iMind

February 2022

General Adult Faculty Newsletter

iMind

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In this issue

Editorials:

2. Update from the editorial team

3. Chair's Blog, Dr Billy Boland

4. Spring Conference 23-24 March 2022

The creative corner:

8. Mind the brain, Dr Mudasir Firdosi

Autobiography:

7. My name is… Dr Parvinder Shergill, higher trainee and film director

New Ideas:

9. Implementing a new Innovative idea for UK Mental Health Services to continue to sail through patient consultations in times of COVID-19 Pandemic, Dr Deepak Swamy

13. Far Away From Home, Dr Josephine Holland

15. Remote ECG device pilot, Dr Mani Santhana Krishnan, Lauren Bennett and Charlotte Fox

Features:

17. “Can’t get enough (of) Psychiatrists”, Dr Andrew Moore

20. Supporting Our Teams Through And Beyond The Pandemic, Prof. Russell Razzaque

22. Nigerian Psychiatrists in the United Kingdom Support Group, Dr Hal Abdullahi and Dr Chukwuma Oraegbunam

23. Community mental health transformation: opportunities and challenges, Dr Helen Crimlisk and Rosanna Flury

28. My World Shattered and Rebuilt, Dr Bhargavi Chatterjea Bhattacharyya

30. Calling expert witnesses, Prof. Keith Rix

33. Moving overseas in the middle of the pandemic, Dr Clare McLean

35. Adapting to change post-pandemic, Dr Ajmal Anjun

37. How compassion-based care can steer us forward post-COVID, Dr Hussein Omar and Dr Hana Algeilan

40. Reflections from doctors with ADHD in the UK, Dr Shevonne Matheiken, Dr Emma Isabella El Makdessi and Dr Victoria Galvis

45. Adapting to change post-pandemic, Dr Aya Abdelaziz

47. Silver linings and new beginnings, Dr Zainab Abdul Hameed

Update from the Editorial Team

Dear all,

Happy 2022! We hope the new year started well for everyone and that you're all keeping safe.

We are very excited to share with you the latest issue of our Faculty's newsletter. The main topic is adapting to change post-pandemic and we have received some very insightful pieces on how our colleagues have managed these unprecedented times in both their professional and personal lives. We have Dr Crimlisk and Rosanna Flury talking about the opportunities and challenges of the community mental health transformation and Dr Natarajan shares some exciting details about the upcoming spring conference which will be held jointly with the Psychotherapy Faculty.

There are lots more very interesting articles that we hope you'll enjoy reading.

Starting with this issue we added "the creative corner" where colleagues can share with us their artistic side through poems, short stories, paintings, drawings, book reviews and so on. Breaking the ice is Dr Firdosi with his amazing poem entitled "Mind the brain".

Our ambition is to introduce an essay competition to our newsletter, so stay tuned!

The next newsletter is due in the summer of 2022, so the deadline for submitting your articles is May 2022. The theme will be "Relationships and continuity of care" and we would like to hear from students (medical, nursing and physician associate), trainees, consultants and other professions and of course, patients and carers.

With warm wishes,

The editorial team

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Dr Andrea Tocca- @DrTocca (Twitter)

Chair's blog
by
Dr Billy Boland

Welcome to the winter edition of the General Adult Faculty newsletter. I still don't think it's too late to wish you all a Happy New Year. 2021 was again very demanding for all general adult psychiatrists. We are working hard at the Faculty to try to make 2022 a little brighter.

We are really looking forward to hosting our spring conference jointly with the Psychotherapy Faculty in March (see page 4). This will be 2 half days split across 2 consecutive days, with plenty of breaks, and will be online. We all know how demanding excessive screen time can be, so this should make it a little easier.

We had good feedback for our online conferences last year. One of the advantages I have really valued is that people have been able to join from around the globe. I was particularly pleased that at our main conference in October 2021 we were able to hear how General Adult Psychiatry was practiced in other countries. We had speakers joining us live from New Zealand and Malawi. These kinds of events were just not possible before we held online conferences. We do know how much people have been missing connecting with colleagues face to face however, and we are planning on making a return to having at least some in person events in the near future.

In England, the development of the community mental health framework is still moving ahead. This gives a real opportunity to transform community mental health services, which have been sadly underinvested in for too long. We have been working closely with the College Engagement Network to help psychiatrists influence how this is introduced into their local services to get the best outcome for patients. For more details on this, please check Dr Crimlisk's and Rosanna Flury's blog on page 23.

Do enjoy this edition of the newsletter, and I hope to see you at our upcoming conference in the spring.

Best wishes,

Billy

Joint Faculty Spring Conference 2022- General Adult Faculty & Medical Psychotherapy Faculty

by
Dr Priyadarshini Natarajan

Online conference over 2 half days:
23 March 2022 Afternoon
24 March 2022 Morning

From the General Adult Faculty and Medical Psychotherapy Faculty, we are delighted to present a joint spring conference in 2022. This is the first time in years that the two faculties have come together to produce a joint conference. We wanted to choose subjects that would highlight the importance of relationships in clinical care… importance between the relationships between brain, mind and body, relationships between clinicians, patients, families and teams, relationship with the external world, our current psychiatric practices and training, and also relationships between our two faculties. We consider this an excellent opportunity to share our experiences, our ideas and our dilemmas in one common platform.

The conference will highlight the importance of relationships in clinical care including aspects of trauma in its various facets. We have lined up renowned speakers, who will address the subject from a wide range of angles and depth which will be relevant to all of us involved in mental health. We have a session looking into the epigenetics and relational aspects of mind and body, followed by a session on care and treatments including what it means to be trauma sensitive, trauma skilled and trauma informed. We have a separate session led by trainees to elaborate on topics related to trainee burn out, the impact of culture and events such as the pandemic on training. We also have a session about safety and wellbeing of patients and staff. We invite you all to come participate in a great event, like we have never had before.

The conference will be available to watch live, or on-demand from your home or work. With each title we aim to provide a platform for thought-provoking subjects and a wider discussion, on all the important aspects of mental health care. This conference, therefore, will be relevant to a large audience including anyone working in the field of mental health: OTs, Nurses, Therapists, Psychologists, Trainees, Lived Experience Practitioners or Representatives, Psychiatrists, GPs as well as service users and their carers.

Speakers & Chairs:
Dr Matthew Anastasis, Core Trainee, Camden and Islington NHS Foundation Trust
Dr Meda Apetroae, Trainee Representative, General Adult Faculty
Dr Sophie Atwood, Consultant Psychiatrist in Psychotherapy, Medical Psychotherapy Faculty
Dr Alan Baban, Trainee Representative, Medical Psychotherapy Faculty
Rachel Bannister, Lay Representative, Royal College of Psychiatrists
Dr Chloe Beale, Consultant Liaison Psychiatrist, East London NHS Foundation Trust
Dr Annamaria Cattaneo, Biological Psychiatric Unit, IRCCS Instituto Centro San Giovanni di Dio Fatebenefratelli, Brescia, Italy
James Cooke, Lay representative, Royal College of Psychiatrists
Rebecca Davies, Interim Head of Occupational Therapy, South London and Maudsley NHS Foundation Trust
Dr Lucinda Donaldson, Consultant Psychiatrist, Camden and Islington NHS Foundation Trust
Dr Josie Fielding, Trainee Representative, Medical Psychotherapy Faculty
Dr Rachel Gibbons, Chair of the RCPsych Patient Safety Group & Chair of the Working Group on the Effect of Suicide and Homicide on Psychiatrists
Christopher Holman, York Group Work
Jacquie Jamieson, Lay Representative, Royal College of Psychiatrists
Dr Diana Menzies, Consultant Psychiatrist in Psychotherapy, SouthWest London & St Georges Mental Health NHS Foundation Trust
Emilia Molimpakis, Chief Executive Officer and Co-founder, Thymia
Dr Jo O'Reilly, Consultant Psychiatrist in Medical Psychotherapy, Camden and Islington NHS Foundation Trust
Dr Joan Rutherford, Chief Medical Member, Mental Health Tribunal
Dr P. J Saju, Consultant Psychiatrist in Medical Psychotherapy, SouthWest Yorkshire Partnership NHS Foundation Trust
Dr Sarah Thornton, Consultant Anaesthetist, Member of Royal College of Anaesthetists
Dr Andrea Tocca, Associate Medical Director, Cumbria Northumberland Tyne and Wear NHS Foundation Trust
Dr Jon Van Niekerk, Group Clinical Director, Cygnet Health
Dr Indira Vinjamuri, Consultant Psychiatrist, Mersey Care NHS Foundation Trust
Cath Wakeman, OBE, Chief Executive Officer and Trauma Therapist, IMARA

For more information on the event and to book a place please visit the event webpage

Mind the Brain

by
Dr Mudasir Firdosi
Consultant Psychiatrist and Clinical Director of Quality Improvement, Kent and Medway NHS and Social Care Partnership Trust, Executive Member, Faculty of General Adult Psychiatry (GAP), Royal College of Psychiatrists, London

Once mind and brain
Sat down for a tete a tete,
I don't need you for my existence, said the mind.
I am the soul, I am the person.
I am therefore you are.
I am, thus the belief that I am not made of anything,
yet,
everything is because of me.
Gods may have created you from the mud,
But because I am, so the gods are within you.
Brain, astounded, couldn't utter a word.
Indeed, I am nothing, but a receptacle for you to remain.
For what use would water be without a vessel to hold it?
Yet I am the reason for your terrific claims,
The minute I die, you no longer prevail.

