Spring Edition, 2021

# Psychiatry–West Midlands

*The West Midlands Division e-Newsletter*

# Contents

## In this issue:

# Editorial

*Dr Nilamadhab Kar, Editor*

## Positive changes in mental health care due to COVID-19 pandemic.

Is there any silver lining in these very challenging stressful times? Volumes have been written accurately describing the multiple interrelated stresses and their impacts during the COVID-19 pandemic. Deaths, bereavements, job loss, financial problems, social isolation, inability to be near one's close family members at the time of their need, domestic violence, difficulties in continuing education are some of the stresses that are going to influence mental health negatively for a long time. It has been reported that during the pandemic, mental health issues are increasing;[1,2] higher proportions of general population are now having anxiety, depression, posttraumatic stress,[3] self-harm behaviour (reported in some countries)[4] etc. However is their anything positive from this crisis?

Many positive changes have been reported in the environment,[5] e.g. decreased pollution, increased use of technology, unified global efforts to tackle the crisis, sharing the resources to low-to-middle-income countries, and many more. In a study, people reported some positive effects such as quality time with spouses/partners, with children, improved relationship, increased exercise, better quality of sleep, developing new hobbies and many more,[6] which are relevant for mental health.

In psychiatry, the increase in the mental health problems in the community has reflected on the increased referrals and crisis calls, probably admissions. There have been many changes in the mental health service provision, all over the world, considering the limitations of movements due to lockdown, physical distancing and to decrease the chance of spread of infection. Increased use of digital technology, tele-psychiatry, remote-clinics and case conferences through telephone and video conferencing has been noticed. It may be better to reflect any positive changes in the service delivery that have been learned during this period that may be continued in the future. Although definitive answers of positive changes and effectiveness of these modifications to deal with the situation are awaited from research findings, some generalisations can be made.

It is quite possible that many patients may opt to have some of their follow up appointments over phone or video; saving time, hassles of travel; and it will certainly decrease the rates of non-attendance. Multidisciplinary case conferences can be held through video conferences, which has been so easy these days. This will be time and cost effective. There are some concerns about patients, especially elderly using the technologies and the availability of appropriate gadgets and connectivity. Gradually technology will become simpler for people to use and address some of these current challenges. It is imaginable that more and more psychological interventions both one-to-one and group therapies will be conducted on digital platforms.

Most of the educational programmes and conferences can be held online. Webinars have become common and in all probability the trend will continue into the future. There are many benefits: these methods save time, are economical to arrange, and can be designed to have active participation of the attendees. These technologies are evolving and will become more efficient.

Public education platforms are replete with suggestions and advices related to taking care of mental health and stress management techniques during the pandemic. Although many of these were present before the pandemic, probably the public awareness and use have increased. However it needs to be seen how far they are really effective. Realisation that impact of the pandemic affecting such a large number of people all over the globe will lead to research about developing effective methods to tackle the mental health of the masses beyond the clinic rooms. More public health interventions will be tested. Most probably mental health services will have greater role in public health.

There has been some adherence to public health messages related the pandemic.[5] As human behaviour is one of many crucial elements in controlling the spread of virus, there may be more research to explore methods to change public behaviour related to pandemics; factors influencing adherence to the public health messages; how these can be applied to managing future pandemics or similar catastrophes etc.

In these terrible times, people may realise the priorities of their lives and re-set them. These could involve family, finding time for themselves, their individual factors of resilience, the buoyance factors, search for meaning in life, spirituality etc.; and these are probably going to help in their overall mental health.

If nothing else, COVID-19 has at least given jolt to rethink about the traditional methods of service delivery and to explore other methods which can be equal or even better. Learning from the challenges of the pandemic may lead to some lasting changes in mental health service delivery, all over the world.

# Editorial

## References

1. Jia R, Ayling K, Chalder T, Massey A, Broadbent E, Coupland C, et al. Mental health in the UK during the COVID-19 pandemic: cross-sectional analyses from a community cohort study. BMJ Open. 2020;10:e040620.
2. Niedzwiedz CL, Green MJ, Benzeval M, Campbell D, Craig P, Demou E, et al. Mental health and health behaviours before and during the initial phase of the COVID-19 lockdown: longitudinal analyses of the UK Household Longitudinal Study. J Epidemiol Community Health. 2021;75:224–31.
3. Kar N, Kar B, Kar S. Stress and coping during COVID-19 pandemic: Result of an online survey. Psychiatry Res. 2021;295:113598.
4. John A, Pirkis J, Gunnell D, Appleby L, Morrissey J. Trends in suicide during the covid-19 pandemic. BMJ. 2020;371:m4352.
5. Nelson B. The positive effects of covid-19. BMJ. 2020;369:m1785.
6. Williams L, Rollins L, Young D, Fleming L, Grealy M, Janssen X, et al. What have we learned about positive changes experienced during COVID-19 lockdown? Evidence of the social patterning of change. PLOS ONE. 2021;16:e0244873.

# Chair's Column

## By Dr Ignasi Agell


### Welcome to the spring newsletter of our Division

This is a welcome to all of you, especially to our new members and affiliates, and a see you later from me as this is my last newsletter as Chair of the Division.

It has been both an honour and a pleasure to serve as Division Chair for the last 4 years and I can only encourage you to work with the College, in whatever capacity you can or want. I always remember Professor John Cox, past President, saying that the College did not exist per se, that We were the College, the members, and as such we shape it.

Finally, thank you to you all, to those that have served with the Executive Committee, and particularly to our fantastic staff, Marie and Daljinder.

### Events

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

### Summer Academic Webinar 11 June 2021 – 9.30-14.30

Bookings are now open for the West Midlands Division Summer Academic Webinar. To view the programme and book your place please visit our website.

### Celebrating 180 years of history

This year we're celebrating our 180th anniversary. Find out about our history and see how you can become involved with the celebrations. Celebrating 180 years of history | Royal College of Psychiatrists (rcpsych.ac.uk)

### First ever RCPsych member survey

RCPsych is launching its first ever comprehensive membership survey – which will be open to all members between 19 May and 13 June. Members feedback will help shape the future ways in which the College delivers its services and activities, particularly as we turn our attention to the easing of the pandemic. As a valued member of the College, your participation in the survey would be gratefully appreciated. Look out for emails from Research by Design containing a link to complete the survey. The RCPsych is your College, please help shape its future.

### Email: westmidlands@rcpsych.ac.uk

### Executive Committee

Committee Meetings

All committee meetings are being held remotely until further notice. The next meeting dates are 25 June and 22 October.

### 2021 Election

The RCPsych West Midlands Division 2021 Election results:
Chair, Dr Muhammad Gul
Vice-Chair, Dr Suchithra Thirulokachandran
Financial Officer, Vacant
Executive Committee Members (x3) - Vacant

### Recent Appointments:

Intellectual Disabilities Regional Specialty Representatives: Dr Ambreen Rashid and Dr Yim Lun Wong
Child and Adolescent Regional Specialty Representatives, Dr Triveni Joshi and Dr Jugjinder Singh

### Current Appointed Vacancies

- Addictions Regional Specialty Representative
- Perinatal Regional Specialty Representative
- Mentoring Lead
- Specialty Doctors Representative

The closing date is 31 May 2021. Further information is available on the College website.

