



Trent Division Newsletter

Summer 2019

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Editorial

Dr Samuel Tromans and Dr Lesley Thoms, Co-editors



Dear Colleagues

We hope that you enjoy the Summer 2019 Trent Division e-newsletter, which contains an eclectic range of articles, including:

- Mindfulness in Clinical Practice
- Reflections on a Journey Leading to becoming a RCPsych Star
- Work on Recruitment and Retention of Psychiatry Trainees
- An e-Interview with Leicestershire Partnership NHS Trust Medical Director Dr Sue Elcock

As always, we are very thankful to contributing authors throughout the Trent region, and hope that their articles generate a lot of interest and debate.

If you are interested in contributing to the next edition of the e-newsletter, please email Marie on 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.

We would like to finish this editorial by saying that we will both be leaving as editors after publication on this issue, to focus on other projects, including our respective PhDs. It has been an absolute pleasure to work together as co-editors over the past couple of years, as well as working with Yousuf (Zakaria) for the previous years. We are also very grateful to Marie for her support and hard work in supporting production of the newsletter, as well as Anand and Chris (Rusius) for their support as the chairs of the Trent Division over recent years.

Finally, we would like to thank everyone who has submitted articles, partaken in e-interviews or contributed to the newsletter in any other way over the past four years. It is very much appreciated, and without your efforts, the newsletters would not have been possible (or, at the very least, would have been extremely brief ;)).

Best wishes
Sam & Lesley
Co-Editors of the RCPsych Trent
Division Newsletter

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Welcome

Dr Anand Ramakrishnan, Trent Division Chair



As usual, this newsletter brings you a lot of information, ideas and networking bits to keep you busy for a few hours.

It's been a busy time with lots of activities of various faculties and our division in our area. In March there was Faculty of old age psychiatry conference at East Midlands Conference Centre which was well attended. In May, for the first time, Trent division joined hands with RCPsych Northern Ireland to hold a joint meeting at Belfast in the salubrious and fantastic Titanic centre. We had a unique opportunity to meet, mingle and exchange ideas and information with many leading luminaries in psychiatry in Northern Ireland. Thanks to Dr Gerry Lynch, Chair of the RCPsych Northern Ireland and his efficient team for excellent organisation of the two-day event.

Our carer representative on the Executive Committee, Rachel Bannister was a participant and speaker in a keynote programme at International Congress, of RCPsych at London in early July.

We have finalised the programme for our Trent annual conference on Friday 8 November 2019 at the Double Tree Hilton Gateway Hotel, Nottingham. The registration has started and hopefully we will build on last year's attendance as we have an extremely well organised programme.

There are other significant issues facing the membership, like elsewhere in the country due to cut in funding, lack of resources, severe workforce issues both medical and nonmedical and pension tax issues facing many consultants and other senior doctors. These issues along with the political situation in the country point to an un-settled, difficult and tumultuous days and weeks ahead. Let us work together and strive for a better tomorrow where we are better off and feel energised with improved morale to look after our patients with due care and skills that they deserve.

Best wishes

Dr Anand Ramakrishnan

BSc, MBBS, DPM, MMedSc, MSc, FRCPsych
Chair, Trent Division, Royal College of Psychiatrists

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Mindfulness in clinical practice

by Dr Sophia Senthil MBBS, MRCPsych

Consultant Psychiatrist, Lincolnshire South Integrated Community Mental Health Team, Lincolnshire Partnership NHS Foundation Trust

In this blog I intend to explain what mindfulness entails. I have briefly referred to the science behind it before exploring how it is used in different psychotherapies, and my own learning experience of Mindfulness-Based Cognitive Therapy (MBCT).

What is mindfulness?

Mindfulness is translation of term from sati language that means "awareness" or "bare attention".

Jon Kabat-Zinn (1994) described mindfulness as "paying attention in a particular way; on purpose, in the present moment, and non-judgementally" (pg. 4).

On purpose: mindfulness is the deliberate paying of attention to experience as contrasted with 'autopilot mode', where we act with less than our full awareness of what we are doing.

In the present moment: mindfulness emphasises paying attention to our experience as it unfolds moment by moment, as opposed to being caught up in plans or worries about the future or recollections about the past.

Non-judgementally: mindfulness encourages us to pay attention to experience with an attitude of friendliness and curiosity in order to be able to explore it fully, rather than reacting with hasty (and sometimes habitually negative) judgements.

Definitions below narrate different ways of explaining this concept:

"keeping one's consciousness alive to the present reality" (Hanh, 1976, p. 11)

"Facing the bare facts of experience, seeing each events as though occurring for the first time" (Goleman, 1988, p. 20)

"Mindfulness involves intentionally bringing one's attention to the internal and external experiences occurring in the present moment" (Marlatt & Kristeller, 1999, p. 68)

"In a state of mindfulness, thoughts and feelings are observed as events in the mind, without over-identifying with them and without reacting to them in an automatic, habitual pattern of reactivity" (Bishop et al., 2004, p. 232)

History of mindfulness dates back to 2500 years ago when Buddhist teachings embrace a number of mindfulness practices and methods for developing and sustaining mindfulness and benefits of engaging in practices. Towards the end of 19th Century, mindfulness approaches evolved gradually but steadily into European and North American countries, receiving boost by the psychedelic movements in 1960s.

Although mindfulness can sound quite ordinary or spontaneous, it is the antithesis of mental habits in which the mind is on automatic pilot and in this usual state, awareness is dominated by a stream of internal comment which overlooks or is insensitive to what our immediate experiences are.

Mindfulness is a method of practice whose intended outcome is quality of paying attention that is sensitive, accepting and independent of any thoughts that may be present.

In psychological terms, practising mindfulness leads progressively to awareness of and freedom from mental conditioning.

On this basis, two components of mindfulness include the capacity to direct and maintain receptive awareness and to sustain an awareness or accepting attitude towards all experience (Bishop et al 2004).

Mindfulness, as a therapeutic tool, is the development of the ability to recognise and disengage from mind states characterized by self-perpetuating patterns of ruminative or negative thoughts

Not surprisingly mindfulness involves self-regulating the attention of the brain so that it is maintained on immediate experience, thereby allowing for increased recognition of mental events in the present moment, and orientation to experience that is characterized by curiosity, openness, and acceptance. This involves the shift of mental gears from 'doing mode' to 'being mode'.

How does the brain pay attention and what are the challenges to mindfulness?

Key functions of the brain are holding onto information, updating awareness and seeking stimulation and the key mechanisms involved are Dopamine, the gate to awareness and the Basal Ganglia.

Human beings evolved continually scanning and shifting wide focus of attention in order to survive the 'monkey mind'. This generic, hard-wired tendency

varies in the normal range of temperament, extending from 'turtles' to 'jackrabbits'. Life experiences such as painful or traumatic events can heighten scanning and distractibility. Modern culture with its fire hose of information and routine multi-tasking causes stimulation-hunger and divided attention.

Mindfulness and science

"Mindfulness in the scientific domain is largely unconsidered outside the fields of philosophical and religious studies" (Dane, 2011, pg. 998). However, the brain has been studied in people practising mindfulness and other forms of meditation; EEG studies reveal significant increases in alpha and theta activity during meditation. It has been postulated that mindfulness can help to tune into the changes in sensations in the body. This ability is thought to be associated with the right anterior insula (Craig, 2009), an area that is larger in those who practise meditation (Luders, 2012), which correlates in size with the length of mindfulness meditation practice. In people with no experience of mindfulness training, fMRI indicates that strong emotions tend to evoke a response in the right insula cortex, which is associated with activity in the ventromedial prefrontal cortex (Farb et al, 2007). This is related to self-referential processing, such as rumination, in which one is caught up in emotions. Mindfulness training leads to a decoupling of the insula with the ventromedial frontal cortex and a correlation with activity in the dorsolateral prefrontal cortex. The latter is associated with the ability to label and be more accepting of emotions (Lieberman et al, 2011) that leads to down regulating limbic activity.

