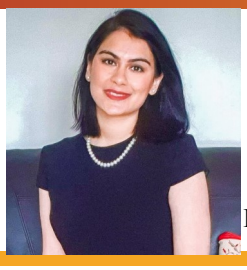
Summer Edition, 2022

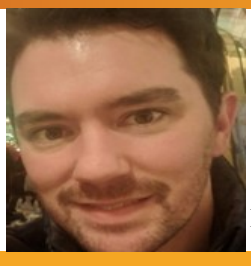
Psychiatry-Trent

The Trent Division eNewsletter

Editorial



Dr Sidra Chaudhry



Dr Kris Roberts

In this issue:

Dear Colleagues,

Welcome to the Summer 2022 Edition of the Trent Division e-Newsletter. We hope it finds you well.

Conference season is upon us! There is such a broad range of events across all specialities, and it is always exciting to take advantage of them in the lead up to the International Congress in Edinburgh. The return to face-face events is a welcome one; learning and listening purely through software has been necessary, but isolating.

Through this lens, in May, the topic of loneliness during Mental Health Awareness week was a pertinent one as we continue to adjust to post-pandemic life. One of our articles in this edition, *A Deeper Insight into Psychiatry: A Reflection on Vulnerability* by Lowrie Churchill highlights the difficulties faced by many of our patient groups, touching on loneliness.

However, we are not impervious to loneliness and isolation as professionals. Psychiatry has its own unique set of demands. I would encourage you to listen to the You Are Not Alone podcasts, produced by the Psychiatric Trainees Committee of the Royal College.

They touch on several areas that affect our wellbeing and is something I've really enjoyed during the period since our last newsletter.

Speaking of which, we very much hope you enjoy our selection of articles in the coming pages. Dr Beena Rajkumar has taken part in our "Meet the Member" section this time, and her story and insights are as interesting and enjoyable as you'd expect. Thank you to her, as well as to all the other contributors for their varied and interesting efforts.

We continue to encourage submissions on a range of topics. The process of submission is very simple and we are happy to guide anyone wishing to contribute to the newsletter. It's a great way to keep your CV's ticking over too - you'll get a certification for your portfolio.

In the same vein, please also nominate colleagues who you feel are deserving of some acknowledgement to our Hall of Fame. It's important to recognise good work and spread some positivity!

Enjoy the Summer Edition!

Best wishes,

Sidra and Kris

Dr Sidra Chaudhry and Dr Kris Robers Co-editors, Psychiatry Trent

Get Involved!

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

The division welcomes articles of local interest relating to psychiatry. We encourage trainees to get involved as well as patients and carers.

Submissions could be along the following lines:

Interest articles
Are you personally involved in any local work that you would like to increase awareness of? Is there a topic in mental health which you find interesting and would like to share with your colleagues? Do you have a personal experience within psychiatry you'd like to share?

Event articles
Would you like to share a review/feedback from a conference or other mental health related event that you've attended?

Opinion pieces/blog articles
Are there any issues in mental health that you are passionate about and wish to discuss with a wider audience?

Cultural contributions
This could be in the form of artwork, photography, poetry or an article relating to your insights, interpretations and observations of
relevant popular culture, the arts and theatre.

Research/audits
Have you been involved in any innovative and noteworthy projects that you'd like to share with a wider audience?

Patient and carer reflections
This should be a few paragraphs detailing a patient or carer's journey - you may have a patient whose story you would encourage to share; or it could be a case study including a patient's perspective. Confidentiality and Data Protection would need to be upheld.

Instruction to Authors
Please consider your articles to be as precise as possible. As a guideline, articles on interesting topics, research/audits, good practice and opinion pieces may be up to 1000-word limit which may include up to around 5 essential references. Articles on events or conferences should be within 500 words. Please follow Instructions for Authors of BJPsych for reference style. Authors must obtain written permission from the original publisher if they intend to use tables or figures from other sources, and due acknowledgement should be made in the legend.

Authors are expected to be aware of and comply with best practice in publication ethics. Please declare any conflict of interest related to the article.

Disclaimer:

The opinions expressed in this newsletter are those of individual authors and do not necessarily represent the views of the Royal College of Psychiatrists

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Chair's Column By Dr Shahid Latif

@DrShahidLatif

Dr Shahid Latif, Chair Trent Division, RCPsych

Dear Members

Welcome to the summer newsletter of our Division, we hope that you enjoy learning more about what is happening within the Trent region.

A big thank you to our joint e-newsletter editors, Dr Kris Roberts and Dr Sidra Chaudhry for their input and for putting together this edition in partnership with our members and support from the RCPsych Division Manager, Marie Phelps.

International Congress
We're looking forward to the RCPsych International Congress, taking place from 20-23 June 2023. We also plan to record all of the sessions from the Congress (where speaker permission is given). Those delegates who were unable to join us live in Edinburgh will be able to purchase these recordings after the Congress has taken place. If you are interested in purchasing these recordings and not attending the Congress in-person, please sign up to our recordings mailing list.

Get in touch
We are keen to hear from our members please email us with your suggestions for future events, topics and how we can get more members involved in our divisional activities to Marie Phelps at Trent@rcpsych.ac.uk

I also encourage you to use our Twitter account **@rcpsychTrent** to communicate with your peers, share best practices and raise the profile of psychiatry in the Trent region, currently with 1040 members.

Executive Committee
Committee Meetings: The next meeting date is 6 July 2022.

Current Vacancies: There are currently the following vacancies within the Trent Division Executive Committee, for further information about how to apply please refer to our website or email Trent@rcpsych.ac.uk

- Regional Advisor for Derbyshire, Lincolnshire and Nottinghamshire
- Regional Advisor for Leicestershire, Northamptonshire and Rutland
- General Adult Regional Representative
- Eating Disorders Regional Rep
- Neuropsychiatry Regional Rep
- Rehabilitation and Social Psychiatry Regional Rep
- Specialty Doctors Committee Rep

Events
The College is continuing to provide online content and webinars, which I hope that you have been able to join. As a division we are planning our first face to face conference since the pandemic began, which will hopefully take place in November 2022 – more details will follow.

Trent and West Midlands Joint Spring Webinar
Thank you to both the Trent Division CPD Lead, Dr Santosh Mudholkar and the West Midlands Division Academic Secretary, Professor Saeed Farooq for arranging our first ever joint spring webinar. The event was very successful with the fantastic line up of speakers, which included Professor David Kingdon, Dr Pratima Singh, Dr Rashi Negi, Dr Amar Shah and Dr Kate Lovett. We hope to provide more joint events in 2023.

Mental Health Act Section 12 and Approved Clinician Courses
These courses are supported by the Trent Division and continue to be successful. Bookings are open, please visit our website to book your place.

Trent Medical Student and Trainee Event
I'm pleased to update you on a Medical Student and Trainee webinar being arranged by the Trent Division. It's taking place on **13 July 2022 from 9.30-4.30** – please spread the word within your networks. Delegates will be able to book their place by registering online on our website. Trent events and training courses | Royal College of Psychiatrists (rcpsych.ac.uk)

Student/Foundation Doctor Associate
Please invite your foundation doctors and medical students to sign up to associate status, it's free to join via the College website. Joining includes perks like access to free or discounted events, free electronic subscription to RCPsych magazines and discounts on all other RCPsych publications and free access to Trainees Online (TrOn) our online training module.

Applying for Fellowship
We award Fellowship as a mark of distinction and recognition of contributions to psychiatry. You're eligible if you've been a Member for 10 continuous years or more and can demonstrate significant contributions to the core purposes of the College:

- setting standards and promoting excellence in mental health care
- leading, representing and supporting psychiatrists
- working with patients, carers and their organisations.
- Fellowship is open to both UK and Overseas Members, but unfortunately Affiliates and Associates can't apply.

If successful, Fellows can use the title FRCPsych once they've paid the prescribed registration fee. Find out about how to apply.

