London Division eNewsletter - Summer 2016

Editorial from Dr Rory Sheehan and Dr Chris Symeon

Welcome to the summer issue of *The Psychiatric Eye* in which we explore how technology influences our work as psychiatrists. The topic proved popular with readers and generated a number of submissions by authors who draw on their own experiences and approach the theme from different angles.

Several articles explore how technology has revolutionised how we communicate with patients and obtain information. Dr Fabian Bonello reflects on the challenges that electronic patient records can pose for effective information sharing and highlights a novel strategy that has been used to mitigate these problems. Dr Ram Seth and colleagues have contributed a piece highlighting the scope for computer-assisted assessment and therapy to improve the reach and cost-effectiveness of interventions; and Dr Romayne Gaderlab extends this discussion by asking whether technology could take us away from forming authentic human connections with our patients. The potential of technological innovation to improve efficiency is examined by Dr Michael Rutherford and colleagues, who present the result of a project to embed voice recognition software into clinical practice.


Congratulations to Dr Christian Brown who tackles a dilemma that will be familiar to many – managing patients' use of smartphones on acute psychiatric wards – and asks how we can protect our patients from harm whilst respecting their right to least restrictive treatment.

You have won yourself two tickets to any upcoming London Division event.

Don't miss our regular features including highlights of the 2016 International Congress by Dr Andrew Sommerlad, and a FaceTime interview with Dr James Woollard, who tells us about his work as a senior clinical fellow in mental health technology at NHS

England. Our ‘Culture Vulture’ article, Technically Speaking by Dr Peter MacRae, describes the co-production of an ingenious piece of modern theatre aimed at tackling mental health stigma. And we are proud to introduce a new addition to our regular items that will showcase artwork related to mental health - our debut is ‘The Watcher’, an unusual and thought-provoking painting by George J Harding who contributes a brief commentary explaining the symbolism in the work.

Once again, many thanks to all our contributors. We hope you enjoy reading - join the conversation @ThePsychEye

Chair's Message

 *Dr Shakeel Ahmad , Chair of the London Division Executive Committee*

A lot of us would have had the pleasure of attending the College Annual Congress recently. It has rejuvenated our up to date knowledge on various aspects of psychiatry. As we all know, the Congress is such a wonderful event with a huge choice of educational and learning opportunities. At times it becomes hard what to choose and what to miss.

We were informed this has been the biggest Congress in terms of numbers of attendees, both locally and from abroad. Of course, it also gives us our much needed CPD points for our appraisals.

This is our Congress. While its reputation grows as one of the top educational events in the world in the field of psychiatry, we can also participate in the Congress by helping the organisation of the event in many ways. We can help with operational organisation, coordinating events, hosting workshops or seminars, poster presentations, etc.

Thank you to all who contributed to the Congress this year and made it the big success it has been.

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Themed Article:

Mobile Phones, Digital Spaces, and Inpatient Admission

Dr Christian Brown

Mobile phones are essential components of modern life. They haven't just changed the way we communicate, they've changed the way we think and learn. Many people live the greater part of their social lives through mobile devices. A phone today is more than just a phone - it's a bank, a camera, a photo album, a music library, a supermarket. It's a diary, a gateway to friends and family, it's a thousand newspapers and a million books. It is quite possible to live in a digital world, where mobile phones are the door and the key.

The implications for inpatient admission are complex and profound. On one hand, phones provide a tether to normal life, much needed in a socially sterile and other-worldly inpatient atmosphere. On the other hand, they might subvert the 'safe space' environment which wards are designed to provide. The unique challenge posed by mobile technology lies in the multitude of different functions encapsulated by a single device. Confiscation of a phone might constitute a significant restriction of personal liberty. Indeed, for those who live most of their lives through digital means, it follows that confiscation of a phone should be justified with as much care as involuntary detention itself.

In the same way that physical admission might protect patients from harm in physical spaces, confiscation of mobile technology might protect from harm in digital spaces. Manic patients might continue to over-spend in online shops, or give money away through mobile banking. Others might, in a vulnerable state, expose themselves online physically or mentally, in a way which puts them at risk. Some patients might be in abusive relationships, their phones allowing them to continue receiving abuse, or to continue abusing. One can find entire online communities which normalise pathological behaviours, take the 'proana' movement for one.

Any one of these reasons might be sufficient to justify removal of a phone from a detained patient. However, to do so would be at the expense of all other social and personal functions which the device supports: the counter-effects need to be considered.

Many people find solace and counter agitation by listening to music on their phones. Rather than joining the queue to use the expensive and temperamental pay-phone (situated in the middle of a busy ward), they contact their partner or parents in the privacy of their own room - support and love are often easier to find with a little privacy. There's no end to the information available online regarding mental illness - our patients are right to stay informed, and the internet used carefully is a rich resource. Phones also allow the banalities of normal life to continue, paying the bills, keeping up with the news, providing some normality at a time of probable distress and change.

There is no clear guidance on how to approach the new, and unique problem which arises when the use of mobile technology is thought to be putting patients at risk. Thoughtless confiscation is heavy-handed and fails to appreciate the multimodality of digital technology. Crucially, a risk assessment and plan which considers a phone as a functionally singular device, has failed.

If there is thought to be a risk associated with an item of technology, then staff ought to understand what the device means and does for the patient. A list of functions which the patient frequently uses should be drawn up, and each should be risk assessed separately. In some cases, it might be possible to mitigate risk without confiscating the phone. For example, with over-spending, the underlying credit card could be cancelled. It might seem like an easier option to take the phone away, and if the phone is of little use or importance to the patient this may still be the most appropriate thing to do. However, if the patient is highly dependent on the device, the ease of confiscation should not trump the other restrictions it will impose.

