Winter Edition, 2022 | Issue 2

Psychiatry

The Northern and Yorkshire Division eNewsletter

Editorial

In this issue:

Hello, and a warm welcome to the second edition of the RCPsych Northern and Yorkshire Division eNewsletter. One of the many privileges of being Secretary and Northern and Yorkshire representative for the Psychiatric Trainee Committee is becoming Editor of the Newsletter, and I must express my thanks to all of the submitting authors and also to departing Editor, Dr Sharon Holland, who has now got her RC wings.

I should take the opportunity to remind you all that voting for our next President is currently open and all members should have received emails with online voting instructions. For more information about the candidates, visit: Presidential elections | Royal College of Psychiatrists (rcpsych.ac.uk).

The articles submitted to the newsletter range widely and reflect the many facets of our work and interests. We start with our Chair, Dr Paul Walker, providing a divisional update and move to a career retrospective from Dr Bob Adams with general practice's loss being psychiatry's gain. Dr Jozsef Svavuj outlines the poorly understood phenomenon of 'misophonia' and the aetiological basis and treatment strategies. We have a look ahead to 'News Way of Working 2.0' and the push towards net zero in psychiatry by Dr Prasanna DeSilva, whilst Dr Sana Fatima and her co-authors discuss the approach to the recognition and challenges of neurodiversity within the trainee workforce. Dr Amelia Gledhill reflects on the thought-provoking reworking of the story of Joan of Arc in the play '*I, Joan*' and Dr Shumaila Shahbaz outlines her work on improving the experience of undergraduate medical students on their psychiatric clinical placements in SWYPFT. We finish with a report on the recent Northern and Yorkshire Autumn conference and look ahead to a return to in person events in 2023.

Thanks also to our Divisions Committee Manager, Moinul Mannan, and Chesnei Monrose, Divisions Administrator, without whom production of the newsletter and the other work of your RCPsych Division may not be possible.

If being published in this august organ is not incentive enough, there is the fantastic prize of £50 for the article selected by the Editorial team. Congratulations to Dr Szavuj, who is this edition's winner. Please kindly submit your articles of 500-1000 words length for the next edition by 18th May 2023 to: northernandyorkshire@rcpsych.ac.uk.

Merry Christmas!

Dr John Moore, Editor, Northern & Yorkshire Division eNewsletter

Chair's Column

By Dr Paul Walker

It's Christmaaaaaaaasssss!!

A warm welcome to you all as we head towards the end of this turbulent year and into 2023. I hope all of you who celebrate Christmas have your trees and decorations up and manage to get some quality time off to spend with friends and family.

It's been a busy year for the Northern and Yorkshire Division and at last we have been able to meet in large numbers face to face again at our Autumn Conference on the 30th September 2022 at York Racecourse. There have been fundamental changes to the way our division is run and administrated in terms of Royal College staffing. Suzie Veitch, previously our Division Manager is now our Divisions Events Manager so it's great to be still working with her and a warm welcome to Moinul Mannan who has taken up the role of Divisions Committee Manager of the Northern & Yorkshire Division which meets quarterly. Welcome also to Chesnei Monrose, Divisions Administrator and Michelle Alves, Divisions Events Administrator.

With everything that's going on at the moment, the cost of living crisis, the war in Ukraine and now the public sector strikes, it's more important than ever that we support each other and maintain our wellbeing and your local division of the Royal College aspires to be central to this.

On this note, I must make a personal plea for members to consider taking up some of the vacant roles at the division, such as Regional Specialty Representative roles and particularly the Deputy Regional Advisor and the Regional Advisor role. These are especially important in maintaining quality and "do-ability" of the posts that local Psychiatrists are working in to minimise the ever present danger of burn-out and over-work. Please do talk to me or Dr Sunil Nodiyal, our Vice Chair for any further information on these.

I must offer my thanks, particularly to Dr Sumeet Gupta, our Academic Secretary for working so hard in arranging this year's academic conferences. There is a vacant post for a second Academic Secretary to work with Sumeet and these posts are great for networking with national experts.

Congratulations to Dr Sachin Gandotra and Dr Anisha Nakulan for successfully applying for the Royal College Leadership and Management Fellowship Posts starting from August 2022 for Tees, Esk and Wear Valleys and CNTW Trusts respectively.

And finally, my personal thanks to Dr Mani Krishnan for organising the recent Dean's Grand Round, jointly hosted by the Northern and Yorkshire Division and Old Age Psychiatry Faculty on early diagnosis and treatment of Dementia. This webinar attracted around 1200 subscribers which I co-chaired with Krish and the event received excellent feedback. Do look out for future Grand Rounds.

I wish you all a Happy Christmas and prosperous New Year and look forward to seeing as many as possible of you face to face or at least online for our 2023 events.

Dr Paul Walker
Chair, Northern & Yorkshire Division

Northern & Yorkshire Autumn Conference Poster Winners

- Best Medical Student/FY1 Poster Prize: Felicity Allman
- Best FY2/Trainee Poster Prize: Dr Anna Taylor and Dr Daniel Romeu
- Best SAS Doctor Poster Prize: Dr Jennifer Gilligan

New Northern & Yorkshire Division Members

- Dr Natalie Smith - Perinatal Rep
- Dr Tolu Olusoga - Regional Advisor

New Northern & Yorkshire Fellows

- Dr Daniel Edward Anderson
- Dr Alexander James Bailey
- Dr Miriam Isaac
- Dr Kedar Ravindra Kale
- Dr Joji Varicklayil Kuriakose
- Dr Gregor Russell
- Dr Ann Elizabeth Ryman
- Dr Padakkara Jayarambabu Saju

Northern & Yorkshire Division Vacancies

- Academic: Division-wide
- Addictions: Division-wide
- Child and Adolescent: North East region
- Child and Adolescent (shared role): Yorkshire region
- Eating Disorders: North East
- Forensic (shared role): Division-wide
- General Adult (shared role): North East region
- Intellectual Disability: North East region
- Liaison: Yorkshire region
- Old Age (shared role): Yorkshire region
- Rehab and Social: North East region

07.30am, October 18th 1983 Canteen at the District General Hospital

By Dr Bob Adams

I don't think I've ever been this tired before. It was non-stop all night clerking admissions on the medical wards and in A&E. Twenty-one I think, but I lost count after the tenth. A relentless assembly-line of sick bodies that soon became a stream of events; demanding bleeps, bloods to take, drips to site and drug charts to write up. Meanwhile the nurses sat calmly at their desks making notes and sipping tea while I rushed from bay to bay. Everyone seemed to know what they were doing. I just went with the flow.