Audit of Attention Deficit Hyperactivity Disorder (ADHD) Medications in Transition ADHD Referrals to the Sheffield Adult Autism and Neurodevelopmental Service (SAANS)

By Dr Deepak N Swamy, Associate Specialist in Autism and Neurodevelopment and Becky Richmond, MBChB Student, Sheffield Medical School, University of Sheffield

Dr Deepak N Swamy

Becky Richmond

Background

Attention Deficit Hyperactivity Disorder (ADHD) is a common neurodevelopmental disorder which usually manifests as a triad of symptoms – inattention, hyperactivity and impulsivity although there can be variations. In UK alone it is estimated that between 2% and 5% of school age children have ADHD, and between 3% and 4% of adults have ADHD[1].

In the UK Stimulants and Non-Stimulants are the two types of ADHD medications available. The main five medications for ADHD treatment are Methylphenidate, Lisdexamfetamine, Dexamfetamine, Atomoxetine and Guanfacine. Each of these medications has different licensing requirements[3].

When a child with ADHD is transferred to the adult services, their treatment could possibly be reassessed to see if it is still appropriate and necessary, which will allow a smooth transition from Children's Services to SAANS. Guanfacine is not licensed for use in the UK in adults with ADHD[4]. Therefore, patients who were prescribed Guanfacine as a child, will need to be prescribed an alternate medication after age 18.

Aims

The purpose of this project was to look at the transitions young people make when moving from Children's service to SAANS. The aims of this audit were to look at real-time transition referrals and any limitations in the process. Examples of these would be lengthy waiting times and inappropriate medication combinations. The audit would then suggest potential improvements and plan further recommendations to improve practice, enhancing the quality of the service at SAANS.

Design and Method

The ADHD audit tool was formed by the Neurodevelopmental Specialist based on the NICE guidelines of diagnosis and management of ADHD. It included demographic factors, clinical factors affecting ADHD treatment, current ADHD medication and additional psychotropic medications. The audit data was collected retrospectively and then analysed. A randomly selected sample size of 50 patients was included out of 1150 active ADHD transition referrals between April 2019 and October 2021.

There were no ethical implications, due to the data collection being retrospective and kept strictly confidential. No ethical approval was needed as the audit did not impact patient care in any way.

Results

The audit provided comprehensive data relevant to real time transition referrals within the SAANS. Shortfalls in the referral process were able to be identified.

About 66% of patients were referred to SAANS by their GP, rather than the Children's Services. At age 18, for ADHD patients who are on single ADHD medication, Children's services usually refer transition patients back to the care of GP. GPs are advised to continue ADHD medication and monitoring as per the NICE Guidelines, unless an issue arises, such as requiring a medication review. This explains why average age of referrals is around 20 years for patients. Of the 50 transition patients, 23, 21 and 6 were referred in 2019, 2020 and 2021 respectively, showing the extent of waiting times for appointments at the SAANS. Only 2 of 50 patients had been seen by the service and discharged back to GP, further showing lengthy waiting times to be seen by the service.

21 patients were on ADHD medication. 3 out of 21 patients in the audit were taking Guanfacine, which is an off-label prescription in adults. Furthermore, 4 patients were on additional psychotropic medication - 3 patients were also on an SSRI, and one patient was also on a Tricyclic Anti-depressant.

There were some special considerations as sample included women of reproductive age. As per the BNF, ADHD medication is not suitable for women who are planning to conceive or pregnant women[2] or breastfeeding mothers. 36% of participants were female, however none were pregnant. One patient each were planning to conceive and breastfeeding respectively, however both patients were currently not on any ADHD medication.

Discussion

This audit was comprehensive and provided insight into ADHD transition referrals, highlighting complexity of the referrals process. Transition referrals only make up a small number of referrals to the SAANS. Therefore it provided detailed and specific data on this sub-group of transition patients. The findings emphasise the importance of a seamless continuity of care of transition patients from Children's services to SAANS.

This audit project had some limitations. Of the 50 transition referrals in the audit, only 21 patients were taking ADHD medication. So if there was a higher percentage of patients on ADHD medication, that would have made the data more robust. It would also highlight more patients who are on additional medication combinations. A further limitation of audit could possibly be the impact of the COVID-19 pandemic. Data included referrals from April 2019, however patients from March 2020 onwards would have had increased waiting times possibly due to pandemic. This may be due to travel restrictions delaying appointments or preferring to postpone appointments due to wanting face-to-face appointments rather than video consultations. The pandemic possibly impacted on mental health of patients which may have resulted in an increased number of patients taking anti-depressant medication.

To assess the impact of audit changes made to the transitions referral process, a re-audit can be done in the future to see how the transitions referral process has changed. The re-audit sample should only include patients who are already taking ADHD medication.

Conclusions

This audit will enable SAANS team to look at the transition referrals process, waiting list limitations & medication combinations with respect to ADHD transition referrals. Appropriate service specific quality improvement initiatives can be undertaken to make positive changes for the service. A standard transition referrals letter or information leaflet can be formed and provided to Children's services informing patients about possible review of their ADHD medication when they get transferred to SAANS, especially when they are on off-label ADHD medication as an adult. This will allow for a smooth transition of care from Children's services to SAANS.

Acknowledgements

We would like to thank Chloe Wong Xin, MBChB Student, Sheffield Medical School for her participation in completing this audit along with the 2 authors, however she has not contributed to writing this article being published, but she has given permission for this publication.

Becky Richmond would like to thank the SSC Admin team of Sheffield Medical School for giving her an opportunity to work with Dr Deepak N Swamy, and the support they provided around the project.

Declaration of Conflict of Interest: None.

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Welcomed and valued: Improving the experience of Medical Training Initiative (MTI) trainees in a Mental Health Trust

By Dr Toby Greenall, Dr Afeez Enifeni and Dr Beena Rajkumar – Lincolnshire Partnership NHS FT

Abstract

Aims and Methods

This evaluation looked at international medical graduates on the Medical Training Initiative (MTI) scheme running in a rural mental health trust and aimed to better understand the experiences and challenges faced by the trainees who were currently in or had recently left the scheme. A focus group was undertaken to explore the aims.

Clinical Implications

MTI trainees are like other trainees in many ways but are not identical. Innovative and bespoke approaches are required to ensure they can make the most of their skills and expertise. This includes supporting them to adapt to work and life in the UK, adapting and developing their clinical skills, and supporting cross-cultural exchange. MTI trainees in psychiatry have much to give and there are some simple actions that can be taken by hosting organisations to make their contribution even more meaningful.

Introduction

The Medical Training Initiative scheme began in 2009 as a Tier 5 Government Authorised Exchange immigration category that was established by the UK Department of Health.(1) It is now run by the Academy of Medical Royal Colleges and aims to support doctors from low and middle-income countries (LMIC) to gain experience of working in the UK for two years before returning to their home country. Within psychiatry, the Royal College of Psychiatrists (RCPsych) provides GMC sponsorship for doctors who are already specialised in psychiatry in their country of origin and supports them to work in mental health trusts across the country at a third year core trainee level (CT3), from entry.

Lincolnshire Partnership NHS Foundation Trust (LPFT) has been committed to employing MTI trainees for several years and has much experience in supporting trainees on the scheme. This has been a mutually beneficial experience for the Trust and for trainees who have generally reported positive experiences. The Trust now has the highest number of MTI posts in the East Midlands region. However, given the high number of MTIs, it was felt that it was important to understand their subjective experience and to obtain more detailed feedback from them. This would ensure that the organisation was responsive to their unique circumstances and that it was able to offer effective and appropriate support.

Previous published explorations of the experiences of international medical graduates have tended to focus on those working in acute hospital settings rather than psychiatric or community settings as in this evaluation.

Aims

This evaluation aimed to better understand the experience of trainees that are currently in, or have recently progressed through, the MTI training scheme within Lincolnshire Partnership NHS Foundation Trust. We aimed to also understand the challenges that MTI trainees face to inform the way in which the Trust supports MTI trainees in the future.

Methods

Sampling and Recruitment

A qualitative methodology was used to obtain data, to inform the evaluation and to achieve its aims. We obtained a list of the current MTI trainees working in the Trust as well as those that had left the Trust within the last year from the medical education team, as well as email addresses for these trainees. Seven trainees were emailed asking if they wished to take part in the evaluation by attending a one-off focus group. They were informed that the focus group's aim would be to understand the challenges faced by MTI trainees so that more effective support could be planned.