If the risk cannot be adequately addressed without the removal of the phone, then ways of replacing the other functionality of the device should be found. Music could be listened to on another device, the news could be made available on a ward-computer, and alternative telephones should be available.

With time, people will become ever more dependent on mobile digital technology. There should be a concerted effort to better understand the ways in which this can benefit admitted patients, as well as risks this poses. Formal guidance about mobile technology should be developed to guide clinicians through challenging practical dilemmas, as well as reassure patients that their liberties are not being restricted arbitrarily.

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Themed Article:

Cracked screen - The shadow of new technology and its effect on death and dying

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Dr Matt Rinaldi

The Happiness Institute of Copenhagen recently published 'The Facebook Experiment'. It demonstrated in a sample of 1095 Facebook users that one week away from Facebook improved their life satisfaction and made them feel less sad, lonely and angry. They conclude that Facebook is 'a constant flow of edited lives which distorts our perception of reality' [1]. With such a claim, it is important to tease this apart psychoanalytically and how recent changes in social media re affecting our grieving processes.

The narcissistic view of ourselves that is presented via social media outlets is documented as one part of the analytic research into social media [2]. In summary, social media allows one to present an idealised version of oneself through selected

attractive selfies, success stories and considered witty remarks presented as off-the-cuff humour. This is to the exclusion of our fallibilities and weaknesses in the search for external validation or

‘likes’. This narcissism is exemplified in Facebook’s refusal to compliment the ‘like’ feedback function with a ‘dis-like’ button, enhancing the narcissistic feedback loop.

The opposite of ‘likes’ is the phenomenon of trolling. Behind a screen of anonymity, online personas aggressively attack people’s posts. These range from general feedback to harsh criticism. It snowballs, becoming ever more brutal and derogatory, in turn attracting more trolls. This process has driven victims to suicide. Studies suggest that their behaviour stems from sadism, antisocial behaviour, psychopathy and Machiavellianism [3 & 4]. The extremes of feedback seen in online comments boxes represent pathological splitting and makes it difficult for those overly involved with social media ‘realities’ to appreciate the complexity of human nature.

Defence mechanisms are also revealed in the invention of smart-phones. Our oral connection several times a day whilst cradling against our phones provides to the adult what breast-feeding and holding does to the infant, much as the transitional object. This idealised ‘smart-phone self’ has perfect memory (accessible emails and SMS threads), is intelligent (Wikipedia access), nourishes us (HungryHouse), tells witty tales (holiday photos on demand), tells us where to go (maps), remains close-by and slim and attractive throughout its life span. Just like the ideal mother.

We are trusting more of ourselves to our phones. Weighing scales and even toothbrushes are being developed with Wi-Fi connections. In the near future, it could be de rigueur that our phone will know how often we brush the inside of our left upper molar and the rate at which we are increasing our body fat percentage. Ever more, the distinction between ‘me’ and ‘my phone’ is becoming blurred.

We defend ourselves against general anxiety by projective identification with our smart-phones and it is revealed when one loses or has their phone stolen. It is more than simply the loss of an object, it is a loss of the object; of self and the ability to connect with others. I pay as much for life insurance as I do to insure my phone and this reflects the relative value I attach to each.

Furthermore, the development of ‘apps’ whereby one can store photos, videos, text, body fat percentage, tooth-brushing technique data in discrete locations

within one's phone represent fragmentation. As Klein warns us [5], this process, if prolonged or enduring, weakens the fragile unintegrated ego and causes severe disturbance. Clinically, this is of concern for anyone who identifies overly with their phone and can explain why the aforementioned Norwegians felt such relief at disengaging with at least a part of this process.

The internet, whilst vital, alive and expanding is also a grave yard as websites are coded, uploaded and superseded. Old sites are rarely removed, existing until the domain name expires. Heaven's Gate is a chilling example of this. Most of the members of this California cult committed mass suicide in 1997 by eating poison-laced apple sauce. Despite this, their philosophy and testimonials persist on the internet and the marketplace even allows you the option of purchasing their videotapes [6].

Whether it be in the face of pending mass suicide or the distant inconceivable death of a frustrated, blogging teenager, these are e-defences against the death anxiety. Knowing that so long as the post is made on a website with an indefinite lease on the domain name, they are reassured that their posts will remain to outlast them. These are an

extension of defences previously outlined in legacy planning. As Kierkegaard might put it, bloggers, ‘tranquilise themselves with the trivial’ [7].

This process complicates grieving. Facebook is aware of the impression an idle profile-page gives off to visitors - it is ambiguous yet is clearly of value to the user in minimising death anxiety and in mourners in maintaining an image of the deceased. This is partly the reason why Memorial Pages [8] (virtual tombstones) became so popular in 2015. However, knowing that it is an idealised self that users have libidinised their Facebook accounts with, this will stall the grieving process as Freud pointed out in Mourning and Melancholia [9], it is a narcissistic object relationship that the melancholic has with the abandoned object.

This is presented as one part of the ever-changing landscape of social media and as more evidence emerges as to its influence on our mental health, it is important for us to remain vigilant for changes and to consider further how we as psychiatrists will advise on the use of these technologies using the analytic principles underlying our engagement with the technology.

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Themed Article:

Patient Decision Aid (PDA) for antidepressant use in pregnancy: Our experience running a pilot RCT

Emma Molyneaux (Phd)[1] and Ruth Brauer (PhD)[1]

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The huge potential and the possible pitfalls of technology in psychiatry have been the topic of much discussion in our office over the past year as we run a pilot of an online patient decision aid (PDA). This PDA is designed for women who are pregnant or planning a pregnancy and have been recommended to start or continue using an antidepressant during their pregnancy but are unsure what to do. Women making this decision can fall into a gap between services – their antidepressants are usually prescribed by a GP who may not have specialist knowledge of the current evidence around depression and antidepressants in pregnancy.