My name is...
by
Dr Parvinder Shergill

I am a SpR in Psychiatry, CNWL.

However, to some I am also known as a film director.

From a young age, I have always wanted to work in the film industry, however I knew as a female South Asian it would be a struggle for me to get work in the industry, and that I would need to bring life experience and skills to the table.

I was also fascinated by literature and started writing my own fictional stories from about 14 years old. I decided I would first gain a degree I could get work with anywhere in the world then support myself financially as I funded myself in film. I enjoyed science, and so it made sense for me to do a Philosophy BSc and Medicine. Once I graduated, I lost myself temporarily in the world of training, and I fell upon psychiatry, which I truly felt passion for. I took a year off in my CT training to pursue writing and I started to write pieces concerning mental health, and articles on what it was like to be a female south Asian doctor in the modern day. I also was part of a mental health podcast that won a prize with The Royal College of Psychiatrists, and we were invited to Parliament to record an episode. After my CT training, I took some time working as a speciality doctor as I funded myself through acting school alongside. I left acting school in 2019, in which I felt frustrated with the industry having poor opportunities for women of colour. Therefore, I decided to take matters into my own hands, and I wrote my first play, HER, which was a dark comedy about mental health with LGBT themes. I directed-produced-write and starred in it with a female cast. It was incredibly well received, and on occasion, is on tour in the UK and now in Greece.

I then in 2020, moved onto Film work. I wrote a number of short films, that had elements of mental health in them to showcase mental health storylines in a cinematic way, with a diverse cast. One of my short films, was a comedy about COVID in which was aired on a BBC platform, and I won best actress and best Romance film at the film festivals.
Another film, PHANTOMS, was a LGBT horror about pseudocyesis, with an all-female cast of colour.

I then moved on to feature films, one is THE LINK, which is the first mental health thriller series with an entire cast of colour alone, that I wrote-directed-produced and starred in. This is the first of a trilogy which we have showcased at the CNWL film event and is currently streaming on

AMAZON PRIME. My second feature film I was commissioned for called DADDY BLUES, which is also on AMAZON and gaining interest from BBC journalists, and highlights fathers mental health.
I have also many other film projects concerning mental health that I am currently involved with. For me, I find the film industry are not well equipped about education concerning mental health, which for me I feel is important to address. That's why, all of my films have an element of mental health, in which I want to educate the audience in specific mental health illnesses in a unique film story we have not yet seen on the screen. Whilst also staying true in offering women more roles in the crew behind the camera, as well as always having a lead actor of colour in my films. I really hope I part of the change of reducing mental health stigma, gender stigma, and ethnic stigma in the film industry, and amazingly I have been BAFTA recommended which is a huge honour.

I don't know where the future will take me, but for now I am enjoying working both in the NHS in mental health, but also the film industry in paving a way for mental health films to be taken seriously whilst trying to a make a change for diversity.

Implementing a new Innovative idea for UK Mental Health Services to continue to sail through patient consultations in times of COVID-19 Pandemic

by
Dr Deepak N Swamy, Associate Specialist in Autism and Neurodevelopment, Sheffield Adult Autism and Neurodevelopmental Service (SAANS), Sheffield Health & Social Care NHS Foundation Trust

Introduction

COVID-19 Pandemic is known to have started in December 2019 and then spread slowly in many countries until end of February 2020. However, WHO declared COVID-19 as a Global Pandemic on 11th March 2020. By that time, already COVID-19 had spread to several countries. Subsequently it spread like wildfire to almost all major countries possibly by air route and sea route. As the situation worsened, undoubtedly this had a huge psychological impact on global population on a mass scale.

Background

For NHS Patients, an important aspect was to have continuity of care and being able to consult Clinicians for their mental health needs. With the advent of COVID-19, it was imperative to have a secure video platform in our Sheffield Health & Social Care NHS Foundation Trust. This would help to facilitate clinical assessments via video consultations with patients. ‘Zoom’ platform was considered a security risk and concerns were raised about privacy and confidentiality. MS Teams was approved to use within teams internally in our Trust.

Attend Anywhere

Attend Anywhere is an Innovative Video Platform for Patient Consultations. It is a secure web-based video platform that has been introduced in our Trust. It is a Cloud Software approved by NHS England. It can be used for patient video consultations and also internally for meetings within teams. Privacy & Confidentiality concerns have been addressed. Patients are asked not to record video consultations as a pre-requisite for signing up. I had first volunteered to use this software for patient consultations when it was first introduced in April 2020.

Clinician Instructions

As per NHS England, decisions on the suitability of patients to be seen via VC should be clinically led at Trust level in line with Trust approved standard operating procedures and relevant clinical guidance. This was agreed upon and implemented in our Trust. The website that is used to access Attend Anywhere is https://england.nhs.attendanywhere.com/. Clinician will receive e-mail with Account Creation and Sign-in instructions. There is a link to troubleshooting if there are any problems with signing in or technical issues.

Patient Instructions

Patient Information Leaflets about Instructions are available at - https://nhs.vc/sheffield-adult-autism-neurodevelopmental-service. Patient first needs to enter basic demographic details. Then self-test equipment and patient's name will display in waiting area. Clinician logs in and joins call in waiting area. Carers or Family members who are in multiple locations can be added to the consultation provided the patient has given consent to this.

Positives of Attend Anywhere

- It is a secure video platform and needs limited set up requirements
- There is no need to install software
- Any device (Ipad, Tablet, Mobile, Laptop) can be used
- Suitable for Acute, Routine, Community or Inpatient consultations
- Possible for MDT working with different clinicians and patient in different locations
- It meets the NHS Clinical and Information Governance requirements.
- Rapid implementation can be done.
- It provides an identical method of patient consultations almost similar to face-to-face consultations.
- It aids home working for NHS professionals.
- It allows to follow guidance for COVID-19 and prevents spread of COVID-19 infection
- It allows consultation irrespective of COVID-19 status of patients
- There is provision for multiple participants to be present in the same consultation

Negatives of Attend Anywhere

- There is a need for awareness of basic IT knowledge and having Internet network

- Logistical issues can crop up
- It is not appropriate for physical examination
- Not possible for monitoring physical parameters, imaging and blood tests.
- Patient’s preference for face-to-face consultations
- Technical glitches during consultation
- Sufficient mobile charging
- Patients not logging in at the time of appointment leading to DNAs
- Distractions during consultation

Further Ideas and Improvements

- Better Video platforms can be explored and developed
- Technical issues can be improved to avoid glitches
- Network connectivity issues need to be minimised
- Some patients might not be comfortable with Video interface and may prefer just Audio interface.
- Skype Business call can be combined with Attend Anywhere to ensure connectivity.

I have done a presentation on Attend Anywhere in the Quality Improvement Week held in October 2020 at our Trust. This gave me an opportunity for Colleagues and Carers to become aware about this new technology that enables patient consultations but still prevents spread of COVID-19 infection.

Conclusion

Attend Anywhere seems to have become a new Innovative idea that has captured the imagination of NHS professionals and patients alike. It seems to have transformed patient care and how Clinicians interact and communicate with patients in the NHS during COVID-19 Pandemic. It maintains confidentiality and meets the NHS Clinical Governance requirements. As the saying goes, “Necessity is the mother of Invention”, Attend Anywhere has set a new benchmark for creating innovative solutions in times of crisis!

Acknowledgment

I thank the support of my Colleagues and Managers in my Department at Sheffield Health and Social Care NHS Foundation Trust for providing logistics and making it possible to roll out this new video consultation software in a relatively short time for patient consultations. I also thank them for providing me an opportunity to utilise this new video consultation software.

