicians questionnaire):**

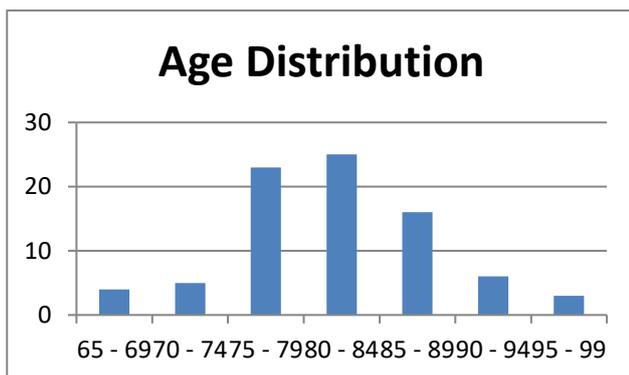
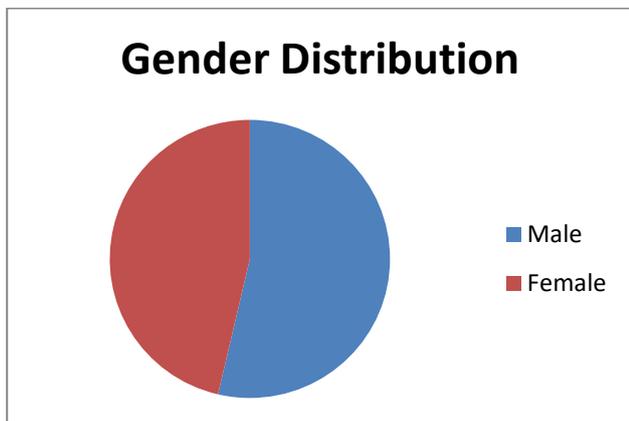
This questionnaire was sent out to 22 senior medics and higher trainees within MHSOP at Nottinghamshire Healthcare Trust. Ten responses were received and the results are as follows:



The majority of clinicians (90%) agree with the significant impact of Parkinson's on mental health and 80% agreed with the need for an integrated service that would offer mental health as well as physical health support for patients with Parkinson's disease. 100% of psychiatrists agreed with the importance of involving clinicians from the Parkinson's disease service as part of the MDT management plan.

**Part Two (review of current practice):**

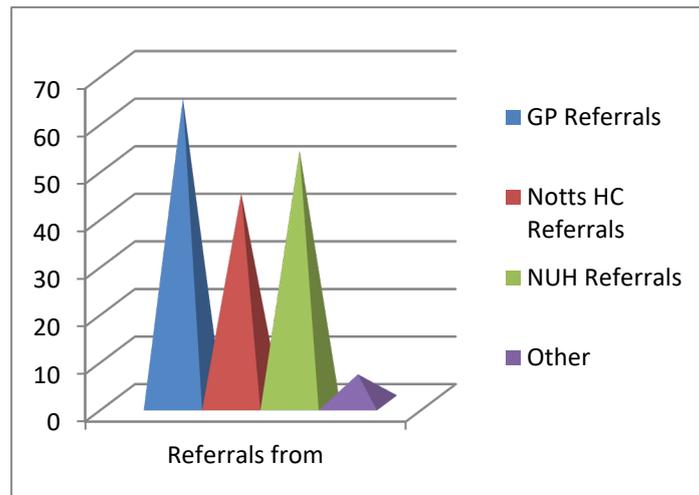
Of the 82 patients, 44 (53.7%) were male and 38 (46.3%) were female. The age range for these patients varied from 67-98 years with a median age of 80.5 years.



Between the 82 patients on the list, 167 referrals to MHSOP services were generated. These included referrals from primary care, secondary care and between different mental health teams.

38.3% (64/167) were referred by primary care, 31.7% (53) were referred from within NUH (mostly to liaison psychiatry services)

and 26.5% were referred between different mental health teams.

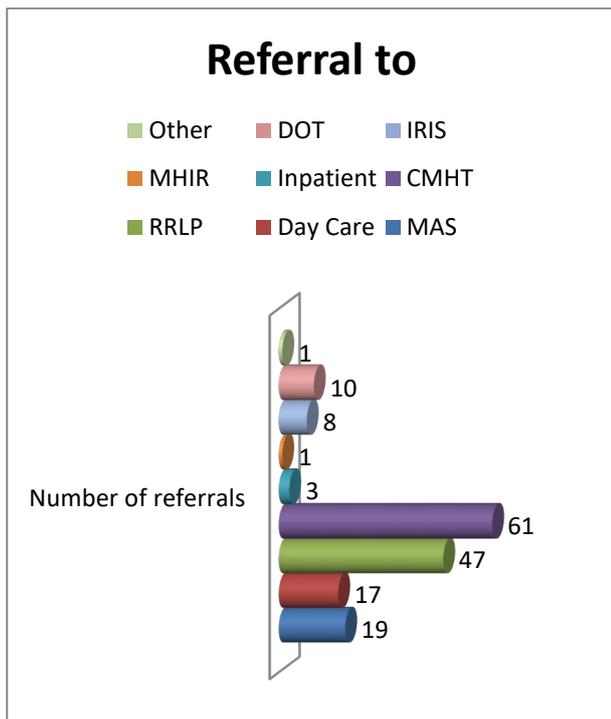


We looked at the number of referrals made by the Movement Disorder Service (MDS) to Mental Health Services for Older People (MHSOP). There were a total of 31 referrals from the MDS clinic, but the majority (68%) of these came via the GP, introducing delays and a lack of communication between the MDS and MHSOP services. Only one referral was made directly by the doctor from the MDS clinic to MHSOP.

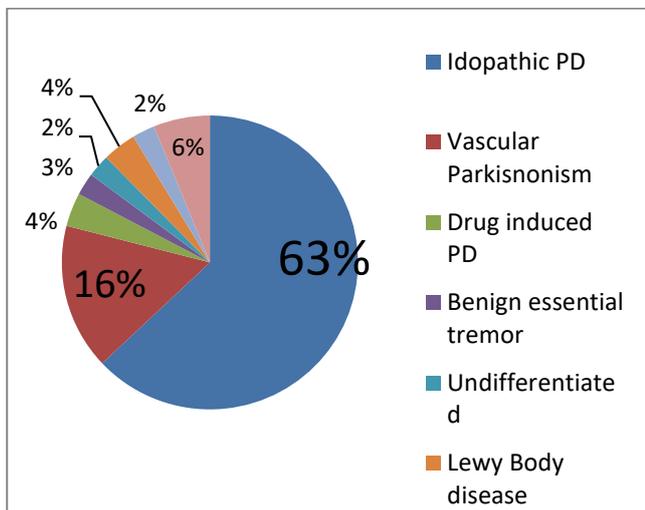
Of the 31 referrals, 3 patients had not made any contact with the MHSOP as there was no documentation of referrals being made. 7 out of 31 recommended referrals were communicated and received in MHSOP.

Once a referral had been made, it took an average of 31 days before first contact was made between MHSOP and the patient. It then took an average of 5 months for the MDS team to receive recommendations for treatment.

36.5% (61/167) patients were referred to the Community Mental Health Teams (CMHT's), 28.1% (47) were referred to Rapid Response Liaison Psychiatry (RRLP), 11.3% (19) were referred to the Memory Assessment Service (MAS) and 5.4% (9) were referred to the Intensive Recovery Teams (IRIS/MHIR).



Of the 82 patients, we have identified a spread of diagnoses. As expected, the majority of the patients had a diagnosis of Idiopathic Parkinson's Disease (IPD) (63%) from the Movement Disorders (MDS) clinic. The variety of diagnoses is illustrated on the pie chart below.



We also compared the documentation of the physical health diagnosis between that of the MDS clinic and the MHSOP team. We discovered 18 patients (22%) that had been incorrectly identified as either having Parkinson's Disease when they did not or vice versa, in the MHSOP records.

With regards the mental health diagnosis, there were 9 (11%) instances where Cognitive Impairment was identified in the MDS clinic but MCI or Dementia was not diagnosed by MHSOP, and 4 (5%) of patients whose mental health diagnoses in MDS did not match those made in MHSOP (e.g. depression identified by MDS not diagnosed by MHSOP and anxiety identified by MDS diagnosed as Depression by MHSOP).

Overall however, most cognitive impairment identified in the MDS clinic was diagnosed as dementia by MHSOP (33 patients, 40%).

We looked into the distribution of medications that were being used in managing Parkinsonism as well as treatment of mental health conditions. We also looked into the prevalence of polypharmacy in our data group. The results are as follows:

42 out of the 51 patients (82%) who had a diagnosis of Idiopathic Parkinson's Disease had Levodopa prescribed. In addition, 6 out of the 42 (14%) had either a dopamine agonist or alternative PD adjunct used in combination.

30/82 (37%) had been prescribed antidepressants and two of those were using a combination of antidepressants. 40% of the patients were prescribed Mirtazapine, and this was the most commonly used antidepressant, with SSRI's the second commonest.

9/82 (11%) had antipsychotics prescribed. Quetiapine (77%) was the most commonly used antipsychotic, with Amisulpride the most common alternative.

