February 2023

General Adult Faculty Newsletter

iMind

February 2023

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Update from the Editorial Team

Dear all,

Happy New Year! Despite the pain our profession is going through right now, we wish 2023 brings you the hope that together WE CAN make the NHS a better place for our patients and for everyone working in it!

We are very excited to share the latest issue of our Faculty's newsletter with you. We chose not to have a theme this time and we've received lots of interesting articles on different topics. Amongst other great articles, we have Alison Summers talking about how psychiatrists can make a significant contribution to asylum decisions, Dr Cowan telling us how tai chi and qigong can help in the treatment of mental disorders and I will be sharing some exciting details about the upcoming trainee and SAS doctors spring conference which will be held on 16th March 2023, the first event of its kind organised by our Faculty.

Our "creative" and "wellbeing" corners are proving to be very popular and it's great to know that we have so many talented colleagues amongst us. Please continue to share your work with us in future issues of our newsletter.

I will take this opportunity to announce that I am stepping down from my role as editor, because, for me, 2023 will focus on my growing family for which I am extremely excited! It was a pleasure working with such talented and passionate colleagues on the editorial team and I am forever grateful to the entire executive committee of our Faculty for giving me the chance to further better myself and for believing in me! I hope our paths will cross again in the future and will have the opportunity to work with you again!

Dr Bachlani will also be stepping down from his role on the editorial team and we would like to take the opportunity to thank him for his leadership and contribution to the editorial work. He will be sorely missed, but he will always have a door open when the moment will be right.

The next issue of the newsletter is due in the summer of 2023 so the deadline for submitting your articles is June 2023. Our theme for this issue is **"resilience in the workplace".** We would like to hear from students, trainees, speciality doctors, consultants and other professionals and of course, patients and carers.

With warm wishes,

Meda and the editorial team

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Chair's blog
by
Dr Billy Boland
@DrBillyBoland

Welcome to the winter edition of the Faculty newsletter.

Thanks to those of you that joined the conference in October of last year. It was the first time that we had a hybrid event. There was a bit of nervousness as to how that would go, but from my point of view it seemed to work really well, and the feedback we have had has been positive. Holding it both in person and online meant that for the first time since before the pandemic began we were able to come face-to-face with general adult colleagues from across the UK.

This was a really happy occasion, and allowed us to network, have lunch together, connect and reconnect. The technology also meant that people could readily join online. Though there was the odd blip as there are with new ways of working, it did mean that people could join who did not want to or could not travel, meaning that the event was inclusive of a range of needs.

Our next conference is a joint trainee and SAS drs conference that is happening in the spring. The spring conference has become an annual fixture for the Faculty in recent years but we have not yet had a joint trainee and SAS drs conference which makes this event so unique. The programme is now out and has been curated by the conference committee led by our excellent trainee reps Meda Alinia, Josie Nott and Henny Blyth and the SAS drs rep Hina Tahseen. You will see that they have come up with an exciting and varied programme. It is a credit to them, and a testament to the value trainees and SAS drs can bring. Do encourage your colleagues to attend.

Thanks to those of you who put your name forward for our Faculty elections. In the next weeks we will get to decide who our new elected executive committee members will be, as well as our new finance officer, vice chair and chair. It has been incredible to see the turnout for the college presidential elections and I would encourage you to use your vote for the Faculty elections as well. Our new president elect Dr Lade Smith is a general psychiatrist by background. It will be important for our new

officers and elected members to connect with her to make sure that the needs of general adult psychiatrists are addressed going forward.

It's been a wonderful period for me as Faculty chair, and sadly I will be stepping down at the International Congress this year as my term of office will come to an end. The Faculty has grown in recent years and we now have over 12,000 registered members. We remain the largest Faculty within the college by some margin. Whilst there has been investment in community mental health services in recent years, general adult mental health services remain under resourced and we will need to have a strong Faculty committee to ensure the development of services and the development of our specialty in the future. Please do give our new executive committee colleagues your full support when they are elected.

Meanwhile I look forward to working with you over these final few months. As ever do get in touch with me if there is anything you need to raise with me or the Faculty.

Best wishes,

Billy

Faculty of General Adult Psychiatry Trainee and SAS doctors Spring Conference

by Dr Meda Alinia

Live stream (available OnDemand) on 16th March 2023

Organising committee: Dr Meda Alinia, Dr Josie Nott, Dr Henny Blyth, Rachel Bannister, Jacquie Jamieson, Dr Indira Vinjamuri, Dr Joan Rutherford, Dr Hina Tahseen

The General Adult Faculty is excited to present their first-ever trainee and SAS doctors spring conference! For this conference, we chose subjects that are highly relevant to the current times- we will have talks on navigating coroners court, when the professional becomes the patient, neurodiversity within professionals and Open Dialogue.

The conference will be taking place online and will be available to watch virtually The event will also be recorded and available to watch on demand.

During the lunch break we will be hosting breakout rooms for informal chats with trainees and SAS doctors alongside another breakout room at the end of the event to allow reflection on the day.

We will also be hosting a poster competition, so if you haven't submitted your abstract yet, we've extended the deadline until 7th February 2023.

Speakers:
Caroline Aldridge - carer
Dr Jeya Balakrishna - consultant forensic psychiatrist
Belinda Cheney- judge
Dr Conor Davidson - RCPsych Autism Champion
Dr Tom Gant - consultant psychiatrist
Dr Jacqueline Haworth - trainee
Christina Helden - trust lawyer
Dr Gareth Jarvis - consultant psychiatrist
Tracy Lang - carer representative
Mandy Stevens - registered nurse
Dr Caroline Walke r- clinician and therapist

For more information on the event and to book a place please use the following link:

Faculty of General Adult Psychiatry Trainee and SAS Doctors Spring Conference 2023 (rcpsych.ac.uk)

Be you- Illustration by Dr Deepika Natarajan, core trainee year 1, Tees, Esk and Ware Valley NHS Foundation Trust

Broad beans, a short story

By

Dr Reem Abed, consultant psychiatrist, Sheffield Early Intervention Service

Heba woke up. It took her some time to focus as if she was looking through frosted glass. She felt hungover yet she had drunk no alcohol the previous night. She looked around her. She was lying on a bed in a comfortable room, not her own, with windows overlooking the many trees of Sheffield and its undulating hills. "Fancy a brew, love?" A young kind female face appeared. She cast her mind back. She struggled to recollect what had happened and how she came to be where was.

Five days earlier she was at the threshold of her parent's house in turmoil. "I need to go back upstairs and revise, A-level exams start tomorrow," she thought, exasperated. A wave of apprehension swelled inside her stomach and surged up to her chest. The pressure was unbearable. This was the most important thing she had done in her life to date. She couldn't breathe. She started retching but nothing would come out. "Why won't you eat the bagila, I made it especially for you?" Her mother had said impatiently. The broad bean and lamb stew which Heba had previously eaten with gusto now made her feel nauseous. The house reeked of broad beans. A sudden pain inside her head was searing, like someone was drilling into it. She pushed open the heavy front door, a gentle breeze caressed her, willing her to go outside into the street. "Go Heba, leave the house, they are not to be trusted," a voice suggested to her.

She caught her reflection in the mirror on the way out. She was short, like most Arab women. She had her mother's round face and her father's fleshy knees. She had unruly black eyebrows, like a bird's nest surrounding her dark brown eyes. Her black hair was matted and knotted, she hadn't brushed it in a while. She didn't look typically Arab, like those glamorous women from the Gulf states. Her once curvaceous figure was now a distant memory, she was now thin and gaunt.

She looked back inside the house. She couldn't see her parents, but she could hear muttering. She couldn't quite make it out, but either way, they were against her. They weren't to be trusted. Raised voices in Arabic now.

Now the voices were audible. "What shall we do? Shall we call the police? Call the police, are you crazy? What are they gonna do? Take her to the cells?" They were blowing everything out of proportion. It was just a scuffle really. Only mum's face was bleeding. And the TV was smashed. Or was it? She just couldn't

be there anymore. Everything felt alien to her. Her family looked and sounded different. Almost like they weren't real. In fact, she was sure they weren't real. She had to get out of there. She had to get to somewhere familiar.

It was unusually hot for June. She walked down a tree-lined street in Nether Edge in Sheffield. Thoughts raced through her head. Yallah Heba! Focus! She headed down Sharrow Vale Road, towards her old primary school. Conversations were replaying in her head. "Study hard, Heba, and you'll get into the university you want."

"Are you all right, love? You're chattering away to yourself," an older woman smiled kindly at her. Heba desperately wanted her to go.

"Yeah, I'm fine thanks, just late for...something"
"All right" she said puzzled.

Heba carried on. Her mobile phone rang. It was Christie. Not Christie again. She ignored the call.

She went past the butchers and the post office. When did Sharrow Vale Road become so fancy? Donuts? Burritos? She arrived at her old school. She admired the architecture. Life was so simple then. She remembered playing rounders in the top yard without a care in the world. She remembered the school trips to Bishop's House and Kelham Island. When did it all go wrong? Her phone rang again. It was Zaid. She answered it.

"Heba, are you there? Where are you? Your parents are worried sick about you. Tell me where you are and I'll come pick you up."
Heba was silent. Oh yeah, the patriarchy coming to save me yet again. I don't need a guy telling me what to do. Or my parents. Or anyone. I'll show them. She put the phone down. Zaid was also eighteen and doing his A-levels. He had beautiful cappuccino coloured skin. She liked his skin. Heba was rather paler, which made her jet black hair all the more striking.

She carried on walking. She entered Endcliffe Park where she used to play as a kid. The pain moved to the right side of her head and settled there. Heba felt like she wanted pull her hair out to get rid of the pain. She got some bread out of her rucksack and fed the ducks. The sun was beating down. The headache wouldn't stop. I need to make it stop. Heba called Christie. "Christie, can I meet you?" "Yeah, sure, I can meet you wherever you are. You're at Endcliffe Park? I can meet you at the cafe?"