Conflict of Interests

None

References:

1. https://www.digitalmarketplace.service.gov.uk/g-cloud/services/672141309373271
2. https://www.attendanywhere.com
3. https://england.nhs.attendanywhere.com
4. https://digital.nhs.uk/
5. https://www.england.nhs.uk/
6. https://improvement.nhs.uk/

Far Away From Home- Have you looked after an under-18 on an adult psychiatric ward?
by
Dr Josephine Holland, CAMHS ST4 East Midlands

"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 NorthWest.

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
- 25 interviews completed with Consultants from across England
- 20 regional interviews completed with young people, parents and professionals

How can I get involved?

Qualitative Interviews:

- 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.
- 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) has been admitted since 1st February 2021 to either:

- o An adult psychiatric ward
- o a CAMHS General Adolescent Unit (GAU) over 50 miles from their home address
- o 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.

F A R
AWAY FROM HOME

NIHR | Applied Research Collaboration East Midlands

Remote ECG device pilot

by
Dr Mani Santhana Krishnan FRCPsych - Consultant in Old Age Psychiatry & Senior Clinical Director, TEWV *(pictured)*
Lauren Bennett - Innovation Coordinator, TEWV
Charlotte Fox - Programme Manager, Digital Transformation, AHSN NENC

During the pandemic we looked at ways of getting ECG monitoring done for patients who need to be initiated on anti-psychotic medication or who need monitoring of anti-psychotic medication. Due to shielding as well as Covid restrictions, routine primary care investigations were generally reduced as well as it was difficult to arrange home ECG's due to patients shielding.

We came across a solution around the end of March 2020 in the USA the FDA had given an emergency authorisation for the use of a live core 6 lead remote ECG device as a device that could be used to monitor QT prolongation measurement because one of the medications that was used for treatment of Covid (Hydroxychloroquine and another antibiotic Azithromycin). We discussed this possibility with the Clinical Leaders group and also wrote an initial paper that was taken to the Gold Command. Considering lack of further means to do the ECG monitoring we got support from both Gold and Silver Command to run this as an initial pilot.

Our older adult psychiatry directorate support this pilot; initially we procured 30 devices and distributed them across 3 MSHOP localities and then 2 AMH localities, Teesside and Durham.

From the beginning we had support from our innovation team Lauren Bennet provided support in this pilot project and very quickly we also had further support from Academic Health Scientist network of NorthEast and North Cumbria. We developed a standard operating procedure/guidance for practitioners which were developed by a group of medics within our teams and we also developed a few step by step guidance of how to record and send the ECGs as video training. This was both in SDG's, QUAG's as well as in Consultant meetings.

We developed a questionnaire to get feedback on the usability as well as patient feedback. All the feedback has been excellent please see the poster in the link.

From the initial pilot we have now completed over 1000 ECG's and invariably all the patients really preferred this to the routine 12 lead ECG process.

About quality of ECG, the ECG graph is quite clear and able to identify the QT measurement easily. We were also able to get some validation studies from the company, please see the reference below.

We are continuing to assess the project as a pilot; one of the trainees in Adult Mental Health also did a comparison of the 6 lead and a 12 lead ECG for reliability of QT measurement and found to be reliable on comparison. We are expanding this assessment to do a further paired ECG comparison in the next few months.

Scalability

After initial pilot we have had further support from Academic Health Scientist Network as well as NHS X who have supported this project and identified as one of the positive digital innovations that was developed in the NorthEast. They have offered a further 100 devices to TEWV and also 40 devices to our neighbouring Trust CNTW. We have been collaborating with CNTW and they have started using the device.

Future Plan

1. To embed training for staff (the training module is already developed and with the training department for sign off)
2. Once the project is completed annual evaluation and then passing the ECG devices and training to our training department as well as to individual directorates.

Link to AHSN resources Page

The Tees Remote ECG Pathway - AHSN NENC AHSN NENC (ahsn-nenc.org.uk)

To view the poster of the project, click on the icon below

Tess Remote ECG Project Poster.pdf

Can't get enough (of) Psychiatrists

by
Dr Andrew Moore
Consultant Psychiatrist, Devon Partnership NHS Trust

Dear Agony Aunt Andrea,

Please help me. I'm at my wits end, and don't know where to turn! I was happily managing our Mental Health Trust Medical Staffing Team, but recently a horrible new tension has built up inside me. So rather than suffer in silence, I need to share it.

I just can't get enough of Psychiatrists.

There, I've finally said it!

Don't get me wrong, I still have quite a lot of them, but nowadays just one more vacant post makes me all quivery. Even holding on to the ones I've got is a struggle nowadays. It's also a two-way thing… they feel the tension too.

The good news is that I'm already benefitting massively from 'replacement therapy', with a whole range of the latest 'non-medical' alternatives. I'm using Non-Medical Prescribers, Advanced Clinical Practitioners, Multi-Professional Approved Clinicians, Physician Associates, basically anything with two, three- or four-letter acronyms. They're a great addition, but still leave me wanting more Psychiatrists as well. Given the pressures I don't think I'm being greedy: am I wrong to think I need them both?

With hindsight, I didn't realise how good Psychiatrists are till I was short of them. They work holistically, flexibly, and efficiently, scratching the clinical, leadership, educational and legal itches all simultaneously. They even keep going well into the night! Joe public might prefer to avoid them, but staff and patients alike know that when the mental health chips are down, you don't quite know how much you need a Psychiatrist till you need a Psychiatrist.

Please, please can you help me?

A Medical Staffing Manager (name and address with-held)

Dear Mental Health Medical Staffing Manager,

You poor thing. You are in a fix, aren't you! But don't panic. I'll guide you through. Firstly, it's really important for you to know…

1) I believe you. Reading between the lines, I wonder if significant others have not believed you, or just ignored you? New national data confirms 10% vacancies for years now; you are not imagining it[1] .
2) It's not your fault. You are on the receiving end of a sequence of "hospital passes" (see link) down the years, as policies have "passed the problem along" for someone else to deal with. Now it's you.
3) You can do something about it. Not easily; you will need help, and time, but it is possible. Be brave.

Here are my suggestions:

A. Share your concerns with someone you Trust, e.g. your Medical Director and CEO. Look outside too (ICS's are trendy), and seek out fellow sufferers of this under recognised, little understood problem. Use influential acronyms: RCPsych, NHSEI, HEE, even your MP. Don't be shy. Ask and you will receive. Don't and you won't.

There are two past policy watersheds when we were all simply too polite. With "New Ways of Working" (around 2005), Psychiatrists basically said "don't worry, we'll manage somehow by finding different ways of doing the same work with the same workforce we already have". Between 2010-2020 Consultant Psychiatrists increased by just under 10%... which sounds good till you realise all other medical Consultants increased by an average of 43% (some by 100%!)[2]. Quietly Psychiatrists inched forward, whilst other specialties leaped.

Around 2010, with financial austerity and Modernising Medical Careers, Psychiatric training numbers were cut, and future training progression was hopelessly over-estimated. Nowadays only 15% of psychiatric trainees complete their training without any delay or dropout[3]. This has squeezed the Psychiatrist supply, with the delayed effect really kicking in just when we need them. The brilliant 'Choose Psychiatry' campaign

[1] Workforce figures for consultant psychiatrists, specialty doctors psychiatrists and Physician Associates in Mental Health, Royal College of Psychiatrists Census 2021, https://www.rcpsych.ac.uk/improving-care/workforce/our-workforce-census (accessed 23/12/21)

[2] Royal College of Psychiatrists workforce data from NHS workforce statistics, 2021

[3] Understanding Career Choices in Psychiatry, Research Department of Medical Education, UCL Medical School, https://www.ucl.ac.uk/medical-school/sites/medical-school/files/rdme-final-report-understanding-career-choices.pdf (accessed as of 23/12/21)

helped fill the Trainee posts we have, and trainee placement numbers are creeping up again, but it’s early days yet; it takes 10-15 years to train a Psychiatrist. Regarding austerity, bold national projections of extra Psychiatrists don’t easily translate into front line funding decisions; there’s no guarantee the funding will be available or spent on Psychiatrists. But for now the mantra is “Training, Recruitment and Retention”.

B. Psychiatrists may seem to be the problem, but they’re also part of the solution. Be nice to the ones you have. Offices, secretaries, and good IT matters, and help reduce the tension. They’re usually happy to share ideas too.

C. Keep looking elsewhere. Welcome more acronyms: IMGs (International Medical Graduates), CAPs (Clinical Associate Psychologists) and primary care ARRS workers (Additional Roles Reimbursement Scheme) can all contribute.