### Mentoring

Please continue your engagement with mentorship. The next mentoring meeting organised by Geoff Marston have been scheduled for 2-4pm via teams/ teleconference on 24 May.

Thank you to Dr Geoff Marston, Dr Jan Birtle and Dr Andrew Leahy for facilitating the **West Midlands Mentoring Training Webinar** held on **Friday 13 November 2020,** which was well received by the delegates in attendance.

### West Midlands Independent Psychiatrists Group (WMIPG)

The WMIPG meet 3 times a year and the next meeting dates are 18 June and 19 November (10am-1pm) via teams/teleconference.

The West Midlands branch of PIPSIG provides a network for independent psychiatrists, promotes responsible practice in relation to appraisals and revalidation and acts as a source and resource for continuing professional development. Anyone interested can be added to the contact list.

### Follow us on Twitter @rcpsychWM

# Communication in the COVID-Age

by Dr Shell Samnani, MBChB, MRCPsych, ST5 Dual General Adult & Medical Psychotherapy - West Midlands Deanery Trainee

## Abstract

2020 Coronavirus Pandemic has thrust the world into immediate technological dependency. Trainee psychiatrists are no strangers to e-portfolios, virtual learning and IT communications, but with this current situation we find ourselves in constantly evolving territory unlike ever before. Such swift change creates an opportunity for reflection and evaluation of progression. In this brief article I hope to share personal experiences and reflections, exploring how lockdown and restrictions has impacted my practice and training.

When I started medical school, ethernet cables were prerequisite for internet connection, and your phone was 'smart' if you could play 'Snake' on it. Now, as a dual general adult and medical psychotherapy registrar, it feels almost surreal that we are predominantly reliant on live communication apps such as Zoom to function day-to-day. The advances and changes in how we are taught, and develop in a training capacity, are more varied and abundant than ever. Of course there's been robust provision from Royal Colleges and online Journals for some time, but COVID has pushed this emphasis on IT to an unprecedented level.

In our Trust, we have swiftly adapted to using Microsoft Teams for virtual ward rounds, MDT meetings, PGME presentations, supervision and much more. There seems to be increasing comfort and flexibility in instantly accessing anyone, within reason, as many are stationary indoors for the first time in their career. It feels we have more time as there is little commuting, and paradoxically less time, as there's never felt so much to communicate.

Working in a male PICU setting, the concept of virtual ward rounds seemed absurd but after a few trials, both staff and patients adjusted with seeming ease and have not looked back. When in attendance for ward rounds, an RC will unconsciously influence the dynamic way and how other parties, include a trainees, present. One way mirrors are used in family therapy, and as peculiar a comparison as it initially seems, this is how it's felt when remotely leading a ward round with my consultant virtually observing from the other side of a metaphorical mirror. Although the patient, nursing staff and I are aware he can hear and see us, there's a fabricated sense of security via this modality that feels as close to naturalistic ward round without an RC as possible. This format has provided extra training opportunities whilst minimising contamination through the physical presence an a 'other', therefore be truly observed and then evidence in the form of WPBAs. I've also wondered if the levels of outburst and anger are more curtailed, and the overall 'performance' anxiety reduced without the physical presence of doctors. When we do attend the ward e.g. for seclusion reviews, there's a qualitative difference in how patient's interact versus virtually.

I've had incredible opportunities accompanying my supervisor in settings that are ordinarily quite restricted e.g. prison homicide assessments for psychiatric opinion via Microsoft Teams. There's the added benefit of time saved with no cross-country travel and no physical security checks. I wonder if being observed remotely has made these clients in particular feel less exposure and scrutiny, consequently are more willing to consent to being observed for no benefit to them.

And what of supervision? – It's felt surprisingly easier from a screen, as though there are greater opportunities to have supervision when a designated physical space is not warranted. Picking up the phone or video-calling now seems second nature.

Whereas some might have the opinion that psychotherapeutic work must be done with physical presence, SpR regional Balint has been incredibly useful and successful via Teams. A group of 20+ talking over another was anticipated to be difficult to avoid, but it's been surprisingly easy to raise one's hand, hold one's tongue and provide more space for silence and patience in this forum. In addition, it's been surprisingly smooth transitioning between various platforms for my weekly PIT psychotherapy case - from an older-adult OP setting to telephone to now video (via AccuRx) with Zoom and Teams for group supervision.

But is this all too good to be true?
With instant accessibility and communication, there is a felt sense of blurred boundaries. If home is where we now work, is it possible for us to truly 'turn-off' having never left the confines of our private space? What are we now holding in our homes when our metaphorical 'backyard' has become host to work, play and everything in-between. Will we ever be able to experience our personal and professional roles and responsibilities in the same way again?

Whether it's patient or colleague-related interactions, there are some things that will inevitably be lost in translation through technology. Physical presence and touch should by no means be underestimated, but as we continue to adapt and learn, it does seem virtual training can be hugely beneficial if taken forward with intention not just reaction.

# Comparison of Outpatient Attendance Rates for Face-Face and Remote Consultation: A Service Evaluation of Outpatient Clinics in Coventry and Warwickshire Partnership NHS Trust

by Dr Asma Javed, Dr Nandagopal Suresh and Dr Ayman Zaghloul

*Dr Nandagopal Suresh*

## Introduction

Since the invention of the telephone in 1876, there had been a reluctance in its use as a tool for delivering patient care. However, Covid-19 pandemic forced many of us to use telephone consultation as the first point of delivery of clinical care.

Following the Covid-19 pandemic, RCPsych[1] recommended that remote consultations should be encouraged where safe and appropriate. Though initial consultation could be challenging when patients and clinicians don't know each other, however in the time of the pandemic, remote consultation is better than having no consultation.

With the existing restrictions in place due to the global pandemic, remote consultation has proven to be a valuable tool for healthcare professionals and patients.

As part of the Trust's response to Covid-19, outpatient appointments have been rescheduled to be conducted over telephone/video since March 2020. We conducted this study to assess if there has been any difference in the attendance rate of patients in the outpatient's clinic before remote consultation and compared it to the attendance rate after a switch to remote consultation.

## Aims

This study aims to compare the attendance rates in outpatient psychiatric clinics for face-face and remote consultations and hence to assess the compliance of patients to the two modalities of consultation.

## Method

A retrospective collection of data was conducted from the Patient Administration System for the attendance rates of various IPU (Integrated Practice Unit) clinics pre- and post-introduction of remote consultation.

In Coventry and Warwickshire, the services are categorized in IPU to design the services around the care clusters. IPU 3-8 provides assessment and treatment for patients living with non-psychotic disorders. IPU 10-17 provides mental health services for people presenting with psychotic disorders. IPU 18 -21 provides services to people presenting with dementia.

The data was grouped into two time periods, November 2019- February 2020, where the consultations were face-face and April 2020- August 2020 where the consultations were remote. We deliberately did not collect the data from March 2020 as remote consultation process was new to clinicians and patients and it could have given us falsely high or low attendance rates in the clinics. Within each period, the patients were further grouped into three sets based on their diagnoses with IPU 3-8, 10-17 and 18-21.