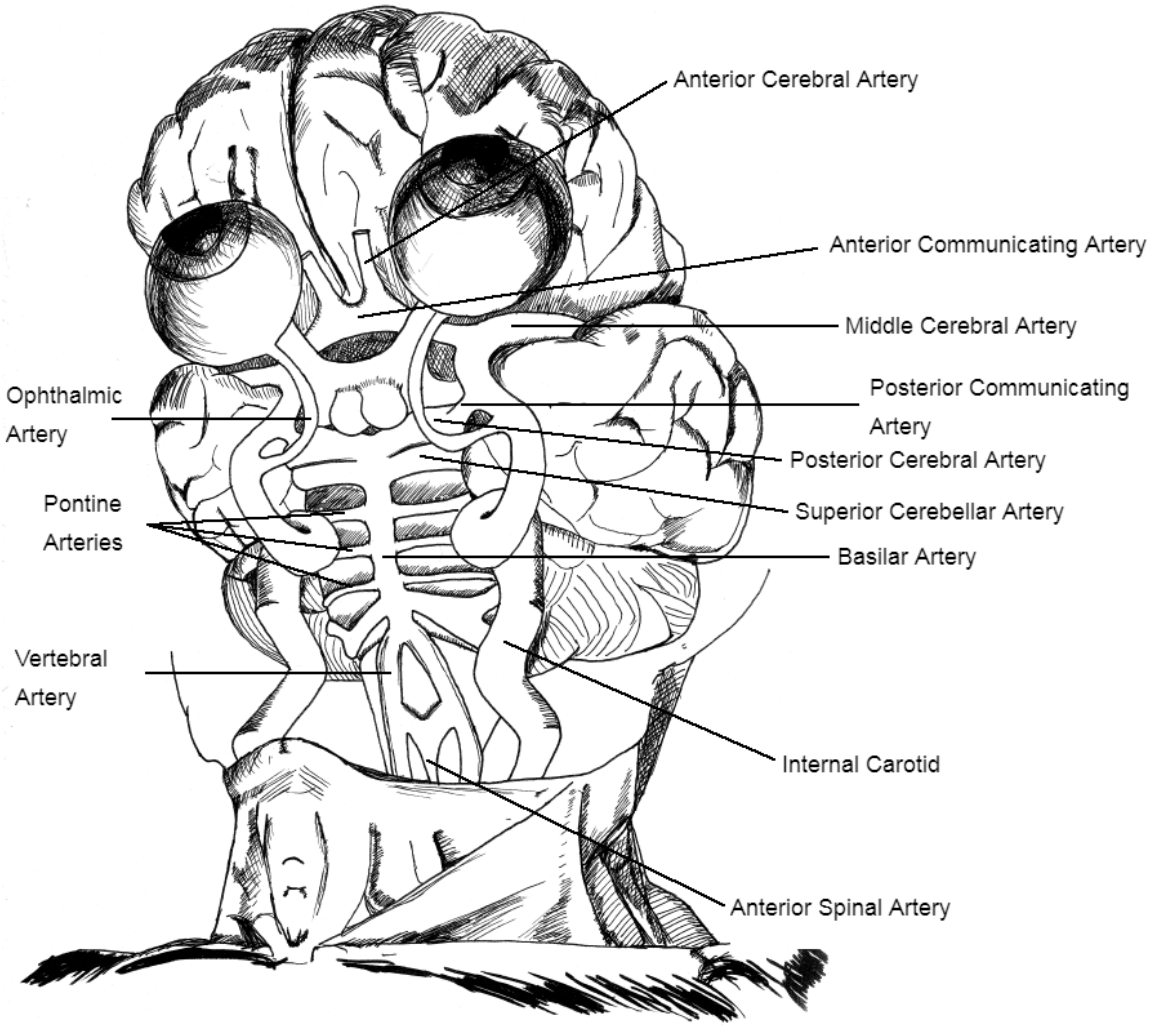
Heba hung up. She had made a big mistake. She was sure now that Christie was working with her parents and the police and that they were all out to get her. She had to get out of the park. She ran as fast as she could. She ran through Bingley Park and into Whiteley woods.

She stopped and sat on a bench. It was cooler now that she was in the woods, the sun peeking through the branches of the trees, the gentle running of the stream. This was familiar. She wanted to stay in this tranquil moment and not be disturbed. Suddenly two police officers out of nowhere approached her. Christie was with them. She betrayed me, she thought.

"Heba, we just want to talk, your parents are worried about you."
"I can't go back home! You don't understand!"
Shouting, noise, a car, a room, two doctors and a social worker. Then silence.

Heba opened her eyes again. "Looks like you drifted off to sleep again, love. How about that cup of tea? It's Yorkshire." Heba looked up and smiled.

"I'd love a cup of tea, thanks."



Circle of Willis- Illustration by Dr Eamonn Kinally, Specialty Doctor in the Mental Health Admissions Unit of Royal Glamorgan Hospital, Cwm Taf Morgannwg University Health Board

Life is Beautiful

By

Dr Vivian Venugopal, Psychiatry Fellowship Doctor, CNTW NHS Foundation Trust

What is Life? Or where is Life? Or when is Life? Perhaps is there Life?

Is it just an illusion we hold onto which is camouflaged in its own word Li(f)e?

Is it a reality too harsh we often dissociate from and unconsciously escape into our own fantasies through wish fulfilment in latent dreams?

What do we bring and what do we take with us from this existential world?

Isn't it an irony we hold onto riches, powers, wealth while in existence but we dissipate without any of it in the end?

We hold onto emotions like love, affection, sorrow which make us feel alive, We are held by emotional bonds who give us countless joy, sometimes indomitable pain which might be all the more protective reason to seldom question our existence.

We are humans after all, the desires of the heart can never be comprehended as it wants what it wants,

We may not be free in our will during this existence as we may not be free in what we want.

Is the meaning of life just a solitary ceaseless pursuit of trying to decipher its very meaning?

Or is it just an endless knot where we keep repeating beyond our conscious will? Doesn't that sound like a game predestined from its beginning?

Well, Li(f)e is what it is and whether it is a beginning of the end or the end of a new beginning will forever be an enigma, an infinite loop we can't break from.

Life is a compendium of jubilations, trials, and tribulations as neither is eternal.

Hence, chasing our reality not at the expense of our dreams but as a foundation of our dreams may be an interesting perspective,

Life is not necessarily pondering about its existential meaning but at least making an endeavour to embrace our reality, suspend our judgments, spread love, kindness.

Beauty of Life lies in the Present which is a Gift, the Life itself!!!!!

Book review- "Recovery – The Lost Art of Convalescence by Dr Gavin Francis"

By

Saskia Ajayi, Senior Assistant Psychologist working for Children's Services in Hertfordshire.

My friend handed me a book: Recovery – The Lost Art of Convalescence by Dr Gavin Francis. They immediately defined this new word for me: 'Convalescence is basically the recovery period after an injury or illness.' She added: 'You'll like this book, it's about compassion in medical care.' I was sold. My friend knew that my prior position as an Assistant Psychologist in a general hospital had stirred strong feelings in me about the need for compassionate care in the medical field.

Although Francis, a UK General Practitioner writes from a medical background, I found this book largely relatable to psychological professions. In just 116 pages, Francis concisely captures factors and specialities that influence convalescence outside of his own forte. He touches on the environment, diet, travel, physiotherapy, psychology, historical and alternative medicines as well as the socioeconomic and political context in the UK.

Francis highlights that modern medicine can feel rushed and has drifted away from focusing on convalescence. He reflects on the UK's increasing austerity, which can limit a clinician's ability to facilitate convalescence. For example, a reduction in hospital beds means that clinicians can no longer grant patients access to inpatient facilities for gradual recovery alone. Instead, the threshold to be admitted to hospital has raised significantly and Francis acknowledges this for mental as well as physical health care.

I found myself nodding vehemently as Francis highlights that '…working to diminish social inequalities is a large part of relieving human suffering…' as socioeconomic and political context are factors that I believe cannot be teased apart from wellbeing and mental health. It was clear that Francis also experiences a conflict that myself and many psychological professionals often experience; at times feeling limited in how much we can offer to relieve distress that is a direct result of socioeconomic disadvantage. The role of community and social prescribing in facilitating convalescence was emphasised, an approach to care that I also align myself with.

Francis writes about the power of being an adaptable clinician who can decipher which type of clinician a particular patient needs. Does this patient need a reassuring clinician? Or a more to-the-point and frankly blunt clinician? Each patient may seek different approaches depending on their circumstances. As a

pre-qualified psychological professional working towards a career in clinical psychology, I can find myself trying to learn how to be the 'right' psychologist.

I enjoyed how Francis mentions the role of intuition when interacting with patients; that at times straying from pre-defined textbook processes and interactions can be beneficial. I felt this was relevant to the psychological profession in which a genuine therapeutic relationship based on trust can at times be more powerful than the actual therapeutic tools offered.

Francis draws the book to a close by emphasising that individuals do have an element of control in their recovery. That expectations and beliefs can influence physiology, behaviours, and feelings. I noticed a theme of balance throughout this book; that convalescence is nuanced and there is not a one size-fits-all. That individuals must take the chance to push themselves to learn their limits but then respect these limits, in turn allowing the opportunity to recuperate and try again.

Film review- The railway man

By

Dr Wico van Mourik, retired psychiatrist/SOAD

The Railwayman, a 2013 film starring Colin Firth and Nicole Kidman is set against a background of trauma and PTSD and the long shadows they cast. It is based on a true and autobiographical story by Eric Lomax. Lomax was captured during the fall of Singapore in 1942 and was sent by the Japanese occupiers as a slave labourer to the notorious Burma Railway. During the opening scenes Lomax is shown in 1980 as a singular, withdrawn and not-so-attractive man; an odd man with a preoccupation with 'the railways'. Lomax describes his life as: "miming in a choir, not living, not sleeping…we are an army of ghosts".