D. Finally, think broad and long-term. This is not an “either/or” problem; when we have enough non-medics and medics, then the services will be fit for purpose, and your tension will melt into the past.

Be kind,
Agony Aunt Andrea

(aka Dr Andrew Moore, Consultant Psychiatrist, Workforce Representative, Executive Committees of the Southwest Division, and the General Adult Faculty of the Royal College of Psychiatrists, andrew.moore7@nhs.net)
Oct 2021
Dr Andrew Moore is a full-time practising NHS Community Consultant Psychiatrist, working in Devon.

Supporting Our Teams Through And Beyond The Pandemic
by
Prof. Russell Razzaque

It is often just after a trauma that the psychological impact arises most intensely. In the midst of turmoil people tend to run on an adrenaline-charged fight-flight response then after it, as the tension dies down, the underlying psychological distress comes to the fore. Matters are then compounded further when a new stress or trauma arrives and, unfortunately, this appears to be the current status across global health services due to the Omicron variant of COVID-19. While the pressure is no longer on ITUs and in-patient admissions as it was last year, the pressure that is arising today is from staff sickness. This has hit mental health Trusts across the country particularly hard as it often sits on top of a service that had been chronically under resourced and running under capacity for a number of years already. In one Recovery team alone in my own Trust, we have 16 people off sick this week and these numbers are escalating across the organization.

Staff burnout had already been a growing concern before this latest turn of events across the system1 and mental health services have been highlighted particularly among them2. To this has been added the significant further pressure of moral injury. In general terms moral injury refers to the psychological distress that arises as a result of an action or omission that does not adhere to the subject's moral code. This has been happening particularly during the pandemic3 and it has been a subject of growing concern in mental health services4 recently as well. Increasingly, the lack of capacity in teams has meant a delayed response to patients or even a raising of thresholds for taking people into service, beyond an already significantly higher threshold in recent years as it is. The discomfort and dissonance that this then creates only adds to the psychological burden that multidisciplinary teams carry with them. It also means that the people the teams take on are experiencing higher levels of acuity, meaning remaining staff are left to deal with higher levels of illness among what is becoming a larger caseload.

The medium to long term remedy for this is, of course, to increase capacity so that the system has more slack to deal with such crises in the future. The mental health transformation, if implemented in a collaborative way with full engagement with staff and clinical leads, should make some in roads in this direction. There will still be a long way to go to build sufficient capacity to ensure resilience in future, however.

In the meantime, psychological support for staff in the frontline is now crucial. Reflective practices like Schwartz Rounds have begun to be used in some Trusts. The creation of safe spaces where clinicians can reflect on their own subjective experiences, as part of an integrated discussion around their clinical work, has been shown to have a substantial impact on morale and wellbeing at work, including when studied in mental health services5. Indeed, such reflective spaces are an integral part of psychotherapy and related psychological and mental health provisions but it is often in the most acute interfaces that they are most lacking.

Alongside the continuing campaign for more resources, therefore, a shift towards more reflective practice that has a greater focus on wellbeing, will be a very important part of our recovery as we travel through and, hopefully eventually, out of this pandemic in the weeks and months ahead. If this happens then it will have conferred a wider benefit on our mental health services and the experience that patients receive in our care in the longer term.

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"Nigerian Psychiatrists in the United Kingdom" Support Group

by
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and Dr Chukwuma Oraegbunam, Consultant Psychiatrist for Older Adults at The Harbour Hospital, Lancashire and South Cumbria NHS Foundation Trust

The RCPsych following a recent survey is advocating for more organisational support for minority ethnic psychiatrists during the current COVID-19 pandemic. We think there is a place for remote (and in-person), peer to peer support for psychiatrists within, between and outside of national groupings particularly via the use of social networking outlets as well.

This need for connectedness and support led to our creation of a 'Nigerian Psychiatrists in the United Kingdom' WhatsApp group to provide a forum for having lively discussions and receiving timely feedback about clinical and non-clinical queries.

The group has evolved from having less than an initial dozen participants to about 135 at the time of writing and comprises of a mixture of trainees, MTI fellows, speciality doctors, associate specialists and consultant psychiatrists.

At the height of the Covid-19 pandemic and through sicknesses (and self-isolation), we found that the group provided a platform for continued support, information, networking, mentorship, coaching and socialising.

We envisage that similar non-organisational, informal, readily accessible groups will evolve (or already exist) to afford minority ethnic psychiatrists support one another during and beyond the pandemic.

The group is free to join but only open to current and retired Nigerian Psychiatrists based in the United Kingdom. Alternatively, psychiatrists may consider joining the Association of Black Psychiatrists in the UK (ABP-UK) which aims to support the professional development of Black Psychiatrists as well as harness diverse ideas, experiences and perspectives to promote innovation and excellence in the delivery of high-quality care for patients with mental illness.

Please email onlinehal@gmail.com for more details.

Community mental health transformation: opportunities and challenges

by
Dr Helen Crimlisk
Consultant Psychiatrist Sheffield Health and Social Care NHS Foundation Trust

and

Rosanna Flury
RCPsych Policy Engagement Manager

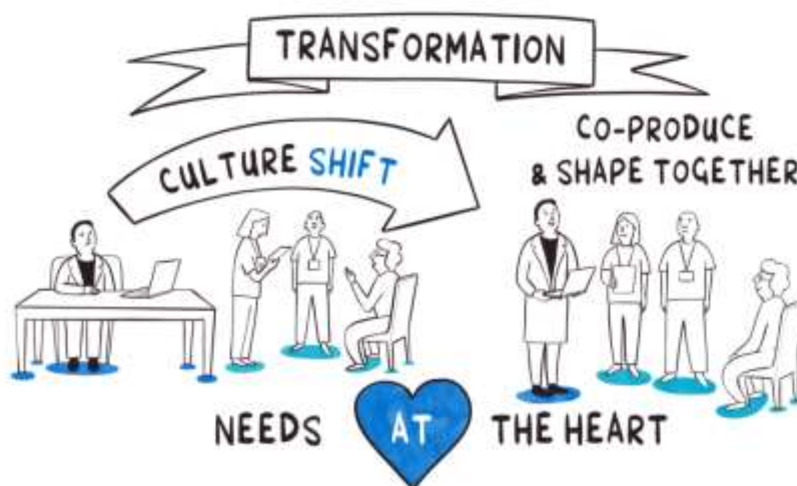
Integrated care to address gaps in provision

It is an exciting time for Community Mental Health services.

The NHS Long Term Plan addresses gaps in provision of care which mean many patients with severe mental illness don't get the care they need or fall through the cracks. Psychiatrists are often also frustrated by the rigid way in which services are commissioned and whilst many services provide good elements of care, they often use governance and service specifications which are not integrated.

There is a need to pay more attention to people's experience in navigating community mental health services as well as specialist services for eating disorders, substance misuse and rehabilitation, and ensure that more patients get the right care without having to navigate multiple service boundaries with reassessments at every juncture.

Transformation means holistic care and co-production



The community mental health transformation Programme has been co-designed with service users and carers nationally in association with the National Collaborating Centre for Mental Health. During the pandemic, 12 trusts in England started work on their transformation and the learning

from these trusts has informed the rollout of the programme across England.

Because of the focus on co-production and the need for locally relevant services, each area will be co-designing their transformation with their local partners. This means there is no "blueprint" to follow and there is a need for systems leadership across the partners from secondary care, primary care, the voluntary, community and social enterprise (VCSE) sector and social care.

Other changes include the discontinuation of the Care Programme Approach and a focus on population-based early interventions and prevention, mapped on to Primary Care Networks which serve between 30 and 50 thousand people.

Equality of access and personalised care

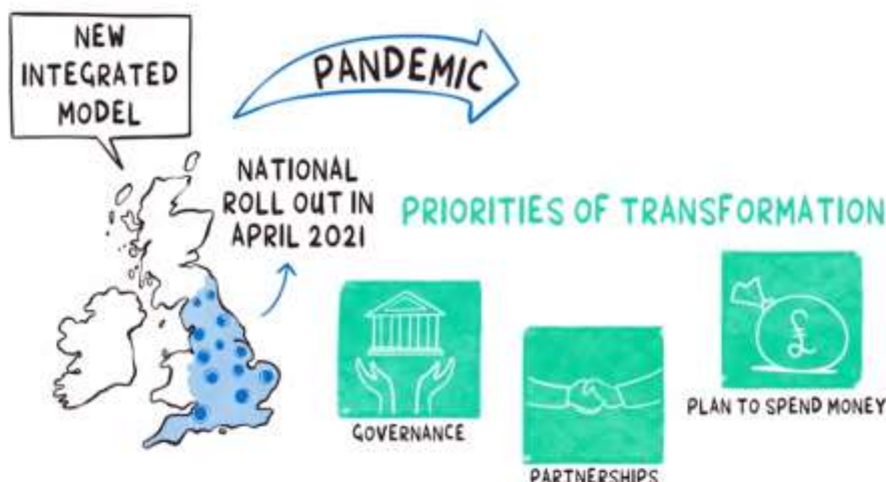
The transformation comes with significant increased funding (£2.9 billion over 3 years) and this will be used to employ and train new staff working across the system with up to 50% of the funding going to the VCSE sector.