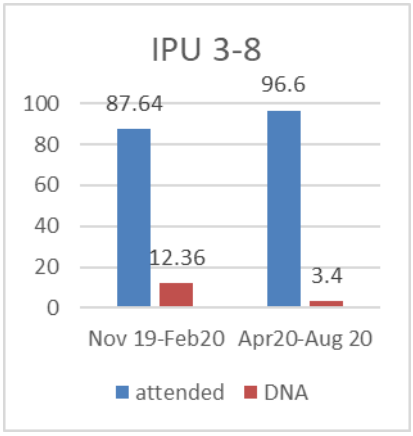
## Results

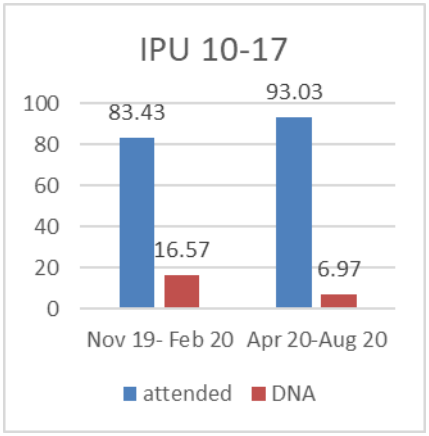
A total of 29,976 patients spanning over two time periods, November 2019- February 2020 (14,066) and April 2020- August 2020 (15,910) were included in the study. The data was gathered individually from three different IPU clinic groups based on their diagnosis to better understand if the compliance rates are affected by the nature of the disease. Table 1 illustrates the distribution of patients in each of the IPU clinics during the selected time intervals.

| | | Total Appointments |
|---|---|---|
| **IPU 3-8** | Nov 19-Feb 20 | 8546 |
| | Apr 20-Aug 20 | 10283 |
| **IPU10-17** | Nov 19-Feb 20 | 3791 |
| | Apr 20-Aug 20 | 4049 |
| **IPU18-21** | Nov19- Feb 20 | 1729 |
| | Apr 20-Aug 20 | 1578 |

Table 1: Total Appointments offered between November 2019-February 2020 and April 2020-August 2020 in all IPU clinics

The percentage DNA rates for each of these clinics during each period were calculated and compared both individually and overall to arrive at the results. Data analysis revealed that there was a significant increase in attendance rates in all the IPU clinics once the remote consultation tool was introduced.



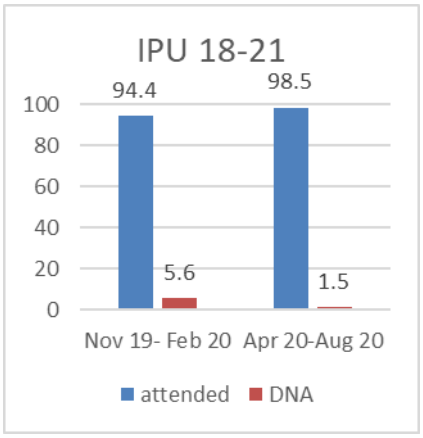




*Figure 1: Comparison of percentage DNA rates in each IPU between November 2019-February 2020 and April 2020-August 2020 in clinics.*

IPU 10-17 showed the maximum increase of 9.6% while IPU 3-8 showed an 8.96% increase and IPU 18-21 showed an increase of 4.1%. The overall attendance rates of all IPU clinics combined showed an increase of 8.5% once the remote consultation tools were implemented.

| | Total Appoint-ments | DNA Appoint-ments | % Rate of DNA |
|---|---|---|---|
| Nov 19-Feb 20 | 14,066 | 1781 | 12.6% |
| Apr 20-Aug 20 | 15,910 | 653 | 4.1% |

*Table 2: Percentage DNA rates in all IPU clinics between November 19-February 20 and April 20-August 20*

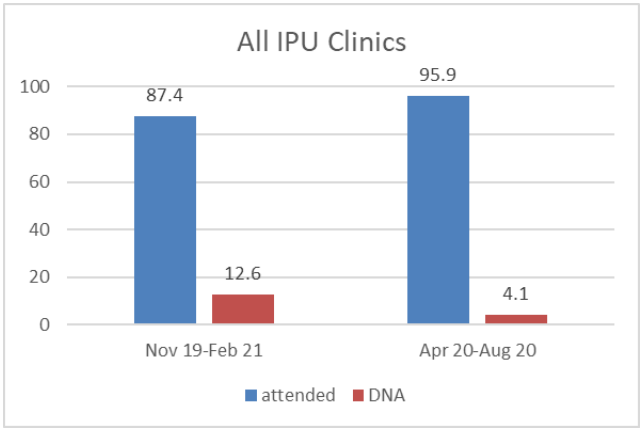



*Figure 2: Percentage DNA rates in all IPU clinics between November 19-February 20 and April 20-August 20*

## Discussion

The data analysis revealed that overall attendance rate has improved in outpatient's clinics following implementation of remote consultation methods.

With the advancement in technology, remote consultation has the potential to augment the existing practice, during and beyond the time of a pandemic. By providing the patients with the ease of attending a medical review from their home, remote consultations save time and travel expense to the patient. Patients with certain conditions like agoraphobia find this modality more comfortable than a face-to-face session. With adoption of electronic patient records and e-prescribing systems, remote consultation can be as effective as a face-to-face session for most of the medication reviews and follow-ups. Most of psychiatric outpatient consultations require minimal to no physical examination, remote consultation could be suitable for most of the patients in these clinics as per GMC recommendations.[2]

## Limitation

We did not gather data specifically for video versus telephone consultation. Trust is in the process of implementing AttendAnywhere video consultation platform. Since this video consultation platform is not fully implemented across the Trust, most of the data correlate to telephone consultations.

## Conclusion and Recommendation

Previous studies have identified that patients prefer the telephonic consultations due to benefits like less waiting time, reduced travel time and costs, and the possibility of increased frequency of contact..[3]

Considering the guidelines from GMC[2] and RCPsych[1], we suggest the patients attending psychiatric clinics should be offered a choice to book either remote or face to face consultation even after the pandemic is over.

Certain situations would warrant defaulting to face to face consultation, e.g., where physical examination is needed, there are significant communication difficulties or lack of mental capacity.

It would be useful to further evaluate the quality of consultations by patient feedback and satisfaction survey inquiring about their preference for remote consultation as opposed face to face consultation

## References

1- Royal College of Psychiatrists (RCPsych). *Digital Covid-19 guidance for clinicians*. RCPsych, 2020 (https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians/digital-covid-19-guidance-for-clinicians)

2-General Medica Council (GMC). *Remote consultations. Remote consultations (over the phone, via video link or online) have increased. So, when is it safe to prescribe without meeting a patient face to face?* GMC, 2020 https://www.gmc-uk.org/ethical-guidance/ethical-hub/remote-consultations

3-Car J, Sheikh A. Telephone consultations. *BMJ.* 2003 May 3;326(7396):966-9. doi: 10.1136/bmj.326.7396.966. PMID: 12727771; PMCID: PMC153854.