Mindfulness for clinicians

When a clinician is more able to sit with their own distress and underlying emotional terrain, he/she is better able to do the same with their patients. This ability to connect to, rather than reflexively try to remove the patient's emotional difficulties, helps to deepen the therapeutic alliance and facilitate longer-term engagement and cooperation with treatment. There is growing evidence that mindfulness in clinicians has a positive effect on therapeutic relationships (Razzaque et al., 2013), improves clinical outcomes and helps to avoid burnout.

RAIN is an acronym for four-step process for mindfulness which involves Recognizing what is happening, Allow what it is, Investigating your experiences and Non-identification, wherein the sense of self is not merged with or characterised by your thoughts or feelings.

Mindfulness in psychotherapy

Mindfulness places 'attention' at the heart of the psychotherapy. Karen Horney (1951) described attention as being the foundation of the analyst's technique and insisted on three qualities of the therapist: whole-heartedness, comprehensiveness and productiveness. In essence, how attention can 'get something going' in the therapy for the patient in terms of their self-awareness and self-realisation.

Mindfulness-based Stress Reduction (MBSR; Kabat-Zinn, 2003): MBSR is a programme that teaches participants to cope with stress, pain and illness by focusing on the present, with an attitude of curiosity and acceptance. Jon Kabat-Zinn, molecular biologist from University of Massachusetts, Boston, was inspired by Buddhist teaching and yoga. He developed a set of practices to benefit the

patients he saw in the chronic pain clinic to relieve their suffering. Since there has been a considerable body of research evidence into efficacy of this practice, it became clear that MBSR training enables people to deal better with chronic pain.

Dialectic behaviour therapy (DBT; Linehan, 1987): DBT emphasises the psychosocial aspects of treatment and operates on the belief of mindfulness for individuals who are prone to react with greater intensity to emotionally stimulating situations.

Acceptance and commitment therapy (ACT; Harris, 2009; Hayes, 2004): ACT uses acceptance and mindfulness strategies, alongside commitment and behaviour change strategies, to encourage acceptance of that which cannot be changed and action in that which can.

Compassion-focused therapy (CFT; Gilbert 2010): CFT focuses on increasing positive emotion in individuals, particularly those from abusive, neglectful or critical backgrounds.

Mindfulness based cognitive therapy (MBCT; Teesdale, 2010): MBCT combines cognitive therapy with mindfulness practice for repeated bouts of depression.

MBCT was developed by the joint efforts of Zindel Segal, Mark Williams & John Teesdale. The main principles are recognizing, de-centering of thought pattern, witnessing them and as an aspect of experience rather than being completely immersed in them as the whole of experience.

MBCT is a manualised, class-based skills-training programme that is designed to enable patients to learn skills that can

prevent the relapse/recurrence of depression. It combines intensive training in mindfulness meditation with psychological education and elements of CBT for depression.

Aims of MBCT are to recognize and disengage from mind states characterized by negative thoughts and see such thoughts as negative events rather than facts.

Participants (typically 8–15) meet together as a group for a 2-hour class, once a week for eight weeks. There is an emphasis on experiential learning. Classes include guided meditation practices, psycho-education about depression, CBT exercises and discussion. The programme includes up to an hour of 'home practice' per day (which consists mainly of guided meditations using a set of CDs or audio downloads).

Meditations include 'formal practices', such as a 'sitting meditation' and the 'body scan', as well as 'informal practices', such as tuning into the breath or body as one goes about one's daily life.

As the programme proceeds, participants are encouraged to deliberately 'turn towards', investigate and 'be with' difficult thoughts, feelings and sensations. Participants increasingly recognise habitual maladaptive cognitive processes, such as depressive rumination and become more skilled at disengaging from these unhelpful processes. For example, by re-directing attention to the present moment experience, participants develop greater levels of meta-awareness and move towards observing thoughts as transient mental phenomena, rather than as facts or accurate descriptions of reality. They therefore bring a less judgemental and more compassionate attitude to the flow

of thoughts, feelings and sensations that they experience.

MBCT Evidence

The first randomised controlled trial (RCT; Teasdale et al, 2000) compared MBCT with treatment as usual (TAU) for people with recurrent depression, who were in remission/recovery. It included 145 patients across three sites; patients were medication-free at the time of entry to the trial. A replication study (Ma & Teasdale, 2004) at a single site included 75 patients. Both trials showed differential effects relating to the number of previous episodes. In the subgroup of participants with three or more previous episodes of depression, MBCT was associated with a reduction in relapse rate by about a half. In the subgroup with two previous episodes of depression, MBCT was associated with a non-significant increase in relapse rates. These two RCTs led to the inclusion of MBCT in the 2004 NICE guideline CG23 (NICE, 2004).

Personal reflection

My reflection on mindfulness is that learning the skills and practising informally and formally has helped me to deliberately introspect or tune into my thoughts, motivations and feelings. It has helped me to deliberately acknowledge people's states, feelings and motivations and thereby handle situations, make better decisions and face challenges effectively.

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Clinical audit on polypharmacy and interactions in Old Age Psychiatry in-patient ward

by Beth Brailsford, Dr Mohanbabu Rathnaiah, Dr Thomas Tribedi, Patricia Mabeza, Dr Claire Fischer, Dr Ayesha Bukhari, Dr Nisha Mokashi

Nottingham Healthcare NHS Foundation Trust

Background

Multi-morbidity is considered to be more than one long-term medical condition being present in an individual [1]. Often closely associated with multi-morbidity is polypharmacy [2]. It refers to the use, by a single individual, of multiple medications concurrently. The King's fund report proposes two kinds of polypharmacy: 1) appropriate polypharmacy: to describe optimised and evidence-based use of multiple medications to manage complex and/or multiple co-morbid medical conditions, 2) problematic polypharmacy: if the various medications prescribed are not in the best interests of the patient [1].

The risks of drug interactions and adverse drug reactions have been found to be increased with polypharmacy [3]. Furthermore, use of additional herbal medications can lead to undesired interactions and side effects [4]. Many of the psychotropic medications commonly used in managing mental health disorders can lead to side-effects, particularly in the group of frail elderly patients [5].

Care Quality Commission (CQC) recommends a minimum frequency of annual medication reconciliation and reviews [6]. NICE and local guidelines emphasise the importance of identifying at-risk individuals, highlighting the elderly with chronic conditions [7, 8].

Aims and Standards

The aim of the clinical audit was to identify evidence of problematic polypharmacy, if any, in the records of in-patients in the last year in Cherry ward, an old age psychiatry unit at Highbury Hospital, and to measure this against a standard of 100% for recognising problematic prescribing. The criteria for problematic polypharmacy will be based on the King's Fund 2013 recommendations report "Polypharmacy medicines and optimisation" [1].

Methodology

Data from all the in-patients, who were admitted and discharged from Cherry ward within the period of one year from January 2018 to December 2018 was selected, to examine for any evidence of polypharmacy and interactions. The main source of information was the documentation in Rio electronic records, including progress notes and discharge summaries. Analysis of the first 43 patient records is presented in this article. Analysis was completed between January 2019 and May 2019.