Provision will emphasise equality of access and culturally appropriate care, particularly for people from communities traditionally not well served. There will be roles for people to be supported to access a broad range of support and to provide a range of evidence-based therapies and interventions.

Learning from early adopters and the College Engagement Network

The national roll out started in 2021 and was informed by the learning of 12 early adopters. They have undertaken the work in very different ways but there is common learning which will be taken forward. The College Engagement Network (CEN) has been working with psychiatrists from these trusts to learn about the successes and challenges and to provide support in leading this transformation.

It has been very useful to have faculty and regional support in the CEN as well as the input of the College Presidential Lead for Primary Care and Community Assets, Professor Linda Gask and the Specialist Lead for Coaching and Mentoring, Dr Jan Birtle who has been supporting the group working on systematic leadership skills and developing action learning sets.



The challenge for psychiatrists

The ambition of the transformation is enormous. It aims at a blurring of boundaries between primary and secondary care, the integration of

traditionally separately governed stakeholders, significant alliance building and increase in the involvement of VCSE with associated issues around power, culture and risk sharing and the employment and training of a number of new staff in new roles.

Transformation only works across systems and this means that clinicians in all mental health services and the psychiatrists within them will need to work differently too. There will be a greater need for relationship building, cross sector working, formal and informal supervision.

As psychiatrists, many of you will have a good appreciation of the power of co-production and recognise the value of people with lived experience. Nevertheless, this challenges us all to take this to another level, working with patients, carers and the VCSE in a way which really transfers power and resources to enable transformational change and shifts in power. Services will have to think more about digital systems and data collection to demonstrate the impact on outcomes.

A group within the College is currently looking at the implications for consultant psychiatry job plans, and consideration will also need to be given to ensure that all psychiatrists (trainees, SAS doctors and consultants) are supported to develop the necessary skills to work differently, which should link in well with the enhanced focus on leadership development and coproduction being emphasised within the College.

To get an idea of the ambition, look at this [five-minute film]

My World Shattered and Rebuilt
by
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Hello from India. I am an overseas member and I had been recently chosen as one of the 25 inspiring women by the College. Let me share my experience over the last eighteen months.

The Covid crisis led to major upheavals in both professional and personal life. At the height of the second wave in India, we heard about friends, relatives and acquaintances passing away everyday. I am lucky that my core family is intact, although I haven't been so lucky with friends. Seeing young and not so young lives snuffed away is heart-breaking.

The covid crisis evolved through stages. At the initial phase, there was total lockdown, life came to a standstill. Some people defied the lockdown with impunity going to the shops every day to buy trivia. Conspiracy theories were rife and people sat glued to the TV sets or scoured the internet for information. People lost jobs or had pay cuts. Once the lockdown was relaxed, people went on with business as usual. The deadly second wave arrived catching India by surprise and it wreaked havoc.

Covid itself hasn't claimed many lives. But the total number of excess deaths in India is to the tune of millions rather than hundreds. (Source: Reuters, July 2021). One of my relatives died waiting for a bone marrow transplant. And there is a surge of suicides. This is not highlighted in the media. Mental health remains a low priority.

But, every cloud has a silver lining. Let me focus on the positive aspect of covid. Although the days of the week lost their distinctiveness, and became a blurry mass, it freed up my time. I could explore other avenues. I did many online courses. In the past, I used to start courses but could not complete them due to time constraints. My knowledge of Neuroscience received a shot in the arm. I must specifically mention two courses which have helped me grasp some of the modern concepts. One of them is Synapses, Neurons and Brain offered by Coursera and the other is NNCI (National Neuroscience Curriculum Initiative). Both the resources are free. I feel conceptualization of psychiatric illness should shift from the traditional biopsychosocial model to the computational

level. Interrogating basic concepts like hallucinations and delusions, exploring predictive errors mediated by dopamine and aberrations thereof as mechanisms underlying such constructs had been an interesting journey. One of my articles, "Origin of the Mind'' has been published in the journal Hektoen International (https://hekint.org/tag/origin-of-the-mind/).

I have also been writing stories. Most of them are being rejected! But I was one of the twenty-five winners of the Eshe writing contest. My story appeared in an anthology titled Everything Changed After That. The writers, all twenty-five of us formed a WhatsApp group and I enjoy the interactions of this online community. It is very heartening to know that a woman living in a cave in Mexico has a copy of our book. I even had to write a review of the same, titled “Reading a Caste Angle in an Agnostic Work is Limiting for Literary Freedom” (https://eshe.in/2021/05/01/bhargavi-chatterjea-bhattacharyya/) in response to an adverse review!

Some other stories of mine have been published online and I self-published one of my books in Kindle Direct Publishing. I have also both attended and conducted webinars, although it is weird to do so without auditory and visual feedback.

On the personal sphere, I have my own share of problems. My son, a Rhodes Scholar, is in Oxford and he has not been home for two years. Although I maintained contact with him over Skype, and now life is limping back to normal, for the better part of two years he was largely confined to his own room. I cannot mention untoward incidents for obvious reasons, but I was on tenterhooks. The worst part was that the borders were sealed, I cannot physically go to him if needed and he cannot come to India. The covid crisis was indeed a war, although we don't know whether it had ended or not!

Overall, the last eighteen months had been a roller coaster ride. It is a syndemic with long term ramifications. The Covid Crisis assumed gigantic proportions in the backdrop of Climate Change and broken Public Health Infrastructure. Collective pain and collective trauma united the World. I wonder what the future has in store for us. Will humanity learn a lesson from this warning and take steps to mitigate Climate Change? Or will it mark the beginning of the end in the relentless progression of the Anthropocene with the Covid crisis being the final nail in the coffin? I don’t know. Only time can tell. I’d watch with bated breath.

Calling expert psychiatric witnesses...

by
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Psychiatrists who provide expert evidence in the family courts may have been aware in November 2020 of 'The President of the Family Division Working Group on Medical Experts in the Family Courts Final Report' (https://www.judiciary.uk/wp-content/uploads/2020/11/Working-Group-on-Medical-Experts-Final-Report-v.7.pdf). This report by Mr Justice Williams is the report of a working group set up to address a problem of a "paucity of medical expert witnesses in family cases involving children". Given that the focus of the family court system is the protection of the vulnerable child, this problem is obviously a serious one.

The working group engaged in a consultation process and surveyed clinicians and lawyers. It identified a number of problems relating to the provision of medical expert evidence to the family courts and it has made a number of recommendations that are intended to address these problems.

The main barriers or disincentives identified to the provision of expert assistance to the family courts were, in order of importance: financial, court processes, lack of training and support, and perceived criticism by lawyers, judiciary and the press. Sixty-two per cent of respondents did not feel supported by their medical royal college or professional association to complete expert witness work.

The lawyers surveyed had noted a decline in the quality of expert reports which may be the result of more experienced and conscientious experts giving up expert witness work and leaving the work for those less able to provide reports of a sufficient quality.

The working group's recommendations include encouragement to the royal colleges to engage with commissioners and / or trusts to promote a more supportive environment to medical professionals who wish to undertake expert witness work and for the royal colleges and the Family Justice Council (FJC) to engage with NHS England and clinical commissioning groups to seek changes to contracting arrangements to enable healthcare professionals to undertake expert witness work within the parameters of their employment contracts. It has recommended the

creation of greater training opportunities for medical professionals, including mini pupillages with judges, cross-disciplinary training courses with medical and legal professionals, and mentoring, peer review and feedback opportunities.

One recommendation was that each of the medical royal colleges and faculties should appoint an expert witness lead to support the work of members undertaking expert witness work. The Forensic Faculty of the College has been asked to consider this recommendation. I have been appointed the Expert Witness Lead for the Faculty of Forensic and Legal Medicine (FFLM) and I will fulfil the same role for the Royal College of Physicians of which the FFLM is a faculty.