Lomax, whilst on a train journey, happens upon Stella, from which develops an immediate connection and not long thereafter a marriage; "for the first time in his life I know have fallen in love". After a short honeymoon, it is not long before Lomax starts to show signs that he is carrying a secret and this shows by his intolerance of the changes Stella brings to their house. He has flashbacks, and sudden bouts of intense fear whereby she is not able to get through to him. Stella (played by Kidman) wants him to talk about his past, however, Lomax says he does not want her in that part of his life. He not only says that she cannot imagine what he has gone through but also: "…the humiliation, the shame is too much to talk about with the one you love". She speaks to a fellow veteran frustrated about not knowing and about how the past is endangering their relationship. She wants to get it all out there in the open; "I don't believe in this code of silence". She does not succeed. It is a very challenging question that I think many a partner/husband/wife encounters: "is my love not enough to heal?". She wants him to heal for himself but also for the relationship, for her: "He is a wonderful man, I have seen it. I love him and I want him back." We are taken into Lomax's past showing various sequences of harsh interrogations, water torture and bone-breaking beatings. In a way the moving between fragments of past and present mirrors the inner life of Lomax moving between the fragments of trauma and human-'being'. A comrade wants Lomax to return to Burma because he is "the only one with the strength" to make a final reckoning with his torturer Nagase, now turned tour guide at the Burma railway museum. He does this in the knowledge that Stella will stand by him, and remain his safe home to return to. Having arrived at the museum he confronts the torturer turned tour guide and makes to put the man through the same as he went through so many years before. Only then does he experience the full horror of his experience in its totality. Not only does he survive this ordeal he also sees events in every detail, details he had forgotten. One detail was how his torturer was humiliated by a superior. From this follows a moment of redemption for both

of them, a form of healing. It is only after this that he can take Stella to the same place and show her where his life was broken and repaired.

It is not easy to draw lessons from such a powerful film. What complexity is involved in trauma seems to make it hard to make simple statements. What emerges is that the experience of trauma generally is one where the person facing it, is all alone and abandoned. The PTSD that follows is suffering in solitude. Even the redemption, the healing that occurs here, is done alone. Perhaps those around the sufferer, think what might help is to hear the story of the trauma and to be able to say: "I understand what you went through". This is an impossible task for the traumatised: in part because of the shame and humiliation of being 'too much to talk about to the one you love", in part because of the fear of not being believed, perhaps even being rejected, and finally because of the fragmentary nature of traumatic memories.

What clinicians, even those with special training in trauma therapy, may need to keep in mind is what Stella ultimately kept in mind. To always be there, create a safe place to return to, to tolerate the emotions without bringing their own emotions regarding the trauma into the room. In a way it appears like a condition for healing. I also felt that in the case of Eric and Stella, when the trauma was re-experienced against the background of having a safe (loving) base the destructive force of the trauma is diminished also.

For more articles like this in which we discuss valuable contributions to psychiatry from the world of literature and film see:

https://medium.com/@from.psychiatrists.shelf

Tai Chi and Qigong in mental disorders

By

By Dr Colin Cowan, independent psychiatrist

Qigong and Tai Chi are mind/body practices involving a series of movements performed in a flowing meditative manner in which relaxation is an important component[1]. Qigong has its origins over two millennia ago as an aspect of traditional Chinese medicine and developed into meditative, martial and health strands, whereas contemporary tai chi is derived from tai chi chuan, a martial art with five main styles passed down through particular custodian families. Both forms of practice have expanded throughout the world with many variations, most commonly encountered in the dance-like set of movements of the Yang style 24-movement form of tai chi.

Both tai chi and qigong have been the subject of many randomised controlled studies in a range of biomedical disease categories. A recent bibliometric review into qigong found 705 RCTs[1] and another into tai chi identified 987[2]. Positive effects have been found in a number of medical illnesses including chronic fatigue syndrome, Parkinson's disease, osteoarthritis of the knee, stroke rehabilitation, diabetes and hypertension.

Their effect on mental disorders have also been investigated through RCTs although less extensively. To look at this more closely I conducted a simple search on the terms qigong and tai chi for systematic reviews of RCTs over the last ten years using PubMed. This identified seventeen, all of which were focused on depression, anxiety and mild cognitive impairment. Many of these reviewers had also searched the Chinese medical databases which brought into range RCTs published in China which could otherwise have been missed. Several studies used a combined category of mind/body covering both tai chi and qigong. Typically these RCTs studied a class led by an instructor two or three times weekly as the intervention.

Of the nine systematic reviews into depression or anxiety (or both), six found evidence of benefit in depression and two did not while four found evidence in anxiety and one did not. These reviews mainly looked at depressive symptoms in somatic illness or in non-clinical populations, and one in substance misuse. The single systematic review which did look at depressive illness found evidence for effect.

Eight reviews looked at cognitive impairment, with improvements in global cognitive functioning found by three reviews for the combined category and five

for tai chi with one finding no evidence. Individual reviews also found improvement in executive function, visuo-spatial ability and mental speed. One review found evidence for slowed progression to dementia but another found no evidence of benefit in established dementia.

The RCTs often did not specify the qualifications and experience of the instructor nor which style of qigong or tai chi being used, or whether home practice was expected as well as the classes. There was also considerable variation in class frequency per week and length of session. Any conclusions of benefit needs to be restricted to the generalised categories rather than a specific style.

Unfortunately, there has been relatively little investigation of depressive illness as opposed to depressive symptoms in other conditions, although one research group has developed a specific intervention based on a simplified form of tai chi[3]. It would be interesting to know whether shorter and therefore easier-to-learn forms of tai chi and qigong would also confer the same benefit and whether practice at home would increase the effect since these tai chi and qigong are eminently suitable for repetition at home. Additionally, could the practice enhance the effect of other established interventions?

This account is not a comprehensive survey of the field but it does indicate some evidence of benefit in mental disorders for tai chi and qigong, both in minimal cognitive impairment but also for depression and anxiety. They are unlikely to be treatments for severe depression but could be an addition to the range of complementary interventions for milder depression and dysthymia, including depression related to physical illness, and also for anxiety symptoms. Similarly they may have something to offer in improving mild cognitive impairment and slowing transition into dementia.

References:

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2. Yang G, Sabag A, Hao W, Zhang L, Jia M, Dai N et al. Tai chi for health and well-being: A bibliometric analysis of published clinical studies between 2010 and 2020. Complementary Therapies in Medicine, (2021), 102748, 60. Available from: https://doi.org/10.1016/j.ctim.2021.102748

3. Kong J, Wilson G, Park J et al (2019) Treating depression with Tai Chi: state of the art and future perspectives. Frontiers in Psychiatry 10:237. DOI 10.3389/fpsyt.2019.00237

Mindlens: A Youtube channel on mental wellbeing and resilience

By

Professor Shanaya Rathod, DM, MRCPsych, MSc (Leadership), MBBS

Mental wellbeing and resilience have a recognised role in managing day-to-day stressors, enhanced interpersonal relations, workplace productivity and ultimately living a balanced and empowered life.

I would like to introduce my Youtube channel- @VideosByShanaya which aims to improve resilience and mental wellbeing.

https://www.youtube.com/@VideosByShanaya

Why this channel: The information in this channel is a culmination of my pioneering work in developing evidence-based frameworks that place the specific culture and worldview of each individual at the centre of their psychiatric and psychotherapeutic treatment.

The unique way that we experience the world is what I call our 'mindlens' or a pair of lenses through which we view the outside world – which gets tinted by our emotions, chipped by our traumas, curved by our experiences – and ultimately impacts how we act and behave in different situations. It takes a lot to understand our own mindlens, and even more to manage it. All too often, self-help books are about quick fixes and solutions that make us feel better in the short-term, but my hope is that the ongoing information from my channel will help individuals in the long-term with long-lasting strategies to understand themselves better and live a happier, more productive and more fulfilled life.

Whom is this aimed at: The information is aimed to help any individual who wants to embark on a journey of self-understanding and building resilience. We all experience stress in our day-to-day life. How we deal with stress and ups and downs on a daily basis is often dictated by our mental wellbeing and resilience. As humans, we place a lot more importance on the objective outer world and assume that our subjective inner world is pretty much constant and similar for everyone. We assume that our inner concerns, interests, neuroses, and experiences remain the same and all overlap in some way. This means we can ignore our inner world and assume it is not important to anyone but ourselves. Nothing could be further from reality. Who I am, how I view myself and my relationship with myself is the foundation on which my emotional life is built. The more stable this foundation, the more balanced my views and interactions with others. When this is not a happy and comfortable relation, I might feel isolated

and lonely, especially during difficult times, and all my other relationships are affected as a result. It is human nature to map our insecurities onto others – when we feel guilty about something, it can be near impossible to react objectively to questions about that situation. We might feel attacked and react defensively even when the person questioning us is doing so without blame or insinuation.
This channel is not an alternative to psychiatric interventions or therapy.

It does however provide psychoeducation and can complement interventions provided by services when considered appropriate. With one video a week I am to slowly build a library of useful information that anyone maybe able to benefit from.

My aim through this video channel is to help individuals feel empowered to surf the waves of life with strength, while enjoying the ride and build resilience.

How can you help: I would value your support through feedback on topics and content with more ideas on what would be helpful.

Please subscribe to my channel and help disseminate through your networks and to your teams and patients.

https://www.youtube.com/@VideosByShanaya

Psychiatrists can make a crucial contribution to asylum decisions

By

Alison Summers, Report writer and Board Member, TortureID (https://tortureid.org); Email address: Alison.summers77@gmail.com

The first time I wrote a medico-legal report for an asylum claim I started to see medico-legal writing in a new light. The client, Hassan[1], was a young man I was working with as a pro bono psychotherapist with the organisation Freedom from Torture. His previous asylum claim, like those of so many people, had been decided by the Home Office to be 'not credible' and the negative decisions he received added a whole new layer of emotional pain to his already considerable difficulties. Although all this happened over 10 years ago, I can still clearly remember the moment my phone rang with the news of the outcome of his new claim. The message I received was that Hassan had now been granted refugee status, and that, in his solicitor's opinion, the clinical evidence had been crucial to this decision. The implications for his future were enormous. Even for me, at the periphery of his life, the relief was huge, and it felt a privilege to have been part of his finally receiving a just response.

Many people seeking asylum in the UK have the same experience as Hassan - an initial negative decision that is later overturned at appeal or in response to fresh evidence. Others receive an inappropriate negative decision that is never revised. Yet the majority of refugees have been exposed to violence, including an estimated 30% having survived torture, and many bear physical or psychological scars of their experiences that could provide useful external evidence to support an account of human rights abuses. For many reasons, such health consequences often never come to the attention of clinicians, and when they do, they are often not documented in the ways that help those deciding asylum claims to take them into account.

Another psychotherapy client who stays in my memory is a young Sudanese man, Ibrahim, who had overwhelming clinical signs of the torture he had experienced. He had multiple burn scars in unusual shapes and locations, highly supportive of his account of having been branded with hot metal objects. He described nightmares and flashbacks linked to these events. I witnessed the changes in him as he spoke about his experiences, including dissociation repeatedly triggered as he approached particular parts of his story, and flashbacks in which he screamed for help and desperately tried to escape the therapy room. In Ibrahim's case, there was no medico-legal report, no documentation of the psychological findings that supported his account, and the only mention of physical findings was a pediatrician's note of 'extensive burns',

with no discussion of their unusual pattern or link to his account of torture. Ibrahim was refused asylum.