Some women receive advice from specialist obstetricians, but this is rare. Most women do not have symptoms that are severe enough for referral to perinatal psychiatric services, particularly if they have been successfully managing their depression with antidepressants for several months or years prior to pregnancy. In addition, specialist services are also often overstretched and have substantial waiting lists. As a result, many women make a choice about antidepressant use in pregnancy without ever seeking clinical guidance and often search online to find information on risks and benefits of antidepressant use in pregnancy.

The amount of information available after typing a few words in a search engine encapsulates both one of the main benefits and one of the major risks of the internet as a tool in psychiatry. We know that women find the ability to access information in their homes invaluable and empowering, and this is particularly the case for groups who may find it particularly difficult to access other services such as women with small children, those who work long hours or those living far from relevant services. However, women in our study have also reported their difficulties finding reliable information among the huge amounts available. As well as the trustworthiness of the information, the way it is provided is crucial. Online resources are often either very oversimplified or are complex academic papers or clinical guidelines, and neither is right for women without specialist knowledge. Having the right level of detail and knowing that the information is evidence based are two of the main sets of positive feedback on the online PDA we have had from women taking part in our pilot study.

PDAs also provide a structure for processing information and encourage thinking about what aspects are particularly important. In addition, providing decision aids online allows information to be accessed where it is needed and not replicated between services. Another benefit, although not covered in our trial, is that online supportive communities can grow, as demonstrated by things like #pndchat on Twitter.

As well as the PDA itself, we have learnt a lot about the practicalities of conducting trials of technology based interventions. When our study started, we planned to recruit women by referrals from local care providers - GPs, midwives and mental health services. We arranged meetings, sent and put up circulars, and were supported by the extremely helpful Clinical Research Network facilitators for South London GPs. Months passed with almost no referrals. The reasons why the online PDAs are helpful are also reasons why recruiting through services was difficult; GPs have little time, women who would benefit from the study are rarely referred to perinatal psychiatry services, and providers often feel that women generally made the decision before coming to see them. Online recruitment by advertising through websites and social media of organisations like NCT, Tommys, PANDAS and Mumsnet proved to be far more successful. We have an online contact form and consent form (both encrypted) and conduct interviews over the phone. Before any woman takes part, we also make contact with their clinician (usually the GP) to inform them that their patient is interested in the study and make sure that the clinician is happy with their participation. This has also increased our use of the other end of the technology spectrum – the fax machine!


PD
Patient Deci

So, what has our experience taught us so far? There is substantial potential in technology including online PDAs, particularly to fill gaps between services and where more time and more specialist knowledge is required than is universally available in primary care. Online tools need to be user friendly, optimised for smart phones and tablets, as well as computers – and to provide evidence based information with the right level of detail. For testing feasibility of an online tool, online recruitment is more effective and provides opportunities for future recruitment. However, relationships with gatekeepers to online groups (e.g. social media managers) are key, similar to clinician champions when recruiting from healthcare settings, perhaps proving that technology lends a helping hand to an investigative mind.

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Themed Article:

Mind the gap – Is patient safety slipping between IT systems?

Dr Fabian Bonello

The digital era has brought many improvements to our everyday lives. It has revolutionised our pursuit of knowledge and our perception of the world around us. It is understandable, therefore, that these innovations have been adopted into our working routines. For years now, technology has transformed and facilitated the practice and delivery of healthcare, including mental healthcare.

We have quicker patient-professional communication, easier access to a vast amount of patient information and support for common mental health conditions, and provision of computerised therapies such as online CBT. But what has the technological revolution done for patient safety? I argue there is a risk to patient safety posed by the interface between differing IT systems.

Health services and social services often commission different IT systems that are bespoke to their needs. However, these systems do not always ‘speak to’ each other. In clinical practice this has led to difficulties in accessing vital patient information between different services; I have experienced this challenge in my current job working in an integrated learning disability team where mental health services use RiO and social services use a system called Mosaic.

Four major difficulties are faced due to lack of effective interface between these systems.

1. Firstly, poorly-informed services. When a person presents for acute assessment, not all relevant information required by mental health services may be available, despite the person possibly being well-known through contact with other services involved in his care, such as social services. This may range from a simple current medication list, to extensive formulation and risk information. Inability to access such data can lead to compromised decision-making and sub-optimal management.

2. The second concern is wasteful use of resources, both as time spent in obtaining relevant information from other services and duplication of work that might already have been done.

3. Third is the issue of fragmented follow-up. Segregation of patient information can lead to poor communication between professionals and reduced awareness about a patient’s needs. An example is when inpatient teams organising CPA meetings but don’t invite care co-ordinator because they are unaware of their involvement. Consequently, such practice may result in inadequate follow-up in the community, posing a risk to the patient’s safety and wellbeing.
4. Finally, one cannot overlook the impact on patient experience. Waiting for professionals to obtain relevant data and repeating information can lead to delays, can be frustrating, and might undermine confidence in our ‘team approach’.

So what is being done to overcome these problems?

In recent years, there has been an increased drive to move towards compiling

Integrated Patient Records. Such records differ from the electronic health records held by a single provider in that they allow for the combination of structured and unstructured information from various agencies, professionals, and IT systems. This can include out-patient and in-patient health records, medical imaging and laboratory results, and care management and clinical pathway information.

The Camden Integrated Digital Record (CIDR) is an example. This was established when the Camden Clinical Commissioning Group developed a partnership between Camden General Practices, University College London Hospitals NHS Foundation Trust, Royal Free London NHS Foundation Trust, Central North West London NHS Foundation Trust (Community Care), Camden and Islington NHS Foundation Trust (Mental Health), Royal Marsden NHS Trust (Coordinate My Care) and the London Borough of Camden (Adult Social Care). Together, these health and social care providers developed a digital record that (with patient consent) enables sharing of information across agencies. This gives all health and social care professionals in the partnership the opportunity to review comprehensive information in a timely manner, thereby facilitating continuity of care wherever and whenever the patient presents.

