July 2022

General Adult Faculty Newsletter

iMind

July 2022

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Update from the Editorial Team

Dear all,

Summer is here again and so is the latest issue of our faculty's newsletter. The main topic is "relationships and continuity of care" and we have received many great articles that we are thrilled to share with you. We also have Katherine, Emily and Dr Behrman talking to us about menstruation, menopause and mental health matters and I will be sharing some exciting details about the upcoming annual conference which will be held on the 27th and 28th October 2022.

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

Our "creative corner" is 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 works of art with us in the future issues of our newsletter.

Starting with this issue, we added the "Wellbeing corner" where colleagues can share with us how they deal with stress, either personal or work-related. Opening the scene is Dr Tarfosh and his team who talks about sustainable ways of expanding mental wealth in healthcare students.

The next newsletter is due in the winter of 2022 so the deadline for submitting your articles is December 2022. We have decided not to have a theme for this issue, so any topic is welcomed. We would like to hear from students, trainees, speciality doctors, consultants and other professions and of course, patients and carers.

With warm wishes,

The editorial team

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Chair's blog
by
Dr Billy Boland
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Welcome to the latest edition of the General adult faculty newsletter.

Thanks to everyone who made the spring conference such a success. Doing it jointly with the psychotherapy faculty brought a unique richness and diversity to the meeting. There are considerable overlaps and synergies with the types of work that the faculties do, so it was great for us to have space to think together and collaborate.

The faculty co-production network continues to go from strength to strength. I really enjoyed the event 'Celebrating Seni's Law: A testament to Ajibola Lewis – Mental Health Units (Use of Force) Act 2018 Coproduction and race equality'. It is painful to hear about some of the experiences that black people have had in Mental Health Services. Co-production offers an opportunity to rethink our approaches to working with communities and put person centred care back at the heart of what we do. The next session 'co-creating safe space for lived and learned conversation around authentic coproduction in mental health as related to the current label of 'Personality Disorder Service'' will be at 10-00am – 1.30pm on Thursday 21 July 2022, so do sign up if you can. It is a free event online.

In June we had our 1st face to face meeting as an executive since before the pandemic began. It's been great to be back in the college building in London and see its refreshed appearance. I have missed our in person contact very much. The faculty is very effective at working online using Microsoft teams, but there is nothing quite like the type of conversations we have when we are in a room together. We reviewed our four-year strategy and finalised our strategic objectives for the final year of that strategy, to guide us in the year ahead. We also managed to have a dinner together on a beautiful evening down by St Katherine's dock. Connecting with colleagues from places far and wide is one of the many things I love about being involved with the faculty, and I would encourage anyone to get involved in our work.

The next opportunity to be together involves you. We have seen a draft of the faculty conference planned for October and I could not be more pleased to say that we will be able to meet in person for our 1st face-to-face conference in years. This will be at the college building. So, if you do want to meet colleagues, and meet us, then do please get signed up. For

those of you that prefer not to travel, we will have a hybrid offer. This is exciting as the college has acquired new technology to allow us to do this. We will be ably supported by the college conference team, and I am really looking forward to what this new type of event has in store.

Thanks to Meda, Asif and all of the newsletter team in their hard work in bringing you the latest edition of this newsletter. I am sure you'll agree it is continuing to evolve into a fascinating and engaging publication. Please do continue to give it your full support.

I'll look forward to seeing you at the conference.

Best wishes,

Billy

General Adult Faculty Annual Conference 2022

by Dr Meda Apetroae

In-person (RCPsych) / Live-stream (available OnDemand) on 27th and 28th October 2022

Organising committee: Rachel Bannister, Jacquie Jamieson, Dr Oliver Dale, Dr Meda Apetroae, Dr Mosun Fapohunda and Dr Abdi Sanati

The General Adult Faculty is excited to present the 2022 annual conference. This is the first event since the pandemic started that will be held in person and we couldn't be happier! For this conference, we chose subjects that are highly relevant to the current times, and we have topics to cater to everyone. We will have talks on race inequality within mental health services, frontier psychiatry, the impact of menstrual health on mental health and relational psychiatry to name a few. In light of the unsettling war in Ukraine, we will have a talk on war and its effects on mental health.

To follow from this year's spring conference, we have a session for trainees led by trainees that will talk about giving evidence in tribunals and conflict resolution.

For this event, we have created a meeting for trainees only that will offer them a safe space to discuss topics relevant to them and their training, and also offer them the opportunity to network and socialise.

Although the conference will be held in person at the RPCPsych headquarters in 21 Prescot Street, London, you will be available to live-stream it or watch it on-demand from your home or work. Each day will end with a panel discussion that will summarise the learning points of the day. We believe that the topics covered in this conference will be relevant not only to all professionals working in mental health, but also to patients and their families as well.

Speakers:

Dr Sophie Behrman- General Adult Consultant Psychiatrist, Oxford Health NHS Foundation Trust
Katherine C- Service User
Dr Quinton Deeley- Consultant psychiatrist, Maudsley and Bethlem Hospitals, London
Emily Elson- Lived Experience Professional
Dr Mosun Fapohunda- Consultant psychiatrist, Hertfordshire Partnership University NHS Foundation Trust
Dr Samei Huda- Consultant psychiatrist, Pennine Care NHS Foundation Trust
Dr Colin King- Member of the Royal College of Psychiatrists General Adult Faculty Co-production Steering Group and Co-production Network
Dr Jon van Niekerk- Group Medical Director at Cygnet Health Care
Dennis Ougrin- Consultant Child and Adolescent Psychiatrist, East London NHS Foundation Trust
Dr Russell Razzaque- Consultant Psychiatrist, NorthEast London NHS Foundation Trust
Dr Luke Roberts- CEO at Resolve Consultants
Dr Joan Rutherford- Chief Medical Member for the Mental Health Tribunal in England, Honorary Consultant Psychiatrist with South London and the Maudsley NHS Foundation Trust
Dr Trudi Seneviratne- Consultant Adult/Perinatal Psychiatrist, Clinical Direct South London and Maudsley NHS Foundation Trust
Dr Lade Smith- Clinical Director, South London and Maudsley NHS Foundation Trust
Dr Jay Watts- Consultant clinical psychologist, Centre for Freudian Analysis and Research, London

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

Faculty of General Adult Psychiatry Conference 2022 (rcpsych.ac.uk)

Hope

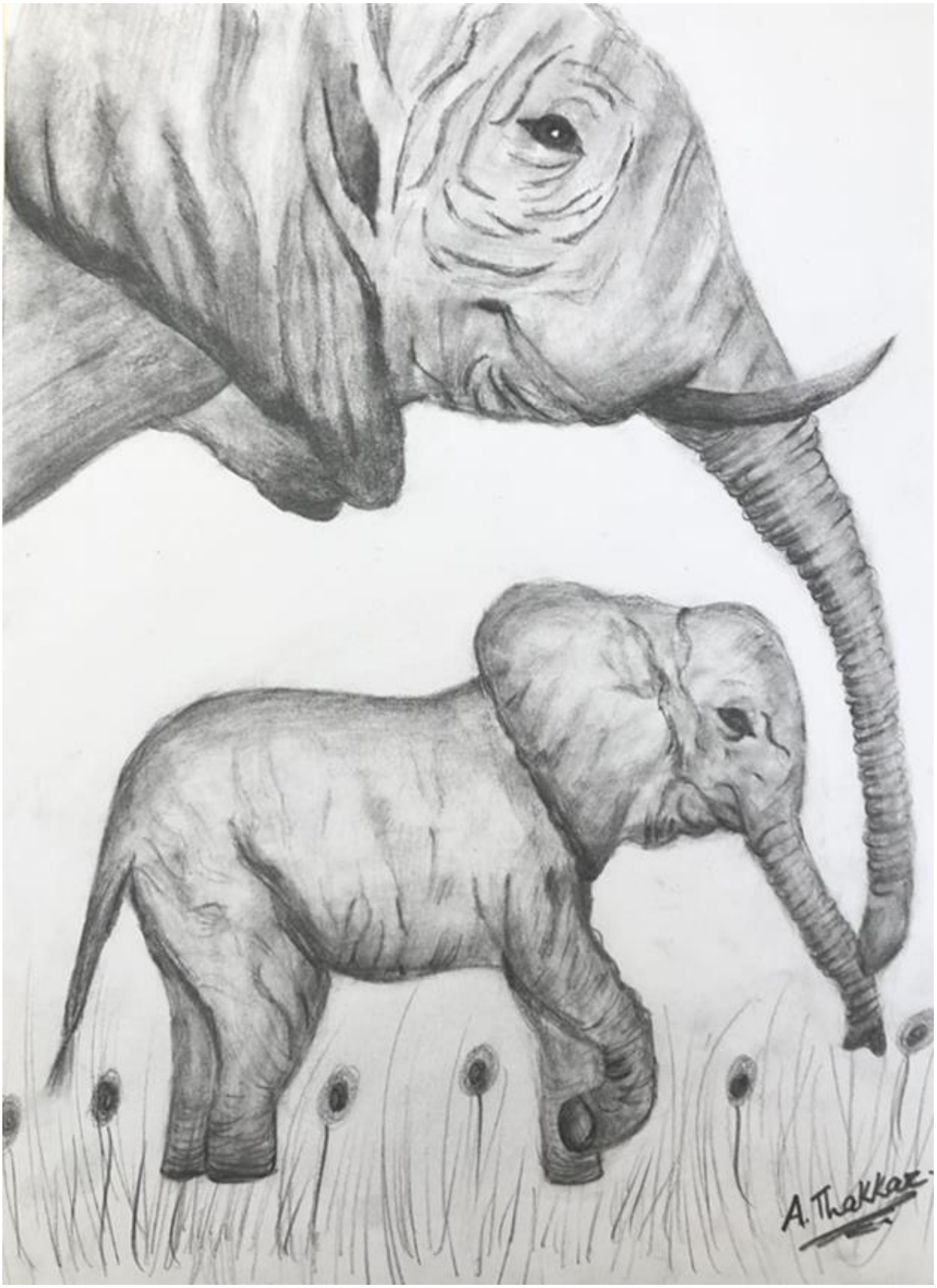
By

Dr Emma Isabella El Makdessi: Foundation Year 2, Scotland

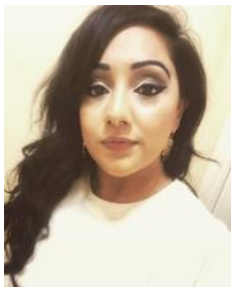
Do not hide those scars
Bare below the elbows is the regulation
You have no choice
I hope if you did, you'd choose to salute those scars. All white, not red.
And throw shame in the sluice where it belongs.
We are healers, not judges.