There have always been strong arguments that those who have experienced human rights abuse should have any health consequences and rehabilitation needs identified and adequately documented at an early stage. Sometimes psychiatrists will find themselves encountering people claiming asylum where clinical findings seem to result from the mistreatment that is the basis of their asylum claim or where their mental state means they would be particularly vulnerable if taken into immigration detention or removed to the country they fled. Not every psychiatrist will want to learn to write medico-legal reports for asylum claims, but every psychiatrist who encounters such patients has the opportunity to make a positive difference to the person's claim by learning to understand what makes routine notes more or less helpful in this context.

There are three reasons why in the UK in 2023 this is more important than ever.

Firstly there are the policy changes introduced by the 2021 Nationality and Borders Act and the Rwanda scheme. Both will have implications for the role and urgency of clinical evidence.

Secondly, there is the expectation that as a result of a recent Tribunal judgement[2], the GP record should be regularly considered in asylum claims. Letters from psychiatrists of course appear in these, meaning more reason to ensure they are written in ways that may provide useful evidence.

Lastly, there is a newly updated version of the Istanbul Protocol, the internationally recognised guidance on documentation of torture and other cruel, inhuman, and degrading treatment[3]. This underlines that documenting torture and ill-treatment is part of every clinician's ethical responsibility.

<u>Addendum and references:</u>

1. The cases are fictional ones based on real experiences

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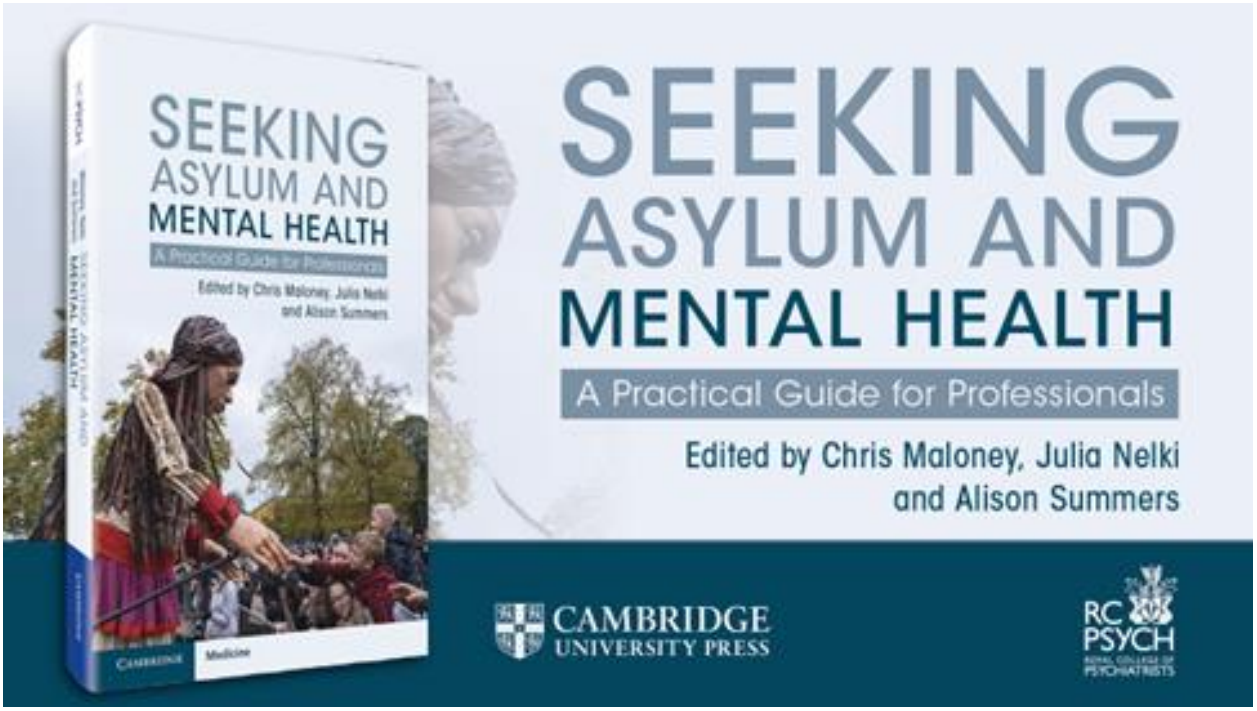


Workforce Capability Tool: a necessary approach to workforce growth and flexibility?

By Dr Ellen Wilkinson, consultant psychiatrist and chief clinical information officer, Cornwall Partnership NHS Foundation Trust

And

Dr Pranav Mahajan, ST6, Sheffield Health and Social Care NHS Foundation Trust

Interviewed by Dr Andrea Tocca, Consultant Psychiatrist and Divisional Medical Director, Southern Health NHS Foundation Trust

-Brief Introduction: Can you talk about yourself?

Ellen Wilkinson is an adult psychiatrist. She was Medical Director in Cornwall's mental health trust for 13 years from 2006 to 2019. She got more involved with the RCPsych when a role came up as Associate Registrar for Revalidation in 2012. When the term came to an end, having enjoyed the experience, she applied to become the Specialist Advisor for Workforce.

Pranav Mahajan is a higher trainee in South Yorkshire. He got involved in workforce related matters when he used his special interest time to work with the mental health trust in Sheffield on the recruitment, integration and development of physician associates in mental health. Owing to this, he has had the privilege of working with the college and HEE more widely on workforce planning.

Ella Robinson was the Policy and Campaigns Manager at the RCPsych.

-What made you get interested in recruitment?

Whilst people think of medical leadership as either grand aspirational strategy (innovator) or rigorous upholding of professional standards (enforcer), the heartbeat of the job is having an adequate, functioning workforce. Whether directly or indirectly, recruitment and its ally retention, is absolutely core to the role – and a direct prerequisite for delivery. This work cannot be sustainably met by a campaign sprint – it's more of a dogged and determined marathon. I'd liken the task to one of sustainable horticulture, nurturing relationships over years to get the very best from people, despite adversity that is often way beyond your control. There is of course a balance to be struck between meeting individual needs and career goals and keeping the service running safely. Knowing your people – and your service well is essential.

-What is capability-based work force planning?

According to NHS England, 'Capability' describes the synthesis of the various competencies a clinician possesses. This includes the amalgamation of their current (not potential) knowledge, skills, values and behaviours as well as an awareness of the limits of their personal practice.

The Long-Term Plan (LTP) which committed that "by 2023, all providers will be able to use evidence-based approaches to determine how many staff they need on wards and in other care settings."
The Interim People Plan outlined that the NHS will "need a transformed workforce with a more varied and richer skill mix, new types of roles and different ways of working…. this will mean supporting and enabling health professionals to work in new ways that make better use of the full range of their skills."

The subsequent NHS People Plan recommended that systems "further develop competency-based workforce modelling and planning" across Integrated Care Systems.

Undisputedly, patients need enough people delivering care. However, they also require the right person at the right time to meet all their care needs as no professional or practitioner can possibly have all of the required skills. The multi-disciplinary team also comprises different approaches and values.

Workforce wellbeing is of course important. One driver for this is for workers to use their full range of skills and to work at top of their skillset. However, working beyond one's depth can also lead to decreased job satisfaction, burnout and potential moral injury. Some services have well-worked capability matrices; others have only custom and practice to guide them. Legislation from 2007 widened access to Approved Clinician and Approved Mental Health Professionals roles under the Mental Health Act amendments. A plethora of three letter acronyms exist for enhanced nursing and Allied Health Professional roles but implementation has been patchy, often based in pockets of enthusiasm, where new roles have been piloted. The workforce is expecting increasing flexibility of hours and roles, which can only be achieved by increasing the numbers of staff overall. Some of the new enhanced roles may help to support less than full time working across health settings.

In parallel with the benefits of taking a more flexible capability-based approach, there are risks. If the underlying issue is cost containment or inadequate workforce levels, the approach may be undermined and not trusted. A recent expose by the BBC alleged that a company who run 70 GP surgeries in England used Physician Associates as GPs with inadequate supervision and oversight from a sparse GP workforce. There may also be risks of confusing cost and value and working with only a short-term view of productivity.

This innovative approach for mental health and psychiatry could prove challenging, where a trainee doctor works alongside a post at a similar salary point with different training and different skill sets. From the perspective of that doctor, it may not be apparent that the broader scope of practice they will acquire will be worth their additional years of examinations, assessments and training. In some NHS careers, career progression has mostly been associated with moving into managerial roles. In a capability-based system, it is likely that continued career and pay progression for nurses and AHPs will be expected as clinical experience and skills increase. An additional benefit for everyone will be to keep skilled and experienced non-medical health professionals at the frontline of patient care.

-What are you hoping to achieve?

The NHS Long Term Plan published in 2019 detailed a commitment to investment in mental health services to meet current and anticipated future demand in England. Health Education England's 'stepping forward to 2020/21' workforce plan suggested recruiting 5,000 people into 'new roles' in mental health services in England. These new staff members will undoubtedly improve the functioning of teams and enhance service users experience, however, to ensure their full potential is being reached, having a good understanding of their role and capabilities and mapping that onto the function of the Multi-Disciplinary Team (MDT) will be vital.

We are hoping to engage the mental health workforce in thinking deeply about four quadrants as part of a workforce optimisation tool (see below). On one axis is the breadth of scope of practice. A broad scope is the ability to work with any patient, any pathway or any scenario within a certain setting. A narrow scope is where someone is highly qualified to work on only one pathway (as in ophthalmology) or only one patient group (as in emergency medicine). One challenge has been adapting this approach to psychiatry practice and mental healthcare. The other axis refers to the optimal level of autonomy – whether oversight is continuous (e.g. students, foundation year 1 doctors), on site, off site or minimal, for example a consultant. We are not saying that consultants (of any profession) work without supervision, but that this is of the peer support "phone a friend" variety, or MDT case discussion, rarely needed in real time. Getting the right people to the table, thrashing out differences in language, culture and expectations has been essential. Matrices for inpatient mental health (common, complex and highly variable) and liaison psychiatry (well defined and documented in Core 24 programme) have been tentatively drafted with willing multi-disciplinary stakeholders.