It is clear that difficulties in information sharing encountered when working across IT systems is a definite pitfall in being able to provide optimal patient care and allows for lacunae in management planning that may compromise patient safety. Whilst some organisations have identified this issue and have worked towards its resolution through the formation of integrated patient record systems, there continues to be a need for the widespread adoption of this model in order to deliver high-quality care.

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Themed Article:

Opening the boundaries of holistic care…..Am I ready?

Dr Sadhana Jacob

As a Junior Doctor in 2016, most aspects of my non-working life have been improved or aided by technology: my smartphone waking me up in the morning, health apps maximising my exercise routines, and social media allowing me to stay in contact despite a gruelling rota. However, the moment I step into work the ease in which I allow these technological advances to become a part of my life falters. Why?

This question was posed to me by the team behind MHL2.0, a project aimed at using technology to improve holistic care in mental health.

My answer…fear. My fear is threefold:

1. I have become comfortable with the systems in place and fear the unknown. My experience of technology in clinical practice has been of time-consuming, cumbersome systems that are more of a hindrance than a help.
2. Opening the boundaries of holistic care. Am I ready to go beyond the traditions of an MDT-led ward round, face to face consultations and care plans developed after a dedicated meeting?
3. Data security - there are a whole host of hypothetical situations in which technological advances might breach information governance standards.

What better way to assuage one's fears than to be a part of the revolution? As the National Information Board states, technology "can give patients and citizens more control over their health and wellbeing, empower carers [and] reduce the administrative burden for care professionals". But before getting carried away by revolutionary zeal I decided to take a closer look at MHL2.0.

myhealthlocker is an established website used in the South London and Maudsley (SLaM) NHS Foundation Trust. It enables service users to "track and monitor symptoms, access their care plans and monitor their wellbeing." MHL2.0 builds on this by bringing together four vital groups: service users, clinicians, carers and researchers. The team spent over 410 hours with these groups, using their feedback to guide development.

The feedback from service users provided unique insights. There is a plethora of research into the benefits of self-management in mental healthcare and service users reiterated this, advocating the use of technology that would enable them to contribute to their care and care record.
MHL2.0 has been designed for easy access by any device. It enables service users to access elements of their care record and make contributions in terms of their mood, journey and goals, to name a few. The service user can choose to share with their "Circle" (a personal support network of clinicians and carers) and remain in control of what information each member has access to. The application also signposts users to supportive and relevant evidence-based resources.
The MHL2.0 team recognise that clinicians are key to implementing a successful programme into the NHS and thus over 230 clinicians have been involved so far. From this extensive stakeholder engagement it has become clear that the application must demonstrate time efficiency and streamline our work rather than add to it. A critical aspect of this was the link to the existing electronic note-keeping system (ePJS) that South London and Maudsley use.

Furthermore, key information from the service user and the contribution of their carers can support clinician decision-making and provide a truly collaborative approach to care.

However, let's not forget my last fear; data security. The first thing to remember is that the Department of Health made a commitment to service users that their healthcare providers would provide them with online access to their health records, care plans and other relevant management information. This was reiterated by the Caldicott 2 Report.

As with the four user groups, the Information Governance team have been consulted from the onset of development and recommended controls such as two-factor authentication for login (password and 4-digit PIN). They have been instrumental in ensuring that service user consent and have control over data sharing.

As a Junior Doctor in 2016 I find myself in a daunting but privileged world of rapidly developing technological advances such as MHL2.0; tools that will revolutionise the way I practice psychiatry and the mental health of those I dedicate my professional life to.

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Themed Article:

Sorry your connection has been lost...

Dr Romayne Gadelrab

Can you believe it was only seven years ago that smart-phones became a regular fixture in our lives? Now in 2016 people are paying large sums of money to attend retreats where their pocket technology is taken away from them, so they can 'digitally cleanse' from the 'tweets', 'likes', 'pokes', and 'pings' they are constantly bombarded with, in order to reconnect with the here and now.

Many articles have been written about the smart-phone generation and the effects these technologies are having on attention spans and feelings of self worth [1].However, we must also appreciate that, for those seeking help, this same technology provides ready access to useful online information regarding mental health and wellbeing.

Stigma is a huge problem that affects those with mental health conditions. We know this impacts initial help-seeking-behaviour. The anonymity of the internet provides a protective space for those having difficulties to find answers or help. Type 'how to cure…' into Google and one of the top results is 'depression'; or 'how to see a...', again, a top result is 'Psychiatrist'. More than ever, people have been turning to the the internet for help and answers. Websites have been developed in all fields of medicine, including our own Royal College of Psychiatrists, to try and provide patients with reliable online resources. As a profession we recognise that people with mental health problems may look to the internet before they approach their GP.

There are a number of websites offering confidential 'Skype'- style counselling sessions. People are paying online therapists for help with anything from low mood to sexual dysfunction. Regulating these services and directing patients to quality

therapists should be a paramount concern. It may not be so long, as we anticipate that patients will be asking us to make a video call rather than have them attend clinic. This could be a very efficient way for us to reach our patients, and may help our somewhat limited resources, reducing the difficulties psychiatry faces with clinic DNA rates. Patients with severe anxiety or depression, rather than being confined to their homes for example, could have the opportunity to have a video conference appointment via their own phone with a qualified Psychiatrist. I wonder in this case what a virtual mental state examination might entail? And what happens when like all my experiences with video messaging, you happen to lose internet connection during an important part of your conversation? And how do we ensure patient confidentiality with the security risks posed with online video streaming?