I can picture him thirty-nine years later as if it was yesterday, sitting there in that canteen with the 'firm'. I can't remember all their names. The consultant had an angular, thin face with receding blond hair cut short. He seemed to know everything – although in retrospect he got the diagnosis wrong on a poor woman who died of what we then called blood-poisoning. At her PM, which we were encouraged to attend, the cause of her terminal decline was found to be a burst appendix. I blame myself and can still picture chatting to her when she was alive, telling me about her family. Just a few days later she was lying on a cold slab. My consultant said he thought it was a waste when I told him I was applying to train in psychiatry. I've never been sure if that was an insult or compliment. Maybe the latter, but I don't think it's been a waste.

The DGH is a premier place to learn medicine and I was lucky to get a pre-reg job here. Incredibly busy; 1 in 3, down to 1 in 2 when others on leave, which is 1/3 of the time. But it's all made worthwhile by the amazing team. Like a platoon in wartime. The SHO as lieutenant, registrar as captain and consultant as colonel. I'm the ensign; incompetent and green at the gills. But I'm learning fast. The reg is a mix of a war weary Martin Sheen, *'I wanted a mission, and for my sins, they gave me one'*, and a Robert Duvall as mad Colonel Kilgore, *'I love the smell of napalm in the morning'*. And yes, the reg actually does say those things as we follow our crazy mission from ward to ward, patient to patient, altering drips, checking blood results, rolling in grenades.

He really did learn a lot during those six months. As he was to realise later, it made a man of him, whatever that means. Exciting times. By the end of the six months, he could put a drip in anyone, anywhere. But what induced him not to try to swap his night on take, just before his interview for the General Practice Training Scheme (VTS)?

I don't know why I didn't swap last night's on-call. Too late now. I'm not usually up all night after working all day. There's normally a brief kip in the on-call room, a quick hour before that interminable bleep wakes you once again. Or maybe I was thinking that the picture of a battle-weary foot soldier, fresh from a night at the coal face, unshaven and slurring his words, might impress the panel enough to give me a place on the scheme?

That made sense. But I think he didn't really want to be a GP. He didn't want to be examining orifices, chests, and other bodily parts for the next forty years. And he had a tendency to let fate decide major crossroads in his life, as it does to most of us. He gave fate two choices: general practice or psychiatry. Fate decided to make that Tuesday night the busiest night of his life.

The other great thing about the DGH is the food. I believe it won a poll as the best in the NHS. After the take, we all tuck into a full English, the 'special', while discussing what needed to be done to settle in the patients for the day. The aim was to get them all tucked up and tickety-boo for the boss's post-take round. I write down the list of actions in my note pad, smeared with blood and other unidentified stains. My white coat bulges with BNF, Handbook of Medical Emergencies, stethoscope, even mini ophthalmoscope – most of the ward ones have flat batteries. After that there will be just two hours to get everything done before a quick change, then head off for the interview. If my car starts. It's a Vauxhall Chevette, prone to letting you down. It already has rust holes in the wings, and it's only two years old!

In fact, he was late for the interview, although his car did start. Maybe he shouldn't have driven after having no sleep for thirty hours. And boy was it competitive.
Twenty short-listed hopefuls for just three places on the scheme. I can't remember what he said. Nor can he. His mind was mainly on how he could get through the rest of the day before a night of glorious sleep.

And it really did decide the rest of his life. Of course, he didn't get on the GP training scheme but, just a few weeks

07.30am, October 18th 1983 Canteen at the District General Hospital

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later, got a place on the Cambridge Psychiatry Rotation. If he didn't like psychiatry he could always go back to general practice. No more Apocalypse Now, or so he thought.

Naturally his consultant wasn't pleased. All that waste of a good training.

Dr Bob Adams
Ministry of Justice

RCPSYCH PSYCHIATRISTS' SUPPORT SERVICE

The Psychiatrists' Support Service provides free, rapid, high quality peer support by telephone to psychiatrists of all grades who may be experiencing personal or work-related difficulties.

Our service is totally confidential and delivered by trained Doctor Advisor College members.

For information about the Coronavirus, please visit our **information hub**, you can also find specific **guidance for clinicians here**.

Get in touch with the support service

Call our dedicated telephone helpline on 020 8618 4020
Email us in confidence **atpss@rcpsych.ac.uk**.

The service is available during office hours Monday to Friday.

Misophonia – when life's noises drive you mad

By Dr Jozsef Szavuj

Imagine the following – a pen being clicked constantly; someone tapping their fingers on a table; loud chewing; or the ever-popular chewing gum popping. If any of these sounds cause you an instinctive fight or flight response, you are not alone.

For years I have struggled with these sounds. If I am in a crowd, I can detect the source of the annoyance and it takes all my control not to get angry. I was told in the past that I was being 'too sensitive' or that 'I should get over it', like many of the 'helpful' pieces of advice received when suffering from any form of mental illness.

That is not to say that my condition, and of many others, can be labelled a mental illness. Its official label is 'Misophonia' or 'the hatred of sound'. Although it seems to have been around for quite a long time, it escaped the focus of research until recently (in the late 2000s), but it is now rapidly gaining ground.

What is there to know about Misophonia?

Certain sounds like slurping, chewing, tapping, clicking, and popping can elicit feelings of rage or panic, leading to 'sound rage'. In addition to auditory cues, the observation of specific movements (e.g., fingers pointing, legs swinging, hair twirling, nail biting) can also trigger intense aversive responses associated with feelings of distress, disgust, irritability, and anger.