The quality of the discussion has so far been excellent. We hope to learn from the tool and further develop it in other areas of mental healthcare.

Other benefits NHSE cite include:

- Facilitating a cultural shift from a siloed, profession and grade-based(hierarchical) approach towards a capability-based approach
- Developing rosters which incorporate staff from different professions
- Identifying skills shortages and workforce gaps
- Facilitating capability-based recruitment
- Supporting workforce planners to understand the capabilities of their workforce
- Identifying training needs to support professional development
- Enabling comparisons of skill mix

Workforce Capability Tool template matrix

		1: Broad scope of practice	***2: Focussed scope of practice***
Level of supervision	***A: Clinical team leader/ supervisor***	*Group **A1-a** (minimal supervision required)*	*Group **A2-a***
		*Group **A1-b** (remote supervision)*	*Group **A2-b***
	B: On-site supervision	*Group **B1-a** (limited supervision)*	*Group **B2-a***
		*Group **B1-b** (close supervision)*	*Group **B2-b***
	C: Complete supervision	*Group **C1** (complete supervision)*	*Group **C2***

-What is the future looking like for our profession?

Excellent recruitment to psychiatry from a low start point has been an amazing achievement and this bodes well for the future. A good workforce can only improve the subsequent training and education of future psychiatrists and other mental health professionals, hoping to create a virtuous circle. However, this pipeline is too far off achieving full recruitment soon as demand rises. We therefore need to work on retention of mental health staff over the career lifespan.
Change, growth, flexibility are all characteristics we need in psychiatrists and other mental health professionals of the future. In turn, they will want career flexibility and opportunities. Capability-based workforce planning may offer some of these options.

If you would like to discuss further or have any questions about workforce capabilities, please contact Andrea Tocca andrea.tocca@nhs.net or Emma Broadhurst emma.broadhurst@rcpsych.ac.uk

Inviting psychiatrists to realise our 'inner mentor'

By

Jeya Balakrishna, Consultant Forensic Psychiatrist, Defence Primary Healthcare, MOD Associate Registrar for Mentoring & Coaching, RCPsych Member of Executives of the Adult Faculty and Child & Adolescent Faculty

In being appointed by our Registrar Trudi Seneviratne to lead on mentoring and coaching for psychiatrists in our College, I pick up from where my predecessor Jan Birtle completed the foundational tasks of the Mentoring Network. I aim to explore simple and user-friendly means for us to help ourselves and to help each other. In this, I am mindful of the wealth of experience outside our College, in healthcare and education, in industry and charities, around innovative mentoring approaches.

In the wake of the pandemic, we have changed the way we practise – Zoom/Teams meetings and conferences offer convenience but change our educational and training experiences and change the way we network. Working from Home (WFH) blurs the boundary between home and work; is the much-vaunted work-life balance better…or worse?

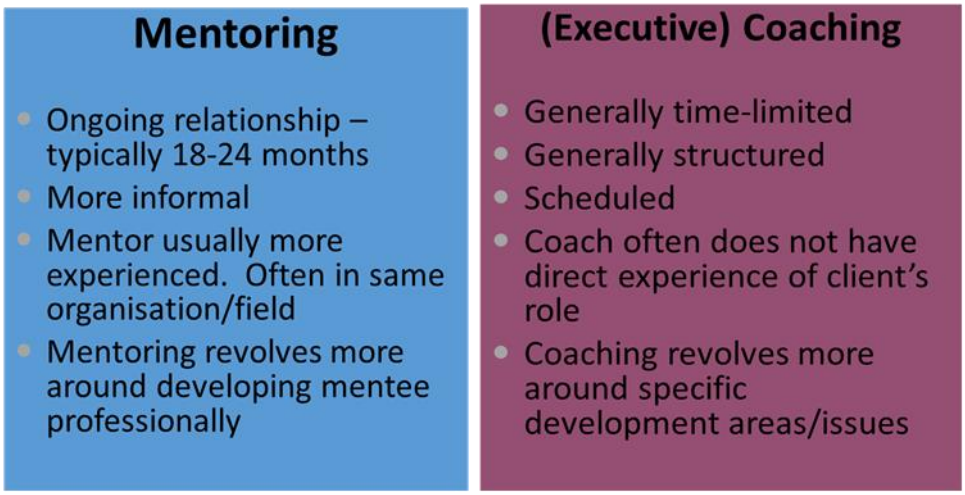
And yet there are opportunities in this change – I have benefited from wide-ranging conversations – *online* – with psychiatrists of diverse roles, grades and backgrounds across the four nations, as I seek to learn from our day-to-day experiences.

So what about mentoring? The myths abound:

- That we each need only one mentor (I have had three in my career);
- That it is not used by successful individuals (mentoring introduces fresh perspective);
- That it is a one-way 'instructional' by a senior, wise colleague to help solve professional issues of a junior.

Yes, mentoring is essentially an interaction between someone experienced with someone less experienced in same profession/occupation in which more experienced person acts as a sounding board and helps less experienced person work through goals and decisions. But it is *a two-way relationship*, where the mentor and mentee each contributes to the relationship and learns from it. Mentor and mentee share those facets of their lives and personalities that they would like to empower through mentoring. The relationship enables reflection; mentoring is a journey that evolves and promotes a growth mindset.

It helps to clarify the difference with coaching:



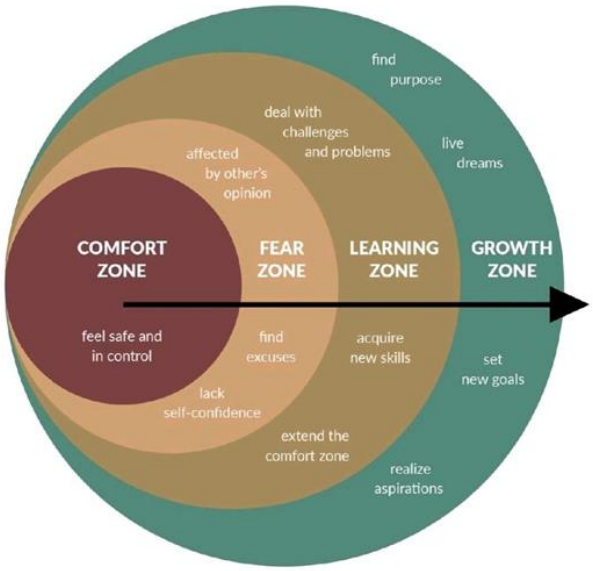
Mary Connor & Julia Pokora (2017) Coaching & Mentoring at Work

Mentoring is typically more *informal* – each of us, at whatever stage in career or professional journey, has given and/or received support and guidance, to and from colleagues. I am keen to promote the 'inner mentor' in us all – the nature of whom we are as psychiatrists and what we do in relational practice. Think about what we each would do as a mentor:

- Create a trusted space
- Promote honesty and openness
- Be an active listener
- Encourage confidence and self-reliance
- Gently guide and advise in a non-judgmental manner
- Help realise potential
- Act in the best interest of the other
- Learn something about ourselves in the process

All this is familiar territory for a psychiatrist! We know how to 'listen' - make eye contact, ask questions that promote discovery and insight, observe non-verbal cues, empathise, help to see things in a different light, make suggestions tactfully. And of course this works both ways, for mentor and mentee.

I am keeping an open mind about how much formal structure and process we actually need, in any initiative to improve how we look after ourselves and each other. Some of our trainees have successfully established peer mentoring schemes to promote mutual support, learning and growth. Many of our experienced psychiatrists in Speciality and Specialist (SAS) grades are at ease as mentors, sharing lessons about practice and professional development. Our College is unique in mandating PDP peer groups amongst us all – could we not harness these established groupings in peer support, as in fact many of us already do?



> ***"Mentoring is a brain to pick, an ear to listen and a push in the right direction."***
>
> Mentor Together (2016)

This diagram about how we travel in life and work - shifting from our comfort zone through fear into learning and growth – resonates with me; I often apply this when thinking about challenges and opportunities, and colleagues I share this with appreciate it too!

As the College considers mentoring approaches, we need not reinvent the wheel. Among a range of mentoring schemes I have been sussing – the British Army, European universities, Veterans First Point, Scotland, medical professional organisations in South-East Asia – I like the refreshingly simple methods used by Mentor Together, India's first and largest youth mentoring non-profit organisation in Bengaluru Karnataka…their refrain, quoted above, is inspired!

Service Evaluation Project of ADHD referrals and ADHD medications in transition age group patients to the Sheffield Adult Autism and Neurodevelopmental Service (SAANS)

By

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

And Chloe Wong Xin, MBChB Student, Sheffield Medical School, University of Sheffield

Introduction

SAANS is a Regional Specialist Neurodevelopmental Diagnostic Service. It is part of Sheffield Health and Social Care NHS Foundation Trust. The service purview includes Assessment, Treatment and Management Service for ASD and ADHD. It is a high demand service with multi-disciplinary team providing multi-faceted input to meet holistic needs of patients with ASD and/or ADHD.

Background

ADHD is a neurodevelopmental condition with onset in childhood and includes a group of behavioural symptoms. ADHD is predominant in males during childhood and adulthood as compared to females. Although prevalence is higher for males (5.4%) versus females (3.2%), presentation in females is somewhat different in symptomatology.

ADHD can be managed with a comprehensive holistic treatment plan that includes pharmacological and non-pharmacological treatment. ADHD medications include Stimulants and Non-stimulants. Stimulants include Methylphenidate and Lisdexamfetamine, and non-stimulants include Atomoxetine. There are also less common alternative ADHD medications such as Guanfacine and Clonidine which are alpha-2 adrenergic agonists but is not licensed in adults and is prescribed off-label in ADHD.

SAANS receives ADHD referrals from Paediatrics team, GPs and CAMHS team for patients who are transitioning from Children's services to Adult ADHD service, and also as new referrals of that age group done by Primary Care to Adult ADHD service. So we have completed this service evaluation project to look at the ADHD medications use in transition age referrals for ADHD assessment to the SAANS Service. This service evaluation project has been included as part of the Research Attachment for SSC Project 2021-22 for MBChB students from Sheffield Medical School, University of Sheffield.