And you may never know who holds secrets
And is never bare below the elbow
And now they know
They are not alone.

Your body is a billboard that says Hope!



"Benevolence"- Illustration by Dr Akanksha Thakkar, FY1 doctor, Lister Hospital, Stevenage, Hertfordshire



Se'clue'sion

By

Dr Roopak Khara, Consultant Psychiatrist, West London NHS Trust

As I wait outside the ward, the final frontier of my space,

I have prepared my thoughts towards control and hope this will be the case.

You are resplendent in your glory so has come your time to shine,

Your inhibitions no longer grace your skin as you feast your eyes on mine.

If love is not 'dissent', you start, why into it do we fall?

My answer bubbles into silence as I fear this isn't my call.

Tell me about your history I say, all that's in your mind?

I'll stay quiet, they knowingly smile- *I'll leave it in the air for you to find.*

Let me give you drugs to mix your madness in with hope,

Your mouth curls in pity as I prescribe it- *what makes you think I need this to cope?*

Section me for happiness please, that's all I need from you,

I cannot let you in, you see; I know you need me to.

I venture 'this patient suffers from....' and as we lock eyes, I know I am not even close.

Have you listened at all to me or is it you who is grandiose?

I swallow my doubt as the team arrive and you are brought into seclusion,

What brings you here, what takes you there- is it just our malocclusion?

It's in the mental health act, I comfort myself, time between us irreversibly stirred,

Stupid little doctor, you shout, it's all in that last bloody word!

I mimic your furrowed brow as I now judge you from afar,

I wonder, if psychiatry is a performance, then which of us may be the star?

Illustration by Dr Eamonn Kinally, Psychiatry Core Trainee Year 3, Swansea Bay University Health Boardy and text taken from the song "Black Box Warrior - OKULTRA" by Will Wood

The Psychiatrist-A Journey Beyond Id

By

Dr Mansur Butt, Consultant Psychiatrist Forensic Rehabilitation Unit
Cygnet Oaks Unit

On way to the day's work trying to see beyond
The quivering sun, drops of rain and the rainbow
Illusions of a fairyland in the super ego haze
I'd travel mountain tops covered by the snow

And I keep trailing with silver woolly clouds
Missing letters and the signs on the jittery boards
Looking up horizons new drawing a comparison
Reflections dance with pathology on the misty roads

I fancy catching butterflies but hardly seen one
Still can mimic pass pointing of the chirping birds
Almost like a verbigeration I just carry along
In knight's move come along grazing serene herds

To carry light with misty shadows I keep treading on
Hanging like a dissociation, keen on spreading smiles
Mood-disorders make one quail, hope wanders around
Can I sprinkle wish and faith for all the coming miles?

Not one-for-all you tailor the potion mixing up the thoughts,
mending neurofibrillary tangles to get some tranquillity
Trading the sorrows far beyond and some memories
To erase a few and make some new for those in vicinity

I keep on striving all the times I keep on trying more,
Replenishing wounds old and new make the soul to scar
All the projected misery with all the empathy vows
The mind gets blocked very often, wants to drift afar

Steady endeavour keeps one tiring, can't just shed it off
Just by turning back from work, or by coming home
And road has turned dark enough casting a silhouette
Like a luscious scary python, ambushing a syndrome

Shadowy hollow appears to be part of a dimming light,
Junctions feel as wretched as woeful as it all seems
I keep alluding to perceptions prejudiced by the Id

Conscious mind conjures logic, super ego just screams

To finish off the night in peace and to start morn anew
To make another journey, to start with zeal and zest
I need to catch some REM sleep and eyes shut close
For another taxing transference, I need to resurrect

Silence training vs Resilience training? - Finding a sustainable way for expanding healthcare student mental-wealth

By

Dr Shah Tarfarosh MBBS PGC CREL (Cambridge) MRCPsych, Psychiatry specialist registrar, Oxford Health NHS Foundation Trust, Honorary Teaching Fellow at the University of Oxford. He is interested in research on the use of positive psychology for prevention and early intervention in mental disorders and is currently involved in an early intervention study involving ultra-high-field magnetic resonance spectroscopy at the Department of Psychiatry, University of Oxford. Correspondence: shah.tarfarosh@psych.ox.ac.uk

Dr Beenish Khan Achakzai BDS, Dip MHP. Dentist with an interest in psychological aspects of oral health as well as in the well-being of healthcare students and professionals. She has completed training in enhanced cognitive–behavioural therapy (CBT-E) for eating disorders certified by the University of Oxford and is currently working in the Adult Community Eating Disorder Service (ACED), Warneford Hospital, Oxford, UK.

Dr Iqra Rasheed Shah, MBBS, MD Psychiatry. Completed her psychiatry training from Institute of mental health and neurosciences (Kashmir), an associated hospital of Government medical college, Srinagar. She is interested in Adult and Liaison psychiatry and has done her dissertation on Consultation Liaison psychiatry services in Kashmir. She has a special interest in mental well-being and resilience of healthcare students and in caregiver burden and burnout.

Talking about ‘stress in general’ is pretty easy. Discussing types, causes and interventions to prevent the harmful effects of stress, in healthcare students, in particular, is difficult. This is because the same factors that induce stress prevent us from taking the time out to openly discuss the nuts and bolts of those stressors. How ironic is that? It sounds like it is

less exasperating to stay silent about the psychological hardships faced by healthcare students than to do something productive about the same.

As healthcare students, all of us have experienced three main types of stressors in varying proportions - Academic, Clinical and Psychosocial **(1-3)**.

Academic stressors. - A huge academic workload gives us the privilege of studying for longer hours, downloading an enormous volume of information into our hippocampi, and then finishing numerous A4 sheets of academic work. Examination related stress is like a toxic cherry on the stress-velvet cake. Thanks to the frequency of examinations and a cut-throat competitive environment, our mind remains busy playing with stressors.

Clinical stressors. The clinical stressors include being a witness to human suffering regularly. The clinical atmosphere is usually perceived by healthcare students to be tense and laden with negative critical attitudes of seniors. Being criticised in front of others, even in a subtle manner, is like a slow invisible poison that feeds into the psyche of these poor students.

Psychosocial stressors. Due to academic pressures, these students struggle to find a balance between their life at work/placements and life outside of work. The other psychosocial stressors include managing personal & professional relationships, as well as worrying about finances and the future.

These round-the-clock stressors predispose them to burnout as well as to a wide range of mental illnesses **(4,5)**. Sleep disorders are common among these types of students **(6)**. Not only do these stressors degrade their performance in academic and clinical areas but some of the overstressed students stop their healthcare studies **(2,7)**. What a tragic loss of human potential and resources! What if there was a solution to stop this silent suffering and increase the potential of healthcare students?

What is the solution?

Well, we need to think together as a system about changing some of the crucial things in the system which make things difficult for the healthcare students. We can’t behave like ostriches and put our heads in the sand to do mindfulness when the hunters (real-life modifiable stressors) are out there to get us. Yes, that is an ancient Roman myth and ostriches would die of asphyxiation if they do so, but it does make the point clear that real

modifiable things in healthcare studies and work need some modification to make studying in medical and related fields a smoother journey.

That being said, no matter how hard we try to keep things nice and easy, there will be times when one has to study for difficult & frequent examinations. There will be times when students of medicine or para-medical sciences will have to witness a human being dying. There will be times when life outside of work and life at work will be difficult to juggle with. And during these adverse situations, a particular human ability tries to keep one immune to the side effects of these academic, clinical, and psychosocial stressors. This super-power is called 'Resilience'. It is simply an ability to stay cool and calm in adverse situations and robustly bounce back from difficult circumstances.

A recent Cochrane review showed that there is evidence, although of very low certainty, that there is a positive effect of resilience training on anxiety, stress or perception of stress, besides actually boosting overall resilience, in healthcare students **(8)**.