The physical characteristics of sounds (intensity and frequency) only partially influence the reaction of Misophonic to triggers (although higher pitched noises tend to be more frequent), rather the person's psychological profile, previous experiences and the context in which triggers are experienced that are the most important.

There are several theories of what Misophonia might be:

- a stand alone condition,
- a condition that can be induced in others,
- a physical manifestation of a psychiatric disorder.

What is the anatomical basis of this condition?

Functional MRI studies showed a greater activation of the AIC (anterior insular cortex) in Misophonic compared to controls, when presented with triggers sounds. The AIC is involved in the 'salience network' which is critical in interoceptive signals and emotion processing (including anger). Increased functional connectivity of the AIC with core parts of the DMN (default mode network), hippocampus and amygdala, were also found in response to trigger sounds.

In 2013, Schroder et al[1] undertook the task of clinically characterising a sample of 42 people with Misophonia (to that date the largest sample), and developed the Amsterdam Misophonia Scale, a six-item self-report scale to assess the type and severity of Misophonia symptoms. The instrument was developed based on the Yale-Brown Obsessive Compulsive Scale used for obsessive-compulsive disorder, but it also maps onto a set of six criteria proposed for the diagnosis of Misophonia:

1. The presence or anticipation of a specific sound, produced by a human being (e.g., eating sounds, breathing sounds), provokes an impulsive aversive physical reaction, which starts with irritation or disgust that instantaneously becomes anger;
2. This anger initiates a profound sense of loss of self-control with rare but potentially aggressive outbursts;
3. The person recognizes that the anger or disgust is excessive, unreasonable, or out of proportion to the circumstances or the provoking stressor;
4. The person tends to avoid the misophonic situation, or if he/she does not avoid it, endures encounters with the misophonic sound situation with intense discomfort, anger, or disgust;
5. The person's anger, disgust, or avoidance causes significant distress (ie. it bothers the person for whom he or she has the anger or disgust) or significant interference in the person's day-to-day life (e.g., the anger or disgust may make it difficult for the person to perform important tasks at work, meet new friends, attend classes, or interact with others);
6. The person's anger, disgust, and avoidance are not better explained by another disorder, such as obsessive-compulsive disorder (e.g., disgust in disgust in someone with an obsession about contamination) or post-traumatic stress disorder (e.g., avoidance of stimuli associated with a trauma related to threatened death, serious injury, or threat to the physical integrity of self or others).

Alongside the psychological signs (distress, anxiety, anger), the subject has physical reactions to the triggers as well; pressure through the body, especially the chest, muscle tightness, increase in blood pressure, heart rate

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and temperature.

Is there a treatment?

To date, little is known about the aetiology or even the pathophysiology of misophonia. Attempts are being made to reduce the distress the person is suffering from when exposed to the trigger, or to break the connection between the cognition and the trigger.

The misophonia management protocol includes:

- Sound therapy – filling the auditory channel with soothing sounds (such as ocean waves, or rain) reduces the strength of the reflex action to the trigger sound; this does not eliminate the trigger or the reaction completely, rather it reduces the reaction
- Cognitive Behavioural Therapy – a course of 6 to 12 sessions is reported to have positive results
- Hypnotherapy – in the short term
- Progressive Muscle Relaxation aims to reduce the anger/rage response following exposure to the trigger.

There is little focus on Misophonia, but thankfully, it is gaining more and more attention within the research and clinical communities. Having a better understanding of it will lead to a better understanding of our patients, and they can also have the reassurance that they are not alone.

References:

1. Schröder A, Vulink N, Denys D. Misophonia: diagnostic criteria for a new psychiatric disorder. PLoS One. 2013;1:e54706)

Dr Josef Szavuj
ST4, Tees, Esk and Wear Valley's NHS Foundation Trust

International Medical Graduates

The Royal College of Psychiatrists is keen to support International Medical Graduates (IMGs) who choose to follow a career in psychiatry in the UK.

RCPsych have produced a guide for International Medical Graduates pursuing a career in psychiatry in the UK. The guide provides a comprehensive overview of working, training and living in the UK as a psychiatrist.

A Guide to Living and Working in the UK for International Medical Graduates

Opinion: New Ways of Working 2.0 to accommodate transformation, integration and net zero

By Dr Prasanna DeSilva

Abstract

New Ways of Working was developed 20 years ago to improve the working experience of psychiatrists. This opinion article describes how psychiatrists can further change their working practices to accommodate community transformation, integration and net zero agendas. An analysis of needs and costs is described, leading to five pragmatic ideas to assist this process.

Background

NHS England expects trusts to provide a strategic plan on how they intend to achieve net zero on carbon emissions by 2030. A policy paper[1] describes potential changes to estates utilising solar panelling, recycling waste, better insulation alongside full remote working. It is assumed that the Community Mental Health Transformation[2]; a major pivot to primary care in mental health provision will 'dovetail' with the net zero mandate, as would the 'Integration' agenda developed by the ICSs (Integrated Care Systems).

Need Based Analysis

The age group most at risk of mental and physical health conditions is people over the age of 85. Frailty is a feature in around 10% of this population.[3]These people are much more at risk of falls, delirium, and dementia, often presenting in crises leading to hospital bed use. Older people are also likely to be malnourished, leading to higher risk of fractures and pneumonia and incurring in-patient care costs.

Adult mental health patients with SMI present to services between the ages of 15 and 25. However, 'early intervention' services are split between child and adult psychiatry departments involving different specialist skills and treatment sites. 'Transfer of care' at the age of 18 is usual practice, which causes difficulty to both service users and GPs having to navigate a different system. Furthermore, in the longer term, patients with SMI die 15-20 years earlier, with around 67% dying of natural causes[4] typically involving community acquired pneumonia, cardiovascular disease, and cancer. Atypical antipsychotics probably contribute to this death rate via increasing cardio -metabolic and thrombo-embolic risk, and at times pneumonia due to aspiration.

The other group of people frequently attending mental health services are those who have experienced various types of childhood maltreatment. It is generally agreed that these victims contribute to between 40% of mental health patients overall[5], with the higher rate amongst in-patients. Despite this, childhood trauma is poorly recognised, especially among those people suffering from psychosis and treatment-resistant depression. There is also evidence that these individuals have difficulty engaging with mental health practitioners leading to non-concordance medication and psychological therapy[6].