## Authors

Dr Asma Javed (ST6 in General Adult Psychiatry) Coventry and Warwickshire Partnership NHS Trust, currently working at Forward Thinking Birmingham, Birmingham Women's and Children's NHS Foundation Trust.

Dr Nandagopal Suresh (GPST1) Coventry and Warwickshire Partnership NHS Trust currently working at University Hospital Coventry.

Dr Ayman Zaghloul (Consultant Psychiatrist) Coventry and Warwickshire Partnership NHS Trust.

# A Cross-sectional Survey of CAMHS Eating Disorder Service in Walsall by Dr Lai-Ting Cheung, Dr Nneamaka Asiodu and Dr Sobia Rafi, Black Country Healthcare NHS Foundation Trust

## Introduction

Eating disorders (ED) can present in a wide range of settings and at any age but adolescents are most at risk[1 2.] It can cause significant physical and psychiatric complications2. Some estimates suggest over 700,000 people in the UK have an ED, 90% of whom are female[2].

The lifetime risk of ED is thought to be 8.4% (range 3.3 -18.6%) for women and 2.2% (range 0.8%-6.5%) for men2. The point prevalence of EDs is thought to be 4.6% (range 2.0-13.5%) in America, 2.2%, in Europe and 3.5% in Asia[2].

The National Institute of Mental Health reports 2.7% of those aged 13-18 struggle with an ED[3]. Overall incidence rate of AN (Anorexia Nervosa) is 6 per 100,000 population with highest incidence in those aged 15-192. AN has the highest mortality than any other mental health disorder – weighted crude mortality rate is around 5.1 deaths per 1,000 person-years and 20% of these deaths are due to suicide2. In addition to assessing for eating difficulties in detail, health professionals should also assess the physical health, effects of malnutrition, mental health issues and risk[1].

The Child and Adolescent Mental Health Service (CAMHS) ED Service is a very essential part of the service provision model within CAMHS. We conducted a cross sectional survey to look at referral practices, quality of information provided on referral and accessibility with the aim to build on existing referral pathways and criteria.

## Method

We aimed to review the referral information, demographics and care pathway for the CAMHS ED specialist services.

All patients under the age of 18 years, known to CAMHS Walsall ED service between 1st April 2018 to 30th April 2020, were included in our retrospective survey. Patients were selected from the local record of referrals into the service. A total of 65 patients were included in the survey.

Data was collected using existing electronic records from OASIS, including clinic letters, assessment records and entries. This was entered digitally using Google Survey, which collated information on age, gender, referral route, referral date, referral information, diagnosis, physical and mental co-morbidities, treatment received, medications, other agencies involved and risk. This data was then analysed using Microsoft Excel.

## Results

The study sample was 65 patients with 45 (69.23%) being females and 20 males. 53 patients (81.54%) were aged 14-18 years. The majority of referrals (52.31%) were from GPs followed closely by referrals from fellow CAMHS professionals (33.85%). 4 patients (6.15%) were referred from paediatrics, 2 (3.08%) were referred from school and 3 patients (4.62%) were either referred from Behaviour Support, LD nurse or Children's Crime Prevention. Most of the referrals had a baseline weight (48 patients, 73.85%) but very few included nutritional bloods (6.15%), baseline bloods (7.69%) or an ECG (3.08%).

17 patients had existing mental health co-morbidities. There was a prevalence of neurodevelopmental disorders with 6 (9.23%) diagnosed with Autism Spectrum Disorder (ASD) or Attention-Deficit Hyperactivity Disorder (ADHD) followed by depression and anxiety.

AN was diagnosed in the majority of patients (22 patients, 33.85%) as well as ASD-related EDs, which made up a large proportion of the cases. The majority were females diagnosed with AN (20 patients, 30.77%) followed by males with ASD-related ED (8 males, 12.31%). Bulimia Nervosa was seen in 5 patients (7.69%).

A multidisciplinary team approach was followed with a large majority receiving nursing support (50 patients, 76.92%). Family therapy and psychology were also offered (28 patients, 43.08% and 32 patients, 49.32%, respectively) as well as medical input (25 patients, 38.46%).

Where medication was required, the majority were managed with anti-depressants and low dose atypical anti-psychotics (16 patients, 24.62% and 15 patients, 23.08%, respectively). Food supplements were prescribed in 13 patients (20.00%). 25 patients (38.46%) were identified as being at risk of starvation, 16 (24.62%) were at risk of self-harm, majority (94%) being females.

*Table 1: Co-morbidities seen in CAMHS ED.*

| Co-morbidity | Female n=45 | |
|---|---|---|
| | **(n)** | **(%)** |
| Anxiety | 4 | 6.15 |
| Depression | 1 | 1.54 |
| Learning disability | 3 | 4.62 |
| Mixed anxiety and depression | 2 | 3.08 |
| ASD | 3 | 4.62 |
| ADHD | 0 | 0.00 |
| Physical health | 9 | 13.85 |

| Co-morbidity | Male n= 20 | |
|---|---|---|
| | **(n)** | **(%)** |
| Anxiety | 3 | 4.62 |
| Depression | 0 | 0.00 |
| Learning disability | 2 | 3.08 |
| Mixed anxiety and depression | 2 | 3.08 |
| ASD | 2 | 3.08 |
| ADHD | 1 | 1.54 |
| Physical health | 3 | 4.62 |

## Discussion

NICE guidelines for ED, published in 2017, advise it is important to provide support for young people. NICE recommends providing psychoeducation, monitoring weight and reviewing mental and physical health using a multi-disciplinary approach and involving families.

Studies have reported an overlap between interpersonal issues, non-verbal communication and restricted interests as well as inflexibility and social insecurity seen in ASD and AN[5]. A cross-sectional study exploring ASD in adolescent females showed 10 -40% of adolescents with AN may have a diagnosis or symptoms of ASD[4]. Another study investigating prevalence of EDs in ADHD/ASD patients found 7.9% of patients had a current or previous ED and 10-13% showed moderate-severely disturbed eating behaviour[5].

Treatment aims to reduce risk to health, help patients reach a healthy weight, provide healthy eating advice, nutrition, prevent relapse, body image, social skills, create personalised plans and self-efficacy[2]. Reviews should include the following measurements; height, weight, body mass index , blood pressure and pulse, relevant blood tests, problems with daily functioning and growth and development[1 2]. Our data showed a multi-disciplinary approach was used in Walsall CAMHS. Patients were offered nursing, family therapy, psychology and medical input as recommended by NICE[1 2]. Paediatricians were involved in managing severely malnourished patients as per the Junior MARSIPAN guidelines[1].

It is important to emphasise to referring professionals the importance of including a baseline weight, ECG and bloods. We only used electronic records for data collection, leading to limited accessibility to certain information, as this survey was completed during the Covid pandemic.

## Summary

Eating disorders can present in a wide range of settings and can cause significant health complications. Anorexia Nervosa has the highest mortality than any other mental health disorder. We conducted a cross sectional survey to look at quality of information provided on referral and accessibility with the aim to build on existing referral pathways and criteria. It is important to emphasise to referring professionals the importance of including a baseline weight, ECG and bloods. Treatment should involve a multi-disciplinary team, their families and include a review of their physical and mental health.