9/82 (11%) had an additional psychotropic medication prescribed, often a benzodiazepine.

Two patients were on a combination of both antipsychotic and additional psychotropic medications.

18/82 (22%) patients were prescribed acetylcholinesterase inhibitors. Rivastigmine was most commonly used (89%).

35/42(83%) patients who were on levodopa were prescribed a combination of either antidepressant, antipsychotic or acetylcholinesterase inhibitors for managing symptoms associated with their mental health diagnosis.

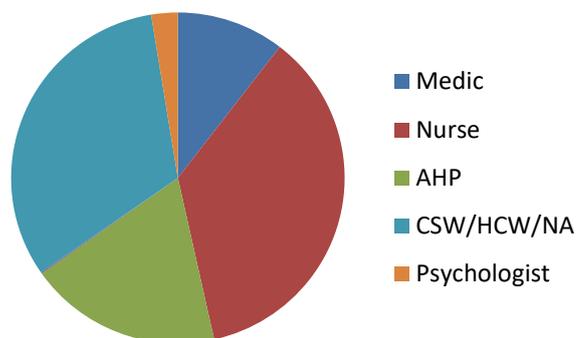
The total number of contacts (for the above 82 patients between January 2017 and October 2018) with mental health professionals from different teams was 1089.

The number of contacts per patient varied from 1 to 267, with the higher numbers reflecting psychiatric inpatient admissions. The majority of patients (56/82, 68.3%) had less than 10 contacts with any clinicians across any teams. 13/82 (15.9%) had between 10 and 20 contacts with any clinician across all teams over the period reviewed.

When stratified by MHSOP service, the maximum number of contacts were with the IRIS/MHIR teams (30.3%). 24.8% of contacts were with the CMHT's, both inpatients and day hospital services accounted for 11.7% of contacts each, RRLP had 8.1% of contacts and MAS accounted for 2.4%.

Across the services, the majority of contacts (36.1%) were with qualified mental health nurses, 32.1% of contacts were with non-qualified staff (e.g. healthcare assistants), 18.7% of contacts were with Allied Healthcare Professionals (AHP's – e.g. physiotherapists, occupational therapists) and 10.5% of contacts were with medics (of any grade).

### Number of contacts with different clinicians



Of all 1089 contacts with mental health professionals, we found only 11 GP letters copied to the Parkinson's Disease Service (9 letters were copied to the consultant, 1 was copied to the PD specialist nurse, and 1 was copied to both). Evidence of phone conversations between services was difficult to consistently identify.

We also looked at the availability of documentation available from MHSOP to the PD medical teams. Only 11 out of the 82 patients (13%) had letters from MHSOP copied to the PD medical team, and most of these were "one-off" letters following an initial assessment.

#### Discussion:

As shown above the responses to the survey questionnaire re-emphasized the need for improved mental health service access for patients with Parkinson's Disease. The second part of the evaluation highlighted the difficulties in the existing clinical practice.

More than one third of patients (36.4%) seen at the HCOP PD clinics in the QMC between January 2017 and October 2018 had significant mental health problems and needed support by the mental health services. This finding is alarming and shows the urgency of a more integrated service provision for the patients of Parkinson's disease with comorbid mental health problems.

Currently PD patients (seen in the Movement Disorders Service) with mental health problems are referred by their GP (in the majority of cases) or from within the acute hospital (from inpatient wards) to MHSOP, before they can access specialist and timely support from the appropriate services. An integrated service with psychiatry embedded within the Movement Disorders Service would eliminate any time delay in seeing these patients, thereby reducing unnecessarily prolonged suffering.

In terms of number of contacts by each team, maximum contacts (30.3%) were made by the Intensive Recovery Teams (IRIS/MHIR), however, they received a much lower percentage (5.4%) of referrals compared to other community teams. This is likely due to the degree of the severity of the illness the IRIS/MHIR team get involved with and the intensive nature of the care (few times on the same day if necessary) they provide. Similarly, only 3 patients (1.8% of referrals) required mental health inpatient stays, but these accounted for 11.7% of all contacts).

Among the rest of the referrals the majority of contacts were made by the CMHT (25.8%) as predicted. It is notable however, that 10% of referrals were made to mental health day services, potentially highlighting a need for specialist day services within this patient group.

Regardless of the settings the qualified nurses were the clinicians who had maximum number of contacts with this patient group. This supports the idea of an integrated service with a qualified mental health nurse who could offer appropriate assessment and support and could liaise with the psychiatrists or other mental health clinicians or teams if necessary.

As evident above the current practice of communication between mental health teams and Parkinson's disease team is poor. Poor communication between

these teams is likely to have a negative impact on the overall care of an individual with Parkinson's disease. Having an integrated service would help linking both the Parkinson's disease team and mental health team together with better patient care and less administrative delay.

There are a variety of underlying physical health conditions seen in the MDS clinic, not just Idiopathic Parkinson's Disease (IPD). We have discovered that there were inaccuracies in relation to the diagnosis of IPD, and this causes delays on future treatment plans and diagnosis of underlying physical health conditions. Likewise, accurate diagnosis and treatment of mental health conditions in these patients is important to ensure appropriate and safe prescribing. All of the patients in our data have long term physical and mental health issues, and side effects from medications increases risks of falls and increasing co-morbidity.

Separate clinics for managing physical and mental health conditions have resulted in long delays and on occasions, missed referrals. From the data that we have gathered, there is evidence to suggest that patients are not getting appropriate care in a timely fashion due to either inability to obtain accurate records or delay in communication between the two organizations. By integrating the MDS and MHSOP services, we can obtain accurate information in relation to both physical and mental health diagnosis, advocate practical prescribing and reduce polypharmacy and its co-morbidities.

#### **Limitations:**

We have only been able to comment on MHSOP involvement in extremes of presentations as less severe cases of depression, dementia and anxiety did not necessitate a referral to secondary mental health services.

This survey was based within NUH and mostly covers patients living in Nottingham City, Rushcliffe, Broxtowe and Gedling. Patients in Mid-Notts (Mansfield, Ashfield and Newark) would generally be seen by PD services based at Kings Mill Hospital. While the findings in the survey are likely to be consistent with other areas, we cannot extrapolate them to other areas of the country.

**Recommendations:**

An integrated service with support for both physical health and mental health sides of Parkinson's disease would benefit patients without going through unnecessary delays in referrals or stopping them from getting lost in the system. It will vastly improve communication between mental health clinicians and Parkinson's disease clinicians and would thereby offer a time and cost effective service without unnecessary duplication of work. It would be more convenient for the patients as in majority of the cases their needs could be met by one single team covering both the physical and neuropsychiatric issues caused by Parkinson's Disease. This would improve trust between the care providers and service users and improve patients' experience of the service. Early recognition and management of neuropsychiatric complication may also reduce the need for intensive recovery and inpatient services, further reducing the burden on mental health services.

## Appendix 1

Survey of clinician's attitude in treating patients with co-morbid Parkinson's Disease (PD)

Likert scale, please score the following statements:

5 (strongly agree), 4 (agree), 3 (neither agree nor disagree), 2 (disagree) or 1 (strongly disagree)

1. PD is a common co-morbid condition in elderly patients with mental health problems.	
2. It is important to be aware of the impact of the illness (PD) and its treatment to achieve a better outcome of mental health issues.	
3. I feel confident in recognising the symptoms of suspected PD.	
4. I feel confident in starting PD medication in someone with suspected PD.	
5. I feel confident in adjusting the dose of PD medications in someone with new onset hallucinations or deteriorating hallucinations.	
6. There is adequate access to PD services for patients with co-morbid mental health issues.	
7. There is a clear pathway for referral to PD services in MHSOP patients with suspected PD.	
8. There is a clear pathway to request advice from PD services when needed.	
9. Involving a PD clinician as part of MDT management planning is beneficial for these patients.	
10. Integrated care between MHSOP and the PD team is the way forward.	

**Appendix 2**

1. Age				
2. Gender		Male		
		Female		
3. Mental Health Diagnoses				
4. Referral Pathway: Referrals from 1/1/17 onwards (or original referral date if referral already open at that time), who made the referral? (GP/internal/HCOP/etc), date of referral, date of discharge (if necessary), additional referrals (who by, when, dates), up to 30/9/18.				
Date of referral:	Referral from:	Date of first contact:	Referral to:	Date referral discharged:
How many contacts with MHSOP services and clinicians has the patient had (between 1/1/17 and 30/9/18)?	CMHT			
	Medic			
	Nurse			
	AHP			
5. How many contacts with MHSOP services and clinicians has the patient had (between 1/1/17 and 30/9/18)?	CSW/HCW/NA			
	Psychologist			
	RRLP			
	Medic			
	Nurse			
	AHP			
6. Specific medication (psychotropic and anti PD).				