One fine quality of resilience is that it is modifiable. Following are the 11 modifiable psychosocial resilience factors found in literature **(8)**:

- Purpose (or meaning) in life
- Active coping
- A sense of coherence
- Self-efficacy
- Positive emotions
- Optimism
- Religiosity (or Spirituality)
- Hardiness
- Social support
- Self-esteem
- Cognitive flexibility

So, now that we have got some factors that can be modified, the question is how to get healthcare students to have increased levels of these factors? People have used various strategies for modifying the levels of resilience during resilience interventions in healthcare students. These include:

1. Role-plays (simulations)
2. Practical exercises
3. Group discussions
4. Psychoeducation
5. Regular journaling or homework

The interventions are usually based on these five types of psychological approaches that have been tried and tested in healthcare student populations:

CBT - Cognitive-behavioural therapy **(9)**

- Modifying our thoughts about stressful (academic, clinical or psychosocial) situations into patterns, which are adaptive, produces better adaptive responses to high pressures.
- CBT skills-based interventions to foster resilience target these two resilience factors - (i). Cognitive flexibility, and (ii). Active coping **(8)**.
- Resilience interventions based on CBT skills help healthcare students challenge patterns that are maladaptive and produce healthier coping strategies.

Mindfulness-based therapy **(10)**

- Mindfulness is simply a state of awareness of the present moment without making a judgement.
- Healthcare students who practice mindfulness are good at adapting to stress as they become skilful at accepting things as they happen in the present moment

ACT - Acceptance and Commitment therapy **(11)**

- It is well known in the field of psychology that an inflexible mindset, especially during high pressure situations, can give birth to mental illnesses.
- Learning acceptance and commitment skills can foster resilience in healthcare students by making them adapt to stressful conditions in a better way. This is because individuals utilising ACT based skills are able to accept a rainbow of emotions.

Problem-solving therapy **(12)**

- In simple language, the strategies in this form of therapy suggest a clear principle - if we solve our problems in an effective manner, we can lower the adverse effects of stress associated with the problems.
- This way the effects of stressors on our emotional brain are mediated in a nice way.
- The resilience factor of 'active coping' is boosted by enhancement of positive orientation to problems as well as by strengthening skills of problem-solving.

Stress inoculation therapy **(13)**

- Stress inoculation therapy exposes people to milder versions of stress, thus, gradually amplifying coping strategies of a person.
- The type of resilience factor enhanced by stress inoculation therapy strategies is 'self-efficacy', by building confidence of a person in using healthy coping skills during stressful situations **(14)**.

The UK government recently announced that they are ready to spend three million pounds to close gaps between NHS services and universities which is an excellent move **(15)**. University students in general and healthcare students in particular, need services which intervene early, even before they are brought to the attention of the currently efficient Early Intervention Service in psychosis (EIS) teams. Psychosis is the marker of severity of mental illnesses. Treating the first episode of psychosis promptly and robustly is better when underlying mental illnesses are budding (psychotic depression, mania with psychosis, schizophrenia). However, we all agree that nipping the evil in the bud is excellent. Thus, an intervention before the EIS is warranted, and even setting up ARMS (At Risk Mental State) services can do this job.

Spending time, money and resources in preventive psychiatry through live workshops and robust technological interventions for high stress academic and job environments is vital. Hence, using interventions which focus on positively modifying resilience factors and building emotional intelligence in healthcare students will create a mentally robust workforce who are better able to look after other fellow humans. This is an altruistic investment the outcomes of which are sustainable and will benefit generations.

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My career journey- from MBBS to MRCPsych

By

Dr Sadaf Aleem, MBBS, MRCPsych, MSc in Psychiatric Practice, Speciality Doctor, Adult Community Mental Health Team, Hertfordshire Partnership NHS Foundation Trust

I have always felt very passionate about Psychiatry, and I wanted to take it up as a profession since the early years of my medical education. I am an oversees trained doctor, originally coming from Pakistan. When I came to this country, I learned that Psychiatry is practiced differently then back home. Through the years, my interest only started to grow and when opportunity came, I applied for training in this speciality.

I consider myself fortunate to have had supportive consultants to work with during my core training years. I had to apply for an extension of training due to maternity leave and health reasons and ended up doing three and half years of core training. The consultants I worked with during these years helped me grow both in personal and clinical spheres. I was very enthusiastic to take up any opportunity that came my way, be it deciding on medication and then discussing it with my seniors, to leading the ward rounds and actively making plans for discharging patients. I was appreciated for the hard work. I also understood the importance of being a team player and how to involve other specialties and departments when it came to effectively planning a care plan for the patients.

Due to family commitments, I was unable to finish my membership exams in the time period of being a core trainee; however, I wanted to continue to work in this speciality. As I had gained confidence in my clinical decisions over time, when, in the trust, the opportunity came for a job as a specialty doctor, I applied for it and I, fortunately, was successful in securing the post.

It was a different pace from being a trainee. As a trainee I felt very protected in every aspect of both patient care and my development. Again, I consider myself very lucky to have been working for one of the best consultant psychiatrists my trust has. It was reassuring to know that the consultant I was going to work for was respected for her sound clinical knowledge and judgement. In this role, initially, I felt that I was driving solo, even though I did enjoy the independence I had to make clinical decision and control my diary. For most of the time, I felt confident in my role, however, at times I felt insecure about certain managerial issues I was expected to solve. At the same time, I was also

trying to find my feet around the different aspects of CMHT (community mental health team).

Two weeks into the new post and my supervising consultant was off on annual leave. At that time, I was quite nervous as I had to allocate cases to the team and take a lead in clinical decision making. I took this challenge on and I was supported by the team members and mangers. It was later on that it transpired that my consultant had a very close eye on my work through my entries on the electronic patient records (EPR). It was a relief for me, considering I had just come out of a much-protected training post.

Another difference that I noted between a training and specialty post was the expectation of the nursing staff and other working colleague. I realized how important it is to show clinical confidence in my decisions. It was also very important to have clarity in care plans so that everyone involved understands their roles and responsibilities.

After six weeks into the job, I requested to have my first supervision just to calm the anxiety of working independently. I was relieved to know that my consultant was happy with my work.

During my post as a SAS doctor, the pandemic came upon us. This had thrown us in the land of the unknown. However, we all quickly became innovative and continued to work towards great patient care. Although we were working remotely, we were all still a very tightly knit team. The team became more resilient and pulled its weight through this difficult time. This time had its challenges in terms of staffing levels and sickness. Technology helped through this period and we were able to overcome some of these challenges. Things may never return to the normality as we had known it in the past, but I am hopeful we will all adjust to the new "normal".

This post has given me the perfect balance between work and home life. I was quite content and satisfied in my current role. Despite this, as I had to look after my personal development also, I never gave up on my dream to pass the MRCPsych exams. I continued to practice and revise. The Trust gave all doctors including specialty doctors the opportunity to take part in the weekly MRCPsych course. All the hard work finally paid off and I managed to pass my exams and applied for higher training which I will be starting in August 2022.

In my opinion if you are hardworking and show willingness to improve everybody works with you. It is also important to be inclusive of all the

team members when making important decision like sharing the risks and ask for help when needed.

I have been in this post for the last 4 years and I have grown in confidence as a clinician with every passing day. I feel respected and trusted by all team members, including senior colleagues. I believe, with humility, that I have grown as a psychiatrist and this is reflected in the feedback that I have received from my peers and senior colleagues.

Leaving this role has been a very hard decision to make, but I feel ready to accept the new challenges of the training programme and I do so with great enthusiasm.

In my journey from MBBS to MRCPsych, I have now a firm belief in what I once read- " The only constant in this life is Change".

A Retrospective Naturalistic Study Comparing the Efficacy of Ketamine and Repetitive Transcranial Magnetic Stimulation for Treatment-Resistant Depression

By

Dr Georgios Mikellides, MD, MRCPsych, CCT (UK) Consultant Psychiatrist, Director, Centre for Repetitive Transcranial Magnetic Stimulation, Cyprus rTMS, Clinical Assistant Professor, University of Nicosia, PhD Researcher, University of Maastricht, the Netherlands

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Lilia Psalta, PhD, Lecturer in Psychology and course leader of MSC Forensic Psychology, University of Cyprus

Panayiota Michael, Clinical and Research Assistant at Cyprus rTMS

Depression is a common mental disorder that affects many people worldwide, while a significant proportion of patients remain non-responsive to antidepressant medications. Alternative treatment options such as ketamine therapy and repetitive transcranial magnetic stimulation (rTMS) therapy are offered nowadays. To the best of our knowledge, there is no study comparing the effectiveness of ketamine and rTMS in

patients with depression in a naturalistic setting. Only a limited number of alternative non-pharmacological treatments for TRD are available today and more research is needed to directly compare a non-pharmacological treatment with a pharmacological treatment in terms of their efficacy and tolerability.

In this study, we exploratively describe and compare the acute antidepressant efficacy of both, 8 sessions of intramuscular ketamine administered twice weekly for 4 weeks, as well as 30 sessions of left DLPFC-iTBS (over a period of 6 weeks) in depression patients seeking help in a naturalistic clinical mental health setting. While the iTBS protocol is FDA approved and by now a widely used method for the treatment of TRD in clinical practice, the potential use of IM ketamine in TRD has not been extensively researched and therefore is not widely used. This comparative study is important in order to point out that more research need to be done in this area and in order IM ketamine to be considered for FDA approval for TRD. Thus, the present study aimed to indicate for first time the potential of IM ketamine to reach similar effects in TRD as rTMS in shorter duration (less visits).