Procedures

The focus group was held virtually over Microsoft Teams on 2nd November 2020 and was facilitated by two of the authors, TG and AE. AE is a current MTI within the Trust while TG was employed as a Medical Education Fellow with an explicit part of his role being to support trainees. Six MTI trainees attended the focus group. The attendee characteristics are displayed in Figure 1.

Figure 1. Focus group participant characteristics. N = 6		
Gender	Male	3
	Female	3
Country of origin	Nigeria	2
	India	2
	Egypt	2
Employment Status	Current MTI Trainee	4
	Previous MTI trainee working in LPFT	1
	Previous MTI trainee working in a different Trust	1
Years Working in the UK	<1	2
	1-2	2
	>2	2

The focus group was recorded within Microsoft Teams and transcribed verbatim in full. Two authors (AE and TG) then completed an independent thematic analysis of the full data set and drew out themes from the raw data. These were then compared by the two authors and discussed in the context of the evaluation aims and those for which there was agreement were included in the final analysis.

Results

A wide variety of themes emerged with regards to MTI experience and challenges. These are:

a) motivations to enter the MTI program
b) adapting to new systems, induction and training
c) support networks
d) mentorship
e) practical support
f) clinical knowledge and experience
g) cultural and structural differences
h) graduating from the MTI scheme.

a) Motivations to enter the MTI program

We found that most participants wanted to gain experience of working in the UK where there was a sense of prestige and high standards of practice. Another driver was the sense that membership exams for the RCPsych would be easier to pass when in the UK, especially the CASC where one participant spoke about the benefits of having clinical experience in the UK. Some participants also hoped to be able to remain in the UK after completing the MTI scheme:

"Perhaps to get more knowledge and expand my horizon and then get into the UK." (P1M)

b) Adapting to new systems, Induction and Training

All participants commented on the induction that they experienced on arrival and how they felt the induction process could be tailored more to their experience, which is characterised by them having never worked in the UK or NHS before:

"…it is our first job in the NHS, so we have to understand the system from the beginning…from the root of the system, so it is better if we receive training in those areas…like the referral systems and how it works and all the stuff." (P3M)

One of the main concerns was around a lack of tailoring specifically for MTIs who were in very different circumstances to other trainees who had previously worked or trained in the UK, for example, a typical foundation year 2 (F2) doctor:

"…someone is coming from F2…they will know that there is a blood system online, there is an online recording system for patients and there are some services that you could refer to. But they need to familiarize themselves with the trust like information, but for us it was like we don't even know that this information exists, so maybe this is the gap that we needed to be covered." (P5F)

The MTI trainees have typically been specialised in psychiatry for longer than other trainees and so have been deskilled to some extent around physical health competencies. This means that some of the MTI trainees have less confidence managing physical health in psychiatric settings, compared to non-MTI core trainees. One participant from Egypt described her concerns regarding these skills;

"Because one of the things that I was really struggling with when I came here a managing the physical health part. Because in Egypt, I wasn't used to doing anything related to physical health." (P5F)

Physical health training had been provided by the Trust for trainees and several participants commented on how helpful this had been.

"I remember that time when we were taken through these physical health training. It was really insightful. I remember I gained a lot. I think it's really gonna help a lot of people who trained abroad." (P1M)

Participants also spoke about driving as a particular challenge and wanted more support around this, especially given the rural nature of Lincolnshire.

"I think it [road and driving training] should be part of the induction package for everybody, especially for those from abroad." (P1M)

c) Support Networks

Participants spoke about various sources of support. These included informal peer relationships, formal supervisory relationships, and organisational support from the Trust, RCPsych and the GMC.

"I think from the Royal College perspective, they were very supportive with like the material and everything, so I have known what I am going to do or like what I need to do." (P5F)

"The CTs actually they are very helpful and the WhatsApp group, and I'm lucky I think because [my clinical supervisor] is very helpful and he is there every day so I am passing by him, asking a lot of questions." (P4F)

d) Mentorship

The participants spoke about how having a consultant mentor from the same background who understood their situation and experience as well as helping them navigate the system would have been a significant benefit.

"..so if [a consultant in the Trust] who is a Nigerian, is interested in mentoring an MTI…he would probably have served my purposes better than say…[moderator T.G., a UK graduate trainee]… who might not really understand me as much." (P2M)

e) Practical Support

Participants spoke about the sort of support that had been helpful in settling them into life in the UK, for example, around housing and opening bank accounts. However, there were some aspects that perhaps were harder to predict, for example, the level of and approach to taxation in the UK.

"I think that the Trust was very very supportive in the start, and they helped me with like opening bank account, and they like guarantee me for the bank account while I didn't have like permanent house" (P5F)

"…it's important when people are coming in, to understand how the payment system here works…I thought it was going to be earning, maybe four or five thousand a month…. Where I come from, even if they tax my money, it is so insignificant, so I have made calculations, I have made projections. I had taken loans to say, "yeah, when I get to the UK, I'll pay it back within a month or within six weeks or whatever". Then my money gets taxed and I'm thinking well, "did my consultants go with part of it?!" (P2M)

f) Clinical knowledge and experience

MTI trainees within the Trust are given the same status as CT3 trainees and this 'trainee status' was commented on by participants with regard to the access that it gave them to training and development opportunities.

"…some people on other trusts have problem with that because they wanted to use the MTI like a specialty doctor or like a trust grade doctor and they didn't allow them to go for post-grad teaching or like prepare for CASC exams…" (P5F)
However, for some participants, working at CT3 level represented a significant change to their role as it had been before coming to the UK where they had more responsibility and autonomy. Some reported feeling that their experience was not being fully utilised and that a culture of more consultant-led care meant they were less able to make independent clinical decisions.

"I was a bit shocked to see how things were being done here…I discovered that it was the consultant that did almost everything. That as a trainee, you just sit back. … probably you chase bloods…type up the ward round…like a med sec. It was really strange to me….initially I struggled to contend with that." (P1M)

Some participants did recognise that the different systems and different clinical presentations meant that their knowledge was not always directly applicable.

"Yeah so I discussed with my consultant that I have the kind of experience back in my home country. And she acknowledge that yeah, I have this kind of experience, but the experience in my country and the working environment here is completely different" (P3M)

"EUPD [emotionally unstable personality disorder] is an extremely…extremely rare diagnosis in Africa, or Nigeria specifically…when I saw them, I clerked them without recognizing them…and I diagnosed maybe my first 10 EUPD patients with bipolar affective disorder." (P2M)

g) Cultural and Structural Differences

Participants spoke about a wide range of cultural and structural differences that they had to adapt to and understand to be able to operate effectively in their new clinical roles. For example, there was a recognition that UK practice appeared to focus on subjective inner experience over psycho-pathology and that there was more emphasis on personal history and patient life experience. MTI trainees tended to be from socio-centric cultures where the involvement of the community and family was the norm. This meant that a more individualistic culture required adaptations to their practices, including around consent to share information with family members.

"…if we talk about the personal history…in UK, people emphasize more on the personal history. They talk about the childhood, birth history, and any kind of abuse and all those stuff. But back in India, it's like yeah we just ask and how was a childhood that's it." (P3M)

"…there's very little emphasis on psycho-pathology in the UK, there's very little emphasis on diagnostic and classificatory systems, so you you…Back in Nigeria you clerk a patient, you write a diagnostic formulation, and from your formulation people can actually pick out what the diagnosis would be. But here, it is more about talking about what the patient feels, how the patient feels and making sure the patient is comfortable and [emphasised] risk assessment." (P2M)

"…in Egypt, I worked more on community mental health as well, so I know that we have this approach of the patients with that we are equal and with no superiority from the doctor…" (P4F)

"…because this was a patient that was telling me that she is alone she had been struggling with certain problems and I was telling her, "why don't you just speak to your doctor or to your family members"…she said "no, no! I don't I don't want to bother them. I don't want to be a bother on him." …we practice this communal way of life back home where everybody is involved…so I was expecting the same here." (P1M)

Professional relationships also required adaptation to cultural differences, where supervisory relationships were often based on different terms compared to UK practice. This left some trainees unsure what the purpose of supervision was and unsure about the pastoral aspects of the relationship.