We have all seen high profile news reports with surgeons undertaking complex surgeries via video links and robots, so it seems to me like it would make sense that as psychiatrists who, for some assessments, require no physical tools but the ability to listen, observe and advise, should be offering similar set ups. If I did not have to travel to patients' homes as much as I do, I could potentially see considerably more patients in a day. Thus helping more people, reducing waiting times and potentially saving the NHS money.

However, if I no longer have to attend the hospital to see my patients, will I then complete my clinics from my living room? Will I still be expected to attend the hospital for a team meeting? Or will this too become a group video MDT meeting? Instead of asking the psychologist next door for their opinion, will I be popping up on their home screen? And in fact in such cash- strapped times, will my job be outsourced to another country where psychiatrists who are paid less can provide a service from their living room on the other side of the world?

In some sense I am excited to see how the incredible leaps in technology, providing what seem like limitless opportunities, may benefit my future patients- video conferencing, virtual reality, and wearable technologies may change how we work, enabling us to see patients more often, monitor their sleep, exercise patterns, recognise warning signs earlier [2] and monitor medicine adherence. However I pose the question that by 'connecting more', will we actually be losing our human 'connection'?

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Themed Article:

The effects of technology on the practice of psychiatry

Drs Ram Seth, Mukesh Kripalani, Katy Briffa, Kareem Oladimelji and Prof. Bob Peckitt

A monthly peer group meeting on Skype by the authors demonstrates the effects of technology on the practice of psychiatry. Technology is increasingly relevant in medical practice albeit developing at a slower pace in psychiatric practice. The growth of healthcare technology in Australia and USA in the last 10 years has been exponential, through both private and state funding investments. Tele-Psychiatry is a multi-million Dollar industry in the USA with growing evidence of cost-effectiveness, public acceptance and overall efficiency. The Royal College of Psychiatrists Private and Independent Practice Special Interest Group has developed Tele-Psychiatry guidelines [1]. In UK we still appear to be entrenched in the traditional model for the need to have face-to-face assessments and/or lack of funds for technological investments.

One of the first computers “Colossus” as a code breaker was a key development for success in the Second World War. In the era of community psychiatry in the UK, computers are mainly used for electronic patient records, prescribing, or communication, but at the expense of time allowed for patient assessments. The Internet and the media is the vehicle for how the public image of psychiatry is formed and shaped [2]. Information is available on the Internet for most mental disorders,

however the quality is variable [3], and it still impacts on the psychiatrist-patient relationship.

“Big White Wall” is an example of an online 24/7 service for those with anxiety or stress problems. It provides professionally trained “Wall Guides”, who ensure a safe and anonymous service for those who register. A presentation by Jen Hyatt the founder of the BWW at the Royal College of Psychiatrists last year highlighted the challenges of dealing from the mild to the most severe of the mental disorders via communications through technology.

Internet screening for mental disorders commonly employs a self-assessment questionnaire (SAQ). The total score on a SAQ determines the advice provided. Computer administered anxiety questionnaires, self-exposure and anxiety-management techniques, have showed moderate-to-marked improvements in agoraphobia, but patients still prefer some contact with a clinician. A two-dimensional computer simulation study for patients with agoraphobia also showed improvement of agoraphobic symptoms [4]. An individual recognising the need and having the motivation to take the SAQ test, and then take up the support offered, offsets the advantages of an instantly available and anonymous assessment. A sound mind can take steps to remedy ailments of the body, but a mind in trouble can find it difficult to remedy its own ailments!

The best-known Internet based therapy is CBT, found to be as effective as face-to-face CBT [5]. Online CBT has been shown to be cost-effective if commissioners are prepared to fund it [6]. Another novel therapy using technology is the Audio Visual Assisted Therapy Aid for Refractory auditory hallucinations (AVATAR) that looks promising.

There is a greater need and acceptance by healthcare commissioners in UK to innovate, develop and embrace new technologies, using the Internet in psychiatric practice. A proactive approach would provide standardised, timely, cost-effective and efficient patient services, and enhance the image of psychiatry. New technologies would also provide a vehicle for education, support structures, specialist liaison groups, conferencing etc as well as more Skype-type peer groups!

The largest technological development in the future lies in the area of artificial intelligence, and “Eliza” (named after the character in "Pygmalion") was the first “computerized psychiatrist” generated in the 1960s by Professor Joseph Weizenbaum. Eliza was an exercise between human communications with “machine Intelligence.” Deep Blue and AplhaGo have come a long way in machine intelligence in defeating the best human brains in chess and GO. Similar technologies today are encompassed in Bots (Web Robots). Bots are used routinely on the Internet where the emulation of human activity is required, for example chat bots and they can be difficult to distinguish from a real person. Behind every Bot lies the “functions of a human brain” and behind every Psychiatric Bot [7], those of a real Psychiatrist. These

developments need to be harnessed to permit further developments of models of the mind, computer-assisted diagnosis, recovery models and learning through simulation. Then Bot based automatons will truly assist in the management of psychiatric disorders, with the psychiatrist acting as a Bot Master.

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FaceTime with Dr James Woollard

Dr Chris Symeon

There are some really exciting developments in technology that will start to have an impact over the next five years, particularly augmented and virtual reality. PokemonGo is only the beginning!

1. Can you tell us about the work you do as a senior clinical fellow in mental health technology?

I work with colleagues in the mental health teams and those working on technology programs in NHS England and other bodies to help co-ordinate policy development and implementation for technology in mental health care. This means I am thinking with colleagues about how we use technology to improve care across all the different mental health disorder, across different sectors, and age groups. I am also thinking about technology in all its forms, from mobile phone Apps to electronic patient records, and how we use it safely and effectively in services.