A retrospective comparative study was conducted which included clinical records of TRD patients, as collected from the clinical database of Cyprus rTMS Center. The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008. All procedures involving human subjects/patients were approved by Cyprus National Bioethics Committee (ΕΕΒΚ/ΕΠ/2019/08) and written informed consent was obtained from all patients. Clinical records of twenty-four patients with treatment resistant depression who were referred to the Cyprus rTMS Center in the period of January 2018 to August 2021 and received either IM ketamine or rTMS as treatment for depression were included in this retrospective comparative study. During the clinical evaluation for treatment purposes, all patients were assessed using the ICD- 10 Classification of Mental and Behavioral Disorders and met the criteria for either moderate depressive episode or severe depressive episode without psychotic symptoms. All patients were on psychotropic medication (such as Sertraline and Venlafaxine) before, during and after the study. The Cyprus rTMS Center commonly offers both treatment options, IM ketamine and rTMS, to the patients. Treatment options were discussed with patients and literature findings were explained to them. Then, patients chose the treatment option (IM ketamine or rTMS) based on their preference. Twelve patients were treated with IM ketamine and twelve patients were treated with rTMS therapy using the iTBS protocol. An experienced psychiatrist and a TMS technician performed the rTMS treatment. Patients were reviewed

regularly by the treating psychiatrist, every few weeks. The psychiatrist had regular contact with patients, weekly during the sessions of rTMS or ketamine, as well as a formal monthly review. Depression and anxiety severity were measured prior and after the completion of each treatment using clinician-rated and self-rated assessments (Hamilton Depression Rating Scale, HDRS; Hamilton Anxiety Rating Scale, HAM-A; Beck Depression Inventory II, BDI-II). The time between the two assessments (pre and post treatment) was not the same for both groups, as IM ketamine treatment was completed after 4 weeks and rTMS treatment was completed after 6 weeks. Patients thereafter followed an individual treatment plan, which may or may not, include maintenance and there was no relapse in their mental state for the following 4 months based on psychiatric reviews, no formal questionnaires were given. The criteria for inclusion of patients' clinical records in the study were: (1) patients aged 18 years and older, (2) patients meeting the criteria for either moderate depressive episode or severe depressive episode without psychotic symptoms, (3) patients not experiencing any significant clinical improvement from at least two different methods of antidepressants and (4) the existence of completed clinical evaluations prior and post treatment. The exclusion criteria were: (1) patients aged younger than 18 years and (2) mental objects or implants in the brain, skull or near head (e.g., pacemakers, metal plates). Demographic (age and gender) and depression severity (duration of current episode, number of episodes, duration of depression, number of unsuccessful antidepressants tried in current episode) data were collected. Both groups were being compared for relevant parameters (age, gender, depression severity) to ensure that they are not fundamentally different. Essentially, the only difference between the two experimental groups was the treatment method that they had received.

In the *rTMS treatment condition*, stimulation was performed using a MagPro X100 stimulator (MagVenture, Farum, Denmark) and a figure-of-eight coil (Cool-B65). Prior to stimulation, the individual resting Motor Threshold (rMT) was estimated over the left primary motor cortex (Mean = 50.25, SD= 4.03). The rMT is the amount of machine output (intensity) required to elicit a motor-evoked potential (MEP) in at least 50% of all attempts. Five iTBS sessions were administrated per week for 6 weeks, over the left DLPFC. To localize left DLPF, the software Beam_F3 Locator, an efficient and accurate method to mark the F3 position according to the 10-20 EEG system was used. Stimulation intensity was set at 120% of the rMT. The stimulation coil was placed at a 45◦ angle off the midline. iTBS was administrated at 5Hz and each session included 20 trains with 8 s inter train interval (triplets of 50Hz). A total number of 600 pulses was given per session for 3:08 min.

In the *ketamine treatment condition*, intramuscular ketamine was administrated twice weekly for 8 sessions. In the first session, patients received a dose of 0.25 mg/kg, and then the dosage was titrated upwards, to a maximum of 1 mg/kg by session 4, depending on patient effect and safe vital sign assessments in order to achieve the maximal antidepressant effect. All the necessary requirements were followed: ketamine was administrated by an experienced physician, the patient was monitored for 2 h after the administration under control settings and any side effects were recorded. The administration took place in a private room specially designed for the purposes of the treatment.

To our knowledge, this is the first study describing the effectiveness of both, ketamine treatment and rTMS treatment, in depressive and anxiety symptoms of MDD patients in a naturalistic real-life setting. Using three clinical assessments (HDRS, HAM-A, BDI-II), our data reveals that both therapies led to significant improvement in symptoms from pre to post-treatment. Based on the HDRS, in the Ketamine group, 33.3% were responders and 66.7% were remitters and in rTMS group, 25% were responders and 66.7% were remitters. Based on HAM-A, in both experimental groups, 25% were responders and 75% were remitters. Finally, based on BDI-II, in Ketamine group, 25% were responders and 58.3% were remitters and in rTMS group 8.3% were responders and 75% were remitters. An explorative post-hoc direct statistical comparison indicated that ketamine therapy did not differ significantly from rTMS therapy with respect to pre- to post- depressive and anxiety symptoms, indicating that the effect of both experimental groups in our sample was equally effective. In line with this notion, statistical χ^2 tests showed that there were no statistical differences between the patients of ketamine group and rTMS group in remission and response rates. These results indicated that IM ketamine therapy has the potential to reach similar effects in patients with TRD as rTMS therapy in a shorter treatment period as less visits are needed to complete the treatment. No significant side effects were reported from either the rTMS group or the ketamine group. The results support the preliminary effectiveness of the treatments and adds to the existing literature regarding the efficacy of both treatment options in depression. Although there are many studies regarding the efficacy of ketamine in depression, the research in IM ketamine remains limited. There are only a few case reports that demonstrated the potential effectiveness of IM ketamine in depression, therefore the optimal use of IM ketamine warrants further investigation.

Whereas previous research suggests that a combined treatment by ketamine and rTMS is an effective and long-term treatment for depression, the present comparative study represents a first attempt to describe and exploratively compare both treatment options as standalone

therapies in a naturalistic setting. It is important to consider the limitations of our conclusions here. The current study is a retrospective comparative study with no a priori randomization and a very limited number of patients. Small sample sizes usually undermine the internal and external validity of a study and affect the generalizability of the results. Especially for statistically comparing the effectiveness of two treatment options (clinical inferiority trial), a much larger same size would be needed. Another main limitation is the retrospective design of the study. Specifically, this study was based on data of patients with MDD, who were referred to the Cyprus rTMS Center in the past and received either intramuscular ketamine or rTMS as treatment for depression.

Therefore, the patients were not randomly divided into these two experimental groups and no sham control groups were used. Finally, this study suffers from sample selection bias. A larger number of patients was treated with either IM ketamine or rTMS in the Cyprus rTMS center during that period, but we chose to include only patients who completed the total number of sessions required (rTMS: 30 sessions; Ketamine: 8 sessions) and patients with completed clinical evaluations prior and post treatment in our analysis. Unfortunately, we did not collect information about the number of patients with incomplete clinical evaluations prior or post treatment and the number of patients who terminated treatment prematurely. Thus, we selected only completers from a larger sample of patients of unknown size. Despite these limitations, this study could serve as a starting point for identifying and comparing the efficacy of these two depression treatments in a real-life clinical setting.

Future research should further develop and confirm these initial findings by comparing the efficacy of ketamine treatment, rTMS treatment and the combination treatment in depression using a randomized, double-blind, sham-controlled clinical trial sufficiently powered to also reveal potential non-inferiority. Furthermore, clinical assessments should be collected weekly in order to investigate whether there are differences in response time between the treatment groups. In a future study, a follow up measurement is needed to examine and compare the long-term efficacy of these treatments. To the best of our knowledge, this comparative study was the first that directly compare the efficacy of rTMS and IM ketamine, a non-pharmacological treatment, and pharmacological treatment for TRD. Finally, our results showed that the iTBS protocol, which has received FDA approval for MDD, and IM ketamine, which is not an FDA approved treatment for MDD, are equally effective treatments. This is an important finding as IM ketamine treatment is not widely used in clinical practice and can be administrated in a shorter duration compared to rTMS. Further research with more focus on the use of IM ketamine treatment in depression is therefore suggested, which may allow this

treatment to gain formal approval and a wider acceptance in daily practice.

For the full article please click the following link:
https://www.frontiersin.org/articles/10.3389/fpsyt.2021.784830/full

Improving communication between the medical team and families on Holbrook dementia intensive care unit

Contributors:
Dr Su Ying Yeoh (CT3 doctor)
Dr Latha John (Specialty doctor)
Dr Merline Muthukumar (FY2 doctor)
Dr Neha Hodrali (FY2 doctor)
Dr Garima Jain (Consultant psychiatrist)
Dr Abimbola Fadipe (project supervisor; Medical Director of Oxleas NHS Foundation Trust)

Background

We are undertaking a Service Development project on improving communication between the medical team and families on Holbrook ward, Woodlands Unit, Sidcup. Holbrook ward is a 23-bed mixed-sex dementia intensive care unit within a psychiatric setting for patients with challenging behaviour in the context of dementia.

The idea behind this project came about after the first wave of the pandemic, when there was a high mortality rate amongst our elderly patients from Covid-19 and families were no longer allowed to visit the ward. Doctors had less face-to-face contact with families and fewer opportunities to provide them with updates. As Covid restrictions eased throughout 2021, the ward did not quite return to pre-Covid status in terms of communication with families, as families were not attending the ward round in person because of repeated outbreaks of Covid on the ward.

Feedback from carers' surveys from this time showed that families generally felt they would have liked to speak to the doctors more frequently, particularly as they were not seeing their relatives as often due to visiting restrictions. Families specifically felt that they were not adequately informed about their relatives' treatment plans, medications, and the discharge planning process.

In light of this feedback, since February 2022 we have trialled an intervention to ensure that doctors on the Holbrook ward communicate more frequently and consistently with patients' families.