"what is the supervision hour for? Because actually we don't….I don't know what is for? Is it just for discussion of the cases which I found difficult? or I need help? Or my own supervision if I have a problem or…what should I talk about in the supervision hour?" (P4F)

Participants also spoke about the general cultural differences that they had to adapt to on arrival in the UK. These included adaptations to the way language is used, for example, making requests in a nondirect manner.

"There is a way you frame the questions here that did not tell me directly what you needed me [emphasised] to do. It was framed in such a way that I could interpret it either way…and I would think "oh yes, it's just a question it's not a suggestion". So, and I would answer it directly and that got me into a lot of trouble. So if someone says "[Referring to himself], when you have time please write a prescription for this patient", and there I am typing up some notes and I'm thinking okay…when I have time so I don't have time now and I'll write the medication on five o'clock when I'm on my way home. But the patient needed that [medication] at two o'clock and then there's a note against my name to say well, "this doctor is not responsive to our needs"." (P2M)

h) Graduating from the MTI scheme

Participants spoke clearly about the lack of clarity around exit pathways or career pathways out of the MTI scheme. The MTI scheme is set up for doctors to return home after their two-year experience, however, many MTI doctors over the years have remained in the country given that they have settled and invested in a new life in the UK as well as embedding themselves in a new way of practicing psychiatry and operating in a new healthcare system. This ambiguity leads MTI trainees unsure what the future holds for them.

"They have no idea about what the training pathways are, except for the proper training in which you pass the exams and go to ST4 and so that leaves you in a limbo. So for a very long time as well, I was just wallowing in a state of self-pity and in a state of angst, wondering, "where is all of this going to lead me?" At a point when I was in training, I had colleagues who, we graduated together, who were already on WHO panels abroad, and here, I was struggling to understand, "after MTI what am I going to do next", okay?" (P2M)

Discussion

Previous studies have examined the experience of international medical graduates (IMGs) in the UK and these identified issues including practical and logistical difficulties, gaps in declarative knowledge relevant to the UK, structural differences, and differences in relational aspects of professional work and clinical care, stemming from training in different models of healthcare. (2,3) However, these studies were undertaken in acute hospital settings and not in psychiatry and so the results are unlikely to be directly applicable to our sample of MTI trainees working in psychiatric and community settings. MTI trainees also differ from many other IMGs in many other ways with regards to training structure, time frame, and other support structures.

Given this, we feel that this evaluation represents a novel understanding of the challenges that MTI trainees, of which there have been 105 joining the scheme nationally over the past 3 years, face.(4) Looking at the results, there appear to be three broad areas in which MTI trainees face challenges and where any focused support could be best implemented. These are arriving in the UK and starting work in the organisation for the first time, adapting to life and work in the UK and in the NHS, and finally, developing and adapting clinical and communication skills to work in psychiatry in the UK.

Arriving in the UK

It is estimated that the cost of training a doctor in the UK is £230,000.(5) Given this, attracting IMG talent represents a significant financial savings for the UK government. Therefore, properly supporting MTI trainees with robust induction and time to adapt to systems and working in the UK should be seen within this context. MTI trainees in this evaluation acknowledged that although their psychiatric skills were at CT3 level, their understanding of the system was not, and so they cannot be treated the same as everyone else and require a bespoke approach. MTI trainees, like any other trainee, are creative and inventive in their approach to seeking out support and guidance to help them with this task, however, this evaluation demonstrates that trainees would value a more formal approach to compliment this.

Adapting to life and work in the UK

As we have discussed, MTIs are like other trainees in many ways, but are not identical. Our evaluation demonstrated the importance of organisations that host MTI trainees undertaking work to prepare educational and clinical supervisors for these differences, to be sensitive to them and to be ready to provide bespoke support as needed to ease their transition to their new work environment. Although some UK graduate trainees will be moving to the area for the first time, all new MTI trainees will and so orientation to the local area, as well as the UK should be built into this support.

Support in the clinical environment

Finally, in the clinical environment itself, we found lots of positive experiences and a sense that trainees and trainers enjoy a mutually beneficial relationship in having MTI trainees who bring a different perspective to the clinical environment.

It appears that robust and dynamic clinical supervision is crucial here; acknowledging differences in practice, identifying and working with strengths, while supporting any areas of weakness. This comes from robust and open professional relationships that allow for honest discussions around potential issues. One-to-one supervision time is the ideal forum for this, although our evaluation shows that our MTI trainees would have appreciated an orientation to supervision. Where there are common areas of potential weakness, these can be supported by specific training for MTIs, for example, around physical healthcare or confidentiality.

Potential solutions

Within our organisation, using the results of the evaluation, we have started to implement solutions to the issues highlighted.

To address many of the issues raised, we have developed a series of induction films that discuss not only how the local healthcare system works and the role of the MTI but also supports MTI trainees to orientate to working and living in Lincolnshire and the UK. These films will also be supported by a written reference guide. The films allow for flexibility of delivery, given that MTI trainees often arrive at different times throughout the year.

In addition, we are working on increasing the awareness amongst supervisors of the specific needs of MTI trainees as well as developing a mentorship program whereby MTI trainees can have a nonsupervisory contact to aid their acclimatisation. As we have seen, exiting the MTI scheme can be just as anxiety provoking for trainees as entering and so through these supervisory relationships, we are supporting trainees in a bespoke manner regarding their exit plans. This might include support to apply for an SAS role or to enter specialist training, or to return to their country of origin.

Finally, we are ensuring that MTI trainees have access to bespoke training and support to meet their needs. Physical health training has been organised as well as on-call shadowing in their first weeks of arrival. We are also now providing support for MTI trainees undertaking RCPsych membership examinations.
MTI trainees provide a unique opportunity to create a symbiosis where both parties benefit from cross-cultural exchange and workforce development. This evaluation has demonstrated to us how we can make the most of this opportunity.

About the Authors

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Data Availability

The data that support the findings of this study are available from the corresponding author, T.G., upon reasonable request.

Author Contributions

B.R. and T.G. conceived the project and T.G. wrote the evaluation proposal. T.G. and A.E. prepared, organised, conducted, transcribed, and analysed the focus group and the data, while B.R. provided support and guidance. T.G. wrote the initial draft and this was refined and revised by B.R. and A.E. All authors read and approved the final manuscript.

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"Reflections on my A Level Work Experience at Berrywood Hospital, Northampton by Karan Damien Thomas, Year 12, Rugby School

Karan Damien Thomas

As someone who is keen to study medicine at university, I was in equal parts relieved and excited, when I received the email from Berrywood Hospital confirming my Work Experience Week in Psychiatry. Relieved, as my efforts to secure an attachment in local hospitals over the past year had been consistently thwarted by the Covid pandemic and excited because this was going to be my first foray into the world of medicine as an observer rather than as a patient! As a 17 year old A level student, my exposure to mental health issues had been limited until then to news, entertainment, and social media communication/ portrayal of depression, suicide, multiple personality disorders, homicide due to psychopathy etc.

On my way to the hospital, I remember being slightly nervous -not knowing what to expect from a psychiatric setting -unsettling images from movies like Joker, Silence of the Lambs etc. were unhelpfully filtering through! However, such anxiety was immediately put to rest on my arrival as I was immediately comforted by the friendly welcome not only from all the nurses, supporting staff and doctors in the Acute Admission ward but also by the smiles of some patients on the corridor.