Financial Analysis

As with acute care, the leading cost in secondary mental health is bed use; with further costs due to delayed discharges[7]. This is partly due to difficulty arranging community follow up and unavailability of prompt specialist opinion on co-morbid conditions (such as autism, ADHD, and dementia).

Other significant costs include senior staff salaries and drug costs. Psychotropic polypharmacy is also financially wasteful, as well as increasing cardiometabolic risks and falls in the elderly. Consequently, ICSs have identified limiting polypharmacy as a key objective in reducing the drugs budget, including regular use of community pharmacists.

Treatment Efficacy Analysis

The common theme in mental health interventions with consistent evidence of effectiveness is rapid assessment, diagnosis, psychoeducation, and treatment[8,9]. Therefore, central government funding is increasingly directed towards mental health triage using PCMHWs (Primary Care Mental Health Workers) embedded within primary care settings to assist GPs to recognise and refer appropriate patients promptly to prevent prolonged symptoms of untreated illness leading to treatment resistance.

Benefits of 'treatment as usual' by secondary care mental health in all age groups is probably confounded by variably long waiting times for specialist opinions. There are also major geographical variations in the types of treatments offered by each mental health service.

Currently available interventions with replicated evidence of efficacy include rapid assessment of first episode psychoses, emerging cognitive decline, and screening for co-morbid mental health issues among Accident & Emergency attendees. However, there remains

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By Dr Prasanna DeSilva

geographical variations even in these services in terms of waits to gain a specialist diagnosis and treatment plan.
Emerging interventions using psychedelic drugs**;** for example**,** psylocibin-assisted psychotherapy for treatment resistant depression and PTSD, as well as ketamine to manage acute depression with suicidality are currently undergoing clinical trials. However, the necessary infrastructure to provide a day care service is not in place and might need diversion of resources from more generic services provided in the community. Furthermore, by 2030, it is likely that other interventions will be available to treat major psychiatric conditions, for example TMS for mood disorders and repurposed vaccines for cognitive decline.

Suggestions Based on Above

Immediate (remote) specialist advice for Primary Care based mental health staff. The idea of placing PCMHWs to triage requests needs to include immediate debriefing with the relevant specialist to provide a working diagnosis and a treatment plan (including relevant investigations, psychoeducation and an initial trial of treatment). Ideally the patient and / or carer should be involved following debriefing via an 'assisted' consultation to enhance patient / carer choice. Furthermore 'scaffolding' when PCMHW's can access the skills of a specialist worker in the medium term would also be beneficial.

To deliver immediate debriefing, it would help if community consultants were decoupled from their current CMHTs. Currently CMHTs are led by non-medical clinical leads and team managers, who could be supported to maintain leadership, with consultants accessed when needed. It would be helpful if consultants are assigned 'medical assistants' who will organise virtual slots based on severity and risks. Arguably, triage nurses should focus on the 15 – 25 age group, when most SMI conditions initially present[10] with a greater likelihood of interventional success.

Advanced consultation skills training. Improving engagement with traumatised individuals require need staff to be trained in advanced communication training involving Trauma Informed Care (TIC)[11]; for example, moving from questioning from 'what is wrong with you?' to 'what have you been through?' TIC should (based on patient feedback) should help staff to establish adequate trust to develop co-produced care planning. The other type of consultation with high user satisfaction is 'open dialogue' a change in consultation which is designed to assist a patient and family to formulate their personal narrative leading to user centred care plans[12].

Physical health care hubs. These day services would manage physical health monitoring on commencing psychotropic drugs and monitor co-morbid physical health issues such as obesity, hypertension, and diabetes[13]. Furthermore, hubs can provide clozapine initiation and psychostimulant-based psychotherapy as outlined above alongside ECT as a day patient. Physician associates (PAs) could also help manage the physical healthcare workload for example for blood testing and ECGs.

'Connected' in-patient care to improve bed utilisation. A single bed management team managing admission, discharge, and transfers to acute care would optimise bed utilisation. Furthermore, LEAN working practices[14] including 72-hour formulation meetings attended by community medics, care co-ordinators, social workers to decide on duration of stay and site of discharge, followed by a further discharge planning meeting at 2-3 weeks should be the norm, with carer input.

As is the norm in acute hospitals, in patients should have rapid access to other diagnostic services though immediate opinions from specialists, with continuity via a process of scaffolding. The known benefits of a ward-based dual diagnosis specialist nurse should be replicated for all wards to try avoiding readmissions of patients with drug-induced psychoses.

Joint working with housing organisations. This could include 'de-escalation' beds in the community backed up by home based assertive mental health input, with admitting rights granted to Street Triage and Crisis Teams. Organisations such as YMCA do have suitable accommodation and would be prepared to offer temporary accommodation, providing community mental health services can provide regular input. More broadly, it is possible to envisage inpatient rehabilitation being transformed to a predominantly community service utilising supported accommodation. Alternatively, the mental health trust can utilise 'spot purchased' care home places to assist discharge older adults from psychiatric wards.

Concluding Remarks

The unavoidable fact on reducing a trust's carbon footprint is to move some services to another

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organisation. The integration and community mental health transformation agenda can assist in this; for example, by moving secondary care community mental health to local authority jurisdiction. Despite the difficulty in integrating with wards, having a single budget covering CMHT's and Social services departments can produce more 'joined up' care in the community; for example, working with housing services as described above. In this system, mental health trusts would provide inpatient, hospital liaison and day services only.

NWW 2.0 could well pose more challenges to psychiatrists compared with the original version 20 years ago. Losing clinical leadership of a specific CMHT and/or losing a geographical sector would also cause disquiet. However, these must be balanced against the benefits of being free of a caseload and responsibility to a challenging (or large) sector, which cannot be 'disowned' without leaving the job. Consultant teams in the community would also encourage sub-specialisms suited to one's interest. NWW 2.0 would also increase working from home, in keeping with net zero objectives.