A pragmatic approach, based on King's fund report, was adopted to identify higher risk polypharmacy:

- All patients with 10 or more regular medicines (for example, those medicines taken every day or every week)

- Patients receiving between four and nine regular medicines who also:
 - have at least one prescribing issue that meets criteria for potentially inappropriate prescribing
 - have evidence of being at risk of a well-recognised potential drug–drug interaction or have a clinical contraindication
 - have evidence from clinical records of difficulties with medicine-taking, including problems with adherence
 - have no or only one major diagnosis recorded in the clinical record
 - are receiving end-of-life or palliative care (where this has been explicitly recognised).

Standard Microsoft tools including Excel were used in the analysis and reporting of results. Medication interactions were investigated using the Medscape drug interactions checker tool [9] and BNF interaction tool.

Results

The average age of the forty-three patients analysed was 75 years old; on average, they had five comorbidities, stayed as an in-patient for 62 days and had a total of eight medications on discharge.

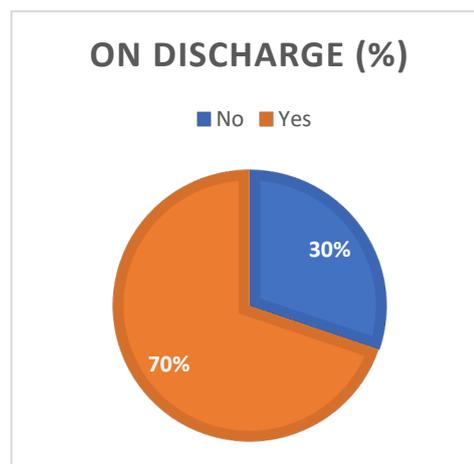


Figure 1: Higher-risk polypharmacy discharge

On discharge, 30 of the 43 patients were at higher-risk of polypharmacy (69.7%); 13 patients (30.2%) were not at higher-risk of polypharmacy [Figure 1]. One patient was at higher-risk of polypharmacy on discharge, having not been at a higher-risk when admitted. Conversely, two patients went from being at higher-risk of polypharmacy on admission to not being at higher-risk on their subsequent discharge.

The total number of patients with a severe interaction recorded was eight (18.6%) [Figure 2]. Of these, one had four severe interactions and the other seven had only one severe interaction.

When all other interactions were taken into account, 31 of the 43 patients had at least one recorded; the maximum number of any other interactions was 22. None of the patients had a record of taking any form of herbal medication.

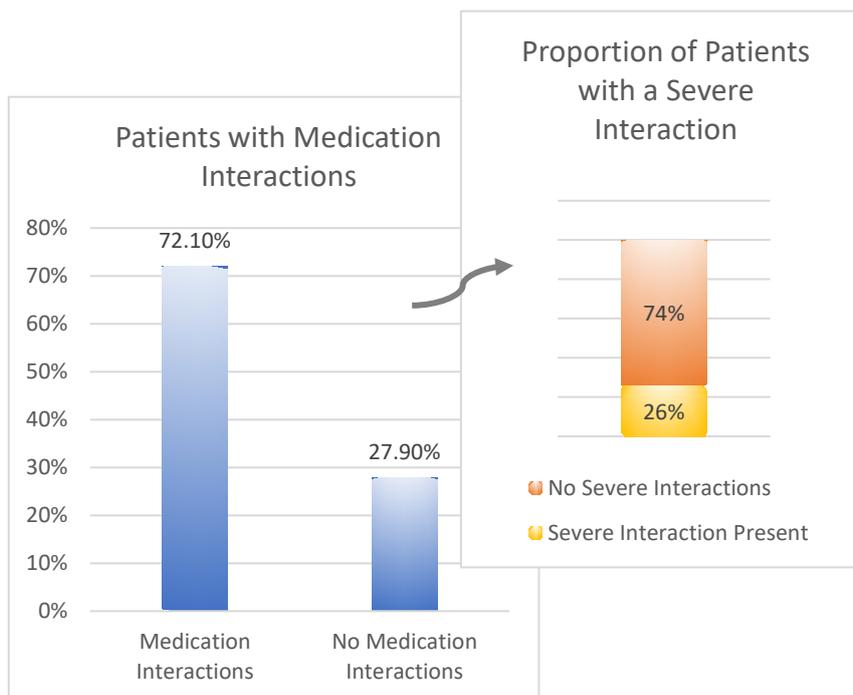


Figure 2: record of those with and without a medication interaction; of those with a medication interaction, the proportion of those with a severe interaction is shown on the second graph.

Discussion and Conclusion

Audit results re-iterated the known fact that a significant proportion of the patients (around 70%) were at a higher-risk of polypharmacy. However, this reflects current practice outlined in the literature; problematic polypharmacy was found to be common among older patients hospitalised with psychiatric illness [10], and the King's Fund report highlighted the high prevalence of hospital-based polypharmacy [1]. Different assessment tools were utilised in these studies, but emphasising the importance of interpretation occurring within the clinical context was a common theme [1, 10]. Following standardised criteria enabled more consistent and efficient medication reviews to be undertaken [11] allowing the identification of problematic polypharmacy [1].

Identification of groups of 'at-risk' patients may partly depend on

diagnostic programming that is adequate enough to facilitate automatic analysis of clinical notes, including incorporation of existing databases of drug interactions and contraindications [1]. Currently, Cherry ward employs paper drug cards without an equivalent to the electronic prescribing system to which clinicians in hospitals and GP settings have become accustomed. Finally, herbal medication is not routinely inquired about, thus, it is inappropriate to draw conclusions based on lack of documentation.

In conclusion, the audit results reveal that the frequency of the occurrence of polypharmacy in Cherry ward is similarly high compared to wider literature. The audit highlights the importance of implementing a template for the recognition of problematic polypharmacy, including severe interactions, along with considering electronic prescribing and using an

appropriate secure app for medication review and dispensing.

Recommendations

- 1) Audit results will be disseminated to all the staff involved in clinical care and the ward doctors will be provided training as part of their induction to recognise and act on problematic polypharmacy.
- 2) Use of an automated electronic system and/or smartphone app [3], to investigate and report problematic polypharmacy and severe medication interactions can be considered for the future.
- 3) Audit will be repeated in six months to complete the cycle.

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Once the details of the nature of the MHA section and the dates were entered into the spreadsheet, automated email notification was designed to be sent out and the Excel spreadsheet would generate a timestamp to indicate that such an email had been sent. The dedicated professional entering the details onto the system would then save the new details in the excel spreadsheet. Junior doctors on the ward, such as a Foundation Year-2 doctor and GP trainee, took the responsibility of entering details onto the system, but help was available from ward administrators as well. This meant that regular manual checking of the sections and repeated email reminders being sent was not required; the Excel spreadsheet in communication with Outlook automatically generated such reminder emails. Delegation of responsibilities and the contingency plan is depicted in figure 2.

Analysis:

Baseline staff survey of the existing MHA reminder system was completed before implementing our automated reminder system in Cherry ward. This was followed-up by repeat staff survey after 3 months.

Results:

Staff from Cherry ward provided feedback that the automated reminder system effectively reduced the experiences of dealing with late section notification or lapses by 43%. This automated reminder system was found to be 16% better than the current Mental Health Act Office notification system. This is likely to be due to this automated system being more flexible in catering for the day-to-day clinical needs of the ward.