It was a busy Monday morning, with six new patients who had arrived over the weekend. The ward doctor, kindly, took me under her wing and briefed me on the background history of the new arrivals whilst we waited for the ward round to commence. She also went through how to conduct a Mental State Examination. Though the information seemed bewildering and overwhelming at first, it proved useful during the ward round. As each patient walked in and sat down, I focussed on applying this newly acquired knowledge. I observed their appearance (the eating disorder patient had wrapped herself with a blanket even though it was a warm day, the emotionally unstable personality patient had visible scars of cuts on her hands and bruises on the forehead from head-banging), there were those who appeared anxious, agitated, or aggressive, those who spoke slowly, softly, or tearfully. I was particularly struck by one 19yr old young man who had attempted suicide with the help of the euthanasia kit he bought on the net! Most importantly, I was struck by how calmly and professionally the Consultant interacted with difficult and aggressive patients. I realised the importance of remembering that patients' behaviour can at times be a result of their illness and hence needn't be taken personally.

Over the course of my time in the acute ward, I was able to identify a manic patient's pressured speech and grandiosity; came to understand how disturbing auditory hallucinations were for patients; the risk that psychotic patients presented to themselves and others and how drug abuse and alcohol could impact on mental health. I also learnt how an imbalance of chemicals in the brain could lead to schizophrenia, depression, bipolar disorders etc and the names of some of the medications like risperidone, olanzapine, clozapine etc and started to understand the practice of sectioning patients under the 1983 Mental Health Act.

Following the ward rounds, I spent the afternoons shadowing the ward doctor who was clerking in patients, observed her doing routine bloods and ECG and watched medical students taking history from patients with Schizophrenia and EUPD. It was interesting to listen to the content of auditory hallucinations and the patients' account of how the voices were telling them to harm themselves or others. I understood the importance of taking a thorough childhood and social circumstances history. It made me realize that context plays a major role in precipitating and perpetuating mental health disorders. Many of the patients were single/divorced, children of abusive parents, exposed to drugs and alcohol at a young age, unemployed or were in unstable relationships. Some also seemed to have other physical health issues like diabetes and hypertension due to the side effects of the medications.

I was also extremely fortunate to spend the remainder of my time on the Rehabilitation Ward. In this quieter end of hospital, I learnt a lot about the holistic 'biopsychosocial' approach to patient recovery. At first, I wondered why patients who seemed very stable, and calm were kept in hospital. However, during the ward round attended by various professionals, I soon realized that medications alone weren't enough to get the patients on their feet again-they needed help with activities of daily living such as cooking, self-care, budgeting and development of social & work skills and psychological support.

I learnt from the case of a young, academy footballer diagnosed with Hebephrenic Schizophrenia, that he still required occupational therapy support to make tea or use the microwave. Then there were those who benefitted from psychology input and from gradual community exposure through volunteering and work as they had social anxiety about being discharged to the hospital. Thus, I realized that recovering from mental health was not a straight-forward process. A range of multi-disciplinary professionals across the hospital and community - ranging from doctors, nurses, occupational therapists, psychologists, social care workers etc, worked as a team to enable patients achieve as much independence and quality of life as possible in the community.

At the end of the week, I was pleased with my stint in psychiatry. While my time on the acute side of psychiatry was extremely well spent learning about various psychiatric presentations and their management, I found my experience in the Rehabilitation ward extremely valuable. The latter highlighted the importance of a holistic approach in medicine where the aim is to not only treat illness with medication but to also manage the devastating impact it has on the patient together with an improvement in the context in which it occurred. This kind of reminded me of my school motto '*the whole person- the whole point*'. The entire experience left me determined to not only pursue a career in medicine but to also apply this concept once I enter its portals.

FAR AWAY FROM HOME

NIHR | Applied Research Collaboration East Midlands

Have you looked after an under-18 on an adult psychiatric ward?

"Far Away from Home" is a mixed-methods study investigating the scale and impacts of adult psychiatric ward admissions and out-of-area admissions for 13-17-year-olds. Funded by the NIHR and led by Professor Kapil Sayal (Nottingham), it reflects a collaboration with regional teams across England including: East of England, East Midlands, West Midlands, Oxford & Thames Valley and the North West.

The study consists of 3 main components:

1) Quantitative
- Surveillance Study of adult ward, far away or out of region admissions
- Investigation of NHS England data

2) Quantitative
- National Interviews with General Adult and Child & Adolescent psychiatrists across England
- Regional Interviews with young people, parents and professionals

3) Health Economics study

Progress so far:
- Over 180 cases reported
- >30 interviews completed with Consultants from across England
- >25 regional interviews completed with young people, parents and professionals

How can I get involved?

Qualitative Interview:
- We are very keen to interview General Adult psychiatrists (STs or Consultants) or General Adult ward nursing leads who have looked after an under-18 on their ward. Interviews are around 30 minutes and completed via MS Teams.
- We will provide you with certificates of research participation
- If you are willing to be interviewed please contact faraway@nottingham.ac.uk

Reporting cases:
- Please let us know if you or a member of your team, including when on-call, has seen any eligible cases (e.g. for assessment or ongoing clinical care)
- Eligibility criteria: The young person (aged 13-17 years) was admitted any time between 1st Feb 2021 – 28th Feb 2022 to either:
- An adult psychiatric ward
- a CAMHS General Adolescent Unit (GAU) over 50 miles from their home address
- or a CAMHS GAU outside their NHS region
- by directly emailing us at faraway@nottingham.ac.uk

Support and Follow the study:
- Data from NHS England suggests that we are still getting significant under-reporting.
- This risks under-estimating the true scale and extent of this issue.
- To raise awareness please follow/tweet @FarAwaystudy or email faraway@nottingham.ac.uk to sign up to our newsletter.

A Deeper Insight into Psychiatry: A Reflection on Vulnerability

by Lowri Churchill, 4th year medical student, Nottingham University and Dr Madhvi Belgamwar, Consultant Psychiatrist, Derbyshire Healthcare NHS Foundation Trust

Lowri Churchill

Dr Madhvi Belgamwar

As a 4th year – soon to be 5th year – medical student, I thought I had by now a very good idea of what constitutes a vulnerable patient. I saw vulnerable patients on my paediatrics attachment – peered at them through the plastic of their incubators: they were tiny, red-skinned, wrapped in blankets and woolly hats. During an obstetrics attachment I met a young service user with learning difficulties, pregnant for the first time. The baby was deemed high risk for Down's syndrome, but when this was explained, the response came back that this didn't matter in the slightest, and I wondered if the implications had been fully understood. Later, on the HCOP (Health Care of Older People) wards, there were elderly men and women in their 80s and 90s, who'd been only just coping with their activities of daily living – bathing, dressing, cooking, shopping - until a sudden unexpected event, as innocuous as a fall onto the living room carpet, or just an everyday E. coli urine infection, knocked them for six, and now here they were supine on the geriatrics ward, classified as frail, needing assistance just to sit up and shuffle to the edge of the bed.

It was easy to see that all these individuals were clearly vulnerable; they were very young or very old, or had an intellectual disability that made life more challenging for them in many ways.

So confident was I that I understood what vulnerability meant, at no point during medical school so far had I even bothered to look up the term. On reflection, I had a very narrow understanding of it.

My final attachment of this academic year was psychiatry. I had been looking forward to this placement - anything involving the brain I find fascinating – though I was not without some trepidation. Since I had no previous experience of mental health wards, my preconceptions of a mental health hospital were gleaned from media articles or tales from medical students who had already completed their psych placements.

I expected therefore to find the wards filled with difficult, aggressive, confrontational patients. I expected self-harm and threats of suicide, use of restraint, and stressed, demoralised nurses. Of course, there were difficult patients, and there was aggression, and I did meet patients who had self-harmed, but first and foremost what I saw in all the patients I met was vulnerability.

I saw that they were hurt, they were unsure of themselves, some were shy, self-conscious and stammered. They had difficulty trusting people, were nervous and paranoid, unsure if people really were who they said they were. It must be exhausting to live like that, I thought, always on guard, over-analysing what others do or say or how they act, always thinking that perhaps someone has an ulterior motive, that they mean harm, that maybe things aren't actually as they seem. Others did their best to be cheerful despite being very unwell and in great suffering.

During a morning ward round I met a service user who put on a big smile for the consultant psychiatrist leading the meeting, despite "feeling miserable" due to what was described as an almost constant barely intelligible mumbling of auditory hallucinations.