References

Available by contacting author

Dr Prasanna DeSilva
Consultant Psychiatrist, Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Mind Ed

MindEd is a free online educational resource covering mental health for young people, adults and older people.

With three quarters of adult mental disorders in evidence by the age of 21, effective early intervention can be essential in preventing the development of ill health and disability.

MindEd – free mental health eLearning | Royal College of Psychiatrists (rcpsych.ac.uk)

Neurodiversity in Post Graduate Medical Education; A rapid solution to faculty development

By Sana Fatima, David Mendel, Paul Sadler, Haido Vlachos, Ayesha Jameel, Jon Cooper

Background

A subset of biodiversity, the term neurodiversity refers to the "virtually **infinite neuro-cognitive variability within Earth's human population**. It points to the fact that every human has a unique nervous system with a unique combination of abilities and needs."

The term and definition of neurodiversity remain subject to debate and discussion, however for the purpose of this work, the term neurodiversity refers to intrinsic differences between human minds and is known to encompass cognitive and neurodevelopmental difficulties including dyspraxia, dyslexia, attention-deficit hyperactivity disorder, dyscalculia, autistic spectrum disorder, and Tourette's syndrome.

Over the past few years, there has been an increasing recognition of neurodivergence in postgraduate medical trainees and the associated challenges that may present in a trainee's educational journey. This is reinforced by anecdotal concern for medical educators and training providers across all four nations in understanding the concept, the associated intricacies, and intersectionality in order to timely recognise and extend appropriate support to trainees.

Summary Of Work

A national Neurodiversity Task and Finish group was established to survey Health Education England regional Professional Support teams about insights into infrastructure, training for educators, triggers for assessment and resource and intervention protocols. A 10-question survey was distributed among participants to understand the knowledge around the subject and the awareness of support provisions and pathways in various localities across England, primarily through Professional Support bodies. This group drew from educational leadership across the country, professional and personal neurodiverse expertise, occupational medicine, employer human resources as well as trainees.

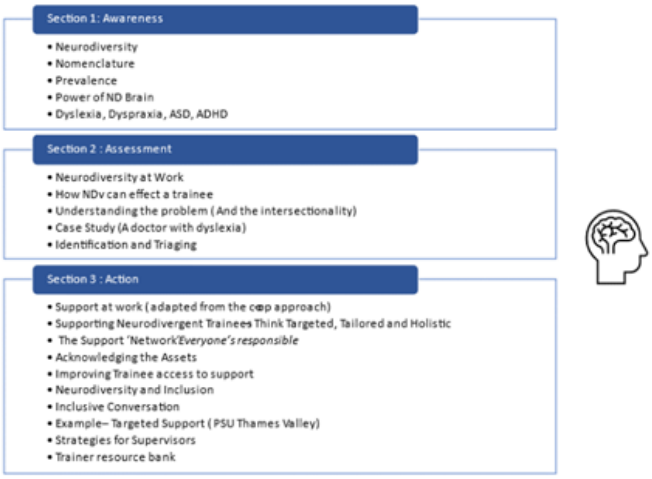
Summary Of Results

The survey confirmed marked heterogeneity in the identification, assessment, and management of trainees and highlighted a 'deficit' approach to neurodiversity. It also demonstrated a paucity of educational and protocol resources for educators and supervisors in supporting neurodivergent trainees.

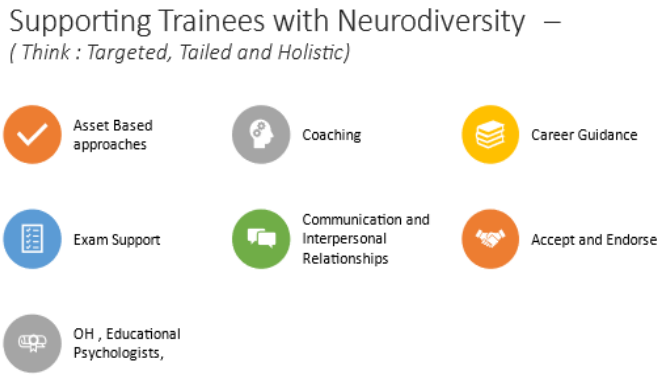
Discussion And Conclusion

As part of the Education and Training subgroup of this wider group, we had the opportunity to start at the basics and developed a guidance document for trainers and trainees that was aimed primarily at early recognition, assessment and support of neurodivergent trainees.

In phase one, we focussed on faculty development, an educational repository for all supervising trainees using a thematic approach following our survey findings specific for neurodiversity: awareness, assessment, and action.



The key theme from both the survey and Task and Finish group suggested a move away from deficit focused methods towards a positive holistic, interdisciplinary approach within a biopsychosocial framework informed, where possible, by the 'strength based' approaches.

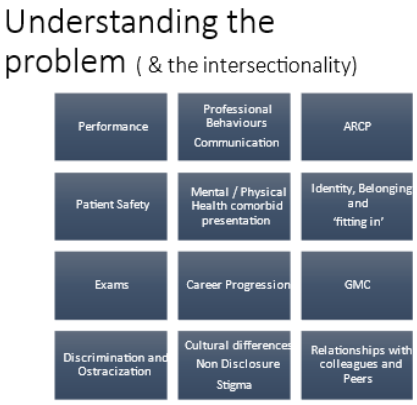


Neurodiversity in Post Graduate Medical Education; A rapid solution to faculty development

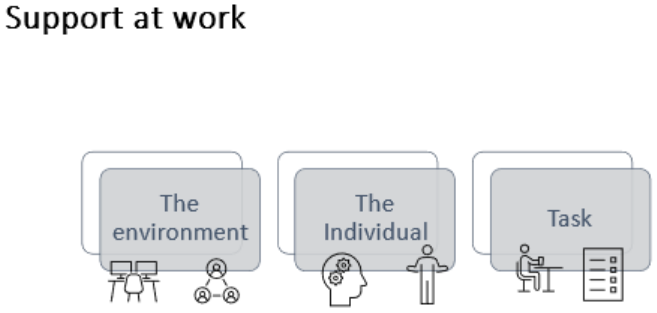
By Sana Fatima, David Mendel, Paul Sadler, Haido Vlachos, Ayesha Jameel, Jon Cooper

The ethos of this work focused on acknowledging the holistic implications on a trainee's life and the vast intersectionality of these presentations. These include, but are not limited to, impact on performance, competence, confidence, personal development, career progression, physical and mental well-being as well as professional relationships (Ellis et al., 2021, Doherty).