	CSW/HCW/NA	
	Psychologist	
	MAS	
	Medic	
	Nurse	
	AHP	
	CSW/HCW/NA	
	Psychologist	
	IRIS/MHIR	
	Medic	
	Nurse	
	AHP	
	CSW/HCW/NA	
	Psychologist	
	DOT	
	Medic	
	Nurse	
	AHP	
	CSW/HCW/NA	
	Psychologist	
	Inpatient stay	
	Medic	
	Nurse	
	AHP	
	CSW/HCW/NA	
	Psychologist	
	Day hospital	

	Medic	
	Nurse	
	AHP	
	CSW/HCW/NA	
	Psychologist	
	Other:	
	Antidepressant	
	Antipsychotic	
	ACEII	
	Dopamine Agonist	
7. Specific medication (psychotropic and anti PD).	Levodopa	
8. Were any CMHT letters cc'd to the PD service? (please note number of letters).	Other psych medications:	
	Other PD medication:	
	Yes (on Rio/progress notes)	
	Yes (on actual letters)	
	No	
Don't Know		
9. If yes to 8, who were they cc'd to?	Doctor	
	Nurse	
	Team	
	Other:	
10. If yes to 8, who were they cc'd to?		

# Community Treatment Order (CTO)

## Challenges, Pitfalls and Reflections

by Dr Madhvi Belgamwar, RCPsych Trent Division Executive Committee Vice Chair and Regional Advisor for Derbyshire, Lincolnshire and Nottinghamshire



CTO remains one of the controversial acts of all Mental Health acts. Amongst various professionals, opinion is divided in relation to their effectiveness.

"'Psychiatric Asbos' were an error says key advisor," The Independent reports. The news comes from new research examining the effectiveness of community treatment orders (CTOs), a legal measure that allows mental health teams to impose compulsory supervision on a patient after they have been discharged from an involuntary stay in hospital.

Patients may also be ordered to meet other requirements, such as taking medication or living in a specified place, or be faced with readmission to hospital. For this reason, CTOs are controversial as they restrict patients' personal liberty.

This well-designed piece of research on patients in England found that CTOs were no better at stopping people with psychosis from being readmitted to hospital care than another type of legal measure that allows patients short periods

of leave from psychiatric hospital care. The study also found that CTOs did not reduce the length of time patients stayed in hospital, the severity of their symptoms, or how they coped in society. They however persist in practice.

The following is a personal reflection on CTO as a community RC.

1) Recall process: The most challenging and complex aspect of the CTOs is a recall process. Further complicated by different Trust policies across regions, may be due to geographical variations and/or roles/responsibilities allocated to team members in relation to the process.

a) During working hours: A Service user on CTO refuses to take medication in the community. As soon as this happens, unfortunately, there is a kind of panic in the team and everyone starts thinking about the recall immediately. There are no such fixed guidelines when to recall patient but it's often left on the judgement of professionals based on potential/ imminent risks. Ideally there should be a negotiation and discussion with patient as to look at reasons for the refusal of treatment and come up with an appropriate/ least restrictive plan. There is no clear rule/ guidance as such who should be doing this in terms of staff such as CPN/ RC but it needs to happen. More often than not, the case is that patient has no insight, so there is a huge reluctance/ ignorance in terms of engaging in any type of discussion/ negotiation and recall is the unequalled option. It is however important that a clinician documents that there has been

an attempt made for such a discussion/ negotiation. There is however support of team members for each other which is just not there out of hours.

b) Out of hours: Often RC is a lone worker. CPN hands over to on call RC about a need to recall a patient due to refusal of treatment. Although attempts were made during daytime, they were futile, largely due to patient nowhere to be found and reported as missing to police. Patient eventually is brought to a place of safety by police during out of hours but found to be under the influence of substances/ confused and as a result no place for a dialogue. Unfortunately there is no clear guidance as to withhold review until patient is out of influence however this would be a common sense approach. The guidance does however say that there RC should have a dialogue with patient in terms of least restrictive options available and the recall notice if served would not be legal otherwise.

c) Serving a recall notice: This often poses a multitude of Practical difficulties and need planning beforehand. There is a concern that if you serve a recall notice without prior arrangements then patient may abscond due to complete lack of insight and subsequent reluctance to engage in the treatment process. One need to therefore have a transport as well as a bed ready prior to serving the notice and in few cases indeed police to convey patient however there is a huge reluctance on part of police. In such cases, a secure patient transport such as Prometheus may be appropriate. A major challenge, now, is to find a suitable bed, however, often there is a Trust policy that recall should not happen out of areas due to unavailability of appropriate RC and external Trust regulations may vary. Waiting for a bed locally however then prolongs the recall and further potential risks waiting to happen in the community.

d) Delivering a recall notice: The code of practice details that one could deliver a recall notice through the post but often this is completely ignored or patient absconds/ AWOL which then causes further problem in terms of locating patient/ reporting patient as a missing which then takes a valuable time away from police who are already reported to be struggling with their own criminal caseload.

e) Convey to Hospital: This is quite distressing for both patient and family to go through and for the witnessed indeed. More often than not, patient has no insight and therefore there is no willingness on part of the patient to be recalled to hospital. One has to be mindful therefore to avoid/ cause minimal physical/ emotional disruption where and when possible to patient and family. However in some cases it is just not possible and it's not just disruption to patient and family but also wider community including neighbours as well as other patients should this be arranged through community outpatients/ clinic based in a hospital/GP practice.

2) Challenges to hospital RCs/ staff: Within 72 hours of a recall, there should be an arrangement by the RC/ staff to Multi-disciplinary review patient and decide further outcomes such as discharge on CTO/ informal admission/ revoke CTO/ section 3. This often comes to on call RC in case the recall happens on Fridays and it could be time consuming. To provide depot injection may at times need coercion on part of staff for patients detained under sections.

3) Challenges to community staff:

a) CTO reviews by RCs and AMHP: Needs a prior planning by the RC. Usually within 2 months of CTO expiry date and hope that admin/ secretary helps you with arranging this. Often this is a multi-disciplinary including AMHP. If patients do

not attend, may happen at times, causing further havoc in terms of bringing everyone together again.

b) Nursing staff: Very challenging, difficult and traumatic work to provide treatment to patients who are often reluctant to take any. Often as a result CPNs are largely abused and feel unwelcomed.

4) Paper and admin work: A hoard of paperwork and immense admin efforts required to arrange in relation to CTO. Just to mention few are paperwork in relation to Report preparation, automatic Tribunal, managers hearing, Tribunal hearing, Capacity assessment, CTO 11 or 12, Organising SOAD, Section 132, Depot

cards, Recall paperwork, Revocation, discharge: These are all must as a part of CTO and demand time from ever busier Psychiatrists.

5) Finally, and not the least, "Getting the balance right" for every staff concerned, as per the code of practice.

Despite the above challenges, CTO does work for some patients. Not completely convinced in terms of reducing number of admissions however it may reduce the length of overall admission.

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# A Discussion Around Common Criticisms of Psychiatry

by Future Doctor James Tawn, University of Leicester



Sigmund Freud and R. D. Laing © versobooks

Having just completed a year studying psychology, and with no prior experience of clinical psychiatry (bar limited primary care experience), I started my psychiatry block with some major concerns regarding the legitimacy of the profession. However, having spent time in a secondary care psychiatric unit, along with some time exploring psychiatric sub-specialties, I have a different viewpoint on some of the common criticisms of the profession.

**Argument against psychiatry:** Psychiatric diagnoses are not reliable, and diagnosis is overly influenced by the physicians' unconscious biases. Experiments such as Rosenhan's 'Thud' experiment have shown in the past that psychiatric diagnosis is often subjective and not always reproducible (Rosenhan, 1973). It is wrong to diagnose people with illnesses when the evidence base has such significant flaws, especially when diagnosis can influence the choice of pharmacological treatment.

**Counter argument:** Many psychiatric diagnoses do have limitations in their reliability, especially when compared to medical diagnoses. An examination of the Kappa values for diagnosis of several psychiatric disorders demonstrates how unreliable certain psychiatric diagnoses

are compared to medical diagnoses; many papers accept a much lower threshold for kappa values in psychiatric disorders than would be acceptable in medical disorders (Spitzer et al, 2012). Furthermore, many symptoms of psychiatric illness are non-specific, which can lead to multiple diagnosis, or a constantly evolving diagnosis. Whilst the argument that psychiatric diagnosis is often lacking in validity has some accuracy, rather than treating a patient based exclusively on their diagnosis, generally physicians treat individual symptoms of psychiatric illness. Whilst from a social and stigma perspective inappropriate labelling and incorrect diagnosis can be devastating, the lack of effect on treatment means that from a strictly medical perspective, a possibly incorrect diagnosis is not catastrophic.

**Argument against psychiatry:** Diagnosis is influenced by cultural norms. Therefore, those who have psychiatric illnesses should not be medicated, rather society should change its outlook on what is classed as 'normal'.

This criticism of psychiatry believes that the validity of psychiatric diagnosis is severely undermined by its dependence on comparing 'mentally ill' people to culturally accepted 'normal' people. Often pointed to is the fact that homosexuality was listed as a disorder in

the DSM until 1974, yet is now considered acceptable in our culture. Another point raised is that in certain cultures phenomena such as auditory hallucinations are considered normal, or a gift. This implies that the "problem" lies within our culture, and our view of these phenomena, rather than with the person themselves. It is argued that if the 'illness' is not considered an illness in certain cultures, then it is not an illness at all. As there is no physical problem to be treated, such as in medical diagnoses, it is completely inappropriate to treat these patients with drugs or imprison them in psychiatric units.