## Funding

This research received no specific grant from any funding agency, commercial or not-for-profit sectors.

## Author contribution

Dr Lai-Ting Cheung participated in data collection, data analysis and writing up the article.

Dr Nneamaka Asiodu was involved in formulating the study, designing the study, creating the questionnaire, helped with data collection and the write up.

Dr Sobia Rafi provided support with formulating and designing the study, supervision and the write-up of the article. The data that supports the findings of the study are available from the corresponding author, [SA], upon reasonable request.

## Authors

Dr Lai-Ting Cheung, Core Psychiatry Trainee Year 2, MBChB, Walsall CAMHS Medical Team

Dr Nneamaka Asiodu, Core Psychiatry Trainee Year 3, MBChB ,Walsall CAMHS Medical Team

Dr Sobia Rafi, Consultant in Child and Adolescent Psychiatry, MBBS, MRCPsych, PGCertME , Walsall CAMHS Medical Team

# E-Interview with Dr Tonye Bennett Sikabofori

## Divisional Medical Director (Consultant Psychiatrist) Intellectual Disabilities. Birmingham Community Healthcare Foundation NHS Trust

***Dr Tonye Bennett Sikabofori MBBS; MPH; ADPH; Diploma (FMHC); FRCPsych.***

Medicine was not my first career ambition. My initial aspiration was to enter university to become a solicitor. However, after being challenged by my peers at secondary school, through a dare like challenge to prove myself, I retook my A level options, resulting in me attending Ibadan Medical School, Nigeria.

Starting my medical career as a surgeon, I had the privilege of experiencing surgical practice in a rural setting which led to me undertaking a Masters in Public Health, to support the community hospital I was serving. My work in Benue State, Nigeria resulted in a life changing move to the UK in 2000. At which point my career direction changed to Psychiatry. After my SHO training, I became particularly interested in intellectual disability psychiatry completing my specialist training in 2009.

During my tenure as a Psychiatrist, I have been the lead psychiatrist for the Intensive Support Service in Northamptonshire and for the Birmingham Community Healthcare Foundation NHS trust. I was executive member of the Faculty of Intellectual Disabilities, Royal College of Psychiatrists. I am an Associate Lecturer for second year dental students, at the dental school University Birmingham.

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

My career as a doctor began with 'boys banter' after secondary school. It was suggested to me that I could not study medicine, I did, I have and now I am a doctor. Proved those boys wrong! I thank them for that challenge as it has brought me to where I am today.

### 2. What trait do you deplore in others?

Everyone has opportunity. I firmly believe that we should embrace opportunity to grow, for the benefit of individuals and for humanity. I find frustration with people who take opportunity for granted and waste opportunity for selfish gains, whether that is monetary, positional or reputational. We are artists of our own making, but we are not alone in the great drawing of life. We should embrace opportunity as a chance to be outward facing and how that opportunity serves the world we are building for everyone's benefit not just our own.

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

'Things Fall Apart,' by Chinua Achebe (Winner of the 2007 Man Booker International Prize.) The story explores the life of Okonkwo. He is portrayed as a great man in Igbo traditional society, who could not adapt to the profound changes brought about by British colonial rule. This classic tragedy, results in the external forces and cultural characteristics causing Okonkwo's downfall. This novel is recognised as one of the 100 best African books of the 20th century, portraying the collision of African and European cultures in people's lives.

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

Apart from taking time to enjoy my family: my wife, my children and our extended family, it can be said that I do like to be strategically selfish with the tele remote, especially when the F1 season is in play!

### 5. Which people have influenced you the most?

Whilst working as an SHO, I was particularly influenced by Dr Ashok Roy. He was the consultant who provided me with the inspiration to specialise in psychiatry for people with intellectual disabilities. He provided me with leadership learning and opportunities that gave me professional toolkits to facilitate my learning forward. I recognise that this grounded approach has allowed me to coach and mentor my junior doctors and support succession planning within the organisations I have worked.

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

If I the opportunity had arisen to be an F1 driver, I would have relished the chance to be a competitive sportsman in that field. Other than that I think I would have probably gone into politics via law.

### 7. How would you like to be remembered?

I would hope that I be remembered as a man of compassion, laughter and hope. My passion and zest for life is exemplified by the American composer Duke Ellington (1894 – 1974) 'Grey skies are just clouds passing over!' My life, hopes and dreams have come to fruition through the opportunities I have had to be heard alongside me ensuring that I am heard.