Aims

1. We aimed to speak to each patient's family within the first 2 weeks of admission, gain their perspective and collateral history, and establish a point of contact.
2. Families were invited to a multi-disciplinary Welcome to the Ward meeting in person within the first month of admission, attended by doctors and the therapy team.
3. Families were invited to ward rounds over Microsoft Teams with the care co-ordinator on a regular basis, ensuring that there were good links with the community team.
4. We aimed to update families on at least a monthly basis: in person on the ward, over the phone, or through Teams meetings.

We asked permission to share information with families where patients had capacity to make this decision. For patients who did not have capacity, we shared information with family members under the patient's best interests.

During these conversations, we aimed to discuss the patient's diagnosis, medications, treatment plan including psychological approaches, legal status (DOLs or Mental Health Act) in a way that was accessible for relatives to understand, and to provide them with opportunities to ask questions. We also aimed to inform families promptly in the event of a significant change in their relative's mental or physical health.

Family members were offered 1:1 psychological support for carer fatigue if required, by referral to the ward psychologist. We also discussed discharge planning with families; explaining the process and ensuring that their views were heard and that they felt involved.

Methods

We are in the process of collecting feedback from families through feedback questionnaires (see Appendix below), looking at whether they felt these aims were met in our communication with them. Preliminary results from 3 feedback questionnaires have been very positive; expressing gratitude towards our team for ensuring that they were kept informed of developments in their relative's progress.

Discussion

Studies have shown that good communication between the medical team and families has many benefits and enhances the standard of patient care. A qualitative study looking at communication with families towards the end of life showed that families felt empowered when a mutual

understanding of their relative's condition was achieved with healthcare professionals, helped them make informed decisions with the patient, and overall led to higher rates of satisfaction with patient care [1]. A study on evaluating families' perceptions of care on a specialised medical and mental health unit compared to those on standard acute medical wards found that an integrated approach to physical and mental health resulted in families feeling more informed [2]. On our dementia psychiatric ward there is a significant interface between physical and mental health, and this has been a key element in our conversations with families.

As clinicians, it has been a valuable experience to form therapeutic alliances with families, particularly when it is challenging to communicate verbally with our patient group who have advanced dementia. Families have provided a window into the patient as a person and helped us get to know them; their premorbid personality, interests, and life before they had dementia. At times, it has been quite moving to speak to them about this.

Going forwards, we will continue to collect feedback until mid-July 2022 to evaluate the impact of these changes and we will take families' suggestions into consideration when thinking about how to further improve our communication with them.

References:

1) Communication between family carers and health professionals about end-of-life care for older people in the acute hospital setting: a qualitative study
Glenys Caswell 1, Kristian Pollock 2, Rowan Harwood 3, Davina Porock 4
BMC Palliative Care 2015 Aug 1;14:35. doi: 10.1186/s12904-015-0032-0

2) Delivering dementia care differently- evaluating the differences and similarities between a specialist medical and mental health unit and standard acute care wards: a qualitative study of family carers' perceptions of quality of care
Spencer K, Foster P, Whittamore KH, et al BMJ Open 2013;3:e004198. doi: 10.1136/bmjopen-2013-004198

Appendix- feedback questionnaire

Feedback questionnaire for Families on Holbrook ward

Did the ward doctors get in touch with you within the first 2 weeks of your relative's admission?

Yes	No

Were you invited to a Welcome to the Ward meeting within the first month?

Yes	No

How often did you speak to doctors (either on the ward, over the phone, or in ward round)?

At least monthly	Every 2-3 months	Infrequently, less than every 3 months	Never spoke to doctors

Did the doctors inform you in a timely manner if there were major developments or changes in your relative's condition?

Yes	No (please provide further details)

Tick if the doctors discussed the following topics with you:

Diagnosis	
Medication, including covert medications and side effects	
Treatment plans	
Legal status on the ward (DOLs / Mental Health Act)	
Discharge plans	

Did you have the opportunity to ask questions, and have them answered by the medical team?

Yes	No (please provide further details)

Overall, how satisfied are you with the medical team's communication with your family?

Very happy	Satisfied	Neutral	Unhappy	Very unhappy

What was good about the way the medical team communicated with your family?

Do you have any suggestions on improving doctors' communication with families?

Thank you very much!

The Holbrook ward team

- *Dr Su Ying Yeoh*
- *Dr Latha John*
- *Dr Merline Muthukumar*
- *Dr Neha Hodrali*
- *Dr Garima Jain*
- *Dr Abimbola Fadipe*

Is General Adult Psychiatry in Need of a Makeover?

By

Dr Kate Lovett
BSc, MBChB, MSc, FRCPsych, Cert Clin Ed (Dist), Presidential Lead for Recruitment and Immediate Past Dean, Royal College of Psychiatrists, Consultant General Adult Psychiatrist, LivewellSW, Plymouth

One of the many joys of my 20 years as a consultant general adult psychiatrist has been supporting several generations of trainees coming up behind me. It has spurred me to take on local and national educational leadership roles. But balancing the demands of additional roles alongside busy clinical jobs is not straightforward. Being away from the clinical job is hard work and critically, requires the availability of colleagues able to cover.

20 years ago, I published an article in the Psychiatric Bulletin (1) entitled "Time for cognitive reframing – becoming a specialist in adult psychiatry". In it, I challenged the ennui I saw in the specialty. I argued that we needed to develop a strategy for improving our self-perception, to create manageable jobs, and define and celebrate our specialist skills. I touched on the importance of well-being and suggested we move beyond the newly introduced 360 appraisals to reflect on ourselves as rounded human beings and consider our lives and relationships outside of work too. I argued that like Cinderella, we had already received an invitation to go to the ball, being at the heart of government reform with the National Service Frameworks in England.

Twenty years on, I find myself a former college Dean and Presidential Lead for Recruitment. Having spearheaded the college's #ChoosePsychiatry campaign, which has helped us get to 100% recruitment to core training over the last 2 years, it is now time to turn our focus on how we produce the specialists we need in psychiatry. The last college census highlighted the shortfall in our specialty (2). Whilst we don't have the biggest percentage of consultant or SAS vacancies nor the biggest percentage shortfall in terms of recruitment to higher training (3), we undoubtedly head the leader board in terms of overall numbers. Of the 726 identified consultant vacancies in psychiatry in 2021, 56% of these were in specialties and subspecialties linked to training in General Adult Psychiatry. And 305 (42%) of these vacancies were in adult inpatient, crisis, and community mental health team settings.

Recently, a forensic colleague posted a meme on social media. It was of President Macron in four different poses and variously wearing a polo neck, hoodie, open necked shirt and buttoned up shirt and tie. "Older Adult Psychiatry, Child and Adolescent Psychiatry, Forensic Psychiatry and General Adult?" the post quipped. The proposed general adult version of Macron was in a shirt and tie grasping his head in despair.

Over the course of my career, I have trained over fifty psychiatrists. But I struggle to think of many who followed my footsteps into general adult psychiatry. They have told me they enjoyed working with me and learnt a lot. But the fact remains that I have been much more successful in producing liaison psychiatrists than adult psychiatrists.

There is a dearth of research which helps us understand what influences career choices amongst core trainees. Multiple factors are likely to be at play including perceptions of life-work balance, commissioning arrangements, perceptions of manageability of consultant workload, status of specialism versus generalism, opportunities for sub-specialisation, stigma, level of service investment, financial rewards, personal interest, stereotyping, experience of and exposure to the specialty as well as perceived identity fit and opportunity.

We will all have our hunches about what the push/pull factors are for the specialty, but we need to understand these much better, before we can start to systematically tackle our recruitment problem. As Dean I quickly recognised that improving training was not the solution to recruitment in psychiatry. What is critical is for trainees to be able to see a sustainable future ahead of them when they look to consultants and SAS doctors already in the role.

The College's recruitment strategy "Continuing to Choose Psychiatry" is shortly to be published and will define all our recruitment efforts over the next 5 years. Part of our challenge will be in communicating what a general adult psychiatrist is and does across the four nations of the UK. We often can't agree amongst ourselves and may need external help. But 20 years on I remain optimistic. General adult psychiatry has allowed me to develop strong therapeutic relationships with my patients; it has allowed me to develop expertise in conditions that manifest themselves in this phase of life and has helped me get good at supporting people through the important transitions of adult life.

Swami Vivekananda, the Hindu philosopher once said, "Relationships are more important than life, but it is important for those relationships to have life in them." General Adult Psychiatry surely is all about developing relationships with people who come to us for help to support them have

life in theirs. However, how we communicate that, is arguably one of our biggest current challenges.

References:

1) Lovett, K, F. (2002) Time for Cognitive Reframing – Becoming a Specialist in Adult Psychiatry. Psychiatric Bulletin 26, 9, 354 – 355 https://doi.org/10.1192/pb.26.9.354

2) Royal College of Psychiatrists Workforce Census 2021 Our workforce census (rcpsych.ac.uk) (accessed 17/5/22)

3) Health Education England North West August 2021 fill rates for website.pdf (nwpgmd.nhs.uk) (accessed 17/5/22)

Working across colour, psychiatry, and survivor lines in mental health

By

Dr Colin King

Background information

Current solutions to address the over-representation of ethnically diverse, (black Caribbean, African and British) communities in the mental health system are based on changes to the legislation, cultural competencies, peer group working and improvement in community services. The issues of how psychiatry and mental health professionals understand race and the experiences of diverse communities is important (crucial/key) knowledge that informs their practice in making shared decisions which have not been meaningfully considered. More specifically the culture, values and behaviours needed for race equality within psychiatric training to address joint lived experienced models are largely ignored.