I spoke to another service user whose mental health problems manifested as a hoarding disorder. Since early life there had been a compulsive acquisition of more and more belongings. A number of people befriended over the years had actually ended up stealing some valuable possessions. A new partner later came on the scene who apparently accepted the hoarding problems, and moved in anyway. But who was this new partner really? Was there a 'best interests' at heart? There was no-one to ask, no trusted family or friends to assess the truth of the situation. It seemed an awfully precarious state of affairs.

During my psych attachment I also visited a local community centre. It was a lovely place – everyone there was on first-name terms. Most people walked through the front doors alone, but were greeted warmly on arrival by others seated around communal tables. I met a number of regular visitors that day, people from a myriad of backgrounds and cultures, with rich and varied social histories, and past psychiatric histories covering a whole spectrum of conditions and disorders, yet the common thread was their vulnerability, more apparent in some than others, but always there. Even though these were people in their thirties and forties and fifties, they seemed to me as innocent as children. I found myself worrying about how they managed the relentless minutiae of everyday life by themselves. I wondered if they were coping, if they managed with food and washing and shopping and bills, if they had kind friends and neighbours or if people took advantage of them.

Before this attachment I had truly not realised what it means to be vulnerable. I had not realised that a mental health problem can make a grown adult as vulnerable as any child or elderly person. But mental health problems can happen to anyone, and any one of us, I realised, can become vulnerable, no matter how invulnerable we think we are now.

As we progress through medical school, we students should ideally become not just more knowledgeable about our patients and their illnesses, but also more understanding of their circumstances and behaviours. Mostly this progression occurs at a constant steady rate, but now and then there is a sudden moment of clarity that leads to a step change. This psychiatry placement was a step change for me, and I'm grateful for the experiences I had and the insight they gave me. The next phase of medical school will be like a new era, a new chapter - which reminds me of a conversation I heard on ward round one morning: "This is the start of a new chapter," the consultant psychiatrist announced. "A new chapter?" this particular service user responded, surprised, "I'm nearly at the end of my life, Doctor!" No matter where we are in our lives, I believe there should always be an opportunity to start a new chapter. Just as the invulnerable can become vulnerable, those with mental health problems who are vulnerable now can, with the right help, support and understanding, become invulnerable again.

Key Practice points:

1) The reflective practitioner: guidance for all doctors and medical students on how to reflect as part of their practice. This was developed jointly by the Academy of Medical Royal Colleges, the UK Conference of Postgraduate Medical Deans (COPMeD), the General Medical Council (GMC), and the Medical Schools Council (MSC).

2) Safeguarding is everyone's business, no matter what speciality we professionals work in. We often look at risk to self and others as a broad category in Mental Health. Risk to self is not just through self harm and suicide but also through being vulnerable.

3) The safeguarding duties apply to an adult 18+ who: Has needs for care and support AND Is experiencing, or at risk of, abuse or neglect AND Is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

4) Document Capacity to understand, retain, weigh and communicate the vulnerability issue in hand. For those who lack capacity consider 'best interest' principles.

5) Consider / Discuss / Refer to safeguarding lead as per the local Trust guidelines or Social Care for further support.

Psychotherapy Training Half Day Online – 30 March 2022

by Dr Elias Diamantis, ST4 General Adult Trainee

I've always tagged myself as a "psychologically-minded" psychiatrist, worried that sometimes we apply diagnoses and medical explanations instead of confronting difficult and complex realities, conscious and unconscious. Our esteemed psychotherapy tutors, Dr Vassiliadis and Dr Phillips put together a great day for Higher Trainees and it was especially valuable for me. At that point I was applying for a dual speciality post: Medical Psychotherapy and General Adult.

We had the engaging Benjamin Fry first, bringing to life the hidden trauma-lions that might blight our lives. His scribbled cartoons carry real pathos, reminding us that at some level we are just frightened little children. He drew no distinctions between us and our patients and I'm sure he brought many trainees' personal lions to mind. Benjamin's simple diagrams made almost a laughingstock of trauma's tyranny but clearly, he is well acquainted with harsh reality and knows first-hand the desperate need for therapies that work. He makes all his illustrations available on his website and they're well worth a look.

In the afternoon, the balance to this broadly behavioural approach was well struck by Dr Brian Martindale. He shared straightforward insights from psychodynamic work with psychotic patients who have arguably "dispensed with reality" for unspoken reasons. The call to valiantly listen for what is told in the content of psychosis rang true with me, echoing my enthused med-student reading of RD Laing's Divided Self. Again, barriers between clinician and patient were eroded and Brian was particularly vulnerable in describing his own "small p psychosis".

As could be predicted, some time-honoured fault-lines between psychotherapeutic schools reared their heads in the plenary discussion. You'll be pleased to hear that therapeutic common ground was found and dialogue fostered. As it was a virtual conference, there was little danger of an actual fight anyway.

Hearing from two very different clinicians with disparate approaches helped to broaden my horizons as I consider what tack I'm going to take in my Medical Psychotherapy journey.

Many thanks to all involved in this wonderful day.

"It was great to make some space for Higher Trainees to think psychologically and hear some different perspectives. We're planning more training days in the future and please get in touch if you're looking for psychotherapy opportunities or interested in Medical Psychotherapy" Dr Nicola Phillips, Medical Psychotherapist and Training Programme Director for Psychotherapy

‘Meet the member’ series, by Dr Beena Rajkumar

Dr Beena Rajkumar

Our ‘meet the member’ series introduces you to members across the Trent Region to learn more about their professional lives and personal histories. Beena has joined as the Trent Medical Psychotherapy Regional Rep in March 2022.

What made you choose Psychiatry?

I come from a family of doctors in India. We are 3 generations of doctors. Even as a child I knew that I had to do medicine and follow the family tradition. My parents wanted me to do Obstetrics and Gynaecology, but I had my heart set on psychiatry since the age of 12.

I was always a people’s person. In school and college my class-mates would seek me out to confide their problems and I was known as the Psychiatrist since the age of 12.

I agreed to follow the family path and do medicine, even though I was a rebel, because I wanted to do Psychiatry.

My understanding of Psychiatry has always been much broader than working within a purely medical model. I have always felt that psychiatry is about the person who has the illness and understanding their vulnerabilities and working with them as a person.

I think the best part of Psychiatry for me is connecting with and understanding the person who has the illness.

None of my friends from school and college are surprised by my choice of choosing to be a Psychiatrist and Psychotherapist. This has been something I have always wanted to do, and this is who I am. I passionately love my profession and feel so deeply grateful for being able to do this.

What are your Background Qualifications:

I did my Undergraduate qualification in Medicine in India. I did my core training in Psychiatry in Newcastle-Upon-Tyne.

I am dual qualified and completed my CCT in Psychotherapy and subsequently a second CCT in General Adult Psychiatry in Nottingham.

I have an endorsement in Substance Misuse.
I completed my Diploma in CBT (Masters Level) in Oxford University an advanced Diploma in family therapy in Derby University.

Tell us about your current roles:

My passions include women’s mental health, working with people who have experienced complex trauma both as a psychiatrist and a psychotherapist using TIA (Trauma-Informed Approach) and TIC (Trauma- Informed Care).

I also love teaching both Psychiatry and Psychotherapy. I am blessed to have a range of several roles that enable me to follow my different passions.

Current Professional Roles:

1) Consultant Psychiatrist, The Vales (inpatient high dependence rehabilitation ward for women), Discovery House, LPFT NHS Trust.

In this role, I work as a consultant in a high dependence rehabilitation ward for women. The cohort of patients that I work with are patients who have experienced complex trauma and who have complex mental health problems, who are detained under MHA.

2) Consultant Psychotherapist LPFT NHS Trust

I work as a psychotherapist with a small cohort of patients who have experienced complex trauma. In this role, I work purely as a medical psychotherapist.

3) Psychotherapy Tutor LPFT NHS Trust

I work as a psychotherapy tutor with trainee doctors in LPFT. In this role, I run Balint groups and supervision groups for trainee doctors in psychiatry.

4) Medical student Tutor for Lincoln Medical School

I tutor and teach medical students from the newly formed Lincoln Medical School.