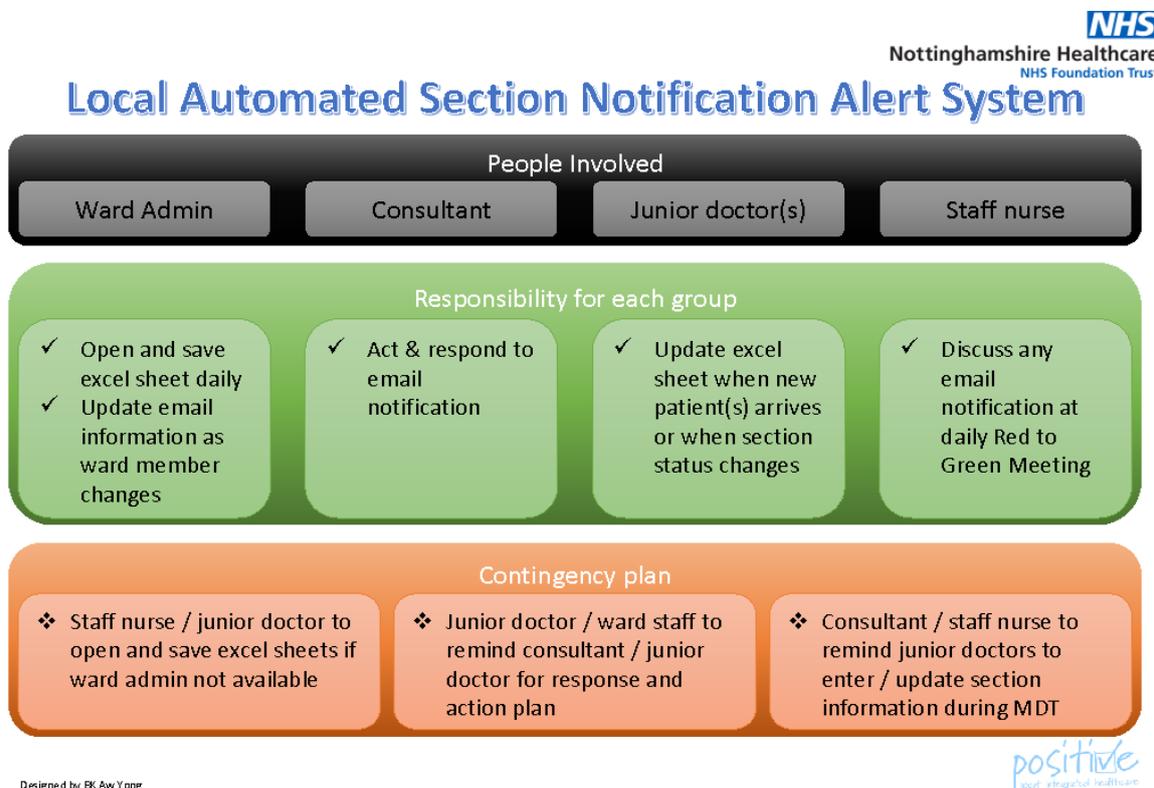


Figure 2: Local automated section notification alert system V1.3



Figure 3: Staff reported experiences in late or lapses in section before and 3 months after the introduction of local automated section notification alert system

Limitations and Recommendations:

Unfortunately, the clinical staff also felt that this current system is 14% and 11% worse in improving the ward functioning and delivering better healthcare than previously anticipated (before the implementation of current system). This could be attributed to a few barriers identified such as the section details not being updated regularly by the designated staff, as well as less attention being focussed onto this system during the period of staff changeover such as the rotation of junior doctors. We have recommended dedicated time from the ward administrators to enter and update the details on this system regularly; this is being actively discussed with the senior management in the Trust through the consultant and ward manager.

Conclusions and future plans:

The pilot implementation project has been fairly successful in identifying the target expiry dates of MHA sections and in reducing the incidents in the ward relating to failure to comply with the target dates. We are going to continue with the current pilot project for three more months, with the designated administrators entering and updating the details onto the spreadsheet regularly. If this reminder system proves to be efficient in the coming months, then we shall consider rolling out onto other in-patient wards.

Acknowledgements:

We thank all the ward staff in Cherry ward, Highbury Hospital, including junior doctors for their help and support.

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Reflection on a journey that led to Psych Star

by India Lunn, *4th Year Medical Student, University of Sheffield*

Reflective practice is a rich and complex process and is a GMC requirement of every medical school. Yet, the requirement for reflection in medical education has necessitated that student reflection is written and assessable.² This sometimes gives the impression for the participants that reflection is a tick box exercise, with the emphasis on completion of the reflection rather than on maximising learning. In Sheffield, we are certainly encouraged to write numerous reflections: 48 reflections are recommended in third year, with typed answers to defined parts of the reflection in separated boxes ('case presentation', 'case discussion', 'learning points', 'implications for future practice'); and each part must be answered according to a set word count. Reflection has the potential to generate enthusiasm and creativity in the reflector, but this is difficult to achieve within the constraints of a tightly defined box and when quantity appears to be emphasised more than quality.

When presenting cases during placements, I am sometimes encouraged by supervisors to reflect. These infrequent occasions do not follow the tick box exercise pattern and therefore I find them invaluable. Often, supervisors lead such a reflection exercise through questioning, which makes my thinking patterns much deeper and more insightful. Questions also provide a structure for reflection which was particularly important when I was new to reflective practice. However, these opportunities are ad hoc and supervisor-dependent.

Additionally, the opportunity for deep reflection takes time; time which is hard to find within a busy placement. Consequently, I needed to be motivated to reflect in-depth independently.

I thrive off the opportunity to reflect deeply but find this difficult when alone. Resultantly, the encouragement of my psychiatry supervisor to meaningfully and extensively reflect on my patient encounters whilst on my 3rd year psychiatry placement was priceless. This way of approaching patients had never previously been emphasised and it sparked my interest in psychiatry. When this supervisor invited me to participate in the first ever medical student Balint groups at Sheffield, I jumped at the opportunity.

Balint groups are based on group discussion, which emphasises the importance of the use of emotion and personal understanding in the doctor's work and the therapeutic potential of the doctor-patient relationship. I found Balint groups improved my own learning outcomes by enabling me to listen and respond to the reflections of others and by using the facilitators' comments to challenge how I think. This altered my own thought patterns, with a direct effect on my approach to patients. Additionally, the groups allow regular supported reflection throughout the year.

Having spoken to other students and professionals at the Royal College of Psychiatrists symposium *Medical Student Psychotherapy Schemes in the UK 2019: "Getting Started"*, it was clear

there was a demand from medical students for Balint groups at other universities, and I knew Sheffield was no different. I felt that the Sheffield Balint groups should be expanded so other students could benefit as much as me from these invaluable sessions.

It was at this point that I learnt about the Psych Star scheme, run by the Royal College of Psychiatrists, to support medical students interested in psychiatry. I knew this scheme would be the perfect opportunity to further my own interest in psychiatry and support the expansion of Balint groups in Sheffield; however, I was hesitant to apply since I believed my relatively recent interest in psychiatry would put me at a disadvantage. Luckily, with encouragement from the Head of Psychiatry in Sheffield, I applied for the scheme and to my huge surprise, I succeeded in the interview and was appointed as a Psych Star.

Since being appointed, I have furthered my experience in psychiatry and planning expansion of Balint groups in Sheffield. I have been appointed an academic mentor to explore my interest in academic psychiatry and I have attended a weekend away with the Balint Society to further my experience of Balint groups. Over the next year, I,

and other medical students, plan to start a Student Balint Society to provide a network for those interested in the groups and a structure to promote Balint groups at the Medical School.