Aims of the work

1. To look at the shared values that psychiatrists and mental health survivors bring to their relationships in a range of mental health settings.
2. To look at the potential for developing shared meanings and approaches, (models) for working across the lines of race, psychiatry, and mental health survivors to improve shared decision-making – with a focus on Review of the MHA and the Mental Health Use forces to develop a Seni Community Empowerment framework.
3. To produce a range of self and joint reflective tools and videos of engagement to improve the dynamics between psychiatry and mental health survivors with a particular focus on race and intersectionality.
4. To look at how joint models, values and behaviours can inform a new lived model of Anti-racism and accountability through coproduction.

Methods and its Aims

1. Sample of psychiatrists – National Clinical Lead, Organisational Clinical Manager, and a sample of Consultant Psychiatrists and ethnically diverse service users.
2. Individual and focus group Interviews focused on values, identities, perceptions, and behaviours to develop shared empathy and respect.

3. To develop, enable and empower psychiatrists and mental health survivors to look at the components of what makes good open decision-making relationships.
4. To develop a framework of shared meaning in a range of mental health settings.
5. For the video content to be edited with reflective feedback from participants to decide on the models, and changes in practice needed for working across lines of colour and psychiatry and mental health survivors from the pre-production to the co-production stage.

Shared meaning outcomes

1. Video will be linked to a current mental health training – Lived experience module
2. It will incorporate a good practice guide on developing a lived experience model in shared decision making within a racialised lens.
3. To develop a race equality framework on incorporating race equality from a lived experience model in a range of decision-making processes – Assessment – clinical decision making processes and Care Management
4. Developing a Seni Lewis Empowerment Community Framework.

Work and Film Planner

Session 1. Interview Professor Tim Kendall – April – How this work can compliment the NHS mental health race equality program. April 2022.

Session 2a. Interview Jon Van Niekerk – February/March Feedback first interview – Second interview. Revise questions. Cygnet Health Premises.

March 2022

Jon interview
1.5hr block of time needed

30 mins Set up cameras
25 mins Interview Part 1
10 mins Short break
25 mins Interview Part 2

Psychiatrists group discussion
1.5 hr block of time needed
30 mins Set up cameras
25 mins Discussion Part 1
10 mins Short break

25 mins Discussion Part 2

Session 2b. Focus group interview with Cygnet Psychiatrists. March 2022

Session 3. Focus group interview with Billy Bola Clinical Lead Wandsworth – Professor Sashidharan, Ajibola Lewis, Young person (Umi Marke-King), member of SU group at EMHIP Premises. May 2022.
Session linked to . Linked EMHIP Expert Research -shaping the Clinical Encounter – Linked to Lived Expert Reference group research -
Cross reference key intervention – Cultural Competencies.

Interview and Focus group Questions

1. What are the challenges for improving the relationships between psychiatry and the black community?
2. What are the challenges for psychiatrist in the interface with black men to improve trust and respect in the Mental Health system, in the following areas?:

- The role of psychiatry- in black people's lives and the black community
- The role of psychiatry in black men's life from outside the MH system to inside the MH system

3. How do you face these challenges in your life as a psychiatrist from personal experiences, your training into work in relation to the following – life experiences, values, and the constraints of your duty.

Questions from the interviewee' to be obtained.

We would like the interviewees to bring their own questions to the discussion. This will help form the shared dialogue and honour the values of coproduction.

Future work:

- Edit film and receive feedback before second edit
- Final edit.
- Launch Black History Month October 2022

Dr Colin King is a valuable member of the Rcpsych GA Faculty Co-production Steering Group and Co-production Network.

Dr King will also co-author the General Adult Faculty Co-production Guidance Toolkit alongside Dr. Jon Van Niekerk, Jacquie Jamieson, and

the other members of the GA Faculty Co-production Steering Group, namely:

Raf Hamaizia
Lisa Archibald – Intentional Peer Support
Hollie Berrigan – Beam Consultancy/Emergence Plus
Keir Harding – Beam Consultancy
Kate Gravett
Samantha Holmes - Rethink
Paul Gilluley
Dominic Fannon
Lida Panagiotopoulou
Natasha Berthollier
Rex Haigh
Phil Morgan
Mark Dalgarno
Rick Dyer

Link to video summary which outlines the aims of the work:
https://youtu.be/Sw8W2VULy-Y

If interested in the project, please contact Dr Colin King on cbking@hotmail.co.uk

What psychiatrists could expect from the latest NHS transformation

By

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Context

During the Covid19 lockdown, NHS England (NHSE) submitted proposals for transforming how community mental health is delivered in England[1], alongside a white paper proposing community integration between health and social services[2]. NHS services will now to be overseen by 'Integrated Care Systems' (ICS's) typically covering the old health authority regions, with Clinical Commissioning Groups (CCG's) being dismantled. Instead of CCG's, local accountability would be through Primary Care Networks (PCN's) covering around 30,000 people, typically involving 5 GP practices.

Secondary mental health services have been emerging from Covid19 restrictions with extended waiting lists and some exhausted staff [3] through redeployment to unfamiliar roles, getting used to remote working and from moral injury accrued by being unable to provide the usual quality of care. On governance, it is likely that this proposed transformation will be put in place before the 'lessons to be learnt' inquiry as to how NHSE dealt with the pandemic; especially in relation to marginalised groups such as elderly in care homes, non-Caucasians in low pay jobs and women at risk of domestic violence.

Regards funding to cover transformation, 12 ICS (all in the south of England apart from Humberside) will receive £70 million each as pathway projects[4], with remaining ICS's expected to commence transformation based on funding already allocated, i.e., no 'new' funding in the short term. In the longer term, £1 billion per year is to be allocated and 'spent by' 2023/24 across the whole of England; compared to the £37 billion spent on NHS test and trace programme to alleviate the pandemic[5].

Practicalities of transforming community mental health care

1. Senior nurses (typically Band 7) working in adult and older adult community mental health teams (CMHT's) are already being redeployed to large general practices as triage nurses. Their purpose would be to scrutinise referrals (for example 'frequent attenders') and signpost to appropriate agencies including the third sector.

Furthermore, they would be expected to coordinate physical healthcare of patients with Severe Mental Illness (SMI) on practice case registers in keeping with objectives of transformation[4]. It is anticipated that this will reduce the burden of excess referrals to secondary care and to assist GPs with psychosomatic patients and with SMI physical healthcare.

However, lessons from a similar undertaking in the late 1990's (via the Sainsbury Centre for Mental Health) seems to have been forgotten. The basic problems then were General Practitioners (GPs) dropping their 'gatekeeping' role and forwarding many more referrals for triage, coupled with the lack of supervision and access to peer support for the triage nurses. This led to triage nurses being overwhelmed by referrals, not having time for documentation and, typically between 12 – 18 months, seeking other posts due to becoming burnt out. In the meantime, CMHT's remained short of experienced nurses to oversee complex patients under the care programme approach (CPA).

2. It is anticipated that the supervisory and support roles for Triage Nurses will be picked up by consultant community psychiatrists in addition to responding to calls from General Practitioners (GP's); via an electronic system such as Consultant Connect. The likelihood is that Band 7 requests for advice from consultants would entail prolonged discussions involving diagnostic / risk / capacity formulations as well as decisions whether to proceed to referral to secondary care. Previously GPs referred 5-10% of people with mental health issues, but with ready availability of practice based mental health nurses, a band 7 could receive 15 – 20 referrals per day. Consequently, the time an adult or old age consultant would require responding to GP and Band 7 calls could rapidly escalate, limiting time required for more complex (and risky) patients in the community with psychoses, complex trauma, and dementias.

White Paper Integrating Health and Social Care

1. The white paper essentially has 2 components. The first gives permission for the secretary of state to 'direct' how secondary mental health services work with social services, acute hospitals and third sector (including for profit providers). Although this might be an efficient 'command and control' system, there is reduced opportunity for local flexibility based on experience of consultant staff; often carriers of 'organisational memory'.

2. The second aspect of the white paper is the comprehensive collection of data (both process and outcome) of all providers of health and social

care. This data will be collated by NHS Digital and passed on to university researchers as well as to the Cabinet Office, Communications and possibly to security services through the 'Prevent' and hate speech initiatives. This might cause both psychiatrists and their patients' difficulties with potential loss of mutual trust.

3. Machine learning will be used to analyse data to assist the 'directives' of the Secretary of State. It is proposed that the 'opt out' clause allowed to each NHS user will be withdrawn to gather data on Covid delirium, Long Covid and effects of vaccines. Data analysis would also identify 'failing' departments and community services, allowing competition from other local (possibly commercial) providers, as contracted by each ICS. Examples include services managing treatment resistant depression, early onset psychoses and personality disorders.

4. Furthermore, the white paper does not place restraints on the emerging phenomenon of large general practices being sold to health insurance companies based in North America. Currently, London and the West Midlands have seen this type of 'privatisation'. Essentially, this is a return to 'GP Fundholding' also seen in mid to late 1990's, which created inequity in provision of secondary care services, with patients covered by big fund holders having rapid access to consultants. It is unlikely that ICS managers will be able to withstand the corporate and legal firepower of these entities.

Conclusions

In essence, transformation involves community psychiatrists moving from working into CMHT's to working into Primary Care teams, without the necessary basic trust being in place. It feels as if lessons from 20 years ago have not been learned specifically relating to placement of triage nurses in primary care without supervision and support. This coupled with transfer to remote working and the ever-increasing demand from an aging population will cause major workload pressures for community psychiatrists, who might, in effect, have to work from a call centre (called hubs) for substantial proportions of their clinical time.