5) DME (Director of Medical Education) LPFT NHS Trust

In this role, I oversee and hold responsibility for Medical Education across the Trust.

6) Co-chair RCPsych WMHSIG (Women's mental health special interest group)

I have a leadership role and contribute to all issues linked with women's mental health and the careers of women Psychiatrists. I champion the cause for women in mental health and women psychiatrists.

7) RCPsych Trent Region Medical Psychotherapy Regional Rep

In this role, I represent the College on all matters relating to post-graduate education, professional development and review and approval of appropriate job descriptions in Psychotherapy.

What would you say to someone who is considering a career in Psychiatry?

I would tell them that psychiatry is the best sub-specialty in medicine. It is the only specialty where we get to know every aspect of a person – the conscious and the unconscious, the past history, the present, and the future aspirations and desires.

We understand the biological, psychological and social aspects of a person. It is such a privilege to connect with another human being on that level and to make a difference.
I would ask trainee doctors to follow their heart and to do what they are passionate about rather than thinking about what looks good to the external world.

What does your role as RCPsych Trent Region Medical Psychotherapy Regional Rep at the College involve?

It is 2 months since I have taken on this role and I am just trying to find my feet. It is early stages and I understand that the role involves all matters relating to post-graduate education, professional development and review and approval of appropriate job descriptions in Psychotherapy.

What do you enjoy most about being involved in the work of the College?

I have really enjoyed my role as co-chair of RCPsych WMHSIG (Women's Mental Health Special Interest Group). I have been the co-chair for the last 3 and a half years and have really enjoyed working with and meeting like-minded women and having that sense of sisterhood and solidarity and working towards common objectives.

We meet in the evenings to do this work and we do it in our own time, but it has been very fulfilling because the issues related to women's mental health and the careers of women Psychiatrists are something that means a lot to us. It gives us the satisfaction that we are making a difference and that we have a voice as women.

In some way, I feel that we are repairing the collective trauma that women have experienced in the past. The experience of working in the College at this current time under the current leadership ie our President Adrian James and our CEO Paul Rees has been genuinely very positive. As a woman of colour working in rural Lincolnshire, I have felt valued, included and felt that I have something to offer. I do feel that our College is heading in the right direction with equality and inclusivity.

Author: Dr Beena Rajkumar, Consultant Psychiatrist and Psychotherapist, DME Lincolnshire Partnership NHS Foundation Trust, Co-chair RCPsych women's SIG, Regional Psychotherapy representative on the RCPsych Trent division executive committee.

Hall of Fame Nominations - Summer 2022

We are excited to announce the summer 2022 Trent Division Hall of Fame Nominations.

Purpose

The aim of the nominations are to recognise and appreciate medical students, doctors of all training grades (foundation, core trainees, higher trainees, SAS doctors, consultants and physician associates), managers, nurses, social workers and support workers (or even teams, if not individuals) for their contribution towards psychiatry in the region. This would in turn help us tell people that they are valued and appreciated for the work they do.

Nominations

Barnsley Older People's Mental Health Team, South West Yorkshire Partnership NHS Foundation Trust

The service was commissioned as a Older People's multi-disciplinary CMHT in 1993 and initially covered functional, organic, crisis team, assertive outreach. In 2006/2007 a separate memory service was established and therefore the team retained a functional focus. The Older People's Mental Health Team is a Secondary care functional mental health service and is part of the Community Business Unit which incorporates Single Point of Access Team (SPA) Core Team, Enhanced Teams East and West, and Memory Services. The team is multidisciplinary and comprises individuals from a variety of professional backgrounds.

The team is now comprising a Consultant Psychiatrist who also looks after inpatient services of 10 beds. Has 7 registered nurses, One full time occupational therapist, One psychologist and 1.6 WTE support workers. There is one Nurse prescriber and 2 Speciality Doctors, one of them works as a link between the team and Intensive home based treatment team.

In 2017 there was an adult service transformation in Barnsley, which was driven by a nationwide ageless agenda. It resulted in the team integrating with wider working age adult services. This period was very challenging as the team lost its identity and didn't have a team base. There were challenges faced with service criteria, staffing, changes in working model, low morale and difficult working patterns. The team has worked hard to retain its identity despite the risk of dilution in the speciality. Even though the team was physically separated lacking a base, it remained connected through use of technology and demonstrated excellent resilience and strength supporting each other.

In 2018 there was a trust wide older adult transformation which resulted in the team re integrating and becoming an Older People's Mental Health Team. It now sits with the already accomplished Memory team for elderly. The team since then has overcome the adversities and worked hard to achieve its own identity back again and regain the confidence of its service users, trust and grow in confidence day by day. There has been hard work and collaborative leadership within the team resulting in self-management, smart existing resource management with recruitment of in-house Occupational therapist, full time psychologist and re organisation of staff which was lacking before..

During the pandemic, there was significant challenges around staffing, disruptions and maintaining contact with elderly patients and carers. The team despite this successfully has retained contacts with service users via telephone, video consultations and also face to face meetings with safety measures. The team has maintained high standard performance and indeed is an achievement as the feedback has been excellent from service users and carers during this time. The team was accredited by the Royal college of Psychiatrist in 2021 which is an incredible achievement in the last 2 years

The population served by the team is nearly 46,532 and approximately have a case load of 330 elderly patients from one of the deprived areas in the country. The average time from time of first referral to first assessment is 17 days. The team has run patient Focus groups on 13th July 2019 and 13th August 2019 and 'Shared experience' was a key theme emerging from feedback provided by service users. This means that talking with others, group work, and peer support were endorsed in service user feedback. Two key suggestions came from this feedback:

1. The service should trial psychological therapy groups
2. The development of a peer-support group should be considered. This would be directed and affiliated 'with' (not by) the OPMHT The team is proud of their recent initiative of group therapy for elderly where people share life stories together, including stories about hope, compassion, kindness, and recovery. The group is based on ideas from 'Narrative Therapy'. This is an approach that is particularly interested in a person's life stories and how sharing these can be helpful to the individual and others meeting with them. The group is an opportunity to have useful and therapeutic conversations about the past, present, and future and also to develop resources and ideas to take away with you each week to support well-being. This happens in Recovery college and facilitated by senior OT and Clinical Psychologist.

Other areas of achievement

- The team are highly regarded by patients and carers and provided overwhelmingly positive feedback. They feel they have been very well supported throughout the pandemic, and the team were described as going 'above and beyond' to help them and provide continuity of care.

- There is an emphasis on family therapy within the service, and the team psychologist is in the process of completing a qualification in family work. Other staff members have also received training in family interventions, and the team hopes to embed family therapy further and offer it as a formalised service.

- There is an impressive range of therapies and interventions available to patients, and many staff members have been trained in delivering these.

- The staff team were observed as cohesive and close knit. Staff spoke of being very supportive of each other within the team, and all agreed that they love working with each other. They have received positive feedback from students regarding this.

- There is an experienced single point of access team in place that en-sure that referrals to the team are appropriate. The team have great working relationships with the.

- Carer engagement is strong and consistent. Carers spoken with feel well informed about their loved one's care and feel that the staff team are supportive of them in their role. Staff members were clear on sup-porting carers in instances where the patient has not consented to their involvement, which the peer-review team recognises as good practice.

- The team is proactive in involving patients and carers in service development, as demonstrated in previous focus groups and service evaluation questionnaires. This involvement has led to developments such as the fast-track pathway for re-access to the service, and the development of peer support groups.

- The service is currently working towards achieving paper light accreditation.

- There is great access to remote working resources and digital technologies. Guides have been created for carers on how to use Microsoft Teams in order to attend reviews and meetings, which has been recognised by the peer-review team as good practice.

- Supervision and support for staff members is strong and consistent. Staff members feel that the service is performing well in this area.

- There are strong working relationships with partner agencies and local services. The team are resourceful and have been able to support patients in accessing a range of different services and supportive programmes, including recovery colleges, social care and community activities.

- The team have been observed as resilient and have managed to maintain a very patient-centred approach, despite the pandemic and lock-down restrictions.

They provide high quality cardio metabolic assessment for their patients to all under Care programme approach.