**Counter argument:** Whilst these are valid points, they cannot apply to severely unwell patients. The argument that a person should not be given powerful psychotropic medication when a diagnosis is culture-bound once again is understandable. However, the majority of people who are considered to be 'different' from those in mainstream society, such as those with Class A personality disorders or traits, will likely never present to psychiatric services, and therefore will never be given psychotropic medication or have their liberties restricted. When the person poses a risk to others or themselves, then I would argue that admission to inpatient units and psychotropic drugs are warranted. If these people are a risk to others, then they must be removed from mainstream society in order to keep others safe. Whilst psychiatric inpatient units may not be the perfect place to keep these patients, they are preferable to prisons, which are completely unsuitable for mentally ill people. Furthermore, in a psychiatric unit access to illicit drugs and alcohol, which could exacerbate the persons' symptoms, is restricted. This can help eliminate these problematic symptoms. Mentally unwell people have a right to be released into

mainstream society and to function to their maximum possible level as soon as possible, and without psychotropic medication these patients may never be discharged. Therefore, it is more humane to risk giving these patients powerful short-term medication so they can be released back into society where they can live a more rewarding life as soon as possible.

**Argument against psychiatry:** What constitutes a delusion? Many people outside the profession argue that psychiatrists have no right to decide what fulfils the criteria of a delusion. Examples of 'delusions' which are in fact reasonable may include a person who is convinced that the world will end imminently because of climate change, a person who is convinced that powerful corporations such as Facebook or Google are spying on them, or a person from an ethnic minority who feels as though systems such as the police are discriminating against them.

**Counter argument:** To some extent this might be true; climate change is damaging our planet, Facebook and Google are known to monitor users' activity and sell their information, and many acknowledge systemic racism is a worldwide problem.

Whilst at face value these beliefs may be reasonable, upon speaking to a person holding these beliefs it should quickly become apparent whether they are delusional or not. In practice it should be easy to differentiate between people who are concerned about feasible possibilities, and people who are suffering from delusional beliefs. Whilst delusions are often rooted in reality, when people believe that things are happening which are beyond the realms of possibility, it is likely the person is delusional. For example, whilst it is possible that google

speakers might listen in to peoples' conversations, it is very unlikely that google has implanted a camera in someones' brain to see what they're seeing. Likewise, whilst a person from an ethnic minority might have been persecuted in the past due to their ethnicity, it is unlikely that the police have broken into their home, planted bugs and cameras and have poisoned their food.

**Argument against psychiatry:** The unknown mechanism of action of most psychotropic drugs. Many psychiatric drugs, including SSRIs, are not fully understood. Whilst many may claim to know the mechanism of action of these drugs, there are still gaps in the collective medical knowledge regarding how drugs interplay with mental illness. For example, it is widely accepted that SSRIs reduce the reuptake of Serotonin. The onset of this effect happens relatively fast, so why does it take weeks before SSRIs reach maximum efficacy? (Bougerol et al, 1997). Some argue that it is unethical to use powerful psychotropic drugs with no known mechanism of action on unwell patients, especially for illnesses which appear to have their roots in lived experience rather than genetics.

**Counter argument:** Psychologists and Psychiatrists are often unfairly dismissive of the treatments that the other offers. Many might believe that because many psychiatric illnesses are predominantly precipitated by significant life events, psychological therapy, rather than pharmacological therapy, is indicated. Despite this, psychological therapies are utterly unsuitable for severely unwell psychiatric inpatients. Whilst psychological therapies often prove incredibly useful, it is difficult to perform psychotherapy on a catatonic person, or a person who cannot hold a conversation as they are too distracted by other hallucinations. Pharmacological

treatment can be key in stabilising their condition before they undergo psychological interventions. Whilst there are weaknesses to the evidence base of many of the medications in psychiatry, for severely unwell patients there is little alternative.

### **Conclusion**

Due to differences in opinion, it is unlikely that those with anti-psychiatry beliefs will ever see completely eye-to-eye with psychiatrists. To date, the response of researchers to criticism has generally been counterproductive. An example of this is the discussion around increased ventricle size and decreased brain volume in schizophrenic patients. Initially this was hailed as evidence that schizophrenia has a neuroanatomical aetiology. However, key studies have questioned this hypothesis, and the evidence now points towards antipsychotic medication leading to these neuroanatomical abnormalities in the brain. Dorph-Petersen et al (2005) showed that both typical and atypical antipsychotics caused a reduction in brain volume in monkeys, and Ho et al (2011) in an MRI study involving over 200 patients and lasting over 8 years found that the presence of antipsychotic medication and medication dose were strong predictors of these anatomical changes, even after controlling for substance abuse, illness duration and illness severity. Despite these doubts being raised, in response one researcher argued that a reduction in brain volume is actually beneficial, and large scale studies such as Kuo and Pogue-Geile (2019) refuse to acknowledge antipsychotic treatment as a confounder when examining the relationship between schizophrenia and neuroanatomical changes. These defences are counterproductive; instead the hypothesis should be challenged and research should move on.

To move forwards with respect, the profession of psychiatry needs to be more open and accepting of criticism, because only by accepting and understanding criticism can effective counter-arguments be thought up.

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## Doctors' Mental Fitness Programme, request for interested parties

by Dr Nick Stafford, Consultant Psychiatrist, Black Country Partnership FT

My name is Dr Nick Stafford, I am a consultant psychiatrist in the Black Country and an executive committee member of the General Adult Faculty. I am the Royal College of Psychiatrists' lead in supporting doctors with mental health needs. This role is part of the College's Workforce Wellbeing Committee, recently established by Dr Adrian James and chaired by Dr Mihaela Buhur. This committee reports to Council through the Education and Training Committee. We are also working in collaboration with other committees in the College as well as external agencies in the field of workforce wellbeing.

Currently one of our main projects in development is called the 'Doctors' Mental Fitness Programme'. This is an ambitious and comprehensive online system of tools designed to help doctors (and hopefully eventually other healthcare professionals) survive, stay well and thrive in the workplace. The primary function of the programme is to support doctors with a mental health problem, past history of a mental health problem or history of work-related stress. However, it will also be designed for those without mental health problems.

Those subscribed to the programme will work through a comprehensive set of psycho-education tools developed by the Committee and its collaborators. Subscribers will complete self-assessments in a number of their health, work and personal domains. They will use the results of these self-assessments to think about having conversations with their healthcare professionals, colleagues, managers and occupational health staff

as appropriate. They will also be presented with educational material to help them improve their coping abilities and skills in each area covered. Content will be evidenced-based where required.

Subscribing to the programme will require some commitment but will be as confidential as you would like, or you might wish to share some of the results with others, such as your manager. The domains covered in the programme are:

1. A review of your mental health care in partnership with your specialist. In this you will build a self-management plan considering your early-warning signs and triggers, with particular focus on your workplace. This section will have a general structure for all mental health conditions and supplemental parts for specific conditions. Common lower cluster conditions as well as more serious conditions will all be included.
2. An annual review of your job plan, so that you can highlight areas of your work that could be improved to help with your mental wellbeing.
3. A stress-risk assessment to identify stress pinch points at work that can be prevented or managed as they occur. This will cover the demands of your job, the support you receive from managers and colleagues, the role you play in your organisation, the control you have over your work, the relationships you have in the workplace and how well you can manage change.

4. Your relationship with your manager, and the conversations you can have with them about aligning the needs of your employer and your health needs.
5. Your relationships with colleagues at work, patients and their carers.
6. An assessment of your organisation's culture and strategies you might need to adapt to it.
7. An overview of your lifestyle and advice on how making adjustments to your lifestyle may make big improvements to your overall health.
8. A validated resilience assessment to help you think about your personal competencies, social competencies, family coherence, social support and personal structure.
9. As part of the resilience assessment you will appreciate the importance of your social life outside work and your family life.
10. An assessment of those things in life that are important to you and sometimes thought of as spirituality.
11. There will be additional tools to help you manage specific situations, such as being a single parent, the difficulties of being an international trainee and what to do if your workplace is particularly challenging.

We are looking for people to consult with on the Doctors' Mental Fitness Programme who:

- a. Have an interest in workplace wellbeing and the support of healthcare practitioners with mental health needs.
- b. Are doctors themselves with mental healthcare problems who would like to help advise on the content of the programme. Your confidentiality would be strictly adhered to, and your name would be acknowledged as part of the programme development only at your choice.
- c. Are psychiatric trainees with an interest in this area and might in addition have skills, as younger members, in web, app and social media development skills.

If you would like to know more about our programme please contact me:

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## What is it Like to Work in a Forensic Inpatient Unit During the Coronavirus Pandemic?

by Dr Georgina Mills, Specialty Doctor, Nottinghamshire Healthcare NHS Foundation Trust

As a Specialty Doctor working in a medium secure unit in the midst of a viral pandemic, first worries seemed overly selfish; Am I going to be redeployed?! Will I have to dust off the stethoscope and pitch up at the local general hospital hoping to beat this virus on the front line?

It's only been four years since finishing my foundation training years, yet still the thought of attempting to hear a heart murmur, pretending I know what is glaringly obvious on the chest x-ray or re-learning how to place a cannula was enough to spark the anxiety. Luckily rumours were unfounded, and I found myself continuing to work in what seemed like a strange and new environment.