Additionally there is a deeper impact on aspects like identity, belonging, 'fitting in', interpersonal relationships and communication. Lastly, as more widely recognised, studies reveal that doctors with registered disabilities including neurodiversity perform noticeably less well in formal assessments and examinations throughout education and postgraduate training (Ellis, Cleland, Scrimgeour, Lee, & Brennan, 2021).



Empowering our trainers with knowledge and expertise is a step towards enhancing their proficiency. It also contributes towards a cultural shift that endorses diversity and sharing this responsibility.



Take Home Messages

- Faculty knowledge and basic understanding of neurodiversity is key to supporting trainees with known or underlying neurodiverse conditions.
- There is inconsistency in the approach across the nation as to how trainees are managed once a neurodivergent condition is suspected.
- A carefully constituted and focussed Task and Finish group can rapidly identify national inconsistencies in neurodiversity and implement rapid educational interventions.
- Nuanced findings from surveys and discussion can reframe the approach to neurodiversity from a medical model to a more comprehensive, asset-based, biopsychosocial model of support and fostering a cultural shift by accepting 'diversity' in all its manifestations.

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Future Plan

We were able to take this educational material and presented this as a workshop at four nation COPMED. After reiteration and feedback, a formal version is being distributed as part of a wider repository of information and guidance that will help support trainers.

Further discussions with AoRMC and GMC on this work is planned.

Dr Sana Fatima
ST5, General Adult Psychiatry , Bradford District Care NHS Foundation Trust

I, Joan - The Veracity of the Voice

By Dr Amelia Gledhill

The Royal Shakespeare Company recently concluded the debut of the much-discussed play, 'I, Joan'. Reviews in the media have focused on the aspects of gender and sexuality which run through the performance – both the playwright and Joan (the character, as well as the actor) are non-binary. I was privileged to see the very last performance of the run, which I gather had elements of improvisational power (directed at modern day politics and societal change) not normally present.

There was a great deal about the play – of which I have heard rumours of a national tour, even so far as 'The North' – which could be dwelled upon. Gender, sexuality, class and race would all have been ripe for discussion. Having recently attended the Yorkshire MAX course on management for final year trainees, there were ample examples of both marvelous and terrifying leadership. However, the topic which grabbed my attention was that of Voice Hearing, and what truths can be found in such psychopathology.

It is easy to speculate about Joan of Arc, but of course we know very little about her/them, and what diagnoses might have underpinned the story. Temporal Lobe Epilepsy; Post Ictal Psychosis; Schizophrenia; Mania; Ergot poisoning (which has itself a saintly nom de plume as St Anthony's Fire) - all of these have been contemplated and debated over.

Additionally of course, those of a religious persuasion may also add in the possibility of a genuine spiritual experience, with no pathology whatsoever. Joan's experience, however, especially in these days of person-centred care, and the (debatable) eschewing of diagnosis, is what drives the narrative. The passion Joan brings to the court when the Voice of God has commanded them to present themselves is unflinching. There is mockery and humiliation, yet Joan persists. On the stage, Joan's unwavering belief in the Voice allows the barriers of misogyny, transphobia and classism to be broken through.

There are victories – both physical, between the warring factions, and moral, when the bullish General finally accepts Joan. The soldiers around Joan are as convinced by the Voice as Joan is – the battles could not be won without that depth of truth. One of the most painful moments in the play is not when Joan is physically wounded, or sees their soldiers dying around them; not even when Joan is humiliated by the clergy and eventually killed.

For at those times, Joan is strong – their belief in the Voice and therefore in their own personhood is absolute. No – the pain is when the manipulative King tries to convince Joan that the Voice is telling them something Joan is not experiencing. The actor has such anguish on their face – a twisting, tormenting expression they indicate within their guts. It feels completely wrong, and untrue, and untrustworthy.

My thoughts at this point were with the patients I have

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seen who experience delusions – those which fit within the classical descriptions, which are so unshakeable as to be undivided from any other belief. To be told that they are wrong, or mistaken, must be painful; humiliating, even. How can they trust the doctor in front of them? How can they trust themselves? The answer is, of course, not collusion; it is likely to be simple civilities such as kindness and curiosity. To be heard, as Joan was, and to be believed – if not for the objective 'truth', but for the truth of the person's experience – could be our greatest gift at that time. In my training,

I have seen psychiatry colleagues vary in their determinedness to eradicate hallucinations in patients with psychosis. Some will not rest until every avenue of pharmacology has been explored; some will accept a reduction in symptoms so as to allow a more peaceful life for their patient; occasionally there are colleagues who subscribe to the tenet of Voice Hearing as a lifelong part of a person. It may be that, depending on psychopathology, and risks, and the wishes of the patient, there is room for all of these approaches. What 'I, Joan' demonstrated to me, however, is that the Veracity of the Voice, as I would call it, can be respected at the same time as working towards recovery – anything other would be as cruel as Joan's final moment.

Dr Amelia Gledhill
Acting Consultant, Honorary Lecturer
Humber Teaching NHS Foundation Trust

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Improving psychiatry placement experience for undergraduate medical students at South West Yorkshire NHS Foundation Trust

By Dr Shumaila Shahbaz and Dr Thimmaiah Rajanna

Aims and Objectives

The project aimed to improve the quality of undergraduate medication education for medical students during their psychiatric placements at SWYPFT (South West Yorkshire Partnership NHS Foundation Trust). We added three more projects to the existing medical students' placement timetable (to inspire them about psychiatry, to offer them peer support during placement, and teach them tools to look after their wellbeing). We planned to run these projects as a pilot and our outcome measure was to have improved feedback from the medical students.