There have been innovations with development of networking forums.

1. The team meets with the Memory team every month to discuss interface patients, joint working aspects, information sharing and training aspects.
2. Every 6 months, the team organises a 'Hub meeting' which is a forum developed for networking with other services like inpatients, Single point of access, Hospital liaison service, primary care, inpatients and Working age services. The Team has a link worker attending meetings with Intensive home-based treatment team.
3. The recent accreditation by the Royal college is a great acknowledgement of its professional growth and commitment to quality.
4. Oaks group – As mentioned above.
5. The team regularly invites various speakers and encourages team members to help learn and harbour a culture of lifelong learning and development. They have had a number of excellent speakers enhancing their skills regularly. The team actively sets aside time to reflect on complaints, complements, serious incidents within the team meeting agenda and incorporates shared learning and duty of candour.

Offender Health Directorate, Nottinghamshire Healthcare NHS Foundation Trust

Offender Health Directorate was started in 2010 following the national shift in commissioning of healthcare in prisons to NHSE. It was nationally the first NHS Trust directorate to focus entirely on prison healthcare. In the beginning the directorate had around ten staff members but over the past decade it has developed into a directorate with 400 + staff from a variety of professional backgrounds such as Psychiatrists, General Practitioners, Physical health nurses, mental health nurses, Psychologists, IAPT therapists, Occupational therapists, paramedics, social workers, pharmacists, pharmacy technicians and those from an administration / management background.

Over the past twelve years many of those who have worked in the directorate have moved on to better things and many have stayed and hence it is difficult to name individual team members.

Currently the directorate provides integrated healthcare (physical health, mental health and substance misuse) to 5000 + prisoners in 8 prisons in Nottinghamshire, Leicestershire and Lincolnshire and has recently been awarded the contract for provision of healthcare at HMP Fosse Way, a new prison in Leicester with around 1200 prisoners.
In addition to the above the directorate also provides Offender Personality Disorder Services in Lincolnshire and Nottinghamshire as well as in HMPs Whatton, North Sea Camp, and specialist Therapeutic Community for those with Learning Disabilities in HMP Gartree and HMP Dovegate.

Offender Health is probably the only directorate in any of the NHS Trusts nationally that concentrates its attention fully on providing integrated healthcare (physical health, mental health and substance misuse) to the criminal justice population in a very challenging environment and has continued to do so year after year for over a decade. The quality of its provision is often better than "equivalent" for a comparable hard to engage population. Moreover it has done so whilst being innovative and maintaining a high level of quality that has enabled two of its establishments to be ranked the top two for three consecutive years in the Royal College of Psychiatrists Quality Network rankings.

Prisoners are society's one of the most socially disadvantaged group with high psychiatric morbidity, shorter lifespan, high rates of substance misuse and as such are severely and multiply disadvantaged. Unfortunately, their reluctance to access healthcare in the community further compromises their health. Historically the quality of healthcare in prisons has been considered not to be equivalent to that in the community and this was one of the main drivers for the commissioning of prison healthcare to be moved to NHSE. Offender Health Directorate has over the years been successful in not only matching the standard of "equivalence" but has in many respects gone beyond equivalence. For instance, in mental health, all routine referrals are seen within 5 days and the average waiting time to see a psychiatrist is around two weeks.

The suicide rates in our prisons over the past decade has been less than what would be expected from the national data of suicides in prisons. Moreover, most of the prisons in the directorate have access to psychologists and psychological therapists. The prevalence of ADHD and other neurodiverse conditions such as ASD is on the rise in our prisons. All our psychiatrists working in the directorate prisons are trained in treatment of ADHD. Neurodiversity services in the directorate prisons are consistently improving under the leadership of our Neurodiversity lead from a Speech & Language therapy background. These improvements include working towards Autism Kitemark with the prison and education providers, establishing ADHD pathways with ADHD services in the surrounding counties and working with the Trust Recovery College to provide psychoeducation in Neurodiverse conditions such as ADHD and ASD.

The quality of mental healthcare in the directorate is such that two of our establishments have been rated the top two prisons for three consecutive years (2018, 2019, 2020) by the Royal College of Psychiatrists Prisons Quality Network. Aftercare of prisoners after they leave the prison is a significant problem resulting in reoffending and return to prison. In order to achieve a better transition to community and to establish links with community services three of our remand prisons (HMPs Leicester, Nottingham and Lincoln) introduced an innovative Critical Time Intervention service, which is a prison outreach service, that supports vulnerable prisoners for a period of upto six weeks in the community to assist them in achieving a successful transition and breaking the cycle of the revolving door. HMP Ranby is a resettlement prison. This is also the site of a NHSE funded pilot project RECONNECT that supports vulnerable prisoners for upto a period of six months following their release from prison. The success of this pilot has resulted in NHSE providing additional resources for provision of RECONNECT services to all prisons in England & Wales.

Offender Health has been very innovative in developing and leading on a number of initiatives in order to continually improve the quality of services provided. These include:

1. Clinical Audit & Research: The Directorate has a robust clinical audit function led by the Directorate Pharmacist and supported by a Clinical Audit assistant. The Directorate also has two academic Consultant Forensic Psychiatrists with their academic work at the Institute of Mental Health , Nottingham.

2. Psychological treatments: Prisons in the directorate provide Step 1 to Step 4 psychological treatments for a variety of conditions including for acute and developmental trauma.

3. Substance Misuse: Under the leadership of Senior Psychologist in Substance Misuse the current treatments are being upgraded to trauma informed medium/high intensity substance misuse treatment interventions.

4. Veterans Regroup Service: Consolidation of national pilot for providing additional support and treatment to veterans in Lincolnshire and Nottinghamshire pre-custody, during custody in prisons and post custody.

5. Through the Gate: Lack of aftercare and social support after leaving prison is a major national problem and this is particularly critical for vulnerable prisoners. Implementation of the Critical Time Intervention projects at HMPs Leicester, Nottingham and Lincoln as well as the NHSE RECONNECT pilot at HMP Ranby aims to address this gap in service provision. Following the success of this pilot RECONNECT is being rolled out nationally.

6. Neurodevelopmental Disorders: IDD, ADHD and ASD are increasingly being recognised in the prison population. Development of a service to address this with a clinical lead in neurodevelopmental disorders and in collaboration with the community IDD/ASD service aims to address this gap in service

7. Older Adult services: There is an increasing prevalence of dementia and working age dementia in prisons. Older Adult services integrating physical health, mental health and social care are being planned.

8. Offender Personality Disorder: With consolidation of the ACORN and SOLAR services at HMPs Whatton and North Sea Camp new community services for high-risk Personality Disordered offenders under the OPD pathway in Nottinghamshire and Lincolnshire are being developed.

9. Wellbeing Centres: Wellbeing centres have been developed in HMP Nottingham and Lowdham Grange. They provide day to day support for patients awaiting admission to secure hospitals or returning from secure hospitals, those with personality deficits resulting in significant self-harm and suicide, those with vulnerabilities due to neurodevelopmental disorders etc. These centres also enable healthcare to provide individual or group psychological therapies.

10.Persistent Pain: Persistent pain is a significant problem in prisons with psychiatric co morbidity and substance misuse problems. Current treatments in most prisons are predominantly pharmacological. A multidisciplinary pain management service with physiotherapy, specialist pain management nurse, health psychology and substance misuse practitioners is being piloted at HMP Lowdham Grange.

11. Medication to manage sexual arousal: HMP Whatton had the first national pilot for treating high risk sex offenders with anti libidinal medication. Following the success of this pilot similar services have been rolled out to seven other prisons in England & Wales.

12. Pharmacy Services: The directorate was one of the first prisons nationally to move to provision of medicines management by pharmacy technicians and senior pharmacy technicians. Additionally they also have Senior clinical pharmacists in each of the prisons who provide leadership in medicines management with more patient interaction and proactive management of medications, medications risks and risks associated with poly pharmacy.

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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 Trent Division is made up of members from Leicestershire, Lincolnshire, Derbyshire, Nottinghamshire, South Yorkshire and the Humber.

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

Trent Division

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