The hospital meeting as the virus ramped up was unfavourably placed on a Friday afternoon, so instead of hiding in my office catching up on admin, as one would usually do by the end of the week, I found myself heading down to see how we would fight this virus!

OK, so no one really thought we would prevent the virus getting into the hospital, but it did seem much debate was over how we were going to protect our patients from it. But was that feasible? Surely, if the media was right, we were all destined to be infected anyway. But here we were considering when and how we would stop 117 leave and family visits and whether we should accept new admissions. Wow, I thought, *this is serious!*

At this point we had only been told to stay home if we had symptoms so there

was much discussion about the legality of preventing our patients' from having leave or visits. Of course, this was made much easier once lockdown came into place and lo and behold, we could hold our hands up and say, "Sorry it's not our decision- blame Boris!"

We all anticipated the uproar from the patients when we had to pass on the news that things were changing. Not only was leave cancelled, but less activities were becoming available to them- no group psychotherapy sessions, no hairdresser, less access to sports and leisure. We had to cut short of stopping shop access, then blood really would be spilled. And let's not forget the clientele we were working with here; we have some very serious violent offenders and self-mutilators in our hospital. Surely rapid tranquilisation was going to go through the roof... and did we even have enough seclusion rooms?!

The first time I recognised the impact of corona on the patients was when we had to inform one of the women's ward of the restrictions. We gathered as an MDT (safety in numbers, right?! ) for the ward meeting and hoped for the best. But it didn't erupt as we expected! A few complaints and wails here and there but the main concern, "Will our families still be able to bring us in our Easter eggs?!" Ah, I thought, *I'm not the only one who's first reaction to the pandemic was selfish!*

So, it seemed our worries about needing to build more seclusion suites and ordering more Accuphase were unwarranted. There were a few more

incidents of aggression but nothing the well-equipped hospital couldn't manage. I wasn't being called more often to rush down and review any newly secluded leave-deprived patients than before and just carried on with my normal day-to-day work.

Patients were accepting of the rules and taking up the extra support offered if needed. It seemed we had underestimated our patients who were clearly adaptable. "If anything," one patient had said to me, "it's you lot who have to deal with it- we're used to all the rules and being locked up!"

And what about dealing with the virus itself? Luckily, we've only had one confirmed case in the unit so far (touch wood!), so it seems acting early from that first meeting may have had an impact. Of course, there were procedures put in place for all coronavirus-related eventualities and we managed this well. Even using enforced shielding on incapacitated high-risk patients went without major incident.

As lockdown came in force, I noticed many changes in the running of the place. Many meetings had limited attendees, and some got cancelled all together. Ward rounds were conducted by Microsoft Teams and face to face reviews of patients were limited. But the biggest change seemed to be in the staffing.

Staffing was a big concern for the hospital- what if all the nursing staff got sick at once? What if a whole MDT had to self-isolate?! Suddenly it seemed many were no longer deemed 'essential' or

could do their work from home- including the consultants! So off they trotted to their safe home havens whilst the rest of us plodded on.

Of course, there were grumbles from the front-liners (myself included)! It not only felt like we were holding down the fort waiting for the proverbial to hit the fan, but what a lonely job it had become; no lunch with the Assistant Psychologist's or coffee breaks with the PAs. Even a lunch time wander to the local park was now prohibited.

I do seem like I am complaining now and maybe in some way I am. It was hard (and still is). But at the end of the day I was pleased and proud to be continuing to do a job I loved whilst many of my non-essential working friends had to spend their time entertaining screaming toddlers or risk pressure sores from endless hours of Netflix. It's nice to be thought of as an essential worker- even if not in the classic coronavirus-fighting-ICU-doctor fashion. And anyway, who can complain when I never had to be redeployed to the Nightingale hospital!

As I write I can see glimpses of normality returning. Shielded colleagues begin to join us and consultants have come out of hiding. Patients are seen face to face (albeit with the barrier of PPE) and are being invited back into ward rounds. Sometimes, as I sit in traffic again on the way to work, it feels as if corona was a distant memory. That is until I get a bleep as soon as I'm in the office with the news that a patient has a cough...

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# COVID-19: Perspectives of a Medical Student

by Future Doctor, Sufficient Nkomo

Getting into medical school was a high point for me in 2019. I wished that I had the prophetic power to foresee that particular year was going to be a mixed bag. I was intrigued by the amount of support we received as medicine freshers, as first years are popularly known in UK universities and beyond.

It was not long before I realised how immense and intense medical school was. Yes, training doctors is paramount, but the main reason that so much such attention was dedicated towards us, it turned out, was because of the demands of the course in terms of the sheer volume of material covered across years.

It was my very first lecture that brought me face to face with reality and right away I knew I had to stay focussed, work consistently and persistently. I savoured the challenge and did not at any point imagine what was yet to happen.

More than halfway through the course, a rare species of coronavirus broke; not only prematurely truncating our first year with all its excitements and challenges, but also bringing the entire world to a standstill. This pandemic was dubbed COVID-19 and I dedicate a few paragraphs to reflect how it impact me as a medical student.

It was towards the end of February, early this year, a few weeks after completing our first examinations (which I can safely say were an eye opener). I managed to pull through that set of exams. Soon after, lockdown was announced. I reflect on this experience as a bitter-sweet experience. It was somehow sweet in that it brought a sense of relief not only to me but to the rest of the students across all

classes if not universities. No matter how many examinations one has taken, it is one aspect of life that we can never get acquainted with or at least get comfortable with.

The relief, I argue, came from a sense of feeling of being afforded a second chance. It felt like an opportunity to regroup and take time to learn material more deeply. Examinations and the pressures that they bring deprive students the chance of studying the material deeply as there is that extra time pressure to master concepts within a defined time period and the requirement to do well in examinations.

Most of us were beginning to feel the pressure and the unannounced break came as a form of welcome relief that eased the pressure that was already mounting while time was fast running out. Although I was managing my revision relatively well, I did ironically at that point appreciate that welcome break.

I was at the same time anxious because I wasn't entirely sure whether we would return to continue our course. What made it worse was the sense of sombreness that echoed on the corridors of medical school which appeared to suggest the end of the world as we know it. There was something apocalyptic about the whole situation, I remember walking past one of the rooms where medical staff were in a meeting and I could just about see through the glass windows all medical staff intensely engaged in deep discussions. The many conspiracy theories circulating in the corridors about the coronavirus outbreak made the situation feel like the biblical Armageddon. As a mature student I not

only worried about my studies and myself but also my family in Leicester.

My institution delayed making the final announcement about suspending classes and I anxiously waited for the green light. After ceasing all classes day after day started to go by and in no time, we were getting used to the new normal.

On the other hand, the lockdown has been a bitter experience in that it deprived us of face to face teaching, placement opportunities and summative assessment. I benefited immensely from various teaching sessions and it was just after the first day of our primary rotation that the announcement to end all teaching was made and it felt as if a rug had been pulled from under my feet. I looked forward to completing my primary care placement because I had benefited greatly from secondary rotations and anticipated more opportunities for learning in my next rotation that never materialised because of the lockdown.

Although we were somehow relieved of not having to take our next assessments there was a sense of disappointment, in that the situation didn't inspire a sense of merit; it didn't make me feel personally confident because it felt as if I have been given a free pass to the second year. Summative exams would have inspired a sense of confidence to make me feel comfortable with the materials I learnt in the first year.

In terms of learning approaches, it has felt like venturing into uncharted territory. Online learning has been the main mode of delivering lectures and seminars, which is unorthodox. I missed interacting face to face with my colleagues and the sense of comradeship that prevailed. As a group we always felt a sense of responsibility towards one another and being apart

did not help to maintain these interactions. As a group one day we would have to rely on one another and team building and ability to learn and work groups begins now. That message was constantly drummed into our heads, but the lockdown appears to have reversed the progress made. As we seek to look for approaches that enrich our learning experience, we keep hoping that one day we will be able to learn and interact as we should.

Although it has been a challenging time specially to keep myself motivated, this time has been a period of personal growth and of self-discovery. Reflecting on how far we have come out as medical students, the Covid-19 pandemic has inspired in us a deep sense of responsibility that has worked positively to promote independent learning. Although this aspect of learning has been to a greater extent promoted by universities, the lockdown magnified the need to promote self-directed learning out of necessity. As doctors we will be looking after patients and it is the responsibility of every aspiring doctor to seek and to attain a standard of knowledge that meets the GMC guidelines. None of us can use the lockdown or any excuse for that matter to excuse incompetence or knowledge gaps for whatever reasons. We must seek knowledge whatever the circumstances because caring for patient requires us to rise above our daily challenges and to seek ways in which we can maintain high standards of care.