I have been inspired to improve and promote reflection at Sheffield Medical School because the opportunities I have received to enhance my own reflective practice have greatly improved my experiences at medical school. Particularly, reflective practice has led to my engagement in psychiatry and I am excited to have found a career I would like to pursue. Regardless of career choice, I believe reflection is a critical skill to support engagement in medicine. I would like all medical students to have better access to meaningful and extensive reflection and hope I can use the Psych Star scheme to complete this aim.

Sheffield Medical School has produced a video about student Balint groups. Please visit <https://youtu.be/btxzKGMVmDM> if you would like to learn more.

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These mythical creatures called Psychiatrists

Dr Sidra Chaudhry, Core Trainee Yorkshire and Humber Deanery

I happened to take a taxi back home from work one day. The taxi driver had a good look at the mental health unit he had picked me from and very curiously asked what I did. When I disclosed I'm a trainee psychiatrist, his immediate reaction was "can you read my mind?"!

I'm sure all psychiatrists at some point have been asked very bizarre questions at parties or family gatherings. At first, there is a general reluctance to sit with you on the dinner table or talk to you – You never know, someone might be ticking all the boxes of the ICD-10 criteria for a certain mental illness in your head as the conversation progresses! If someone does talk to you, how many times have you been faced with questions or requests such as "tell me what I'm thinking?", "tell me about my personality?" It just goes on to show how it can become very difficult for people to differentiate between a tarot card reader and a psychiatrist.

So what exactly is a psychiatrist? The Merriam Webster dictionary defines it as "a medical doctor who diagnoses and treats mental, emotional, and behavioural disorders". I was overjoyed to read "medical doctor" as part of the definition as usually there is a doubt lingering about the authenticity of our medical degrees too!

Keeping all humour aside, as we raise more awareness of mental illness, we are also trying to win a never-ending battle with the stigma associated with those suffering from mental illness and also those who are working with such individuals. This is not just from a

layperson walking on the street, but also within medical professionals who inadvertently play down the role of their psychiatry colleagues. It was a common perception that the most eccentric person in the room was probably a psychiatrist.

Moving on to what the most important people think of us, our patients. The pain of suffering with a mental illness is something unfortunately not everyone is able to comprehend. This makes our jobs tremendous, as we often work with patients and their loved ones to destigmatize their experiences. This is more than just adopting a very hands-off approach, one in which a quick glance or a quick scribble on a prescription is sufficient to complete your assessment. It involves days, weeks and often months of intense work. In this process, it is not uncommon to find many of us experiencing extreme burn out. The following is an excerpt from an article that I found resonated very close to the heart.

"Physicians respond to such patients' needs and emotions with emotions of their own, which may reflect a need to rescue the patient, a sense of failure and frustration when the patient's illness progresses, feelings of powerlessness against illness and its associated losses, grief, fear of becoming ill oneself, or a desire to separate from and avoid patients to escape these feelings. These emotions can affect both the quality of medical care and the physician's own sense of well-being, since unexamined emotions may also lead to physician

distress, disengagement, burnout, and poor judgment. "(1)

I believe it is so important for us to work together to fight the stigma and misconceptions society has about us as psychiatrists. Fortunately we have several platforms already in motion to help promote psychiatry in a positive light amongst medical students and foundation doctors for example the anti-BASH (Badmouthing Attitudes and Stigmatisation in Healthcare) campaign, which aimed to target medical students' perceptions of various specialties influenced by negative perspectives of others and the effect it had on their career choices. This was facilitated by offering work experiences in psychiatry along with engaging with medical students through social media and other innovative ways.

All of us, as part of the mental health fraternity have a responsibility in ensuring we are positively portraying our profession day to day, through our clinical and non-clinical interactions with patients, families, carers, and colleagues and to help demystify our roles in society's wellbeing and prosperity.

Reference

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Tech promoting awareness about parenting

Dr Anish Nrk, *International Fellow in Child Psychiatry, Sheffield's Children's NHS Trust*

As a tech savvy psychiatrist with an interest in child mental health, I have always explored possibilities of using technology to promote awareness and provide psychoeducation. During my limited experience with child psychiatry, I realised that most of the behavioural problems affecting children can be related to faulty parenting in early childhood and these can be more challenging to manage in the long run. I realised that it was easier to encourage new parents to be aware about the long-term benefits about positive parenting than trying to resolve behavioural problems in late adolescence.

This was challenging as most parents do not accept the need to be aware of positive parenting practices. They rely more on an instinctive parenting style. This means following your instinct, which is generally influenced by how you were raised as a child in your sociocultural background. These are not necessarily evidence based or best practices for your child. One common example is punishment. There is a commonly accepted saying 'Spare the rod and spoil the child.' Yet parents never bother to find out whether there are any more effective alternatives to punishment.

After spending an early part of my career as an independent psychiatrist conducting parenting awareness classes and workshops in schools and small parent groups, I realised that it was easy to attend workshops about positive parenting techniques, but when it came to dealing

with real-life situations, parents found it hard to execute what they knew. Although there is plenty of material to read and understand about parenting, parents do not find this information practical when it comes to real-life situations. Also I began thinking about possibilities of providing parents access to positive parenting techniques as and when needed 'on the go'. That is when I came up with an app that would challenge parents to answer real-life parenting questions as a quiz – the *Parenting Challenge*.

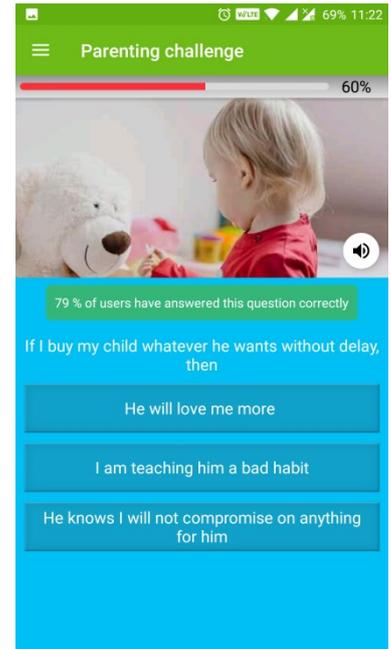
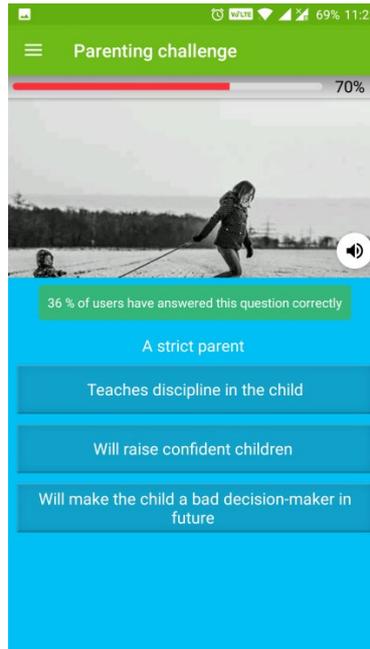
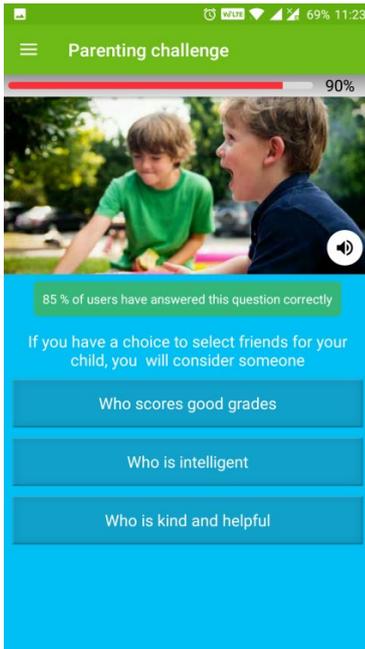
To make it more interesting, the app looks at your current understanding of parenting practices, generating a personalised score card and this can be used to challenge other parents.