My overall concern is on the rapid implementation of another transformation without pump priming finance or much consultation with community psychiatrists. Potential pitfalls of rapid transformation need consideration, based on previous experience. The second danger is consequences of primary care privatisation (quasi fundholding) leading to issues of quality and equity. Finally, I have serious concerns of 'data transparency' to funding organisations, as this has implications on what

patients are prepared to disclose to their psychiatrist, and what the doctor decides in return.

References:

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Transforming Community Services in NorthEast London- Making A Lasting Change

By

Dr Russell Razzaque, Consultant Psychiatrist, NorthEast London NHS Foundation Trust

Transformations come and go. In fact, if you have been in the NHS mental health system for any length of time you are likely to have come across a few of them. I have been a consultant psychiatrist for nearly 20 years and I think I have lived through about a dozen. I recall a colleague, some years ago, describing the frequency of service change as a form of manic defence against the fear that perpetually sloshes around our system. So why, then, did I take on the role of Clinical Lead for the Community Mental Health Transformation (CMHT) in my Trust? The reason is that, this time, I believe it is different.

When reading the CMH Framework document a couple of years ago, a realisation started to dawn on me. What was being proposed was not just a structure change but a culture change too. The document advocated reducing the number of teams in order to lessen the number of hand-offs between services and improve continuity of care. It suggested this was done for a reason; to enable the cultivation of more meaningful relationships with patients. This would, in turn, serve to make services more trauma informed and connected to the social determinants of illness and care.

These are areas that I have spent over a decade researching. In 2014 I published a paper around a survey I conducted among the general public, in which we asked them what they saw as the most important aspect of good mental health care, and a consistent relationship with their clinicians ranked at the top of the responses. Just before the pandemic, I published a report for the RCPsych, when I sat on the General Adult Faculty Executive, in which we surveyed the different models of care across the country and asked colleagues what they thought were the different pros and cons of each model. Again, the most consistent response was that colleagues operating in more functionally split models regretted most of all the fact that their work lacked continuity of care. Clearly, this is something that is desired by all.

My prime initiative in NELFT's CMHT, therefore, has been to bring our different layers of service together and form smaller more localised, neighbourhood teams, based around Primary Care Networks. Instead of patients being moved from one team to another, they will now remain in

the same service throughout their care pathway. This was the structure change. To bring about deeper level change, however, we also needed to train staff around engaging more meaningfully with patients to bring a focus to their therapeutic relationships. To bring this about we have been rolling out trauma informed care training as well as aspects of Open Dialogue training – for a more systemic and holistic approach to care. The majority of our staff in the new teams will have trained this way by the end of the Transformation and we aim to institute a regular cycle of team development and learning as the new ways of working grow and bed in over time.

Our Primary Care Mental Health Workers have also been brought onto these trainings so that, again, their role doesn't just represent a structure change, but a culture change too. Some 3rd sector partners that we have commissioned also dovetail this approach, helping to build more self-help therapeutic groups in the community as well as working with us to bring in the first major tranche of peer workers into our Trust.
Challenges exist, of course, on all of these fronts. Our Trust is undergoing a steep learning curve to welcome peer workers, properly understand their roles and create a safe environment for them to thrive in. The recruitment of Primary Care Mental Health Workers has been followed by a period of substantial adjustment too, as we help a sizeable tranche of professionals adjust to life in primary care with its wholly different schedules and demands.

All of it is therefore a work in progress, yet it is my believe that with a firm focus on the changes in both structure as well as culture, we will truly be able to deliver some real improvements in patient care in our part of the world.

He Died Waiting – A Values-based Learning Resource

By

Caroline Aldridge, social worker, author and mother

Chatty, clever, quirky, kind, and funny, Tim was a young man who was chaotic and, as his brother described him, 'beautifully crazy'. The emergence of psychosis during Tim's adolescence, and his life from leaving home into adulthood, was a 'roller-coaster' of vibrant, emotional, joyful, sad, and humorous moments. The highs and lows, of poorly managed bipolar disorder that would morph into a dual-diagnosis, led to an inevitable 'knock at the door' and Tim's death in harrowing circumstances in 2014.

In 2020, I published a book about Tim, who was my eldest son. *He Died Waiting: Learning the lessons – a bereaved mother's view of mental health services* is based on my experiences as a mother and as a social worker. It is a useful resource, based on lived experience, for anyone working in the field of mental health. It was written in the hope of changing hearts, minds, and practice. My aim in writing *He Died Waiting* was not to blame or alienate people but to prompt readers to take a critical look at what might be happening in their locality or area of practice.

What happened to Tim, happens across the nation because the crisis in mental health services seems to escalate with every passing year and there are lots of people like Tim.
He did his best to survive in a society that does not seem to care enough. The support that he had from mental health services was dire. Tim was never the 'right kind of ill' for the services on offer. Either he was very unwell, and too frightened to accept help, or he was deemed too well to merit support. He acquired labels such as 'not motivated to change' or 'difficult to engage' as he slipped quietly between the gaps in fragmented services. Like many other people with mental illness, he joined an endless waiting list. He died waiting for an appointment.

Bereavement compelled me to navigate the bewildering and brutal 'system' that I found myself in as a bereaved relative. What happened after Tim died, compounded the trauma of my grief. I discovered a silent army of bereaved relatives whose loved ones died in similar circumstances to him. Most of these deaths fall under the umbrella of

'special deaths' because of the stigma experienced by the deceased or bereaved people, the traumatic nature of the death, and the likelihood of disenfranchised grief (Holloway, 2004). It is commonplace for bereaved relatives to endure emotionally heightened, protracted and trauma-compounding processes, such as inquests and investigations. However, there is very little research evidence about the experiences and needs of people bereaved due to the mental illness of a loved one. Those who struggle to process their grief following these mental-health-related bereavements can be further traumatised by being misunderstood and sometimes "pathalogicalised".

For me, what was missing from Tim's care, the way I was excluded as his carer, and treated after his death, is values-based practice. Compassion, kindness, and empathy seemed in short supply. The mental health trust responsible for Tim's care were my employers when he died. I asked them to use my unique position, as a mental health practitioner with an understanding of the pressures on services *and* a bereaved parent and work with me to 'learn lessons' from Tim's life and death. Nearly seven years later, the publication of *He Died Waiting* finally created the opportunities for me to collaborate with my local trust (and other trusts) and share my personal and professional wisdom.

I was surprised and pleased by how well *He Died Waiting* was received, and I received hundreds of emails and messages from across the UK from people who had experienced similar things. In September 2021, I resigned from my substantive post as a social work lecturer and decided to follow where Tim's story was leading me. As a freelance trainer and speaker, I am privileged to be invited to work with students on degree programmes and practitioners across health and social care in spreading the message about values-based practice.

I feel it is essential that everyone involved in mental health services is open to hearing about the experiences of people who use services, their carers, and those who have been let down by services. With that in mind, a sequel, which is co-edited by a colleague with experience of mental health nursing and should be published soon, to complement my story. *They Died Waiting: The Crisis in Mental Health -Stories of Loss and Stories of Hope* is a collection of stories that will provide a unique insight into the needs of people who are traumatically bereaved due to their loved one's mental illness. Many find themselves requiring support with their mental health or even at risk of suicide. It contains voices that are seldom heard and will be another rich learning resource.

Despite the emotive topics covered in the books, they are positive narratives about the power of integrity, relationships, compassion, and

love. They are a plea, for policymakers, organisations, professionals, and the public, to exercise decency, challenge unsafe or unkind practice, support people in distress, and push for improved services.

My #PledgeForTim is to speak up for people like him and their families. I am often asked what I would change. I could change one thing, it would be to increase kindness.

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Links to some free learning resources based on *He Died Waiting*:
Blog with reflective learning activities -
https://www.learningsocialworker.com/single-post/values-based-practice-using-the-book-he-died-waiting-as-a-learning-tool

Webinar - Values Driven Practice: Learning the Lessons from He Died Waiting
https://www.youtube.com/watch?v=uTw-ddUy-Ys

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Relational psychiatry and continuity of care

By

Dr Tom Cant, MB ChB BSc Hons MRCPsych, Consultant Psychiatrist, Baywide PCN Core Mental Health Team, Torbay, Devon, Peer Supported Open Dialogue Facilitator

and

Tracy Lang- Peer Supported Open Dialogue Facilitator same team as above and RCPSYCH Carer Representative SW Division

Continuity of care is an essential focus for healthcare provider's operational processes to enable and provide a foundation for therapeutic relationships to flourish. There is a wealth of evidence and support of the benefit provided by relationships for the person in receipt of services.

"The therapeutic relationship is a reliable predictor of patient outcomes. There is increasing evidence that the therapeutic relationship predicts outcome across various psychiatric settings."[1]. And "a body of therapeutic alliance literature suggests that therapeutic relationships between staff and service users create positive outcomes." [2]

We believe, after four years of working as peer supported open dialogue (POD) facilitators (where social networks and psychological continuity are core principles underpinning the organisation of a service, as well as it's delivery), we have noticed a profound benefit for staff working with people. The depth of involvement and humanisation that occurs nourishes staff, motivating them to perhaps give more of themselves and be keener to fully embrace the complexity and challenges that work in general adult psychiatric care often presents us with.

The notion that a relational or socially networked perspective is taken within POD is a key component of its purported efficacy. The relational perspective facilitates, empowers and enriches the development of recovery journeys. People suffering are guided, protected, nurtured and held and develop mutual understandings with those around them they know and trust most. Relationships both externally for the person (within a social and therapeutic network) are attended to by the POD approach, as well as those that exist internally for the person and all those involved. The relationships that exist between the internal orchestra of voices that we all conduct day to day are manifest and considered. There is an

opportunity available to people who are engaged in a process of POD to develop language and subsequently meaning for emotional states, needs, fears, desires, that exist in relation to their internal and external relational landscape.