Personally, I made significant steps in independent learning. Social media and other virtual platforms have been necessitated by the lockdown and have been helpful resources. Although I have maintained a consistent study routine, I feel the lack of physical contact has deprived me of the benefits of face-to-

face learning for which there is no substitute in providing a rich experience. We are social beings and we tend to fare well in human to human interactions and technology cannot entirely compensate for our need and benefit of face-to-face interactions. In that regard the lock-down period has been a challenge and we all have, to differing extents, felt intense longing for a return to normal semblance. We long for a return to when we could freely roam the corridors of medical school, where I can stroll into the dissection room for my anatomy sessions, where I can do one of those late nights in the library. I hope one day we will be back doing what we love to do, preparing and learning to care for our patients. So far for now it is back to the new normal and hoping that there is light at the end of the tunnel.

The positive outcome of the covid-19 pandemic, however, is that it has provided a wake-up call that highlighted the need for preparedness and of thinking outside the box not only for me personally but for everyone. An important lesson relevant to me is that things don't always turn out as anticipated and one must reflect on those outcomes/events in order to inform and improve future practice. Additionally, life is very fragile, and it changes unexpectedly. I hope these lessons will help us all to mature and gain insights that will make us better practitioners in our various practises. As things stand everything has been thrown into disarray and the whole medical fraternity needs to take time to regroup, hoping we all emerge stronger and more prepared.

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## Psychiatry as a Foundation Year 1 Doctor

by Dr Tamara Chithiramohan, Leicester

My first rotation as a Foundation Year 1 doctor was in Functional Old Age Psychiatry, at the Bennion Centre, Leicester Partnership Trust. When I was ranking the vast choice of foundation year jobs, I knew that I wanted to have a rotation in Psychiatry, as I have always found it fascinating. My medical school placements had been extremely enjoyable, and I thought that a good clinical knowledge of psychiatry would be useful in all specialities.

However, when I realised that psychiatry would be my first ever placement as a doctor, I was initially apprehensive. The psychiatry job as a foundation year 1 doctor is very different to the other hospital-based jobs. One of the stark differences includes doing less clinical procedures. I knew that everyday tasks for a junior doctor, such as cannulas, fluid prescribing, even catheters, were not skills that I would practice over my job on psychiatry. Another major difference was that the psychiatry services in Leicester fall under Leicester Partnership Trust, however the hospital services fall under University Hospitals of Leicester. Therefore, working in a different trust, meant the computer systems would be completely different. And so, I was apprehensive, as I felt that I would be inexperienced compared to my colleagues in terms of doing core procedures, and managing medical problems, as well as not knowing the basic IT systems when I move onto my second job.

However, now that I am 2 months into my next job (Urology), I have realised that I had nothing to be worried about. Just like any new job, it takes time to adjust and to learn the nuances of that speciality. I was of course right that I was less

experienced than my colleagues in dealing with medical emergencies, or knowing the IT systems. However, I could learn from my colleagues, and was proactive in practicing procedures. I now feel that I have learnt a lot, and continue to improve every day. I have also used the knowledge I gained in psychiatry multiple times over the 2 months in Urology. To start with, multiple patients in Urology (and many other specialities as a whole) present with confusion secondary to delirium or long standing dementia. Secondly, we see a lot of patients undergoing massive operations or with cancer diagnoses, and many suffer with anxiety or depression associated with this. I feel that my time in psychiatry has given me the ability to appropriately address these issues with patients, and direct them to the appropriate services. Thirdly, mental health conditions can affect anyone, and so I have come across many patients with comorbid psychiatric conditions, and in some instances, I have had to utilise the mental health act. Dealing with psychiatric issues in the hospital setting can be challenging for all staff in terms of appropriate management and often patients can be labelled as "difficult". My time in psychiatry has helped me to have a better understanding of how to interact with patients with psychiatric conditions, as well as the legalities associated and appropriate management.

My four-month placement in psychiatry was incredibly enjoyable and enriching for multiple different reasons. Firstly, everyone I encountered on my placement were extremely encouraging and supportive. The start of a foundation year 1 can be very stressful, as it is a lot of responsibility to gain overnight, and it is

our first experience of the real working world. However, I felt very privileged to be in an environment where staff were approachable, and keen to teach, and so the transition into working life felt much more manageable. This was true of the nursing staff, the junior doctors, as well as the more senior doctors and consultants. It was made clear to us in induction that we can always approach any of the consultants for advice and help, which put my mind at ease. Psychiatry is a unique speciality in which junior doctors get an hour of dedicated supervision time with their clinical supervisors every single week. I have not come across another speciality which does this, and in most cases, juniors often struggle to even get their required meeting at the start and end of the 4 months! Initially, I wasn't sure what I would do with this dedicated time, however it turned out to be invaluable. I used it to discuss any queries I had at work, interesting cases, to do the required case-based discussions and to discuss career prospects and projects to get involved with. It turned out to be an extremely productive placement in terms of Foundation year 1 competencies, as well as generally for my professional development. I was encouraged to spend days in different areas of psychiatry such as liaison psychiatry and child psychiatry and all of the doctors I encountered were very keen to teach me. I also completed an audit, did teaching sessions for medical students and nursing staff, as well as led clinic consultations with the supervision of my consultant.

Of course, the clinical experience I gained was particularly invaluable. Working on a functional ward, our patients were elderly female patients with

a range of psychiatric disorders, from anxiety and depression, to schizophrenia and bipolar. And this could sometimes be compounded by a cognitive impairment or dementia diagnosis, and often a range of physical comorbidities which needed to be managed. I therefore actually spent a lot of my placement dealing with patients' physical care needs, which was extremely helpful going forward. As well as interactions with patients on the ward, we also had time in adult mental health in which we would clerk in new patients. I therefore saw many different psychiatric presentations. Often these were emotionally challenging, as patients often had traumatic personal histories. I found the presentations in which patients were actively suicidal very emotionally challenging. However, it was very rewarding to see patients improve in hospital. Some of the patients at the start of their admission seem like a completely different person by the end which was amazing to see.

I feel that the skills and knowledge that I gained through my placement in psychiatry are ones that I will use throughout my clinical career, and have hopefully made me a better clinician. Personally, this placement has solidified my interest in psychiatry, as I loved going to work every day and found it extremely fascinating, challenging and rewarding. However, I would recommend a psychiatry placement for all junior doctors, regardless of career aspirations. I think that it is a unique placement in which you can enrich your knowledge of mental health, which is important in every speciality. I look back very fondly at my first placement in psychiatry, and hope to return to psychiatry in the future.

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## Reflections: Psychiatry as an FY1

by Dr Assad Kido, Leicester

I had the lovely opportunity to have a psychiatry placement as a foundation doctor. I still remember where I was when I found out the specialities that I would have over the course of my foundation years. When I first heard this news, I initially thought it would be rather daunting going on to this job due to the usual anxieties that people have in this time, one day being a medical student the next being a doctor having to make medical decisions. In addition, some medical students also having anxieties starting on a psychiatry placement as a junior doctor due to the transition period from this onto a medical or surgical job, where seniors will now have a raised expectation of them.

I have always appreciated psychiatry as a medical student. I enjoyed my 6-week psychiatry placement and I completed a student selected module in mood disorders during my pre-clinical years. Prior to starting medical school (in my gap year) I worked as a teaching assistant closely with students with special educational needs, some of whom had psychiatric comorbidities that we would help to support in our day to day interaction with the students.

On the first day that I started on the wards, I was warmly welcomed by the clinical staff and the other healthcare professionals. They were all understanding of the fact that this was my first job and in particular, that 2 FY1's were the only junior doctors on the ward on that day. We were both very lucky to have experienced a shadowing period organised by our foundation school prior to working independently on the ward. This ensured that we were able to work confidently with the support of the healthcare staff. In this placement I made strong relationships with

the nursing staff, which not only made the work we had to do easier but also fostered a positive working environment. Because of this, I felt I could approach staff with any questions or concerns that I had and vice versa.

I was placed on an old age functional ward for four months. Although my past psychiatric experiences may not be as extensive as others, I dealt with many common presentations that I had either studied or encountered in the past. This was reassuring as it was a good balance of conditions that I was familiar with and others that were new to me. I saw a variety of psychiatric conditions from mood disorders, psychosis, anxiety, schizophrenia and on my last day delusional parasitosis. From this I learnt a lot about taking a thorough history from patient's, considering different differentials and formulating appropriate diagnoses as well as putting into place an appropriate management plan. I also learnt a lot about the legal aspects of psychiatry. This was very important because as a student we were always taught about this from a theoretical point of view; this became clear to me once I was working in the system and putting these legal frameworks into place to ensure patients are cared for appropriately and legally.

As foundation year 1 doctors we were also given twilight shift where we would clerk in newly admitted patients throughout the hospital. This was incredibly beneficial as we were able to see newly presented patients with a variety of illnesses, after this we were able to discuss them with seniors or our clinical supervisors for feedback and reflection. This helped me develop my skills in psychiatry continuously and I was able to use these skills on the ward during my

day to day activities. Our seniors and clinical supervisors were all very supportive, helping us achieve our personal goals for the placement and our requirements to complete our portfolio. We also benefited from 1-hour timetabled session with our clinical supervisor once a week; this incorporated a mixture of observing clinical examination, discussions based on my previous clinical interactions and other valuable learning points.