Parenting Challenge Quiz: Puzzles for Parenthood
 Handikapp Parenting ★★★★★ 100+
 Contains Ads
 This app is compatible with all of your devices.



After completing the quiz, parents will get daily 1 minute quizzes and weekly revision quizzes to continue enriching what they have learned. It is a fun way of understanding child psychology and parenting as a daily 1-minute quiz. It also lets you check your parenting score and challenge others with your score which is quite interesting!



You can try this Parenting quiz app [from here for FREE!](#)

Some of the responses from parents who used the app had been that it would have been better if they were introduced to the app earlier. To catch parents as early as possible, I launched a smaller app in the playstore targeting new parents with smaller babies and newborns- A [Baby quiz app](#): The idea was to catch parents early who could be introduced to the larger 'parenting quiz app' as soon as possible.

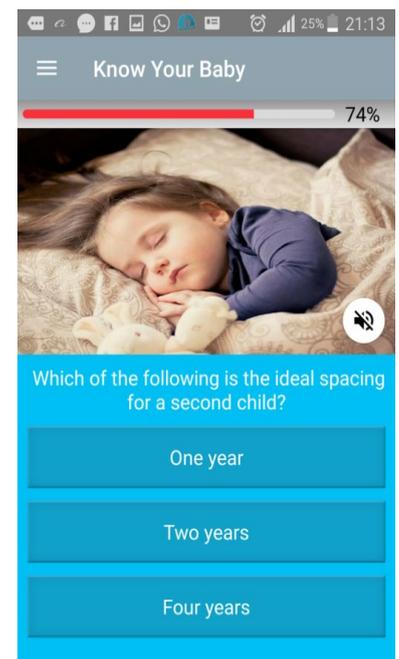
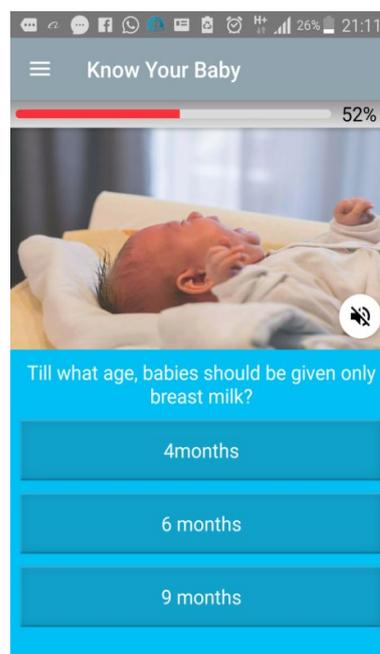
scores and compare them to other new Moms in your social circle.

It's a fun & exciting quiz that will deepen your knowledge about raising kids!

And even if you are sure you have the right information regarding your child's development, you can always get many new and useful tips for parents in this very interesting [Baby quiz app](#)!

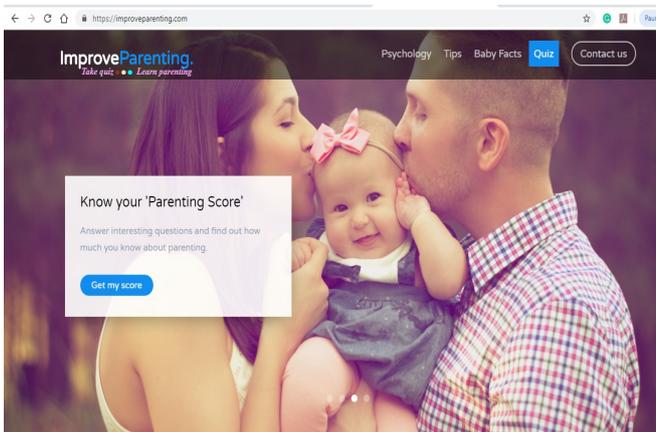
[Baby quiz app](#) is an interesting app for new parents to make them aware of common issues in children and must-know facts in infant care as an easy to navigate quiz. You can test your knowledge about your child's development here by answering 1 minute quizzes on newborn and infant development.

You will also get many valuable tips, which are especially useful if you are a new Mom and Dad. There are questions about baby activities, kid psychology, and other baby things! View your





Realising the need to make the above apps available to parents who may not have a smart phone, I launched a website, which integrated all the parenting apps into a single platform called improveparenting.com



Through this website, parents can understand common parenting mistakes by attempting quizzes. The quizzes are mostly about parenting situations they encounter in daily life. There are also sections for child psychology, parenting and famous experiments in child psychology. Every day there are hundreds of parents who are making use of the app and website, and it all began with an idea to make use of technology to spread awareness about child mental health and Parenting!

[Dr Anish Nirmala Radha Krishnan](#) is currently working as an International Fellow in Child Psychiatry at Sheffield's Children's NHS Trust can be contacted at anish.nrk@gmail.com or anish.nrk@nhs.net

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Working on recruitment and retention of trainees: The CAP perspective

By Pallab Majumder, MBBS; MRCPsych; MD; PhD

*Consultant Child and Adolescent Psychiatrist, Nottinghamshire Healthcare NHS FT
Honorary Assistant Professor, University of Nottingham
Educational Supervisor Mentor, Nottinghamshire Healthcare NHS FT
Academic Programme Lead, Child and Adolescent Psychiatry Programme, HEE East Midlands
Training Programme Director Child and Adolescent Psychiatry Programme, HEE East Midlands*

SUMMARY

In this narrative article, I will discuss in brief, the current crisis in recruitment and retention of Psychiatry trainees, both nationally and regionally; in particular from the perspective of Child and Adolescent Psychiatry. In practice, we have attempted to address this challenge at the regional level in the East Midlands, in line with the lead of the College at the national stage. This has been a story of success so far, which I want to share with the rest of the community with the hope that this could be replicated elsewhere. Here, I shall endeavour to narrate the vision, strategy and implementation of the changes and my hypotheses of the possible underlying psychological, systemic and organisational mechanisms that made the success of our scheme possible over the last 2-3 years.

MAIN ARTICLE

When I was asked by our medical director recently, how could the good stories of our successes be disseminated more effectively, it made me reflect and ask myself this question – are we publicising and propagating the positive stories of Psychiatry training enough at the local and regional level? The context of this conversation was that recently some of our initiatives have led to significant improvement in trainee satisfaction

within the child and adolescent psychiatry higher training scheme, evidenced by the GMC survey results, their teaching and training feedback, as well a remarkable boost to the previously sluggish recruitment drive. The programme has now successfully recruited to 11 posts out of 13 clinical numbers across the region, and recently has also been successful in recruiting into the new Academic Clinical Fellow (ACF) post. My immediate defensive response was yes! I've been telling everyone about our fantastic success with recruitment, taking to the social media at times, and also presented on this in the College conference and career fairs. But then I paused, and thought, how about analysing, synthesising and formulating this (something that we Psychiatrists are the best at doing seamlessly, even at the dead of night at times, without needing any preparation!), so that it could be, perhaps, translated and applied in other training and service areas. Therefore, I am embarking on a brief attempt to illustrate what might have made this possible, and why.