# Poetry by Dr Ian Russell, Retired Forensic Psychiatrist

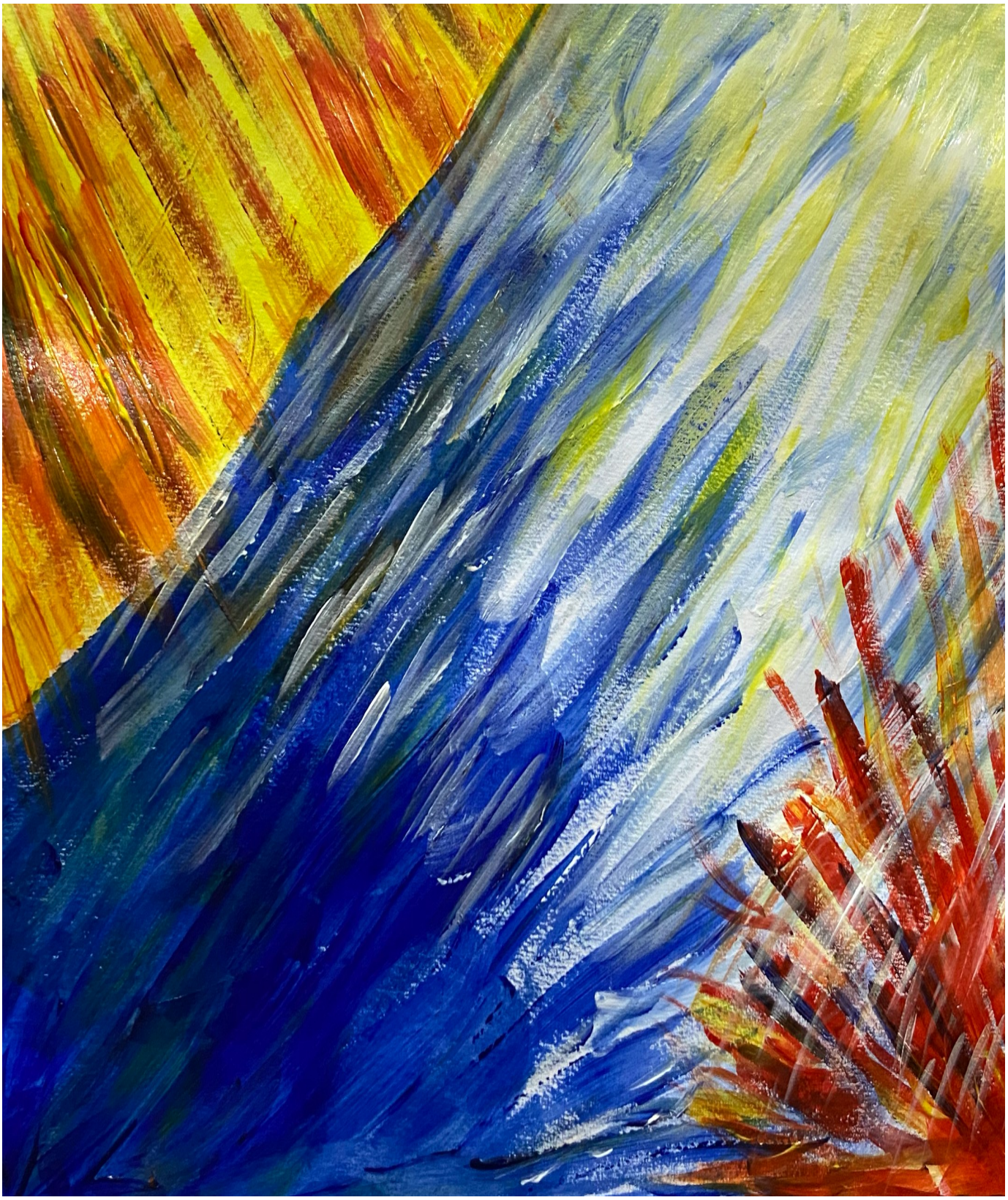
## Poem 1

Here and now
what a gift
of joy and wonder
no wind
grey skies
still and calm
life is beautiful
Be well

## Poem 2

Snow is falling
Ash is burning
embers glow
flames dance, with joy
I contemplate
I breathe
in and out
deep and slow
calm and ease
I smile
freedom
present moment, wonderful moment
Enjoy

# Painting Titled “Blessings” by Dr Ian Russell, Retired Forensic Psychiatrist



# Lifestyle Psychiatry – a Manifesto for Incorporation of Lifestyle Medicine Approaches in Mental Health Care

by Dr Charlotte A L Marriott, Consultant Psychiatrist - Herefordshire and Worcestershire Health and Care NHS

As an NHS Psychiatrist working in Early Intervention in Psychosis, I am keenly aware of the socioeconomic and physical health disadvantage that many of my patients suffer alongside their mental illness. We know that people with serious mental illness, such as schizophrenia, have a life expectancy 15-20 years less than the general population and this mortality gap appears to be widening[1,2]. Much of this excess mortality is a result of cardiometabolic syndrome or suicide. Schizophrenia itself is associated with cardiometabolic comorbidity, and this predisposition is compounded by higher rates of cigarette smoking, diets high in processed food, psychosocial stress, poor sleep routines and low rates of physical activity, and further compounded by the medications we prescribe that have increased appetite, weight gain and sedation as common side-effects, increasing risk for metabolic syndrome[3]. The 6 pillars of Lifestyle Medicine - physical activity and exercise, diet and nutrition, sleep, stress reduction, harmful substance reduction or cessation, and healthy relationships - can help to address these modifiable risk factors, and to combat medication side-effects. There is also a wealth of evidence that lifestyle factors, such as nutrition, nature exposure and physical activity, can reduce the risk of, and improve symptoms of other mental disorders, including clinical depression, anxiety disorders and cognitive impairment [4].

In my clinical work I ask questions about lifestyle and assess motivation to change with every patient. I offer evidence-based information to help people make informed choices. My Trust has a 12-week nutrition and exercise programme (SHAPE) that we can refer patients to, and a recent evaluation of the programme has demonstrated its effectiveness[5], although uptake by my patients is not as good as I would like it to be and there remain many barriers to lifestyle change that I hope to assess and address. My team launched a walking group in January 2020 and this has become a popular intervention that helps to break down barriers between staff and patients and has enabled patients who attend regularly to form their own support network. We are further expanding our Lifestyle Medicine offering with a cooking group, and plans for a community garden or allotment are being developed.

There is no health without mental health, and there are simple things that we can all do every day to reduce the risk of developing common mental health problems such as stress, insomnia, anxiety and depression. I would like to inspire my colleagues in Psychiatry and General Practice to adopt an evidence-based Lifestyle Medicine approach to patient care, as part of the biopsychosocial framework we all use to inform assessment and treatment, and to reduce the burden of chronic comorbid disease in our patients (and ourselves!). As Chair of the British Society of Lifestyle Medicine's Mental Health Special Interest Group, I and my peers aim to influence national policy and clinical guidelines; we are heartened to see that NICE have incorporated the strong evidence-base for physical activity in the updated guidelines for depression (NICE guideline CG90) but there is still much work to be done in translating the research evidence for lifestyle interventions into clinical practice in the UK.

## References:

1. Laursen TM, Nordentoft M, Mortensen PB. Excess early mortality in schizophrenia. Annu Rev Clin Psychol. 2014;10:425-448.

2. DE Hert, M., Schreurs, V., Vancampfort, D., & VAN Winkel, R. (2009). Metabolic syndrome in people with schizophrenia: a review. World Psychiatry, 8(1), 15–22. https://doi.org/10.1002/j.2051-5545.2009.tb00199.x

3. Pillinger T, McCutcheon RA, Vano L, Cipriani A. Comparative effects of 18 antipsychotics on metabolic function in schizophrenia, predictors of metabolic dysregulation, and association with psychopathology: a systematic review and network meta-analysis. Lancet Psychiatry. 2019 Dec 17;7.

4. Firth, J., et al., (2020), A meta□review of "lifestyle psychiatry": the role of exercise, smoking, diet and sleep in the prevention and treatment of mental disorders. World Psychiatry, 19: 360-380. doi:10.1002/wps.20773

5. Smith, Jo, et al. Early Intervention in Psychosis: Effectiveness and Implementation of a Combined Exercise and Health Behavior Intervention Within Routine Care. Frontiers in Endocrinology 11 (2020): 825.

## Author

Dr Charlotte A L Marriott, Consultant Psychiatrist and Certified Lifestyle Medicine Physician MB BS BSc (Hons) MRCPsych PGCME DipIBLM

# Promoting Staff Wellbeing in an Inpatient Psychiatric Hospital during the COVID-19 Pandemic: A Wellbeing Workshop Initiative

by Fauzia Khan, Assistant Psychologist and Samina Allie, Senior Counselling Psychologist, Black Country Healthcare NHS Foundation Trust

## Abstract

The current paper provides an account of a wellbeing workshop initiative that was pioneered by Samina Allie and Fauzia Khan at an acute inpatient psychiatric hospital in the West Midlands, during the peak of the COVID-19 pandemic. The current paper details the rationale behind the initiative, the content of the workshops, as well as feedback from staff at the hospital.

## Introduction and Rationale

With the arrival of the COVID-19 outbreak, it was identified that there had been a number of challenges that staff across our inpatient psychiatric service had been facing due to the unprecedented challenges that were brought on by the pandemic. These challenges pertained to both professional and personal aspects of our staff's lives. As a psychology team, we recognised the importance of promoting mental wellbeing to our staff, in order to allow them to take better care of themselves. This was important because we recognise that staff working in healthcare settings may often put other's needs before their own, and may therefore be at increased risk of burnout [1].

We sought to introduce a wellbeing workshop initiative to all our staff groups, which included nursing, healthcare support staff, ward managers, housekeeping, ward clerks, and allied health professionals.