Introduction

Over the past few years, mental health issues are increasing in the UK. Medical students are tomorrow's doctors. The next generation of doctors must be fully aware of the importance of mental health in their future careers – regardless of the specialty they ultimately choose and the positive difference that psychiatry makes to people's lives.

This has been recognised by the General Medical Council (GMC) guidance i.e. local education providers working with medical schools must provide quality learning resources and clinical placements.

The Royal College of Psychiatrists developed guidance based on examples of best practice and identified four key areas for action:

1. Excellence in teaching
2. Quality placements
3. Leadership from psychiatrists in undergraduate education
4. Enrichment activities

SWYPFT is a specialist NHS Trust that provides services to over a million people within its catchment area. The trust is also passionate about medical education. The trust Medical Student Policy is developed in line with other relevant trust policies and consideration is given to University's requirements and expectations and Health Education England guidance. It aims to have excellent medical student placement experience which has been highlighted in the previous feedback.

Since the start of January 2020, COVID-19 has caused unparalleled disruption including the delivery of medical education. Clinical rotations were cancelled. These changes have led to less than an ideal clinical exposure for medical students. SWYPFT adopted a blended teaching programme (face-to-face and remote learning).

SWYPFT also promotes high standards of post-graduate training and supports its higher trainees to improve their leadership and management skills. Consequently, the Trust sponsored its few selected higher trainees to attend the Leadership and Management Fellow Scheme of the Royal College of Psychiatrists. The other part of the scheme is to complete a local project. I chose to improve the quality of undergraduate medical education at SWYPFT because I am passionate about medical education. We planned to do more work on excellent teaching, quality placements, and enrichment activities for the medical students. We planned to arrange a mindfulness session, peer support during placement, and an inspiring talk by psychiatrists.

Method

We made SMART goals, set a timeline to accomplish each goal each month. We also identified our team (mentor for the project, associate director for undergraduate medical education, medical education department, other peers doing the Fellowship scheme, IT staff, medical secretaries, core trainees, higher trainees, consultants, and patients). We also identified other stakeholders (medical students, trainees, consultants, medical schools, universities, patients, and the mindfulness coach).

We also made a list of potential barriers (my emotional inner dialogue, time management, material of the courses, personal circumstances, funding, sickness, and planned leave, Covid related issues, issues with technology, and clinical commitment). We identified improved feedback of psychiatry placement experience from the medical students as an outcome measure.

Mindfulness

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Research and practical experience have shown that mindfulness brings enormous benefits such as wellbeing, resilience, cognitive functioning, emotional intelligence, effectiveness, and productivity.

We planned a virtual mindfulness session with a trained coach and utilised unused funding for it. The session covered various aspects of mindfulness (theoretical, reflection, and take-home material) along with mindfulness practice in a psychologically safe place. The students were also invited to practice guided meditation. As a part of the session, they also practiced staying in a moment by giving more attention to it in a non-judgmental way. For example, they were invited to pick up any random nearby object (like a plant pot or a cup of tea). They were asked to focus on the object using all five senses and describe their experience.

Peer Support

For enriched clinical exposure, we planned for medical students to shadow trainees during their placements. We also offered trainees a support letter for them for their portfolio for ARCP.

During the placement, students were encouraged to have an informal discussion with the doctor ranging from interesting cases to useful learning resources and unique clinical scenarios. We kept it very flexible and about 30 - 40 minutes a week.

Inspiring Talk

We arranged an inspiring talk with the title "Choose Psychiatry". For this, we invited a range of doctors from psychiatry subspecialties. The speakers presented psychiatry as an exciting and advancing medical science. They also shared their reasons for joining psychiatry.

We also invited a service user to share her journey of mental illness (having several admissions to psychiatric hospitals and taking several psychotropic medications without any benefits) and the recovery process. Now, she is living in supported accommodation with minimum medication and enjoying reading books, playing piano, and seeing her family. She was confident enough to give an inspiring talk to a bunch of medical students and doctors. She emphasised dealing with the patients at a human level, listening to his/her needs, and giving them time to share their worries.

Results

We received excellent results for the pilot project for each activity.

Mindfulness

The feedback for mindfulness was collected as a questionnaire and combined in a form of a tally. All the attendees found it very useful with the excellent mode of delivery, 80% of students rated it 10 out of 10 for the overall impression of the session and 20% rated it 9 out of 10. Some of the narrative feedback comments are as follows:

- "Thoughts are like clouds in a sky"
- "For their overall experience, they mentioned that session was very insightful and calming and overall"
- "A very positive experience and take time out each day"

There were also a few suggestions for improvements:

- A few more short, interactive guided meditations.
- For medical students, it was suggested to add techniques for stress management during exams, change of placements, career choices, job interviews, working with patients, and difficult personal circumstances.

Peer Support

For peer support, the medical students found it very helpful, motivating, and supportive.
With regards to written narrative feedback, it also showed positive feedback such as:

- "1:1 teaching sessions with the higher trainee to discuss certain cases and problems I found very

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helpful".

- "On the ward rounds and throughout the placement when anyone had free time, they would always provide extra teaching sessions which were extremely helpful."
- "All the online extra teaching sessions and the in-person teaching sessions provided by the consultants and junior doctors."
- "Informal sessions with junior doctors."
- "The registrar who took the time to teach us and help with skills."
- "I have managed to gain a diverse insight into a career in psychiatry."

There were no negative feedback or comments received.

Choose Psychiatry Session

For "Choose Psychiatry Session", the anonymous feedback was collected via Survey Monkey. We received a 100% score for good learning experience, support for professional developments, and structure of the session. We also received an 80% score for the content of the session and the identification of personal strengths and goals. It was also suggested to include a forensic psychiatrist's presentation for the next talk.

Few other positive feedback narrative comments are as follows:

- "A really good session that was inspiring!"
- "More details about old age psychiatry. Range of opportunities along with psychiatry (clinical, educational, and leadership)."
- "It was just interesting to hear about the pros of a career in psychiatry."
- "I also liked that there were different speakers at different stages of training."
- "Useful to have a patient present."
- "Listening to a patient about her story."