Despite my initial apprehensions (prior to starting the job) of doing limited physical health medicine. However due to the nature of the ward the patients had a variety of co-morbidities from poorly controlled diabetes, cancers, hypertension, heart failure, infections etc. We were well supported with other junior doctors, more senior to help us in the management of patients' physical health issues. Because of this, although I was on a psychiatric ward, I was able to independently improve in the management of physical health conditions. As I transitioned onto a cardiology job, I found that although I lacked some familiarity compared to some of the other F1's had I was able to reach a similar level as them in respect to medicine with time (yet I am still learning every day, as per the vocational nature of the job) and have my psychiatry knowledge as an additional advantage.

The main tips I would give to a foundation doctor who will be having a psychiatry placement is to make the most of being in a different medical environment. There are many opportunities that are available to make the most of such as clinics, ECT sessions and outreach. During this time, I also made valuable friendships that have

remained even after the placement. Only after starting a job on a medical ward did I realise the strong rapport and relationships that I was able to build with patients due to the amount of time I spent with patients. This was also due to the relatively long admissions patients had. Due to this I have felt invested in patient's care, endeavouring to help them, going above and beyond to do such. This also allowed patients the trust to confide in me during their hard times. As a result, I have been able to develop my communication skills with patients, relatives and other team members. This has been particularly useful in medical wards where although I have less times with each patient. I have been able to condense the skills that I have learnt to still foster good relationships with patient's, despite the rush of a ward round and other clinical jobs.

Although I currently do not have any aspirations to become a psychiatrist, I used this placement as an opportunity to learn as much about psychiatry as I can. I also learnt a lot of transferrable skills from this placement, this was important for me as a lot of psychiatry is interwoven in all aspects of medicine. Patients can often have psychiatric co-morbidities that need to be managed on the wards or in the community, not all of which needs to be referred to a psychiatrist. If anything, referring to a psychiatrist may even delay a patient from getting better if the management plan is clear. If I had the opportunity to choose my foundation placements again, I would definitely choose a psychiatric placement as I learnt so much from it that I will use with me throughout my medical career.

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# Views, experiences and opinions of physical health care in individuals with severe mental illness: a qualitative research study

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Dolly Sud, Senior Clinical Pharmacist (Leicestershire Partnership NHS Trust) & PhD student (Aston University, outlines the protocol for this original research study. This is followed by some personal reflections and commentary on some initial findings. Although the study protocol focuses on the role of pharmacy, the research study itself revealed broader and important issues including perceptions of information received around medication side effects, understanding of the role of pharmacy and impact of medication side effects on daily life. A unique aspect to this study is recruitment of service users and **their** carers (aka dyad).

Webpage for research study:

<https://www.leicspart.nhs.uk/about/research-and-development/research-featured-study/cardiophitness-research-study/>

Most recent newsletter:

<https://www.leicspart.nhs.uk/wp-content/uploads/2020/01/Study-Newsletter-January-2020.pdf>

## **1.0 Background**

Individuals with Severe Mental Illness (SMI) (e.g. schizophrenia, bipolar affective disorder) have a higher risk of physical illness<sup>(1)</sup>. These physical illnesses exist within the general population, but their incidence and impact on morbidity and mortality in those with SMI is significantly greater<sup>(2)</sup>,

resulting in a 20% shorter life expectancy<sup>(3-6)</sup> and a two-to-three-times higher mortality rate<sup>(7-10)</sup>. This gap exists in countries considered to have high standards of healthcare<sup>(11)</sup> and can in part be accounted for by a higher relative risk (around one- to five fold)<sup>(12)</sup> for cardiometabolic risk factors and metabolic syndrome. For example, in England 40.5% of adults who have SMI are smokers<sup>(13)</sup>, more than double the proportion of smokers found in the general population (15.5%)<sup>(14)</sup>.

Not only is diet poor<sup>(15,16)</sup> in individuals with SMI levels of obesity (40-60%) are up to four times higher than in the general population<sup>(17-19)</sup>. Metabolic syndrome is one of the most prevalent risk factors for developing cardiovascular disease (CVD) in those with SMI<sup>(20,21)</sup>. Thirty-seven per cent of those with chronic schizophrenia have metabolic syndrome<sup>(22)</sup> compared with 24% in the general population<sup>(22)</sup>.

Antipsychotics, used to control psychotic symptoms in SMI, are associated with physical side effects including weight gain (more common with newer antipsychotics)<sup>(23,24)</sup>; the greatest weight gain occurring in the first few months of use<sup>(23,25,26)</sup>. Weight gain also occurs with antidepressants (used to treat negative symptoms in SMI), and mood stabilisers, including valproate/valproic acid and lithium salts<sup>(27)</sup>.

Physical ill health in SMI may be due to a genetic predisposition, although lifestyle factors such as poor diet, smoking and obesity/overweight play a prominent part<sup>(28)</sup>. In addition, for those with SMI, inequity in access to and quality of care exists<sup>(29–31)</sup>.

'Medicines optimisation is defined as a person centred approach to safe and effective medicines use to ensure that people obtain the best possible outcomes from their medicines'<sup>(32)</sup>. Medicines optimisation is an important consideration in those with SMI. Intolerable side effects are a significant contributor to non-adherence with psychiatric medications<sup>(33)</sup>.

Metabolic side effects such as central obesity/weight gain, further contribute to lack of adherence<sup>(33–35)</sup>. Research studies investigating the use of strategies such as adherence therapy, cognitive-behavioural and motivational strategies for those with schizophrenia to improve medication adherence have yielded varying results<sup>(35)</sup>.

Pharmacists are experts in medicines optimisation and have knowledge, for example, about side effects, adverse drug reactions, screening and interpretation of blood tests, choice of medication and strategies to improve adherence as well as being an important part of the multidisciplinary team<sup>(36)</sup>. In addition, they can provide information, tools and signposting to facilitate positive lifestyle changes such as smoking cessation<sup>(37)</sup>.

Currently, pharmacists work in many different environments<sup>(38)</sup>.

- Community pharmacies (sometimes called retail or high street pharmacy) and hospitals. Most pharmacists work in community and hospital pharmacy. This includes specialist mental health pharmacists
- Pharmaceutical industry (e.g. drug development)

- Prisons, primary care organisations, universities in teaching and research, the military, veterinary pharmacy and pharmacy organisations

The views and perspectives of patients with SMI, their carers and care professionals are crucial in understanding the current and potential roles that pharmacy could play in the management of cardiometabolic risk factors, metabolic syndrome, diabetes, heart disease and related disorders.

This research study has been informed by a previous literature review on this topic<sup>(39)</sup>; to our knowledge there is no published literature that investigates or explores patients', caregiving dyads, carers or care professionals' perspectives of how they view and utilise pharmacy for support. In addition, nothing exists which attempts to triangulate the views of these key stakeholders on these issues. The small amount of experiential data that does exist has not been subject to any qualitative analysis or synthesis. We could not find any studies have purposively sought the perspective of service users, their carers or care professionals, rather it was collected incidentally. This study was therefore undertaken to address this gap<sup>(40–49)</sup>.

Ultimately the aim is to reduce the inequalities in health that exist for individuals with SMI by improving the physical health of those with SMI. Here, we propose to examine in detail the role of pharmacy, pharmacists and to improve physical health in people with SMI.

## **2.0 Aims and objectives**

The overall aim of this research programme of work is to explore the place and contributions of pharmacy in providing support and care (including lifestyle and medicines optimisation) for cardiometabolic risk factors and metabolic syndrome for individuals with SMI.

This study had four main objectives:

1. To examine and understand the experiences and views of patients with SMI and their informal carers about care received for cardiometabolic risk factors, metabolic syndrome, diabetes, heart disease and related diseases;
  2. To examine and understand how patients with SMI and their informal carers engage with activities for cardiometabolic risk factors, metabolic syndrome, diabetes, heart disease and related diseases;
  3. To explore the views of patients with SMI and their informal carers on whether and how they utilise pharmacy for care and support for cardiometabolic risk factors, metabolic syndrome, diabetes, heart disease and related diseases;
  4. To explore the views and experiences of care professionals on providing care for cardiometabolic risk factors, metabolic syndrome, diabetes, heart disease and related diseases; as well their views on pharmacy and pharmacists providing this care.
- 21 care professionals (3 consultant psychiatrists, 1 speciality registrar in psychiatry (St5), 1 core trainee in psychiatry (CT2), 1 specialist mental health dietician, 1 physical health nurse working within psychiatry, 6 mental health nurses, 6 GPs, 1 occupational therapist, 1 mental health support worker)
  - 11 pharmacists (5 mental health pharmacists, 5 community pharmacists, 1 GP practice pharmacist)
  - 8 adult carers (6 of whom were dyads defined as people each of those service users nominated as a person they get a significant amount of support from who is not a care professional)

### **3.0 Study design**

An exploratory qualitative study design that will follow Consolidated Criteria for Reporting Qualitative studies (COREQ) guideline will be employed <sup>(50)</sup>. This will be undertaken using semi-structured interviews where participants provide a detailed account of their views guided by an interview schedule. The setting will be in both primary care and secondary care in the UK. The target population are individuals aged 18 and over with SMI, informal carers of those with SMI and care professionals directly involved in their care.