There is a greater recognition that child mental health is a growing area of concern and requires further developments in quality and efficacy of service provision. Without addressing the

issue of training the best talents to develop a cohort of good quality clinical leaders, transforming the child mental health care in the country may be hard to achieve, despite government's current ambition. Over the recent years, CT (Core trainee) recruitment remained significantly low but fairly stable. ST (Higher Trainee) recruitment had become incredibly challenging. In 2011, the CAP (Child and Adolescent Psychiatry) higher training scheme filled 91.86% posts, which fell to 55.88% in 2016¹. One could speculate that the possible contributing factors are community and professional stigma, declining number of senior psychiatrists and trainers, poor experience of CAMHS (Child and Adolescent Mental Health Service) placements as CTs, quality of mentorship and training, work-life balance, job satisfaction, interpersonal factors, lack of academic opportunities, possibly brain drain to other promising countries, sparse information on training scheme on the websites and so on and so forth.

A number of measures have been taken at the national stage recently, like 'Student Associates of the Royal College of Psychiatrists', Summer School or an Autumn School, University Psychiatry Societies (in 30/32 medical schools) and the #ChoosePsychiatry social media campaign spearheaded by both President and Dean of Royal College of Psychiatrists. Regional Health Education and local Trusts in many places have also been doing their bits in attempting to turn the tide. Career fairs, information booklets, taster weeks for foundation doctors and medical students, buddying schemes and a number of active workplace based experience schemes for senior school students are to name a few of the local measures being taken in various regions across the country.

Coming back to our local story, I have been in the privileged position of experiencing the Child and Adolescent Psychiatry training scheme in East Midlands both as a trainee and as a trainer. That perhaps offered me the opportunity to reflect and try to acknowledge what really matters for a trainee to feel motivated, enthusiastic and positive about their training, and what ultimately leads to a successful and attractive training scheme. When I finished my training back in 2013, the East Midlands Child and Adolescent Psychiatry training scheme was not thriving in terms of its reputation, recruitment and overall trainee satisfaction, actually far from it. In 2013/2014, this programme failed to recruit any higher trainee in two consecutive cycles of recruitment. At that juncture, the appetite for a positive shift (I somehow prefer the word 'shift' over 'change') was brewing. The coming together of a few likeminded (or shall we say complementary) and enthusiastic people at the right time, might not just have been a lucky coincident. This, however, motivated initiating and driving significant transformation over the last 3 years to reshape our Child and Adolescent Psychiatry training scheme.

Steps that contributed to the positive shift

Since 2015, a number of developmental and quite transformative plans were made and put into action in order to revamp the training scheme, as it was desperately felt that the very survival of the scheme depended on 'something' being done. These included –

- **Enhanced trainee-trainer involvement:** This has been achieved by strengthening distributed leadership (Training Programme Director, 2 academic leads and educational supervisors for each

region, trainee academic leads and representatives) creating enhanced connectivity across the region. Trainees developed a WhatsApp group. That is a valuable tool not only for the group to stay connected, but also provide 'buddy support' for each other when in need of advice, guidance or even informal supervision. Trainees (sometimes with trainers) also have regular meets IRL ('in real life' – an acronym created by a generation increasingly preferring virtual connectivity over face to face).

- **3-year rolling academic programme:** An academic programme compatible with the new Royal College curriculum was developed. The programme has three terms each year with each term consisting of 10 half-day teaching sessions. Teaching sessions are innovative and interactive, led by experts in the fields. Ongoing quality improvement of teaching is ensured through a set review process led by the Trainees at the end of each term on a regular basis.
- **Open academic event:** We invite eminent national authorities presenting interesting topics in an open forum for trainees and consultants across the region once in every academic term. This is part of, and embedded in, the academic programme.
- **Creating additional clinical placements to enhance the range of training opportunity:** We have worked hard, with the prospective Clinical Supervisors, to get as many clinical placements approved for training as possible. This has eventually led to a very wide range of options available for trainees to

choose from across the region, according to their interests and training needs. We now have approved clinical placement in Community CAMHS, Looked After Children, Paediatric Liaison, Neurodevelopmental services, Eating disorders, Learning Disabilities teams, Early intervention psychosis and substance misuse team, Secure children's home and Inpatient unit (potentials in near future - PICU, Specialist eating disorder unit and Forensic CAMHS).

- **Closer links with academic institutions:** Eminent academics in Nottingham (the Institute of Mental Health) and Leicester (Greenwood Institute of Child Health) are offering plenty of research/ academic opportunities through able supervision. There are two academic training posts in Nottingham and Leicester and a new ACF post has been developed and successfully recruited in recently.
- **Research workshops:** Trainees are being offered regular research supervision workshops, which is embedded in the training, to complete systematic reviews, and be involved in other research, resulting in many publications, fellowships and research prizes.
- **Additional training in systemic / psychological therapies:** Numerous opportunities have been developed for trainees to gain experience in psychological therapies, all of which are embedded in the programme, so that trainees do not have to 'sort it out' themselves.
 - Brief and Systemic Therapy course – An accredited course based at Lincoln into which most of the trainees have been opting.

- Systemic therapy teaching module – 10 weeks “Introduction to Family Therapy” which is one full term embedded in the academic programme
- Family Therapy clinics
- CBT and Psychodynamic therapy supervision.

My hypothesis of the possible mechanisms that underpinned this shift

In the early days and months of this transformation, while the vision was being conceived inside our heads, the strategic plan of improvement was also taking shape, taking into consideration the need of a high quality learning environment; constructive and supportive interpersonal dynamics; satisfactory, enjoyable and fulfilling trainee experience; enhanced trainee-trainer involvement, distributed leadership and enhanced connectivity across the region. Unspoken, in the midst of this however, was a palpable urge for a different, supportive culture.

A culture of high morale can be associated with improved productivity, improved performance and creativity, reduced number of days taken for leave, higher attention to detail, a safer workplace, and an increased quality of work². In addition to that, organisations with a culture of high morale have higher rates of recruitment and retention³. Employees who work for an organization with high morale develop higher rates of job satisfaction, creativeness and innovation, commitment to the organisation, eagerness to satisfy group objectives instead of individual objectives, and they desire to improve the organization's performance⁴. On the other hand, big organisations could stand to lose up to 350 billion dollars per year because of the loss of productivity caused by low morale⁵.

In order to uplift the morale and overall ‘positive vibes’ in the scheme, we fostered openness and transparency to establish trust between trainees and trainers⁶, empowered trainees to lead, take decision and make a difference, and had more frequent informal interactions⁷ so that the support system remains intact and robust. We know from systemic therapy principles that systems (family, group, team, service, and organisation) can often become laden with ‘problem-saturated stories’⁸, forcing every discourse into an inadvertent position of gloom (or problem solving at its best); to the extent that celebration may even look like a crime. This cultural position (which is evidently prevalent in many public sector organisations these days) is hard to shift (perhaps harder in bigger systems), and requires conscious efforts to constantly remind ourselves so we can avoid the temptation of carrying on with problem laden narratives only (perhaps we can learn some tricks from some contemporary corporate giants like Google, Apple or Facebook about workplace culture). But isn’t that what I am doing right now? So, I shall remind myself to leave that behind, and once again emphasise that we have managed to ensure celebration of every little milestone along the way; with words of mutual appreciation, or a working lunch, for example (we know from attachment theory that food is a strong symbol of nurture and care – I recently saw one of the acute Trusts in the region very cleverly spending on free pasta and coffee with flu jab for staff, and probably saving thousands on sick pay by making sure everyone comes along to get immunised). We have tried to take the setbacks on the chin, learn from them and move on without wasting too much emotional energy on them. Ultimately, the message we most importantly want to propagate through every action

(rather than speech) is that we value our trainees and we do care.