There were numerous aims that we hoped to achieve. These were:

- To offer a space away from the ward environment where staff could engage and participate in a workshop that focused purely on their health and wellbeing needs.
- To provide staff with a safe space to talk about their concerns, and allow them to feel listened to and heard.
- To offer the opportunity for staff to express themselves, make sense of their thoughts and feelings and to explore and introduce new ways of coping.

## Delivery of Workshops

The workshops were delivered for each staff group in four consecutive phases, in order to ensure that the unique and individual needs of that particular staff group were addressed effectively.

## Content of Workshops

The workshops were curated on the premise of promoting wellbeing because we recognised the pressures that staff were experiencing and noticed they were beginning to feel burnt out.

In caring and helping professions, staff are often so used to taking care of the needs of others that they often lose touch with caring for themselves. We believed that drawing on interventions from Compassion Focused Therapy [2] would be greatly beneficial and appropriate, because it would encourage staff to take a more compassionate approach to their own self-care needs. We also drew on self-soothing, from Dialectical Behaviour Therapy [3], and Mindfulness, in order to promote the development of adaptive coping strategies. Staff were given the beginnings of a self-soothing box to take away with them and develop (Figure 1.). It was believed that providing staff with this box would be more beneficial, than simply introducing and talking about self-soothing skills, as it would provide them with something more tangible to draw upon. They were also provided with an 'Envel-Hope of Happiness', which is a symbolic keepsake (Figure 2.).


*Figure 1*


*Figure 2*

The content of the workshop included creative activities, namely a 'Self-Care Vision Board Exercise' that utilised items from our creative wellbeing toolkit, which included natural objects, miniature figures and imagery cards. This exercise provided staff with the opportunity to creatively express their coping skills, and aspects of their personality outside of work. There were a number of benefits behind this. This task allowed staff an opportunity to share personal aspects of themselves with colleagues, which helped to model adaptive coping strategies and strengthen working relationships as staff were able to learn more about one another. It also allowed staff to see a visual representation of their strengths and resources, which they may not otherwise have been able to identify and reflect on so easily. Below are examples of the vision boards (Figure 3; 4.).

*Figure 3*

*Figure 4*

## Feedback

The feedback we received was overwhelmingly positive. These are some of the comments staff shared:

"When we look at working on projects around Staff Health and Wellbeing, it is important that we achieve many factors. Of course, it needs to be beneficial to the Health of those accessing it, but it also needs to be engaging for staff, relative to their own situation, appropriate for the individual but also for the team, and educational. The Workshops have been successful in bringing all of these factors together. At a time when staff resilience needs to be stronger than ever, they have been delivered to teams with very positive feedback and received recognition on private staff spaces."

"The workshop came at a great time for our team. With the restrictions imposed by COVID-19 and the changes that were made to our method of working, staff wellbeing was more important than ever. The workshop was delivered within a safe, person-centred way, which ultimately made engaging with the session natural and enjoyable. There were ample opportunities to talk about how people felt, and the facilitators did an excellent job in making members feel valued and appreciated"

## Future Directions

Due to the success of the wellbeing workshop initiative, there were discussions within the Trust to see how this initiative could be replicated and delivered service-wide at a more corporate level. We were consequently involved in training wellbeing leads within the Trust, so that this could be taken forward and cascaded more widely.

This initiative has received recognition at a national level, being shortlisted as a Finalist in the APT Awards for Excellence in Fostering Good Mental Health in the Workplace 2020, which was a huge achievement for our Trust [4].


## References

1. Oddie, S., and Ousley, L. (2007). Assessing burn-out and occupational stressors in a medium secure service. *The British Journal of Forensic Practice*, 9 (2):32–48.

2. Gilbert, P. (2009). Introducing compassion-focused therapy. *Advances in Psychiatric Treatment*, 15(3), 199 -208. DOI: 10.1192/apt.bp.107.005264. Retrieved from http://apt.rcpsych.org/content/15/3/199

3. Linehan, M. (1993). *Cognitive-Behavioral Treatment of Borderline Personality Disorder*. New York: Guilford Press.

4. Association for Psychological Therapies (2020). APT Awards for Excellence 2020: Finalists and Award Winners. Available at: https://www.apt.ac/awards/apt-awards-for-excellence-2020.html (Accessed: 03 February 2021).

## Authors

Fauzia Khan, BSc (Hons), MBPsS, Assistant Psychologist, Black Country Healthcare NHS Foundation Trust;

Samina Allie, CPsychol, AFBPsS, Senior Counselling Psychologist, Black Country Healthcare NHS Foundation Trust.

# RCPsych Trainees' Conference 2021: Breaking Barriers to Recruitment & Retention

## By Dr Laura Stevenson, West Midlands Psychiatric Trainees Committee Representative

A huge thanks to all of you who were able to join us for the second national conference hosted by the Psychiatric Trainees' Committee (PTC) on Thursday 25th and Friday 26th March 2021. The conference had originally been scheduled to take place this time last year, following on from the success of the 'Supported and Valued' inaugural conference, however, due to COVID-19, was understandably but unfortunately delayed. The virtual platform however enabled a far greater reach and we were pleased to welcome a number of international delegates to the conference.

In total there were over 200 delegates across the two days and the feedback thus far received has been incredibly positive. The role of the PTC is to advocate for, represent the views of, support and encourage trainees within psychiatry and we hope that through some of the sessions you were able to learn more about how we have been doing this and what has been achieved. Our chair, Dr Luke Baker provided an overview of some of the projects the PTC has been leading on and the progress made. We worked hard to source some inspirational speakers from all four devolved nations across the two days who covered a huge variety of topics of interest. These ranged from learning to lead, an update on the changes to the curriculum and e-portfolio, personalised training and asking for the job you want. The session delivered by Dr Rebecca Lawrence, a psychiatrist with lived experience, and that by Dr James Tidder, focussing on dealing with significant events, were highlighted for their personal account and openness.

We were joined by some of the College Officers including the President, Dr Adrian James, Dean, Dr Kate Lovett and Chief Executive, Paul Rees amongst others. We had been made aware already of an issue relating to some of the questions in the recently sat Paper B and were pleased that the Officers had the opportunity to address this directly with those of you in attendance.

As well as the above we were able to hold 5 workshop sessions throughout the two days on a huge array of useful subjects. These included getting the most out of special interest sessions, quality improvement, less than full time training, pathways to ST and CESR and trainee opportunities in publishing to name but a few. All of the workshops and sessions will be available to view for those of you who did attend so please do catch up on the really valuable sessions and workshops that you were not able to get to on the day!

A large part of this event at its conception revolved around trainees' having the opportunity and space to meet each other, network and share ideas and practice. This is harder to facilitate virtually but we took the chance to think outside the box and organised a virtual escape room on Thursday evening which went down a storm! Congratulations to those of you who managed to make it back from the Arctic! We hope you had a great time!

We are already starting to look to the future and what our next conference might involve and would very much welcome your views and suggestions so please do get in touch via the usual channels.