Aims

The aims of this service evaluation project were

1. To review the clinical, demographic and social factors of transition age patients who were referred to specialist adult neurodevelopmental service in Sheffield.
2. To ascertain current referral status for transition age patients referred to specialist adult neurodevelopmental service in Sheffield.
3. To analyse ADHD medication use in transition age patients referred to Adult ADHD service.

Method and Sample

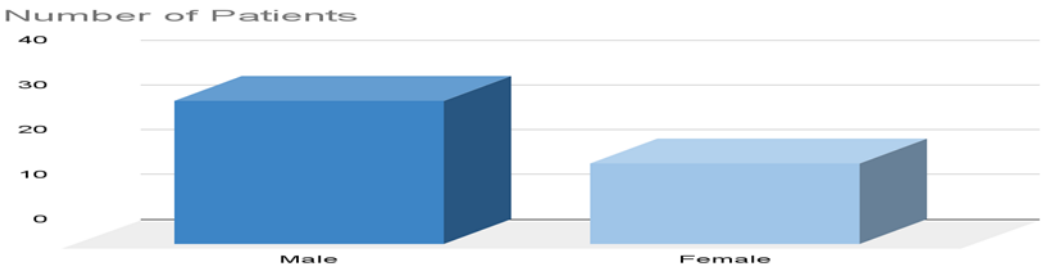
A service evaluation tool was based on the NICE guidelines of diagnosis and management of ADHD (NG87). The service evaluation tool was created by the neurodevelopmental specialist as per the transition referral patterns and ADHD medication types.

It was identified that 1150 patients of transition age group were referred to the SAANS Service between April 2019 and October 2021 and majority of the patients were still on the waiting list for ADHD diagnostic assessments and remaining were already diagnosed with ADHD and were referred by Primary Care for a review of their ADHD medication. For this project, a sample of 50 patient referrals was randomly selected as a pilot project. There was no ethical approval needed to complete this project as it was retrospective data collection and had no bearing on any patient's clinical journey or impact on any clinical interventions. Patient data was collected from the trust's patient electronic record system, which was kept totally anonymised and was kept strictly confidential.

Results

Demographics and Gender Prevalence

Our project sample had 32 males and 18 females included in the random selection of 50 patients. From the results, it is observed that male patient numbers outweigh female patients which correlates with the male to female ADHD patient prevalence ratio.



Source of ADHD Referrals

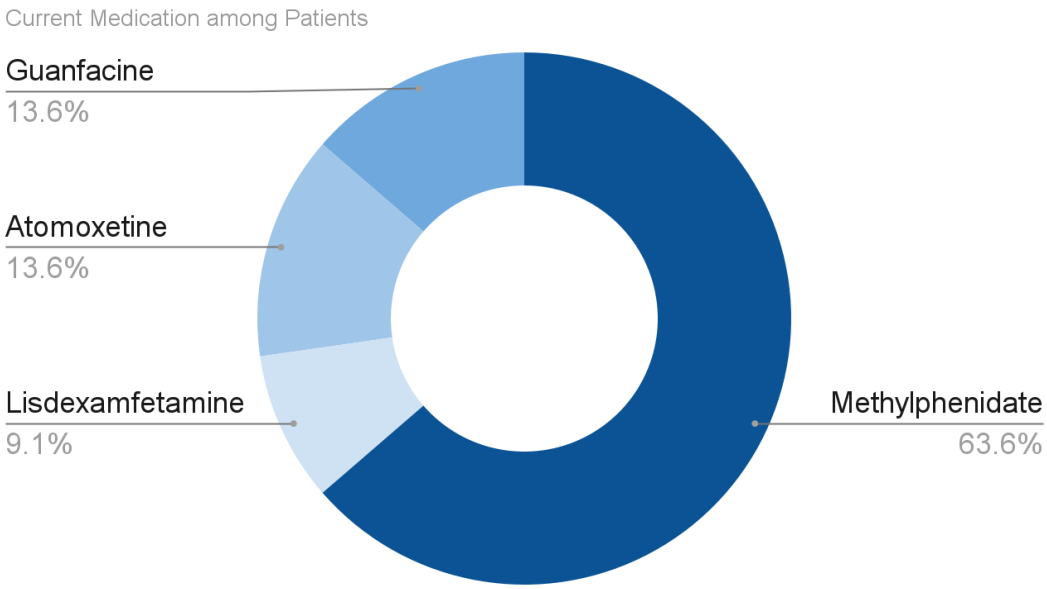
The project sample had 31 patients with local referrals (from within Sheffield) and 19 patients with national referrals (from outside Sheffield). Majority of patients (about 33 patients) were referred by GP surgery.

ADHD Medication

Out of 50 patients, 21 patients were currently on ADHD medication, while 29 patients were currently not on ADHD medication. Out of 21 patients on ADHD medication, 20 patients were on single ADHD medication, while only one patient was on combination ADHD medications. The combination ADHD medications were Methylphenidate along with Guanfacine (off label use in adults) prescribed in that one patient. Methylphenidate was most commonly prescribed in 14 patients. Atomoxetine and Guanfacine were prescribed each in 3 patients respectively. 2 patients were prescribed Lisdexamfetamine.

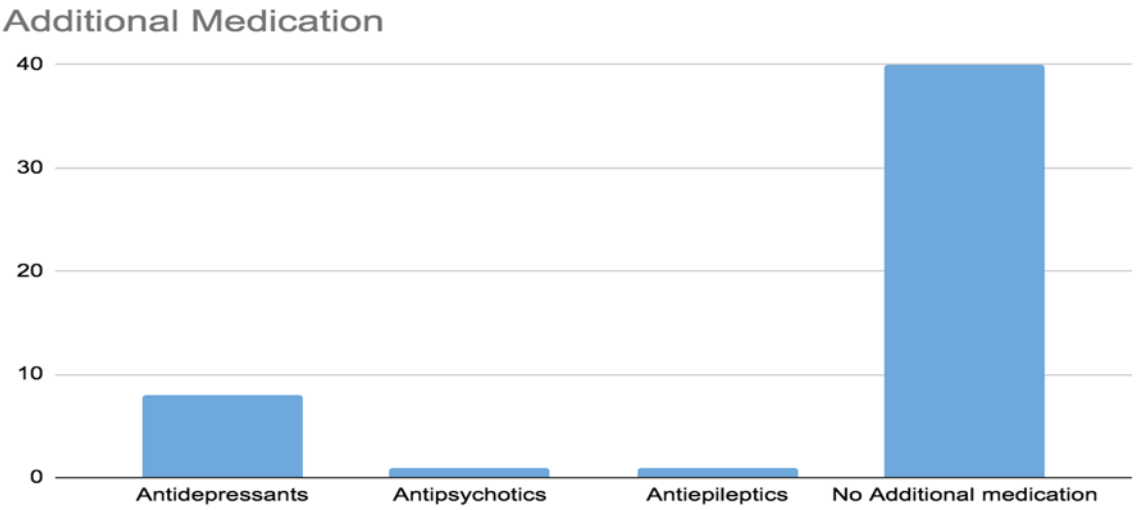
Special Considerations

It is important to consider some special considerations for women with ADHD who are of reproductive age group. As per BNF, there is limited experience and so advice is to avoid prescribing ADHD medication (unless potential benefit outweighs risk) for women who are planning to conceive, who are pregnant and who are breastfeeding. In our project sample, we found that out of 18 female patients, 1 patient was planning to conceive, 1 patient was breastfeeding and both were not taking ADHD medication.



Additional Medications

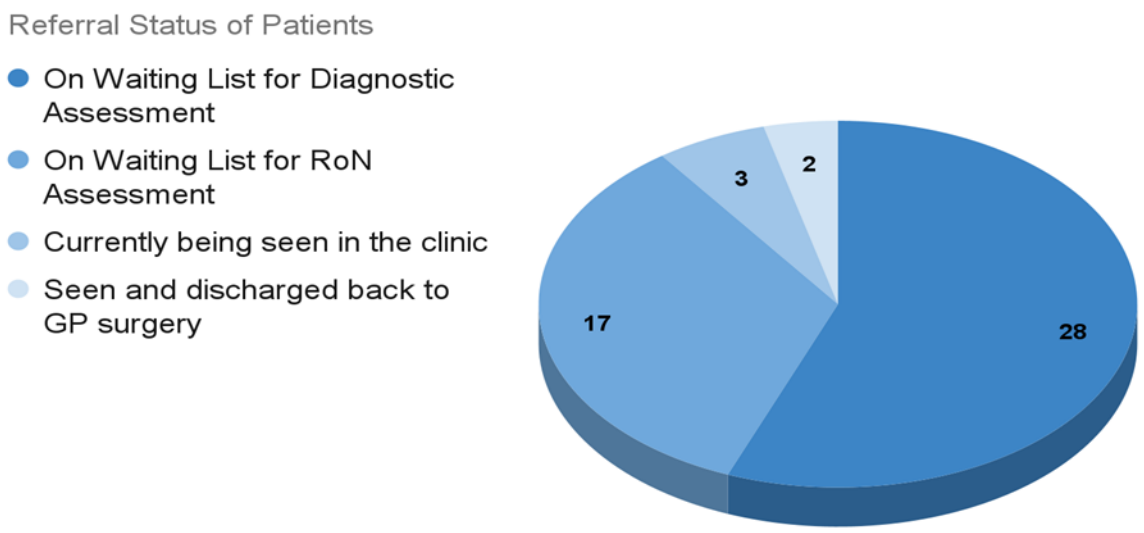
Of the 50 patients, 10 patients were also on additional comorbid medications. So 7 patients were taking SSRIs, 1 patient was on Tricyclics, 1 patient was on Antipsychotic, 1 patient was on Antiepileptic/Mood Stabilizer, and no patients were on Mirtazapine. Out of 10 patients on additional medication, 6 patients were taking Single ADHD medication - 3 were on Methylphenidate, 2 were on Atomoxetine and 1 was on Guanfacine.



Assessment Waiting times

In the project sample of 50 patients, 23 patients were referred in 2019, 21 patients were referred in 2020 and 6 patients were referred in 2021. However, majority of patients – 45 patients were on waiting list as detailed in the below graph. This is clearly an issue of mismatch in supply and demand as the referral rates are high, and resources are limited in the service. This is probably a

reflection of comparative waiting list times as compared to similar contemporary Neurodevelopmental Services within the UK.