Another recommendation was that the FJC should create regional subcommittees to support and maintain the implementation of the recommendations, including setting up and delivering training to experts and lawyers; setting up and delivering a medical mini-pupillage scheme (providing the opportunity for medical experts to sit with judges); and promoting inter-disciplinary respect and cooperation through promoting feedback from judges and lawyers to experts and vice versa through mentoring and peer discussion of cases in an anonymous environment

The regional committees correspond to the NHS regions and for each there are legal and expert co-chairs. All of the regional committees are anxious to make contact with psychiatrists, and other medical specialists, who already provide, or would consider providing, expert evidence to the family courts.

It would be helpful to find out to what extent the problems identified nationally are also local problems. But it may be that there are areas where things work well and psychiatrists in these areas may assist in helping to improve the provision of expert evidence throughout England and Wales. The working group identified not only disincentives for consultants taking on expert work but also for 'senior registrars' [sic] so we would like to hear from specialty registrars who have been able to obtain expert witness training and from those who would like to obtain it. We may be able to facilitate secondments or attachments so that specialty registrars can gain experience working with consultants who undertake expert witness work and provide opportunities for them to sit with a judge on a case.

Although this initiative comes from the family court system, my hope is that some of its recommendations will spill over into the other legal jurisdictions and improve the provision of expert psychiatric evidence to the whole of the justice system.

I would like to hear from general psychiatrists who are already providing expert evidence for the family courts, so that we can create a database, and from those who would be willing to undertake this work and may need their contact details passing on or advice as to training.

Moving overseas in the middle of a pandemic: An opportunity for growth in the chaos.

by Dr Clare McLean- psychiatry trainee originally from New Zealand. She is currently an ST4 trainee in Learning Disability psychiatry in Oxford Health NHS Foundation Trust

As a medical student I visited the UK on my elective placement and was in awe of the opportunities available. I remember hoping that one day, I would spend time living and working in the UK. I returned to New Zealand and settled into life as a junior doctor. I eventually began psychiatry training in New Zealand, unsure whether my dream of working overseas would ever become a reality. However, when my partner was offered a position at the University of Oxford in 2019, I realised that this was my chance.

After some extra study and a lot of paperwork, I gained my MRCPsych and GMC registration, and was eligible to work as an ST4 trainee in the UK. I decided to train in Intellectual disability psychiatry, as this was not an option for advanced training in New Zealand. It seemed like a great learning opportunity, and I felt it integrated well with my interest in Consultation-Liaison psychiatry. With everything sorted, I planned to fly to the UK in June 2020.

Unfortunately, in March 2020 all our lives were turned upside down as the World Health Organisation declared a pandemic. I settled down to complete more training in New Zealand and wait, sheltered from exposure by the ‘go hard, go early’ approach of the New Zealand government. We watched as much of the rest of the world was overwhelmed by case numbers and forced to lockdown for months on end.

By the beginning of 2021, I decided that the opportunity to spend time training overseas was too good to miss out on. Vaccines had arrived. I prepared to move to Oxford to begin working in the NHS.

Moving during a pandemic had its share of challenges. We flew through Singapore, and Changi Airport, usually thriving, was completely deserted. New Zealand’s borders remained closed, with a very limited number of Managed Isolation places available. Essentially this meant once I walked past the customs border, I was leaving my friends and family behind. There would be no summer trips home or visits from my parents. Prior to leaving New Zealand, I had not treated a single patient with Covid and didn’t know anyone who had been infected. As soon as I boarded the plane to Heathrow from Singapore, I knew that this was about to change.

Within a few days of arriving, I attended the group orientation for doctors new to my Trust. Unfortunately, just as I was getting to know all my new colleagues, I was required to return home and self-isolate. It turned out I'd been exposed to Covid on the plane.

I emerged from self-isolation to find a world very different to the essentially pre-pandemic country I had left in New Zealand. I met junior doctors who had never experienced work without Covid and listened to their stories of working on the Covid wards with a mixture of fascination and dread. Their stories sounded to me like they had been working in a warzone – with limited resources and uncertainty, they had done what they could. I found it difficult to believe what they had been through. I also had to get used to working in a different system – one where telemedicine was utilized regularly, and PPE was worn always. My team was working mostly remotely when I arrived and it was difficult trying to understand my new role, getting to know everybody and getting used to remote working. They were extraordinarily patient as I slowly started to figure everything out. Although New Zealand has a similar health system to the NHS, it is not identical and there were a lot of subtle differences and ways I needed to adapt.

I am starting to find my feet. Even during a pandemic, the opportunity to work overseas has been full of benefits. In fact, the pandemic has added an additional layer of complexity and therefore learning. I have learnt about my own ability to adapt and tolerate uncertainty over many months. I have also learnt that no matter where I am doing my job, the joy of working closely with patients, families and colleagues is still present.

In psychiatry, the opportunity has been particularly invaluable. I have had a chance to undertake additional training in a fascinating subspecialty and developed additional skills in the assessment and management of patients with intellectual disability, epilepsy and neurodevelopmental disorders such as ADHD and autism. I have been able to engage in excellent research and leadership and management training. I feel invigorated. When I do decide to return to New Zealand, it will be with new ideas and learning that will be invaluable for my career, and for the patients and teams I work with. I would encourage anyone considering this opportunity to go for it.

Adapting to change post-pandemic

by
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"As the hours blended into each other, every day seemed the same, you began sleeping all the time or not at all. The window and the screen where the only escapes". This is what I think of sharing with the coming generations about the daunting and tiring time.

The COVID-19 pandemic has wreaked havoc around the world and packs a more enduring punch affecting nearly every aspect of life with its long duration and widespread personal impacts. It has forced a host of changes to how we live and work. No matter how fast and effective biomedical cures and vaccine rollouts are, the stigma, loss and memory still persists. Now adaptation and resilience are the only tools for meeting the demands of a new Covid 19 normal.

Resilience has been defined broadly as the ability to recover from negative emotional experiences by flexibly adapting to stressful circumstances. However, the COVID-19 crisis is unique in both its scale and wide-ranging social and economic consequences. So, understanding how distress levels have responded to the pandemic is of importance. As rightly said by Charles Darwin "It is not the strongest or the most intelligent who will survive, but those who can best manage change". It is human nature to resist change particularly when it comes in the form of adversity or challenges. But change is inevitable and developing the trait of resilience helps us not only survive change but also learn, grow and thrive in it. Resilience is not a trait that people are born with, it involves behaviour, thoughts and action that can be learned and developed. Being resilient does not mean that a person doesn't experience difficulty or distress. Emotional pain and sadness are common in people who have suffered major adversity or trauma in their lives. In fact, the road to resilience is likely to involve considerable emotional distress, but life does not get easier or more forgiving, we get stronger and more resilient.

Some of the adaptations I made were

- wearing a face mask and not get suffocated
- avoiding handshakes and still be respectful
- maintaining distance and still be concerned
- sanitising hands frequently and not look obsessive
- stopped giving good night kisses to my parents, but still love them
- avoiding big round table discussions at the workplace and restoring to Zoom for the same and still learn from it

The pandemic had a heavy toll on mental health. Reaching out to people via telepsychiatry was another feather in my adaptation process.

Learning the art of self-compassion. Self-compassion is the basic building block of self-esteem and underlies the ability to bounce back from adversity. I refuted negative self-talk which erodes self-esteem and self-care.

These changes were a tougher nut to crack and initially provoked anxiety, but there are things in our lives that are good for our development and may provoke anxiety at the same time.

There are concerns about the third wave, but people have accepted and inculcated changes in their lives.

How compassion-based care can steer us forward post-COVID

by
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Specialist Psychiatrist at the American Center for Psychiatry& Neurology, Dubai, UAE *(pictured)*

Compassion is the humane quality of understanding suffering in others and wanting to do something about it. It is an active emotion that demands a response, rather than simply an awareness of the plight of another. Empirically, it can be defined as a virtuous response that seeks to address the suffering of a person, through relational understanding and action.

Compassion-based care can be viewed as a practice that incorporates a dynamic, individualized and complex construct that stems from the innate virtues of a healthcare provider, and which can be further nurtured by experiential learning and reflective practices.

The provision of compassion involves a broad range of qualities, skills and behaviours which together focus on the alleviation of suffering. These include: showing warmth and understanding, providing personalized care, acting towards patients the way you would want them to act towards you, providing encouragement, communicating effectively, and acknowledging patients' emotional issues.