### **4.0 Progress/current position**

Between February and September 2019 56 participants were recruited to this research study as follows

- 16 adult service users who have a diagnosis of SMI

### **5.0 Reflections and commentary on initial impressions**

Data from this research study is currently being analysed and reviewed. Some initial reflections on the findings important for practice:

- most service users could not recall receiving any information about side effects of psychotropic medication directly from a healthcare professional (e.g. face to face, part of consultation);
- the severe mental illness medication journey is a complex and very difficult one. Service users and carers describe in great detail and depth experiences of side effects that impact significantly on quality of life and ability to function whilst still experiencing residual symptoms of severe mental illness. In particular many described the hounding, perpetual and unfaltering impact on hunger, craving and appetite for carbohydrate and fat rich foods.
- Awareness of pharmacy and pharmacists' roles amongst most participants was limited. Greater presence within secondary care multidisciplinary teams and interdisciplinary working appears to be highly desirable but not borne out in practice. Interaction with community pharmacists was described by many

- service users and carers as being of a purely transactional nature
- Inclusion of dyads provides important perspectives on the experience of care for both mental and physical health for those with SMI in particular how the relationship between service users and carers can impact on health.

## **6.0 Conclusions**

As far as we are aware this is the first research study looking at the role of pharmacy in providing support for physical health and also the first to recruit caregiving dyads of those with SMI. The findings will be useful in informing care from both medicines related and physical health perspective. Currently, the full dataset is being analysed and findings will be available in due course.

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## Interview: Dr Avinash Hiremath

New Medical Director of LPT & Consultant Psychiatrist in Intellectual Disability



What are the challenges you have faced during the COVID-19 pandemic in your new role?

I used to read about the VUCA world; Volatile, Uncertain, Complex and Ambiguous, and the challenges that come with such environments. The COVID-19 experience was the real VUCA experience. The situation is unprecedented and unparalleled and has challenged everyone in terms of their values and their outlook; not only colleagues but also patients. The real challenge is to get through this with confidence and hope, and to be able to summon that within myself and others, as a leader, is one hell of an ask. I have been fortunate to work with some great colleagues in LPT who just get on with doing what they do best, and I am surrounded by people of great calibre who have helped me stay steady during these times.

As I said, the real challenge is one of confidence and hope, that we will get through this and it will be ok soon.

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

Hidden with the seeming gloss of a successful career is a litany of failures; a failed cricketer, an unpublished poet/writer etc. But many people may not know that I am a half-decent cook, who can put together a 3 course meal and leave the kitchen spotlessly clean (by a man's standards, which aren't that bad really, I don't know why women stereotype us a certain way!!) at the end of that cooking adventure.

What trait do you deplore in others?

Lazy parking with that rear wheel just encroaching into half a foot of what would have been a decent space in a full car park; leaving unclean cups in the office sink when you are caffeine dry and no dishwasher liquid in sight; misplacing the TV remote when your favourite show is about to come on; the friendly customer in front of the Q leaving the shopping till with all their stuff on the belt having suddenly remembered that one item on which their life depends.....life's many but smallish frustrations.

But, on a serious note; we are all the victims or victors of our own experience and circumstances. Behind every deplorable trait is a story; and being open to that story is truly emancipating; to not have to judge someone. I am trying to learn how to do that. If any of you out there have mastered it, please tell me how.

But I still don't get why someone can't park properly though!!!!

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

Ok, this is exciting. I can share with total enthusiasm as books and movies are my best friends. I am sure you will kindly indulge me; three books and two movies.

The Mahabharata; it's an Indian mythological epic and is thought to be the longest poem ever written going back thousands of years. I think there is an answer to everything about life in that epic.

Siddhartha by Herman Hesse; it's the most beautiful description of a journey of spirituality I have had the pleasure of reading.

Jonathan Livingston Seagull by Richard Bach; uplifting and inspirational.

There are so many movies, but the two I would watch again and again are: Life is Beautiful; intensely moving Italian movie; about a Father who does everything he can to preserve his son's innocence in a Nazi concentration camp Kaagaz ke Phool (translated as "flowers of paper"); a 1950's Indian film about a movie-directors' encounters with his own existential angst and the opportunistic world around him.

#### [When not being a psychiatrist, what do you enjoy?](#)

Everything that I am lucky to enjoy. Spending time with friends and family. And when I get time to myself, my sanctuary has the following:

Books; I am currently reading works by the Japanese author Haruki Murakami.  
Music; I listen to anything that makes me feel good, currently into Indian classical.  
Movies; where is that remote now!!!

#### [Which people have influenced you the most?](#)

Most people who have touched my life have left me with the gift of experience; and that includes teachers, friends, family, colleagues and my patients/their families.

My biggest influence was undoubtedly my Father. He came from nothing and was able to build a life for himself and family through sheer discipline, hard work and determination. We disagreed on many things but shared a deep, albeit hidden affection for each other that we never got around to expressing properly. He is there somewhere up there peacefully watching over me, and hopefully I will make him proud someday.

#### [If you were not a psychiatrist what other profession would you choose?](#)

A professional sky diver, or a rally car driver. I haven't done either but maybe, maybe someday!!!!

Thinking of what gave me joy growing up; I enjoyed teaching, theatre and writing. Guess I might have found comfort in any activity that challenged me and allowed me to express myself best, but I guess I responded to the calling that was truly meant to be and chose Psychiatry. If the mind and heart remain true and youthful, I might do something different with my time in my later years' but I am in a good place now. The most exciting part of the future is the unexpected journeys it takes you on and I just wish it continues to enthral and excite.

#### [How would you like to be remembered?](#)

Well, I don't believe in being remembered really. But if I am able to touch as many people as I can with kindness, goodwill and compassion; and they in turn spread the same, that would be most fulfilling. Isn't it beautiful if we can all bequeath the best of us through deeds and actions and that lives on through others? What's in a name or identity anyway!

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## Trent Division Annual Conference

**All College physical events are on hold for 2020. The College is looking into online solutions where appropriate.**

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## Poster Presentation Prizes

**All prizes are currently on hold for 2020.**

Topics: quality improvement, audit or research.

The prizes are open to student associates, trainees and specialty grade doctors working in psychiatry within the Trent Division.

To enter candidates should submit an electronic PDF copy of their poster along with an abstract of approximately 500 words to [Trent@rcpsych.ac.uk](mailto:Trent@rcpsych.ac.uk)

Shortlisted candidates will be invited to display their poster (maximum size A0) at the Trent Division Annual Conference.

First Prize of £100 and a certificate will be awarded to the best poster presentation by a Student Associate, FY1-2, a CT1-3 trainee and by a ST4-6 trainee or specialty grade doctor, who will also be required to give a 7 minute presentation plus 3 minutes for questions at the conference. The first place entrants will be notified 4 weeks prior to the conference in order to have time to prepare the presentation and given complimentary admission to the conference.

Second Prize of £50 and a certificate will be awarded on the day.

Shortlisted Student Associate/FY1&2 entrants will receive complimentary admission to the Trent Division Annual Conference.

Shortlisted trainees CT1-3/ST4-6/specialty grade doctors will be required to pay for admission to the Trent Division Annual Conference.

Please see the [Regulations Document](#) for more details.

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## 2019 Poster Prize Winners

**1<sup>st</sup> Prize FY1-2: Dr Tamara Chithiramohan**, A Meta Analysis: The Association between Maternal Postnatal Depression and Offspring Psychiatric Outcomes in Adolescence and Young Adulthood

**2<sup>nd</sup> Prize Student Associate: Danielle Williams**, Why Eurocentric medicine needs to globalize. My elective in Sierra Leone

**1<sup>st</sup> Prize CT1-3: Dr Samreen Samad**, Mental Health Life Support (MHLS) an innovative strategy for improving preparedness in Foundation Doctors

**2<sup>nd</sup> Prize CT1-3: Dr Emma McPhail**, An audit of safety assessment, safety plan and care plan quality and recording within South Derbyshire CAMHS

**1<sup>st</sup> Prize ST 4-6: Dr Robert Bartram and Dr Ryan Dias**, Bitesized Teaching

**2<sup>nd</sup> Prize ST 4-6: Dr Kaanthan Jawahar**, Evaluation of an alcohol related brain injury (ARBI) diagnostic service pilot

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## Executive Committee

The Trent Division Executive Committee meets four times a year at different Trusts within the Trent Region.

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

The next meeting takes place via Microsoft Teams at, 9.30am-12.30pm on Wednesday 20 January 2021.

## Vacancies

- CPD Lead
- Rehabilitation and Social Psychiatry Representative

To apply for the post please forward the following to the [division office](#):

- an up to date CV
- the name and contact details of two referees (who must be Fellows or Members of the College but not a member of the Education and Training Committee).

**Closing date:** Friday 4 December 2020

Applicants should have held a substantive Consultant or Specialist Associate post for at least 2 years, however this requirement may be reduced to 1 year with the agreement of the Regional Advisor.

Find out more about our [Regional Advisors and Speciality Representatives](#) roles, including full job descriptions.

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## Section 12(2) and Approved Clinician Training Courses

Online courses for Section 12 approval induction are now up and running. Updates will be published on the College website, here:

<https://www.rcpsych.ac.uk/events/conferences/section-12-and-approved-clinician-training>

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## Get Involved!

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