Discussion

This ADHD service evaluation project completed has certainly provided further insight into ADHD referrals of transition age group patients to SAANS. It has highlighted the complexities of ADHD referrals and the importance of seamless continuity of care for transition age group patients being transferred from Children's Services to Adult Neurodevelopmental Service.

The sample size of 50 patients included in this project was felt insufficient although it was considered as a pilot project. However one of the limitations is 29 out of 50 patients are currently not on ADHD medication. This has arisen due to a number of patients being on waiting list. As a result they have not yet been diagnosed with ADHD and so have not been started on ADHD medications yet. So only 21 out of 50 patients were currently taking ADHD medication. This could possibly due to duration of referrals period included in this project (March 2019 to October 2021), or due to impact of onset of COVID-19 pandemic since March 2020.
One suggestion to minimise the sample size limitation for a future similar project or a re-pilot of this would be to include only those patients who are already on ADHD medication. Another simple way to overcome this limitation would be to include a larger sample of about 100 patients.

Conclusions

This service evaluation project of ADHD referrals and ADHD medications in transition age group patients to the SAANS is an important milestone to be completed in the Specialist Neurodevelopmental service. The project remained focussed and completed its stated aims which were essentially to analyse ADHD medication use in referrals of transition age group and the different clinical,

demographic and social factors present in the service evaluation sample. It touched upon the lengthy waiting periods for ADHD assessments and medication review appointments. It also highlighted the factors affecting an ADHD medication's likelihood to be prescribed. This project can be used as a baseline for further future service evaluations or re-evaluation to be done for ADHD referrals and ADHD medication use in the SAANS service.

Acknowledgments

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Declaration of Conflict of Interests

None

Abbreviations

- ADHD – Attention Deficit Hyperactivity Disorder
- SAANS – Sheffield Adult Autism and Neurodevelopmental Service
- RoN Assessment – Reassessment of Needs Assessment
- SSRIs – Selective Serotonin Reuptake Inhibitors
- NICE – National Institute of Clinical Excellence
- ASD – Autism Spectrum Disorder
- CCG – Clinical Commissioning Group
- CAMHS – Child and Adolescent Mental Health Services
- SSC Project – Student Selected Components Project

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

By

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ABSTRACT

The original New Ways of Working was developed 20 years ago in the North of England to improve the working experience of psychiatrists. This opinion article describes how psychiatrists can further change their working practices to accommodate community transformation, integration and net zero agendas. An analysis of needs and costs is described leading to 5 pragmatic ideas to assist this process.

BACKGROUND

NHS England expects Trusts to provide a strategic plan on how they intend to achieve net zero on carbon emissions by 2030. This request has been accompanied by a policy paper[1]. Camden, and Islington Trust has produced a draft strategy[2]. Both documents describe potential changes to estates utilising solar panelling, recycling waste, better insulation alongside full remote working. It is assumed that the Community Mental Health Transformation[3]; a major pivot to primary care in mental health provision will 'dovetail' with the Net Zero mandate, as would the 'Integration' agenda developed by the various Integrated Care Systems (ICSs).

New Ways of Working (NWW) in psychiatry originated in 2001[4,5] to reduce work related stress achieved by delegating duties (such as initial assessment and care coordination) to other members of the Multi-Disciplinary Team (MDT). Further changes involving splitting consultants to in-patient and community, followed with community consultants working in to psychoses, mood and organic pathways in some areas.[6] These changes have been largely accepted by consultants and employers. However, issues pertaining to waiting times for diagnoses, delayed communication with other agencies including primary care have persisted.

NEED BASED ANALYSIS TO GUIDE STRATEGY

In terms of need, the age group most at risk of mental and physical health conditions is people over the age of 85. Frailty (with both physical and psychomotor disability) is a feature in around 10% of this population.[7] These people are much more at risk of falls, delirium, and dementia, often presenting in crises leading to hospital bed use. Older people are also likely to be

malnourished, especially regards protein and essential nutrients leading to higher risk of fractures and pneumonia, incurring in-patient care (around £800 / night).

Adult mental health patients with 'severe mental illnesses' (SMI) present to services between the ages of 15 and 25. However, 'early intervention' services are split between child and adult psychiatry departments involving different specialist skills and treatment sites. 'Transfer of care' at the age of 18 is usual practice, which causes difficulty to both service users and GPs having to navigate a different system. Furthermore, in the longer term, patients with SMI die 15 - 20 years earlier, with around 67% dying of natural causes[8] typically involving community acquired pneumonia, cardiovascular disease, and cancer. Atypical' antipsychotics probably contribute to this death rate via increasing cardio-metabolic and thrombo-embolic risk, and at times pneumonia due to aspiration.

The other group of people frequently attending mental health services are those who have experienced various types of childhood maltreatment: a mixture of emotional neglect, physical and sexual abuse. It is generally agreed that these victims contribute to between 40% of mental health patients overall[9], with the higher rate amongst in-patients. Despite this, childhood trauma is poorly recognised, especially among those people suffering from psychosis and resistant depression. There is also evidence that these individuals have difficulty engaging with mental health practitioners leading to non-concordance medication and psychological therapy[10] a potential extra cost due to prolongation of care and polypharmacy.

ANALYSIS OF FINANCIAL COSTS

As with acute care, the leading cost in secondary mental health is bed use; with further costs due to delayed discharges[11]. This is partly due to difficulty arranging community follow up and unavailability of prompt specialist opinion on co-morbid conditions (such as Autistic spectrum, ADHD, and Dementia). Additionally, there is waste of resources due to out of area placements in private hospitals which merely 'house' patients without arranging proactive treatment and organising community follow-up when appropriate.

Other significant costs include senior staff salaries and drug costs (especially atypical antipsychotics). Psychotropic polypharmacy is also financially wasteful, as well as increasing cardiometabolic risks (and falls in elderly). Consequently, ICS's have identified limiting polypharmacy as a key objective in reducing the drugs budget, including regular use of community pharmacists. It is also likely that ICS will expect mental health trusts to 'flatten' their management hierarchy and utilise non-consultant grade medical staff.

TREATMENT EFFICACY ANALYSIS

The common theme in mental health interventions with consistent evidence of effectiveness (both in terms of recovery and reduced overall costs) is rapid assessment, diagnosis, psychoeducation, and treatment[12,13]. Therefore, central government funding is increasingly directed towards mental health triage using 'Primary Care Mental Health Workers' (PCMHWs) embedded within primary care settings to assist GPs to recognise and refer appropriate patients promptly to prevent prolonged symptoms of untreated illness leading to treatment resistance (for example in depression and psychoses).

Benefits of 'treatment as usual' by secondary care mental health in all age groups is probably confounded by variably long waiting times for specialist opinions. There are also major geographical variations in the types of treatments offered by each mental health service (even within a Trust). Perhaps this could explain the lack of central government enthusiasm to increase funding for generic services compared to specific interventions in primary care (for example an algorithm to assist GPs to manage depression).

Currently available interventions with replicated evidence of efficacy (a combination of effectiveness and patient acceptability) include rapid assessment of first episode psychoses, emerging cognitive decline, and screening for co-morbid mental health issues among Accident & Emergency attendees. However, there remains geographical variations even in these services in terms of waits to gain a specialist diagnosis and treatment plan, which appears to detract from outcome (for example as measured by unplanned admissions).

Emerging interventions using psychedelic drugs**;** for example**,** Psylocibin assisted psychotherapy for treatment resistant depression (TRD) and Post Traumatic Stress Disorder (PTSD), as well as Ketamine (another psychostimulant) to manage acute depression with suicidality are currently undergoing clinical trials, with evidence of effectiveness. However, the necessary infrastructure to provide a regular service (via day care) is not in place; and might need diversion of resources from more generic services provided in the community. Furthermore, by 2030, it is likely that other immune based interventions will be available to treat major psychiatric conditions, for example 'Trans cranial Magnetic Stimulation' for mood disorders and repurposed vaccines for slow down cognitive decline.

SUGGESTIONS BASED ON ABOVE

1. **Immediate (remote) specialist advice for Primary Care based mental health staff.** The idea of placing Primary Care Mental Health Workers (PCMHW's) to Triage requests needs to include immediate debriefing with the relevant specialist to provide a working diagnosis and a treatment plan (including relevant investigations, psychoeducation and an initial trial of

treatment). Ideally the patient and / or carer should be involved following debriefing via an 'assisted' consultation to enhance patient / carer choice. Furthermore 'scaffolding' when PCMHW's can access the skills of a specialist worker in the medium term would also be beneficial.

To deliver immediate debriefing, it would help if community consultants were decoupled from their current Community Mental Health Teams (CMHT's); New Ways of Working 2.0 as it were. Currently CMHTs are led by non-medical clinical leads and team managers, who could be supported to maintain leadership, with consultants accessed when needed. It would be helpful if consultants are assigned 'medical assistants' who will organise virtual slots based on severity and risks. Arguably, Triage nurses should focus on the 15 – 25 age group, when most SMI conditions initially present[14] with a greater likelihood of interventional success. This would require a unified skill base currently held by paediatric and adult psychiatry.

2. **Training staff in advanced consultation skills**. Improving engagement with traumatised individuals require need staff to be trained in advanced communication training involving Trauma Informed Care (TIC)[15]; for example, moving from questioning from 'what is wrong with you?' to 'what have you been through?' TIC should (based on patient feedback) should help staff to establish adequate trust to develop co-produced care planning. The other type of consultation with high user satisfaction is 'open dialogue' a change in consultation which is designed to assist a patient and family to formulate their personal narrative leading to user centred care plans[16]. Other consultation techniques with evidence includes using 'validation therapy' to de-escalate agitation among people with cognitive impairment.

3. **Physical health care hubs.** These day services would manage physical health monitoring on commencing psychotropic drugs and monitor co-morbid physical health issues such as obesity, hypertension, and diabetes[17]. Furthermore, hubs can provide clozapine initiation and psychostimulant based psychotherapy as outlined above alongside ECT as a day patient. For various reasons psychiatric patients fail to access consistent primary care, and a hub could utilise seconded GPs to assist medical care. Physician associates (PAs) could also help manage the physical healthcare workload (for example for blood testing, ECG recording and if needed CSF sampling).