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Interview

Dr Sue Elcock MBChB,
MRCPsych

Medical Director and
Consultant Forensic
Psychiatrist

Leicestershire Partnership NHS
Trust



I am a consultant forensic psychiatrist and first worked in the National High Secure Service for Women at Rampton Hospital 2005-2015, specialising in working with women in personality disorder. I was also the Associate Medical Director for Revalidation at Nottinghamshire Healthcare NHS Foundation Trust and implemented revalidation.

I am also passionate about medical education and after being the Training Programme Director for Forensic Psychiatry became the Head of School for Psychiatry for Health Education East Midlands, overseeing the merging of the north and south schools of psychiatry in the east midlands (2010-2015). I became Medical Director at Lincolnshire Partnership NHS Foundation Trust in 2015 and really enjoyed being involved in the Trust moving from Requires Improvement to Good with the CQC. I joined Leicestershire Partnership NHS Trust in October 2018 as Medical Director and completed the circle as I did my SHO psychiatry training here 20 years ago.

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

I am a keen musician and almost became a music teacher rather than going into medicine. I have grade 8 music qualifications in clarinet, bassoon, piano, flute, oboe and saxophone. When I decided to apply to go to medical school my family was rather surprised and somewhat unsure as I used to faint at the sight of blood.

What trait do you deplore in others?

I absolutely believe that you should never expect anyone to do anything that you wouldn't be willing to do yourself. I have sometimes seen this not being the case in the NHS, particularly around taking credit!

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

I really enjoy using reading and films as a form of escapism from the real world. If I was to be honest I must admit I really enjoy the older James Bond films with Roger Moore and to be more modern I love the fast and furious films.

When not being a psychiatrist, what do you enjoy?

I really enjoy cooking and travelling. I'd had some of the most amazing holidays including seeing polar bears in their natural environment, when we were told not to walk outside the town as the polar bears like to get into bins! I've seen brown bears fishing for salmon and have walked the wall of china. I'm looking forward to my forthcoming trip to Japan, badly timed to coincide with the world cup.

Which people have influenced you the most?

I must admit I've learnt from many colleagues over the years during my training, as a consultant and then as a medical director. At my heart I am passionate about forensic psychiatry and a number of colleagues inspired and influenced my development during my career. It wouldn't be fair to mention anyone in particular for fear of missing out some! I still recall 1 specific teaching experience as a medical student at Birmingham University, when a particularly inspiring Senior Registrar I was placed with, tasked me with speaking with a gentleman in the medium secure unit due to be transferred to a community placement as part of my special interest placement. We had a very pleasant discussion and when I learnt of his offending history, it taught me the importance of being non judgemental and understanding

why I wanted to learn why people did offend and what can be done to reduce the risks in the future.

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

Funnily enough, apart from music, I've also always been interested in money. Anyone, who knows me will laugh at this as I love cars so don't have lots of money left! My dad was a bank manager and I used to really enjoy spending time at his work, using the calculators and helping out. I would have probably gone into banking in some form, now I enjoy working closely with the Director of Finance as second best!

How would you like to be remembered?

I don't care as I'll be dead! But if it was for anything it would be for being fair.

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Babies

By Nandini Chakraborty

She told us of the one,
She could not keep for fear-
Of losing what she had,
Already close and dear.

The badges kept an eye,
Followed every turn,
The laughter and the screams-
Until reviews could burn.

She held them close to her
A precious four to keep,
And pushed all else afar,
And yet a fifth reached deep.

The fifth was given up-
It was a festive day
Crackers, sweets and lamps galore,
And no one came the way.

And no one had the time
To sooth her as she bled
To lose the child within
And more that she would shed.

The first day back at work,
She did not tell them all,
Baby shelves she stacked all day,
The tears were hers to fall.

She said we made it better.
We took her pain away,
Hearing out her story,
And helped her hope again.

We had not checked the clinic,
That ran next door to us;
It was a baby check-up-
Proud mamas in a fuss.

As we opened our door,
It hit her with a bam,
A crowd of fussing mamas,
And babies in their prams.

Trent Division Annual Conference

Theme: Prevention

Date: Friday 8 November 2019

Venue: Double Tree by Hilton Hotel Nottingham Gateway,
Nuthall Road, NG8 6AZ

Topics and Speakers include;

Prevention in Mental Health, *Tammy Coles and Charlene Mulhern, PHE*

Suicidal thoughts and behaviours in autism, *Dr Sarah Cassidy, University of Nottingham*

Shared decision making, the service user and carer view,
Vanessa Pinfold and Laura Fischer, McPinn Foundation

Preventing Suicide – What we know and what we need to do, *Prof Louis Appleby CBE, University of Manchester*

The Milestone Study – improving transitions in mental health care, *Prof Swaran Singh, University of Warwick*

Improving outcomes following childhood trauma in low and middle income settings, *Prof Panos Vostanis, University of Leicester*

For further details, the programme and to book [click here](#). (This link takes you to the events page on the College Website.)

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Poster Presentation Prizes

The Poster Prizes have now closed.

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 by **31 August 2019**.

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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2018 Poster Prize Winners

1st Prize Student Associate: Katherine Newton, Parenting Interventions in Perinatal Mental Health Services: A Systematic Review

2nd Prize Student Associate: Duncan McGregor, A Quality Improvement Audit on DNA Follow-up in Derby Drug and Alcohol Recovery Service

1st Prize CT1-3: Dr Pranav Mahajan, Raising Awareness of Clozapine Induced Constipation and Associated Serious Consequences

2nd Prize CT1-3: Dr Kinza Khan, Audit of the appropriate use of Section 2 of the Mental Health Act

1st Prize ST 4-6: Dr Deepa Bagepalli Krishnan, Quality Improvement Project for out of hours clinical handover

2nd Prize ST 4-6: Dr Siobhan Smith, Electroconvulsive Therapy under Section 62

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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 at, 9.30am-12.30pm on Wednesday 20 November in Sheffield.

Vacancies

- Addictions Representative
- CPD Lead
- Education and Training Committee Representative (Co-opted until 2021 election)
- Forensic Psychiatry Representative
- Liaison Psychiatry Representative
- Medical Psychotherapy Representative
- Quality Improvement Representative
- Workforce Lead

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).

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.

Closing Date: 30 September 2019

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Section 12(2) and Approved Clinician Training Courses

[Book now](#) to avoid disappointment, there are limited places available!

Courses are open to candidates from all professions and have been approved by the Midlands and East of England Approvals Panel. All courses will take place in Birmingham.

We advise you to check with your [local approvals office](#) for information on the criteria for approval/re-approval, and to confirm which course is suitable for your requirements before making your booking.

Please note that attendance at a course is only one part of the approval process, and a course certificate should not be offered or accepted as evidence of approval.

Click on the link below for further details of each course and to book online.

[Section 12\(2\) Induction Course, Birmingham, 18 & 19 September 2019](#)

[Section 12\(2\) Refresher Course, Birmingham, 2 October 2019](#)

[Approved Clinician Induction Course, Birmingham, 16 & 17 October 2019 – **Sold Out**](#)

[Approved Clinician Refresher Course, Birmingham, 13 November 2019 – **Sold Out**](#)

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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).

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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