Importantly, compassion requires health care professionals to engage suffering on both a personal and professional level, using interpersonal skills to care for patients, and intrapersonal skills to care for themselves as caregivers.

Recently, there has been an increase in research on the neurophysiological, psychological and social dimensions of compassion. However, the need for compassion within health care is not a new concept. It dates back to the first principle of the American Medical Association code of ethics which stated, "A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights".

The benefits of compassion-based care are numerous and include: improved health care provider-patient relationships; higher patient satisfaction; reduced patient anxiety; higher pain tolerance; and improved stress response.

While the importance of compassion has been extolled in fields such as psychology, social work, and theology, it is now being recognized for its positive impact in healthcare. Compassion-based care is emerging as a competency that healthcare providers are expected to deliver. More recently, recommendations from the Francis Inquiry report advised that all health professionals be trained in compassion, that compassion be considered and evaluated as a core competency of healthcare providers, and that system-wide standards of compassionate care be adopted and implemented.

Arguably, there has not been a time in living memory where we are more in need of compassion-based care than now. The COVID-19 pandemic has negatively affected many people's mental and physical health and created barriers for people who were already suffering from mental and/or physical illnesses.

A poll from July 2020 found that as a result of worry and stress over Coronavirus, many adults were reporting specific negative impacts on their mental health and wellbeing, such as difficulty sleeping (36%), reduced appetite (32%), increased alcohol consumption or substance use (12%), and worsening of chronic conditions (12%). As the pandemic wears on, public health measures expose many people to situations linked to poor mental health outcomes, such as isolation and job loss. Young adults have also experienced dire consequences such as closure of universities and loss of income.

A recent study revealed that the COVID-19 pandemic has had a significant psychological impact on frontliners and health care workers. When one is psychologically compromised, compassion towards others may be compromised too, just when the others (patients) need it most. During these unprecedented times, we and our patients are experiencing isolation, fear, anxiety, low mood and many more uncertainties about the future. Providing compassion-based care can empower people to speak openly of their suffering and allow them to feel confident to ask for help, knowing that everything possible will be done to meet their needs. Cultivating compassion training and intervention has been shown in numerous studies to improve health outcomes. There is therefore a compelling need to incorporate compassion-based training in clinical practice at all levels. That would make compassion a more valued and

explicit part of clinical practice. Organizations must institutionalize compassion, so that it becomes self-sustaining.

Creating a compassionate workplace can have a positive impact on staff's commitment to an organization and how they view their colleagues, alongside helping them to deal with the suffering and distress that they face in their job. Perceptions of one's organization can be shaped by experiencing compassion first-hand, and from seeing others receive such treatment, thereby promoting staff resilience.

Future research should focus on developing a conceptual model for compassion-based care and identifying educational approaches to enhance compassionate interactions with patients.

The current times call for careful reflection and reinvestment in compassion as a crucial approach to provision of care. COVID-19 has shown us that there is no distinction between a healthy person and a healthy world; both are immensely strengthened by inculcating compassion at the heart of healthcare.

Reflections from doctors with ADHD in the UK

by

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As neurodivergent (ND) doctors, we wanted share some of our collective experiences and reflections, with the intention to advocate for improvements in the current practice of adult ADHD diagnosis and treatment in the UK. Many of us were diagnosed during the pandemic, and it has been a life-changing event. There have been some critical views expressed on social media by some doctors about the increasing numbers of people (in the general population), who are 'seeking' an ADHD diagnosis since the pandemic, whereas the reality we've seen (and experienced) is that for many people with undiagnosed ADHD, their life-long masking and coping mechanisms failed when the pandemic hit and life as they knew it changed without warning. Most people first describe a sense of relief when they get diagnosed, due to the many things that start to make sense, and because alternate explanations emerge for things they had always believed to be character flaws.

The average waiting times of 6 months to 2 years (and even longer in some regions) for an NHS ADHD assessment are no secret. Those who can afford it seek private assessments, which are incredibly expensive (£700-£900 on average) and involve hefty prescription fees while trialling medications for few months until care can be handed back to the GP. But

many who cannot afford this would be struggling with symptoms whilst on NHS waiting lists, and others would be under various mental health teams being treated for common comorbidities such as depression or anxiety or being treated sometimes with a wrong diagnosis based on overlapping symptoms like racing thoughts, emotional dysregulation or impulsivity, when ADHD has not been considered. We must think of ways to overcome this avoidable suffering for patients and unnecessary costs to services due to underdiagnosis and misdiagnosis of neurodivergence, especially given the much higher and quicker response rates of pharmacological treatment to manage symptoms of ADHD compared to many other things we treat. We also need to think of what meaningful non-pharmacological interventions are currently being offered, if any, including how we support patients to get the 'reasonable adjustments' at work that they are legally entitled to get.

We also wonder whether holding on to the age-old stereotypes (about hyperactive young boys climbing up the wall and disrupting the class) are doing a disservice to high-functioning individuals, and also perhaps contributing to underdiagnosis in women, particularly those with the inattentive type, previously known as ADD. Many adults with undiagnosed ADHD maybe holding down successful professional careers, and not had significant academic issues in childhood, but maybe suffering in other aspects of adult life such as sleep, relationships, co-morbid conditions or chronic stress affecting work-life balance. Social media has plenty accounts from people who were turned down by their GP or even by psychiatrists, just because the clinicians believed (wrongly) that one 'couldn't have ADHD if they were doing well in school/work'.

We talk a lot about co-production in Psychiatry. This is a perfect area to make this happen. There is no dearth of social media influencers who focus on what is like living with ADHD, particularly talking about experiences that are often NOT described as significant in Psychiatry textbooks or part of official diagnostic criteria but actually impact functioning and quality of life significantly, such as Rejection sensitive dysphoria (RSD), time blindness and ADHD tax.

Of course, we may be a privileged group compared to many people living with ADHD, and so we cannot suggest that our experiences are representative or that they can be generalised. However, we do feel that as a unique group (there are over 600 of us on a social media peer group for ND medics), many of whom see patients with undiagnosed ADHD in primary care and psychiatry, there are lessons to be learnt from our voices. It would also be fair to say that in our experience, the NHS (as an employer) and the occupational health teams are often not well-informed enough to meaningfully guide and provide reasonable adjustments for ND

employees. With this in mind, we have put together few narratives from our colleagues with a take home message each. Whether these messages will reach stakeholders in funding, research, medical education and service improvement is up to you, the readers, to decide and take forward in your spheres of influence – we hope that you will decide to do so!

Narrative 1 (Dr Emma Isabella El Makdessi, FY2 doctor):

Unlike many of my neurodivergent colleagues, having ADHD and co-existing dyslexia meant that I was diagnosed at a very young age and given extensive support to bolster my self-esteem and education. Without this, my life may have been completely different. I excelled at school and at university (BA Psych) going on to complete a MSc Neuroscience in KCL. Only when I reached medical school at 24 did things start to change - I was unable, due to the rigid structures, to use the tools I had spent a lifetime developing which enabled me to work at my best. I struggled immensely with impostor syndrome and feelings of worthlessness and was even told things like "don't speak with your hands, sit on them" "do you actually expect to pass?" "Do you really think you can be a doctor?" etc.

Gesturing with my hands: Yes, I do!

I started work during a pandemic without the usual 6-week induction and worked for 16 months in one of the biggest hospitals in the UK. Like at medical school, I struggled with the fixed ways of doing things, the speed, the lack of structure. I felt 'othered' and unwelcome. I sought help but no-one knew what to suggest- I felt I was 'the problematic trainee' and what little self-esteem remained was decimated. I debated quitting.

After over a year, I was given a laptop of my own via Access to Work which has enabled me to keep track, be meticulous with my records, and feel more confident. I found a mentor who recognised how much I cared for my patients. What I lacked in speed of discharge letters, I offered in my manner with patients. I am usually the first to be asked to help in difficult situations like a distressed IVDU patient wanting to self-discharge, or a confused elderly man with dementia refusing his CT scan. I knew then as I have always known that I have much to offer. I confess that over a year of not feeling this was recognised, nearly broke my spirit. I am now working in Paediatrics in a small DGH and for the first time, I enjoy my job.

Take home message: Remember, when a plant doesn't grow you must adjust the environment— blaming the plant will not change its nature. Medicine has asked for problem solvers, so it needs to embrace the

neurodiverse doctors in its ranks who have spent a lifetime problem-solving just to make it through each
day. We are an untapped goldmine, needed now perhaps more than ever. Simple adjustments can go a long way, and should be implemented without undue delay, ideally prior to the start of a new job/post, in accordance with the Equality Act of 2010.