We also collected feedback from the presenters and they suggested having a mixture of presentations (with and without PowerPoint presentations).

Conclusion

The project showed that we can improve the quality of undergraduate medical students by using simple, innovative, and effective measures (mindfulness, peer support, and inspiring talk).

Acknowledgments

- Professor Stephen Curran, Consultant in Old Age Psychiatry and mentor for the project
- Dr Subha Thiyagesh, Consultant in Old Age Psychiatry, Director of Medical Education and Medical Director.
- Colleagues who participated in the project.

References

References available by contacting the author.

Declarations

No conflicts of interest.

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N&Y Autumn Conference 2022

By Dr Paul Walker

Our 2022 Autumn Conference was our first major face to face event post-Covid. Held as usual at York Racecourse entitled 'A NICE day at the races', it was essentially based on the new NICE guidelines for depression but ensuring we had input from speakers with lived experience of the mental health system as well as an overview of when things don't go well.

Our illustrious speakers included an introduction from Dr Adrian James, President of the Royal College. Adrian talked about the first two years of his presidency, the highs and challenges and the four priorities he originally set of:

- Mental health and physical health parity.
- Equality, diversity and inclusiveness
- Workforce wellbeing
- Sustainability

Key points to take home include modelling by the college as estimated there may be 1.8 million new or recurrences of people with mental health problems in England due to Covid. He discussed the recent AGM and then EGM which had to be cancelled because of the death of her Majesty the Queen. Instead, The College will be having a hybrid event at central offices in Prescott Street He talked about the recruitment problems in Psychiatry particularly the specialties of Addictions, Children's Services and Eating Disorders, the new Community Mental Health Framework and Mental Health Act reform.

Our second speaker, Professor Peter Kinderman had to give apologies but we watched his video presentation on psychological options for treatment of depression according to NICE reminding us that for less severe depression, antidepressants shouldn't be routinely offered unless patient's preference and there are tables of ten or so evidence based options for treatment depending on severity and a reminder to always consider the social determinants of depression.

Professor David Taylor, in a change to the planned subject talked about long-acting depot injections and clozapine including data demonstrating their value in reducing side-effects compared to traditional drugs as well as reducing relapses and admissions compared to oral medications. He talked about cutting edge developments of clozapine which have been used at the Maudsley including IM clozapine for resistant psychosis, finger prick testing, three -monthly monitoring and they plan to offer metabolic tests which can help estimate some side-effects.

After the presentation of prizes to the trainees from our President, our first afternoon speaker, Kate King MBE gave us a presentation on her lived experience "living with an

N&Y Autumn Conference 2022

By Dr Paul Walker

Poster Prize Winners with Adrian James at the conference

albatross", she spent about seven years in and out of hospital with severe depression, sometimes under the Mental Health Act and had a variety of treatment, not all of it good and worked with Professor Sir Simon Wessely on the proposals for the reform of the Mental Health Act. Her excellent presentation was punctuated by numerous poems to a very poignant and thought provoking presentation.

Professors Navneet Kapur and Matthew Large talked about the inability of risk assessment tools to provide any better prediction of suicide than good clinical practice. Multiple analyses and literature searches have shown that there has been little improvement in the past forty years of the positive predictive value of rating scales that try to predict suicide. The positive predictive value of such scales is about 5% at best, i.e. they're wrong 95% of the time, they don't pick up "low risk cases" from which the majority of suicides occur. There is no statistical method to enable predicting suicide and using multiple risk factors is little better than a single risk factor. Both speakers emphasised the importance of good clinical practice with multi-disciplinary formulation of a patient using a highly personalised approach involving carers and families and ensuring safer systems and networks with local support systems.

Our final speaker, Dr Rachel Gibbons talked about the effect of suicide and homicide on the clinicians and those left behind. Working through the "eight truths about suicide", the death of a patient by suicide can have a profound effect on clinicians involved in their care and can lead out to burnout, mental health problems or even leaving mental health work altogether. There are no national guidelines about this but the College has produced a report in July 2022 with some very helpful principles.

Thanks to those who attended this event in person. We had excellent feedback and currently we plan for our Spring conference to also be face to face, look out for flyers in the New Year.

Dr Paul Walker
Chair, Northern & Yorkshire Division

Upcoming Northern & Yorkshire Events 2023

Wednesday 22 February 2023
Management of Physical Health in Eating Disorders Webinar
(Online)

Wednesday 22 March 2023
National Mentoring Event 2023
(Online)

Friday 19 May 2023
Northern & Yorkshire Division Spring Conference
(Face to Face)*

Friday 15 September 2023
Northern & Yorkshire Division Autumn Conference
(Face to Face)*

Wednesday 6 December 2023
Northern & Yorkshire Division Well Event 2023
(Online) TBC

Please visit the Northern & Yorkshire Events page for more information.

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*DISCLAIMER: We aim to host 2 face to face events in 2023. Due to unforeseen circumstances, we may have to change this. We will keep you updated.

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

The Northern & Yorkshire Division is made up of members from areas including Leeds, York, Bradford, Cumbria, Tyne & Wear and Gateshead.

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

Northern & Yorkshire Division Vacancies

The Northern & Yorkshire Division have a number of exciting roles to share. Please see our vacancy list below:

Regional Representatives

- Academic: Division-wide
- Addictions: Division-wide
- Child and Adolescent: North East region
- Child and adolescent (shared role): Yorkshire region
- Eating Disorders: North East
- Forensic (shared role): Division-wide
- General Adult (shared role): North East region
- Intellectual Disability: North East region
- Liaison: Yorkshire region
- Old age (shared role): Yorkshire region
- Rehab and Social: North East region

Regional/Deputy Regional Advisor

- Regional Advisor (North East region)
- Deputy Regional Advisor (Yorkshire region)

Executive Committee

- Academic Secretary (shared role)
- Mentorship Lead
- PTC Rep

For more information on these roles and to apply, please click here: Northern and Yorkshire Executive vacancies (rcpsych.ac.uk)

Deadline for next edition
Submit your articles for Summer edition by 18 May 2023 to northernandyorkshire@rcpsych.ac.uk

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