Sending warmest wishes

Dr Laura Stevenson

West Midlands Psychiatric Trainees Committee Representative

# What do Psychologists actually do? An Interview with a Psychologist

by Fauzia Khan, Assistant Psychologist and Samina Allie, Senior Counselling Psychologist, Black Country Healthcare NHS Foundation Trust

**Abstract:**
The interview below was conducted by Fauzia Khan, Assistant Psychologist, at Black Country Healthcare NHS Foundation Trust. The interview aims to raise awareness around the role of a psychologist, and highlights some of the varied duties of a psychologist working within the NHS in the present day context .

Fauzia: Hi Samina, thank you for agreeing to this interview. Perhaps you can start by telling the readers a little bit about your background and what your job role as a Psychologist entails.

Samina: My name is Samina Allie. I am a highly specialist Chartered Psychologist currently working part-time within the Black Country Healthcare NHS Foundation Trust, where I have worked since 2007. My role is very varied and no day is ever the same. I am responsible for a clinical caseload, which includes individual and group work, supervision and reflective practice.

I have also been involved with co-facilitating a Balint Group, which seeks to support psychiatry trainees and junior medical staff to cultivate the necessary skills to think more psychologically, and to encourage them to take a reflective psychotherapeutic approach to all aspects of their routine clinical practice in psychiatry.
My role also involves delivering teaching and training. I have been involved with teaching on the CBT course in the Trust; and have taught on the CBT Diploma at Wolverhampton University. I have previously delivered workshops on Obsessive Compulsive Disorder, Anxiety and Hearing Voices.

## Fauzia: How do you view the role of Psychology?

Samina: I see the role of psychology as a service that complements and enhances the quality of the service provision as it often empowers clients and team members. One way I try to lead others in development of knowledge, ideas and work practice, is by modelling the effectiveness of psychology in the team and in turn the team members might be inspired by what they see. This also raises the psychological profile and mindedness within the team. To evaluate my work informally, I routinely engage in conversations with team members/leaders to see how best psychology could enhance and be of benefit to their work.

## Fauzia: What made you choose this career path?

Samina: I have always been really fascinated by people and when I was younger I got involved with the National Schizophrenia Fellowship (now known as Rethink) and was a befriender with them and also the Samaritans. These roles gave me real insight into the world of mental health and became the foundation for me to build upon my knowledge and further develop my skills and want to take this interest further.

## Fauzia: What is a typical day at work for you like?

Samina: The great thing about my job is that there is never a typical day. Every day varies and each day comes with its own challenges. I think the best thing about my job is being surrounded by an excellent team – where we support one another to do the best that we can in some very challenging times.

## Fauzia: What motivates you at work?

Samina: Supporting our clients to make a small change or help them to understand the journey they have made, and start to develop coping skills so that they can view things with a more positive lens is so rewarding and valuable.

## Fauzia: What are some of your career highlights?

Samina: Quality and service improvements are a key part of my role. I am a member of the Inpatient Psychological Practitioners Network and through this network share and disseminate best practice ideas. I attend several events throughout the year at the British Psychological Societies head office in London. Through this network I have been able to develop ideas and projects, such as the 'Narrative Project', which has been published in the Counselling Psychology Review [1]. I led on the implementation of this project and this enabled me to help, support and strengthen relationships between staff and inpatients. The therapeutic benefits were immense and we were shortlisted as finalists by the Patient Experience Network National Awards (PENNA) for this project, which was a huge achievement for our organisation.

Co-facilitating groups with members of other disciplines is also an area I have been involved in strengthening, as I believe that it allows us to shape and model staff to utilise psychological ideas and develop their skills in group interventions. We have also published articles relating to this [2]; [3].

## Fauzia: What do you like to do in your spare time?

Samina: Work can be quite challenging at times so it's really important to find space to de-stress. I studied Art at A-level and always found it very therapeutic so attend art workshops as a way of relaxing.

## References

1.Whitall S, Allie S. (2011). Using narratives on an acute psychiatric ward. Counselling Psychology Review, 26(3), 34-44.

2. Khan F, Allie S. Benefits of nurse co-facilitation of a Hearing Voices group. Nurs. Times 2019; 115: 54-56.

3. Khan F, Gupta N, Allie S. Reflections on Facilitating a Hearing Voices Group in an Acute Psychiatric Hospital. RCPsych West Midlands Division Newsletter 2020.

## Author

Fauzia Khan, BSc (Hons), MBPsS, Assistant Psychologist, Black Country Healthcare NHS Foundation Trust; Samina Allie, CPsychol, AFBPsS, Senior Counselling Psychologist, Black Country Healthcare NHS Foundation Trust.

# West Midlands Updates

## Executive Committee

The West Midlands Division Executive Committee meets three times a year.

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

The committee's next meeting takes place virtually on **25 June 2021, 9-11.30**.

## Find out more information about the Divisions

Our eight Divisions play a central role in the delivery of services to the 12,000 members in England. The Divisions support members via core activities which are coordinated locally by each Division's Executive Committee and staff.

Read our Dynamic Divisions booklet (PDF) to find out more about the work of our Divisions

## Section 12(2) and Approved Clinician

## Training Courses

Refresher courses If your Approved Clinician or Section 12 approval period is due to expire before 31 March 2021, you will be granted a 12-month extension period. Read further details on the temporary extension.

Further online courses will be available in 2021. Please register your interest to receive updates on future courses.

Section 12 (2) Induction: Find out more about the online course and book your place

Section 12 (2) Refresher: Find out more about the online course and book your place

Approved Clinician Induction: Find out more about the online course and book your place

Approved Clinician Refresher: Find out more about the online course and book your place

Please note: Attending one of these courses is only part of the process to becoming accredited.

We would strongly advise you to check with your local NHS Specialist Mental Health Approvals Lead (PDF) for information on the criteria for approval/re-approval, and to confirm which course is suitable for your requirements before registering for a course.

If you have any queries, please read our Approved Clinician FAQs or Section 12 FAQs. If you can't find the answer to your question there, please contact S12ACtraining@rcpsych.ac.uk

# West Midlands Updates

## Get Involved!

If you would like to submit an article for inclusion in the next edition, please email it to Dr Nilamadhab Kar (westmidlands@rcpsych.ac.uk), Editor by 11 November 2021.

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

# Psychiatry-West Midlands

Royal College of Psychiatrists
C/O 21 Prescot Street
London
E1 8BB

Phone: 0121 803 9075

Email: Westmidlands@rcpsych.ac.uk

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

***The West Midlands is made up of members from Birmingham and the Black Country, Staffordshire, Shropshire, Warwickshire, Herefordshire and Worcestershire.***

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

**Deadline for next edition**
**Submit your articles for the autumn 2021 edition by 11 November 2021 at westmidlands@rcpsych.ac.uk**

**Royal College of Psychiatrists - West Midlands E-Newsletter**

**Editorial Team:** Dr Nilamadhab Kar , Black Country Healthcare NHS Foundation Trust
**Chair:** Dr Ignasi Agell , Midlands Partnership NHS Foundation Trust
**Review Board:** West Midlands Division Executive Committee, Royal College of Psychiatrists
**Production:** Marie Phelps,, Trent and West Midlands Manager, Royal College of Psychiatrists