Narrative 2 (anonymous):

I'm a 39-year-old female medic who was divorced by 30 as relationships have always been difficult for me. I had post-natal anxiety and depression after both my children were born and with hindsight, I would have found this period much easier if I had known about my ADHD then. I had no idea why I've always struggled so much in life and it makes so much sense now. I wish people had realised when I was younger.
I was diagnosed with ADHD after one of my sons was found to be autistic and I think that we should think about the wider family when any person is diagnosed with a Neurodiverse condition.
Despite my difficult personal life, people don't see me facing significant challenges when at work, because I'm very capable clinically and I have masked the executive function difficulties. It does however take me much longer than most people to deal with the administrative side of the job and that has really taken a toll on my mental wellbeing. Since my diagnosis less than a year ago, I've made a lot of progress personally but have faced some significant ignorance and discrimination in the workplace.

Take home message: Do we routinely offer psychoeducation re: neurodiversity and screening to all parents when children are diagnosed with ADHD or autism, given the strong genetic links and the impact/burden of undiagnosed neurodiversity in adults? Do we consider undiagnosed ADHD (or autism) in our perinatal patients presenting with a mental health crisis during pregnancy?

Narrative 3 (anonymous):

I have been living with ADHD my whole life and was diagnosed at least 10 years ago. I grew up in a country where ADHD traits such as drive, passion, lateral thinking and entrepreneurship were not only tolerated but celebrated, and academic achievements were less important than wit or hands-on skills. Fast forward many years and life got harder, I moved to England, a country that I love and call my home. But unfortunately, here I have been met with an incredible amount of mixed responses from the

healthcare profession regarding a trait, a wiring in my brain, that I have as much control over as the colour of my skin or eyes.

My ADHD is a difference that makes me ridiculously bubbly and a great public speaker, a trait that has allowed me to deeply empathise with the most underprivileged of patients, that allowed me to create research developments without being given any tools, and to help patients who were not hoped to be saved from their pain or illness.
But despite this, many doctors have told me that due to my ADHD I am not thought to ever be a safe doctor, that I should never be left unsupervised and I was discriminated against continuing my placement.

I feel ADHD is my superpower, it allows me to solve any puzzle I get my teeth into. It allowed me to teach myself a language aged 3, to learn computer programming aged 10, to become an ALS instructor aged 16 (abroad), but I have also been through severe anxiety and depression, sleep disorders, four suicide attempts, PTSD and I'm not even 40 years old.

I have heard doctors say things like "all these people with ADHD are cuckoo" and "I have never discriminated against you because I never called you names", when the basic understanding of the condition is still quite poor amongst most doctors and their employers.

Take home message: Considering that neurodiversity is commoner than we think, and that we need neurodiversity as much as we need genetic diversity to survive as a species and as a profession, can we really afford to continue being so blind to the plight of our fellow colleagues and patients, just because they are different?

With much gratitude to our colleagues who contributed with the anonymous narratives.

Adapting to change post-pandemic

by

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Almost two years have passed since our lives were turned upside down by the pandemic. I moved from my home country, Egypt, to the UK with my small family in January 2020. We were excited about the next chapter we were about to start in our professional and personal lives. Little did we know that things were about to take a different turn in the middle of settling in.

I was accepted in my current job which also happened to be my first NHS experience. I was set to start during the pandemic's peak. At the time I already had my own share of worrisome thoughts and ruminations that were initially masked with excitement and aspirations, these thoughts were gradually coming to the surface. They were mainly around being a psychiatrist from a different background and how would that affect my interactions and rapport building with patients.

Adding to my worries, we were instructed to conduct consultations over the phone. For several months I had to navigate my way through communicating with patients without seeing them in person. Bodily gestures, facial expressions and posture were amongst several real-life helpful tools I had to start without.

Luckily, one year later, we started to regain our "new normal" lives back. Entertainment places were opening, parks were starting to be filled with children, and I got to finally meet some of my patients face to face after speaking to them over the phone over the course of a year.

The psychiatrist within me was very pleased, finally she gets to do her job the way she used to do and enjoys That was through having a real-life interaction with others, letting them see how I say things rather than just relying on my tone of voice which can be highly subject to individual interpretations when not accompanied by visible body language. Further to that, patient's bodily gestures can give way more than just what they verbally tell you.

On another side, Patients felt more comfortable in person, and some were more open and expressive. Others were mainly surprised by the "young/tiny" look of myself, but this was taken in a jokingly way and gave us something to smile about.

On the personal level, I finally got to see different sides of England. As soon as we were able to, we went on a trip to Cumbria and enjoyed the heavenly scenery of the Lake district. In the summer holiday, we were advised by some friends to take a trip to Bournemouth, which I utterly fell in love with. I had been feeling quite emotional being that long away from home for the 1st time, but certainly having the chance to travel around the country renewed my spirit and gave me energy to carry on.

Today, after almost two years into my NHS experience amidst the Pandemic, I can say that I have gained so many insights into life priorities. I can say that day health, family, and the company of others around you is a blessing, that should never be taken for granted. Nevertheless, even if things were hard, at least we were able to stay safe and genuinely try, to the best of our abilities, to help and support each other and our service users through that difficult time.

Silver linings and new beginnings

by
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Following the outbreak of the covid-19 two years ago, World Health Organisation has recommended several measures to curtail its spread like frequent hand washing with soap water, hand sanitization, encouraging people to put on masks, encouraging social isolation, adoption of lockdown and curfew by different governments all over the world. With the pandemic spreading, the world needs to adapt to the changes brought around by the outbreak of the pandemic. When the pandemic infected most parts of the world, it did not take long before things started changing. There was a profound sense of loss and grief all over the world.

Adapting to change post-pandemic entails ensuring that we can survive in this "new" environment.

Since I live all by myself, away from home, the pandemic didn't have a significant impact on my life. As an "essential worker" working in an inpatient ward, I was still required to show up to work every day, donned in a mask, and go home on time on the now traffic-free roads. The truth is, I no longer had to agonize over finding ways to avoid social situations or get into awkward interactions as I am an introvert; it was my ideal excuse. Even my groceries were delivered to my house. It was fun to see only half of my colleagues' faces and get pleasant surprises when they didn't turn out to be as I had imagined them. As was watching them on a screen in their casual dresses and then getting to see them in life all dressed up in their office couture.

On the other hand, praying for my parents when they got unwell and had to be admitted to the hospital, trying to help my sisters but not being able to be with them to give them a hug and worrying about friends and family took a toll on my mental health. I found myself dreading coming home or getting out of bed. The isolation I felt being unable to go out with friends or colleagues for drinks or for lunch was jarring.

Staff shortages and abrupt changes at work, mixed with misinformation, resulted in many complex feelings of fear and frustration. The challenges in providing high-quality care to patients, the increased workload, and the broader socio-economic and systemic collapse only added to the growing panic. Even if the transition to virtual consultation eased some people's

lives by allowing them more flexibility at work and making patient attendance easier, it wasn't enough. There were more new-onset mental health disorders referred than ever before, and patients who had previously been well on mental health treatments began to deteriorate. I had never seen so many severely ill patients as a junior doctor on the ward.

Even though the pandemic appears to be far from over, the worst is, hopefully, behind us. Vaccinations on a large scale and early diagnosis and isolation methods have saved lives. Even though face masks appear to have become a permanent feature of our dress code and we have had to learn how to "schedule online meetings", we have stumbled upon a few precious gems through these "new moderns". As tragedy often calls for, in looking back at what has been gained from the pandemic and how much we have learned from re-examining not just our services but also our living standards and the quality of our personal mental health; we have discovered that the pandemic has revealed many hidden flaws in our healthcare and social-care systems, brought us closer, made us adopt many new technologies and shone a light on what is most valuable and essential in life. In the post-pandemic world, we need to reconsider how we think about food, water, energy, and how we live.

The pandemic caused a lot of changes to our lifestyles and our desire to be happy. The pandemic has taught me a lot. It has allowed me to reflect and hear a lot of advice and feedback from many people about what I could do to cope with the stress and changes that still affect me today. It has been an eye-opener and quite productive, too, because I have discovered that there is much more to life. Now I am more mindful of the importance of "living only once" and "putting myself first." They are more than just slogans on banners for me and have become my life's motto. Spending quality time with my loved ones has become more meaningful. I have learned the value in letting go of the negatives and making space for the small wonders, the small moments of joy, such as getting a hug or going for a run together or just enjoying my time alone. I also finally mastered baking. In one thing I'm sure of, I'll never complain about being stuck in traffic ever again.