Much of my work is about bringing a clinical and technology perspective to discussion about plans to improve mental health care, whilst understanding the levers in the systems for change, such as how we commission services, setting target for access and waiting times.

What this involves is attending a wide range of meetings, doing presentations to do different teams or groups, and meeting with developers and clinical teams using technology in innovative ways. This may sound dull, but it has so far been a great experience of meeting lots of different people working on some really interesting and exciting projects from around the world.

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2. Are you able to tell us about any interesting projects you are working on now?

We are looking at developing a framework to assess whether mobile phones apps are safe and effective. There are lots of Apps out there, and there is a danger that

some of them are not safe, either because what they recommend is not clinically safe, or that they do not keep people's data secure. The framework we are developing should help give us confidence that we can use the Apps that meet the standards set. We have programme linked to this which will look at specifically taking digital tools, like Apps, for supporting mental health care through the assessment process so by April 2017, we should be able to endorse a selection of digital tools to the professionals and patients for them to use.

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3. How do you see things developing over the next 10 years?

There are some really exciting developments in technology that will start to have an impact over the next five years, particularly augmented and virtual reality. PokemonGo is only the beginning! Having said that, virtual reality has been used in mental health care for 20 years, it just won't cost £20,000 to buy a headset and computer to make it work, more like £800 or less. Augmented reality and virtual reality presents significant opportunity to do things like behaviour experiments or exposure therapy as part of a course of Cognitive Behavioural Therapy. They won't replace face-to-face therapy completely, but more become different ways of doing it. Technology like this will be used in "combinatorial" ways – so patients and professionals can use wearables, mobile phones, tablet computers and virtual reality sets across care pathways, from first becoming aware of a mental health difficult, through receiving help from professional, to supporting sustained health after recovery.

There are some "basics" we need to get right as soon as possible around the technology we use in practice, like electronic health records. We need these systems to talk to each other so that we can share the information between them safely. We should be able to prescribe medication electronically.

In ten years, I think we will be beginning to see useful benefits from the work that is going on now around genomics, gene therapy, personalising medication formulations, different drug delivery mechanisms, and remote diagnostics such as home biochemistry labs. Much of this is possible now but just isn't developed enough for use to make use of it on the scale of the NHS.

I have no doubt that the need to find meaning in our own experiences will still be there in 10 years and all the talk of molecules may not be adequate to satisfy that.

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4. What do you think the main barriers are to technological innovation in healthcare?

We are still learning how to think about how to innovate, how to build the evidence from research that help us feel confident about using technology, and when we have something that we think is good, how we get it used widely and paid for.

I think an innate and understandable conservatism in the practice of many clinicians and managers, along with previous bad experiences of poorly designed technology (like electronic record systems) and fears about information governance are probably barriers to innovation happening and becomingly widely adopted.

We also need to be clear that simply replicating paper processes on tablet computer or mobile phone is not the best way to innovate using technology

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5. How can we anticipate and avoid pitfalls when integrating these innovations into the care for those using mental health services?

I think we have to recognise the sensitivities of those who may be using mental health services, who may have their own concerns about their information being shared, or their sleep or mood being monitored by a mobile phone or wearable. We have to be clear about what the risks are for different groups of people and we ensure that what we can offer can be tailored to address vulnerabilities.

I think we have to be clear about what access to technology those you whose mental health services might have. Do they have a smart phone? Can they afford the mobile data to use the App that you have asked them to download? Can they use their smartphone with enough skill to make use of the App? Do they have a phone signal or broadband blackspot? If we don't ensure we address these issues, we will be commissioning apps and services that people can't or won't use.
Innovation that starts with the real problems of those using services, involves them in developing the solutions, uses really good design approaches that allow quick development changes, and allows patients to have a say in who has access to their information will be the most successful. The same is true for the technology being developed for professionals!

Dr James Woollard

Senior Clinical Fellow in Mental Health Technology and Innovation NHS England

James also works as a Consultant Child and Adolescent Psychiatrist in Oxleas NHS Foundation Trust and can be found on twitter at @psycle_doc

Conference Watch:

Royal College of Psychiatrists International Congress 2016

Dr Andrew Sommerlad

The official theme of the Royal College of Psychiatrists' 2016 International Congress was 'Brain, Body and Mind'. However, rather than an inward focus on bodily function, this conference was very much linked with national and global politics and society.

There was an emphasis on global mental health and how the differing experiences of developed and developing countries could inform one another. Many spoke of the shadow of societal stigma and its effects on our patients and clinical practice. And, taking place so soon after the EU referendum, a great number of speakers expressed concern about the anticipated impact on UK research.

The challenge for the attendee of such a wide-ranging conference with numerous enticing concurrent sessions is the modern phenomenon of FOMO - the 'fear of missing out'. To hear Matthew Hotopf outlining the potential for the UK Biobank (with its half a million participants, 15 million bodily fluid samples, and 20 years of follow-up) I would have to miss Maria Ron, the foremost authority on neuropsychiatric symptoms in multiple sclerosis, describing the optimal management of those common complications. Seeing Tom Burns and Stefan Priebe describe their compelling yet controversial research on CTOs and financial incentives for medication adherence meant missing out on a discussion of the potential of quality improvement projects to make a real difference to clinical services.

The events that brought together the whole conference in the ExCeL arena's huge auditorium were keynote speeches from a range of prominent global experts. Sarah-Jayne Blakemore described her research into adolescence – the period of the brains' greatest vulnerability and when 75% of adult mental disorders begin. She highlighted research demonstrating that adolescents' perception of risk is influenced more by other teenagers than adults, with implications for the development of more effective public health strategies aimed at modifying teenage health and behaviour.