4. **'Connected up' in-patient care to improve bed utilisation.** A single bed management team managing admission, discharge, and transfers to acute care would optimise bed utilisation. A duty Modern Matron running this team should have the responsibility to make decisions on discharge, with advice from specialist medical staff. Furthermore, LEAN working practices[18] including 72-hour formulation meetings attended by community medics, care co-ordinators, social workers to decide on duration of stay and site of discharge,

followed by a further discharge planning meeting at 2-3 weeks should be the norm, with carer input.

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

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

CONCLUDING REMARKS

The unavoidable fact on reducing a Trust's 'carbon footprint' is to move some services to another organisation. The integration and community mental health transformation agenda can assist in this; for example, by moving secondary care community mental health to local authority jurisdiction. Despite the difficulty in integrating with wards, having a single budget covering CMHT's and Social services departments can produce more 'joined up' care in the community; for example, working with housing services as described above. In this system, mental health Trusts would provide in patient, hospital liaison and day services only. Recent issues in ward settings involving abuse would be less likely because of better focus and supervision. However, there would be issues involving job contracts, pension arrangements and interoperability of electronic notes.

NWW 2.0 could well pose more challenges to psychiatrists compared with the original version 20 years ago. This includes stresses involved in rapid response (being immediately available for advice, immediate debriefing PCMHW's for example), and potential changes in one's employer (ex. local authority or PCN rather than a mental health Trust). Losing clinical leadership of a specific CMHT and / or losing a geographical sector would also cause disquiet. However, these must be balanced against the benefits of being free of a caseload and responsibility to a challenging (or large) sector, which cannot be 'disowned' without leaving the job. Consultant teams in the community would also

encourage sub specialisms suited to one's interest. NWW 2.0 would also enhance working from home, in keeping with net zero objectives.

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Psychosis in Kashmir

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If there has been a work of substance and paradigm making with regards to the social perception of Schizophrenia and psychosis, it is Michael Foucault's "Madness and Civilization". It is a scholarly investigation into the social perception and construction of psychosis. In his other work "The Birth of Clinic", Foucault explored the theme "Institutionalisation of Madness" and the exclusion of psychotic people and their confinement to the solitary walls of the asylum. Foucault traced the behavioural trajectory that led to the profiling and subsequent otherization of people with mental illnesses. Though Foucauldian analysis revolved around Western societies, these conclusions yield to the phenomenon of universal character. An attempt to conceptualize the perception of psychosis in Kashmir brings us more or less to conclusions similar to those imported in Foucault's work. Kashmir, a picturesque valley, has always mesmerized visitors despite being sandwiched in a long-drawn conflict. Walter Lawrence, a civil servant in British India, in his book "The Valley of Kashmir" published in 1895, recognized as a masterpiece on the history of Kashmir Valley writes that "It is unfortunate that we possess no statistics regarding lunacy but my frequent tours through every village in the valley have acquainted me with the sad fact that lunatics are common. Some are lunatics from birth, some have gone mad from the excessive use of charras (weed) or have lost their senses through some calamity. The lunatics are harmless people and are well-treated by the villagers. I have discussed the question of establishing a lunatic asylum, but the villagers think that the lunatics are happier as they are and that captivity would do more harm than good" [1]. The last sentence of keeping men with psychosis in the community still holds good to a large extent, but of course, with psychiatry as science becoming more available, acceptable and accessible medical treatment is improving their quality of life and fulfilling the universal dream of treating the mentally ill within families and communities. The first asylum was established by the Prison's Department in 1903 in the backyard of

the Central Jail Srinagar. Subsequently, the hospital still housed in the barracks of the Central Jail was delinked from prisons and established as a mental health facility. In the 1970s it was the Swiss lady psychiatrist Prof. Erna Hoch who worked here as the first Professor and Head of the undergraduate department of Psychiatry who introduced modern psychiatry to treat psychosis. Although two local psychiatrists were posted in the asylum before that, they were not able to mainstream Psychiatry. In Kashmir, the Persian word "devana" can mean both "divinely inspired" and "mad". That the former, exalted sense is still significant is probably confirmed by the fact that the Kashmiris, at least the Muslims, also call their mentally disturbed "khuda dost" meaning "friends of God" [2]. Despite its variegated social mores, which it sustained historically, Kashmir has been characterized by dominant preoccupation with the tendencies of mystical order.

This cultural obsession with mysticism often prompted people to mystify the phenomenon that yielded no readymade meanings to them inside their hermeneutic sphere. Historically, psychosis wasn't diagnosed, to begin with. In cases when the symptoms were too explicit, the patient was excluded and put in the category of either mystic or godmen-their personality wrapped in mystique or attributed to demonic or spiritual possession. They would either live within the very precincts of society with the mode of their existence characteristically different from others, mystified and wrapped in social legitimacy and assent or they would be isolated, ostracised and looked upon with fear and caution.
The conflict in the region turned violent by 1990 and mental health became a consequence. As per the latest Médecins Sans Frontiers, nearly 1.8 million adults (45%of the adult population) in the Kashmir Valley experience symptoms of mental distress with 41% exhibiting signs of probable depression,26% probable anxiety and 19% probable PTSD. The study also revealed that an adult Kashmiri has witnessed or experienced an average of 7.7 traumatic events during his/her lifetime [3]. The sheer number of people seeking help for PTSD, Depression, and other anxiety disorders at Psychiatric Diseases Hospital increased manyfold. It broke the first barriers of stigma, shame, and exclusion and also set the trend of the medicalisation of psychosis and a large part of the community recognizing it as an illness and the subsequent process of seeking medical treatment to ameliorate symptoms. With the community support holding by and large and Psychiatry no longer confined to an erstwhile asylum...now Institute of Mental Health and Neuroscience Kashmir and psychiatrists available in almost all districts, psychosis is increasingly recognized and treated as an illness within the community with family support. The spiritual dimension of psychosis still holds firm in large communities but it does not prevent them from seeking treatment if it is available and accessible.

We as psychiatrists hope that the family structure, the community and mental health care become even more available and patients with Psychosis are treated with care enshrined in community values and the benefits of modern science are taken to make them well and integrate into the community and live a life of quality and dignity.

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Personal resilience in psychiatrists: It is about developing and maintaining it throughout our career graph

By

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Resilience as a concept

Resilience can be described as 'bouncing back despite odds' which we say in common parlays. Resilience is where a person excels despite adversity. It is not a 'static concept' and should be considered as a 'dynamic concept'. This is because we need to imbibe and practice active cognitive processes in our minds and develop positive behaviours to maintain Resilience. There is considerable evidence to show that many people working in health care have high levels of stress and burnout. In this situation, it is important to keep our focus and avoid burn out. Resilience is the concept where in if we as Psychiatrists develop and maintain it, it will provide us immense benefit in keeping us in the right path in our careers and in imparting good patient care.

Burnout and Compassion Fatigue

In 2019, the World Health Organisation recognised burnout as a medical condition, defined as, 'a syndrome conceptualised as resulting from chronic workplace stress that has not been successfully managed'. Symptoms include: insomnia, fatigue, self-criticism, pessimism, feelings of unworthiness, detachment, feeling out of control, low mood and anxiety. Compassion fatigue is an associated term and describes a lessening of compassion over time, with hopelessness, stress and anxiety, sleeplessness or nightmares, and a pervasive negative attitude.

Personal Resilience in Psychiatrists

There are positive and negative factors that influence the well-being and resilience in Psychiatrists. As Psychiatrists imparting care and being mental health providers to patients, it becomes all the more important to maintain our own well-being and resilience. It is important to maintain our own well-being and resilience. As the common saying goes 'Please take care of yourself before you take care of others'. 'Please wear your

Oxygen mask first before assisting others'. It is important to gain insight regarding the interventions that are needed for resilience and to imbibe helpful suggestions to put this into our career practice.

Causes

Doctors are at considerable risk of work-related stress, burnout and mental health problems such as depression and anxiety. The most common causes are high perceived workload, the growing intensity and complexity of the work, rapid change within healthcare, low control and support, and personal experiences of bullying and harassment (Kinman & Teoh, 2018). These factors are particularly relevant to Psychiatrists.

Resilience Types

Resilience can be two-fold, one is inbuilt resilience which we all have inherently to a certain degree. Another is Acquired resilience which we as professionals will have to develop as we progress in our careers. Everyone has resilience – but everyone reacts differently to adversity, with some coping more effectively or more quickly than others. Resilience can be developed and strengthened. It is important to note that there are cultural differences in resilience.

Building Resilience in Psychiatrists

In my view, it is important to build Resilience in Psychiatrists from the initial training days so that it can be developed into full-fledged part of work life. This is especially needed when we finish the training and progress in our career graph to last for our full career time period. There are various ways of building Resilience in Psychiatrists. I have found that inculcating Mindfulness for self-awareness and concentrating on small but pleasurable things in day-to-day life helps. These are the "things" that we usually ignore or consider not relevant in the hustle and bustle of our work lives. These are important if we consider the larger perspective and holistic view of life. This makes me more focused and to concentrate on completing tasks in my work. It also helps me to remain target orientated and to understand things from the patient's perspective.

As a general rule, accepting that 'change' is a part of living, avoiding seeing crises as insurmountable problems and looking for opportunities for self-discovery does help to maintain resilience. An important aspect for resilience that I have found with self-journey is by attending events that are related or unrelated to health discipline. There are two paths to partake in this aspect. One is that you can attend events related to health that adds knowledge and skills to your clinical practice, but not directly

your own sub-speciality or speciality. Another is that you can attend events that are outside health discipline but still adds to your communication skills, leadership and management skills. Recently I attended an event about How to improve confidence in Public Speaking skills. Although I attended this event as a participant and not as a speaker, I was asked to speak about a topic impromptu. The topic is chosen by picking up from a lot. I felt that as there was no time to prepare, it actually helped me to speak well and increased my confidence.

Attending a health event not related to my sub-speciality or speciality gives me knowledge about how other health professionals perform in their disciplines. At the same time, it made me self-aware about the positives or hardships of my own sub-speciality or speciality and gave me a relative perspective for my own clinical practice.

In summary, I would consider Resilience as a life-long concept that should be practised and maintained by us as we progress through our career graph. It is definitely not a one-day concept. There will be highs and lows in our career and personal lives, but if we have the inbuilt resilience that we develop from our training days, then that should sail us through our professional life as a Psychiatrist. Maintaining a hopeful outlook, keeping things in perspective, nurturing a positive view and taking care of ourselves will help us all to maintain our resilience in this COVID-19 times. This too shall pass soon!

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