Vikram Patel and Maria Oquendo spoke of their experience in improving the delivery of mental health services in the world's least resourced countries. In societies where our diagnostic labels hold no meaning, 'global mental health' tailors clinical approaches to patients' and their families' own understanding, and aims to maximise

the coverage of services by, for example, the use of lay-counsellors.

Sebastian Faulks spoke about his novels exploring the experience of mental illness and the history of psychiatric treatment. Comedian Jo Brand reminisced with her old colleague, Professor Simon Wessely, about working as a psychiatric nurse on the emergency ward in south London and recounted some shocking examples of discrimination faced by people in crisis.

The theme of stigma continued with the conference's remarkable accompanying exhibition, 'Registered, Persecuted, Annihilated: The Sick and Disabled under National Socialism'. This concerned the eugenic-driven and Nazi-sanctioned sterilisation or murder of up to 400,000 children and adults with mental disorder or learning disability, and the slow post-war acknowledgement of these horrors.

I left enthused and excited for the future of our profession and congratulate the organising committee for delivering such a successful conference.

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Wellcome Trust Research Fellow and ST6 in Old Age Psychiatry at University College London

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Culture Vulture:

Technically Speaking

Dr Peter MacRae

In December 2015, a colleague forwarded me an email, from a theatre director who was looking for service users to create a play about male mental health and technology. Ignoring the actual request, I emailed back, and asked whether it would be okay for me to turn up. Because I hadn't really been invited, I became the only mental health professional involved in creating the play.

The play was called Technically Speaking, and was devised over 3 months, before a brief run at the Arcola Theatre, in Dalston, in February 2016. We held preparatory sessions discussing theme, and narrative, and throwing a ball around for 'team bonding'. Then, in the final month, there was a slightly panicked flurry of writing and rehearsing, with material drawn from people's direct mental health experiences.

The play became a multi-stranded narrative, following the stories of 3 protagonists, one experiencing psychosis, one with an anxiety disorder, and one in the role of carer for

someone with mental illness. We had a 4th actor, continuously on stage, voiced by Siri (Apple's 'virtual assistant'), representing the influence of technology. Siri intervened in the protagonist's lives, becoming the persecutor of the character with psychosis, whilst also informing and connecting the characters.

Our priority was to offer an authentic portrayal of mental ill-health, and to deliver an anti-stigma message which might encourage men to communicate about their own mental health issues. The use of technology came second, but provided an opportunity to tell the story in more interesting ways:

- Audience members provided their mobile numbers before the performance, and then received text messages, and live audio, during the play.
- A projection screen in the background displayed images and GIFs relating to the onstage action.
- Between the scenes, audience members used their mobile phones to vote on questions about mental health stigma, and saw their own polling data appear live on a screen in front of them.

The intention was to provide both sides of the argument for the influence of technology on mental health. We considered education and communication, including the potential benefits of anonymous help-seeking. These were counterbalanced against the potential distraction and disconnection associated with the ubiquity of electronic devices, throughout our lives.

We didn't collect robust evidence; I don't know how successful the play was in communicating anything authentic about the experience of mental illness, or in addressing stigma. But it did make a few audience members cry, each night. I chose to assume that this was because of the play's theme, rather than its quality. Crying isn't a great marker of success, but the play did seem to connect with a significant proportion of the audience.

I really enjoyed creating something new, with a group of people who wanted to convey their direct experience of mental health issues. I'd recommend responding to emails that aren't really intended for you.

Dr Peter MacRae | Peter.Macrae@elft.nhs.uk

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Audit:

Evaluation of the Use of Voice Recognition Software in two Mental Health Trusts

Dr Michael Rutherford, Dr Adil Akram, Dr Martin Schmidt, Thikra Denha, Nicki Rayment

Acknowledgments - Our thanks to Azlan Luk (SABP Clinical Lead), Gill Hill (SABP Transformation Lead), Mike Frain (SABP IT Lead), David Green (SWLSTG IT Lead), Ann Traynor (SWLSTG Merton HTT Manager).

Introduction

Electronic patient records (EPR) are used extensively in Mental Health Trusts and their introduction has coincided with an increased administrative burden for clinicians.

Voice Recognition (VR) technology has been trialled in specialties including radiology, emergency care, pathology, paediatrics and gastroenterology with mixed results. Some evaluations report more rapid production of clinical letters whereas others describe more clinician time being spent on administration.

There have been only two studies into the use of VR technology in psychiatry Derman, Arenovich and Strauss and Sandilyan and Darley (10) and only one of these found objective benefit – clinic letters were produced more quickly although at the expense of more clinician time being spent dictating and editing letters.

Methods

South West London and St George's Mental Health NHS Trust (SWLSTG) and Surrey and Border Partnership NHS Foundation Trust (SABP) co-operated to trial VR technology across several mental health teams. It was hoped that the use of VR software would reduce administration time and improve team efficiency, with the time saved being spent on increased clinical contact.

Baseline measurements of the time clinicians spent typing electronic notes of various types were measured prior to the introduction of the VR software. All participants received 3 hours of training in how to use the software. Repeat measurements of

typing times were taken at the end of the trial. Qualitative feedback was obtained from participants using a standardised proforma to determine the acceptability of the software, their subjective judgement of its usefulness, and whether the training had been beneficial.

Results

The SWLSTG Trust found the time taken to produce electronic notes was halved. The change in typing times for the different types of notes for SWLSTG is shown in Figure 1 below.

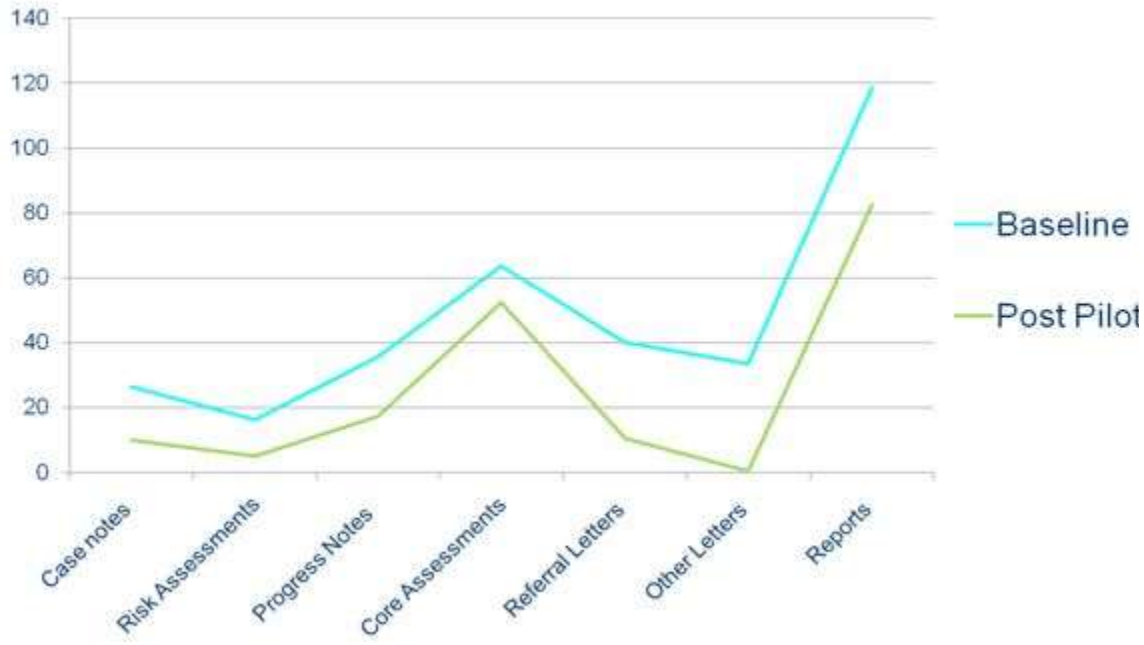

Figure 1 – Graph of typing time spent on different administrative tasks

In SABP Trust, 3 of the involved clinicians completed the entire trial; 5 others provided partial results. The partial records were mostly due to staff leave during the course of the trial and some participants having difficulty using the software. The findings identified in the SABP pilot are detailed in Table 1 below.

Positive	Negative
▪ Increase in clinical contact time by 148 minutes per day. ▪ Turnaround time for letters and reports was reduced from 6-7 days to 1-2 days. ▪ Reduction of typing time by 51 minutes per day.	▪ Increase in overall RiO time of 51 minutes per day (which appeared to be due to increase in clinical contacts).

Table 1 – Positive and negative findings from SABP

Both trials found that additional time was required for editing after transcription but the overall process was still faster than manually typing notes or having traditional dictation typed by an administrator.

SWLSTG staff universally felt that the training they received before using the VR software was essential. 75% stated that they became accustomed to the software "quite quickly" and that the VR software made them more productive. All felt that their need for administrative input had diminished. 70% of staff felt the technology was compatible with their daily activities.

SABP staff found the software fairly intuitive and straightforward to use and 60% felt that it made their production of notes more rapid. Some staff described problems with having to be vigilant when checking for spelling mistakes and others had difficulty accessing the software due to moving office or not being able to use their own computer reliably. 60% involved expressed an interest in continuing to use VR software.

Discussion

VR technology appears to show promise for clinical psychiatry and may enable clinicians to meet the demand for increasing amounts of documentation without a reduction in clinical time. It can reduce administration time, increase contact with patients, and reduce the delay in sending out letters.

Effective utilisation of VR software requires investment such as appropriate training and the provision of other resources, including a specific computer, Dictaphones and a relatively quiet environment in which to work.

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Round Up - London Division Executive Committee Meeting held on 1 June 2016

Dr Zaubia Alyas

The majority of discussion focused on recruitment. Dr Hughes reported that the status of the College Recruitment Lead had been altered accordingly to Associate Dean.

Data generated from the BMJ careers fair was seen. The majority of visitors to the stand were from GPs and medical students. The information being sought was information about training rotations and obtaining specialist qualifications.

With respect to Medical Student engagement - the outgoing recruitment lead, Dr Brown had been visiting PsychSocs, with the College President, Professor Wessley, to strengthen associations. A more deliberate presence at Careers Fairs was planned and a new Work Experience Week initiative is being planned.

Upcoming London Division events were discussed including the SAS event on 14 September, the Medical Students Reception on 19 October and the annual Academic event on 22 November.

London Division Info

London Division Executive Committee

The London Division Executive Committee meets four times a year at the College's HQ. Approved minutes from previous meetings can be accessed via our members login.

London Division College Vacancies - Your Division Needs You!

We have a number of vacancies for College posts available and are keen to see them filled as soon as possible, particularly the **London South West Deputy Regional Adviser** role. Take a look at our Vacancies page to see how you can get involved and support your Division.

London Division Events

The London Division hosts a number of events each year. Our next event is the SAS Educational Event on 14 September, take a look at our Events page for details on how to register and about our future events.

 One of the objectives of the London Division is "Recruitment into Psychiatry".

On 6 July, we hosted a drinks and canapé reception for medical students and Foundation Year doctors.

This was held at College HQ as part of the IoPPN Summer School. We were delighted to have the College Registrar, Dr Adrian James present and share a few inspirational words.

Photo taken at IoPPN Drinks Reception at RCPsych, 6th July

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Look out for the call for articles for the next themed newsletter -'The unique challenges of being a psychiatrist in London'

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