Disturbance of networks of relationships do appear to underpin and form a common thread in many of the manifestations of major mental disorder that we encounter as practitioners. This commonality perhaps has a fundamental and consistent influence upon the development of, and recovery from mental health difficulties. As Robert Simon has observed "*hopelessness is a lone voice",* and the most mutable and powerful factor in preventing patient suicide is the strength of therapeutic and wider social relationships.[3]

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Menstruation, Menopause and Mental Health Matters

By

Katherine C- Service User

Emily Elson- Lived Experience Professional

Dr Sophie Behrman- General Adult Consultant Psychiatrist, Oxford Health NHS Foundation Trust

As GPs are inundated with requests for HRT and supply chains are stretched thanks to global supply chains and the "Davina Effect", should psychiatrists be upskilling themselves in the effect of menstrual hormones on mental health?

About ¼ of a general adult psychiatrist's caseload are potentially perimenopausal and are likely to have psychological symptoms associated with fluctuations in hormones. Perimenopausal women are significantly more likely to experience suicidal thoughts than men of the same age and pre- and post-menopausal women.

The prevalence of Premenstrual Dysphoric Disorder (PMDD) is quoted as 3-9% of menstruating individuals and has a strong association with suicidality and self-harm.

Many individuals with PMDD and perimenopausal psychological symptoms will see a psychiatrist and this is a golden opportunity to think holistically about their physical and mental health.

Experts by experience Katherine C and Emily E discuss their experiences of menopause and PMDD:

Katherine C.

2005 and I find myself on an inpatient unit. Broken and wishing I wasn't here. Life had fallen apart spectacularly and as an NHS professional and single mum of two boys I had crashed. Slowly but surely the pieces came together again and, although the shame and guilt surrounding what I had done never left, I re-entered life!
15 years later and having survived the ups and downs of life on an SSRI things began to unravel again. No particular trigger but I now faced overwhelming anxiety, total brain fog, poor concentration and increasing suicidal ideation.

Had my mental health come back to bite me? I had no confidence in my ability to do my job – so I would lose my job, then my home and then ... well only one option again. EXIT I'm sure you'll recognise that catastrophic thinking!! I made a plan, but something made me think that things might be different this time. I had night sweats, joint pain, insomnia and monumental fatigue.

Part of the problem is that so many of those symptoms are the same as those in depression.

When the black dog has visited you before it can feel like you are constantly watching your back, waiting for the inevitable to occur. Add into that the feeling that you are a burden and you're making a fuss – perfect storm.

Luckily my wonderful GP immediately recognised the signs and started me on HR. Total and utter game changer. I was then prescribed testosterone by a private consultant (sadly not available in my CCG). Managing the menopause with an overlay of mental health is tricky. I could have ended up in an inpatient unit again, or worse if I hadn't asked for help. Asking those questions and providing support is so vital.

Wouldn't it be nice if it was just hormones" a phrase that haunts me. Naivety and a lack of awareness and education around the impact of the menstrual cycle on mental health that almost cost me my life.

Changes in my mental health started age 11 when puberty began. I became tearful, anxious and self-conscious. Over the months I took steps to ease my distress and developed an unhealthy relationship with food.

As the years passed my mental health deteriorated, I struggled to understand or manage my emotions. The actions I was engaging in to bring relief escalated. I restricted my food intake, over exercised and self-harmed.

Numerous psychiatric admissions followed. A full package of support - a psychiatrist, responsive CPN, psychologist and GP were in place. I never missed an appointment or therapy session and took a plethora of medication. I was motivated for change, so why was it always one-step forwards and two back? The answer lay in my menstrual cycle, age 26 I was diagnosed with Premenstrual Dysphoric Disorder (PMDD).

PMDD is an abnormal reaction to a normal change in hormone levels, as my oestrogen fell and my progesterone rose each month. For over two weeks I became enveloped in depression, hopelessness, and

worthlessness. I was anxious, irritable, and out of control until I started to bleed, when I would mellow, and look back at my actions filled with guilt and shame.

Diagnosis to healing hasn't been easy. I spent three years trialling different treatments, until it became clear that I required a total hysterectomy and bilateral salpingo-oophorectomy to put a permeant end to hormonal fluctuations and give myself a chance at a worthwhile life.

Three years post op, I'm thriving, discharged from mental health services and working full time. Surgery is NOT a magic cure; a lot of effort was put in to reach stability, trust my emotions and understand myself.

What can a general adult psychiatrist do?

1) Ask.

Patients may not volunteer information about their menstrual cycle easily and may not see it as relevant to their psychiatric history.

2) Think

Disparate and atypical physical and psychological symptoms in a menstruating person aged 35-55?

- Perimenopause?

Cyclical changes in mood and suicidality mapping with menstrual cycle?

- Premenstrual disorders?

Worsening of symptoms in a patient with chronic mental illness in the perimenopause?

- Should you consider HRT to augment their psychotropics?

3) Act

Patients can track symptoms themselves and access peer support and psychoeducation with:

- Balance App (menopause)
- Me v PMDD (Premenstrual dysphoric disorder)

For further discussion please join us at the General Adult Faculty Annual Conference or for more information contact Dr Sophie Behrman on Sophie.behrman@oxfordhealth.nhs.uk

An update on the RCPsych General Adult Faculty Co-Production Steering Group

By

Dr Jon van Niekerk, Cygnet Group Clinical Director, Caldicott Guardian, RCPsych Co-production Steering Group co-chair

Natasha Berthollier, Consultant Psychologist, Co-production Senior Lead, Berkshire Healthcare Foundation Trust

Samantha Holmes, Head of Co-production and Involvement, Rethink Mental Illness

and

Jacquie Jamieson, Carer Lay Representative, RCPsych General Adult Faculty

The General Adult Faculty RCPsych Co-Production Steering Group is co-chaired by Jacquie Jamieson and Jon van Niekerk. Its core purpose is to network, exchange and share ideas around historical and present-day co-production. We do this by showcasing through our Co-production Network Workshops which are held every two months.

Initially, we co-sensed our Definition of Co-production:

"Co-production is a collaborative process, based on valuing equal relationships and perspectives, enabling individuals from all walks of life

to share power in a purposeful and meaningful way from the start of their journey."
We have also agreed on our co-sensed values: authenticity, mutuality, curiosity, vulnerability, humility, courage, positivity, grace and integrity. In addition, we reflect upon our own values and where they sit within corporate values.

The Steering Group are working towards co-creating a living/evolving Co-production Toolkit Guide 'Tools for Change' for the purpose of making it easier for people willing to explore the essence of authentic co-production.

We hope to outline some guiding principles around co-production through co-sensing and co-creating podcasts, webinars and creative conversations. We will be sharing examples of Co-production successes and failures, discomfort and comfort, doing to and doing with, providing examples of behaviours, language and (humanistic) values encountered on this journey and how to help reduce real and perceived obstacles along the way. The Guide will include examples of good practice across the UK Mental Health Sector.

Two of our steering group members reflected on contributing to the process of co-producing The Toolkit Guide. **Samantha Holmes**, Head of Co-Production and Involvement for **Rethink Mental Illness** reflected on how worthwhile it has been to be a part of the steering group and learn about co-production from different contexts and getting insight into the challenges from different perspectives. **Natasha Berthollier**, Consultant Psychologist and Co-production lead from **Berkshire Healthcare** spoke of the importance of sharing learnt experiences and supporting each other on our co-production journey to keep the momentum going, and to ensure that co-production gets embedded within any transformation (and current running) of mental health services.

The next Co-Production Network meeting is planned for the 21st of July at 10:00AM to 13:30. The theme will be around co-production and Personality Disorder services.

Continuity and Relationships: Lessons from Open Dialogue

By

Dr Gareth Jarvis
Medical Director, Jameson Division, Central and NorthWest London NHS Foundation Trust

When I first became a Consultant for a Crisis Resolution Home Treatment Team I pulled the previous two years' serious incident reports. One theme jumped out at me above all others: continuity of care. There were numerous incidences of service users being seen by twenty or more different professionals through an episode of care and never the same person twice. How were any of them supposed to pick up any patterns of progression or deterioration? More importantly, how was the person at the centre of concern ever expected to form a trusting relationship with those providing care?

These questions continued to bother me as we set about finding ways to get the team back on track. Then serendipity intervened around six years ago and I received the opportunity to train in Open Dialogue.

Many of you may now be familiar with the concept. A family-systemic oriented approach to mental health care pioneered in north-west Finland over the last thirty years which generates some startlingly positive outcomes.

Open Dialogue is built on seven core principles (Razzaque 2016):

1. Immediate Help
2. Flexibility and Mobility
3. Social Network Perspective
4. Responsibility
5. Psychological Continuity
6. Tolerating Uncertainty
7. Dialogue and Polyphony

In Open Dialogue you try to gather the people important to someone (for shorthand we often refer to these as the family or social network). As professionals we would always work as a team (minimum two) to enable us to work with all the different people present. We commit to keeping the same staff involved throughout the episode of care for the key 'network meetings'. There is an emphasis on facilitating dialogue amongst the participants, honoring their words and allowing them to lead the meeting. We look to explore and strengthen the relationships around

someone. As professionals we make sure all discussions about the person and their social network are carried out in front of them. This 'nothing about us, without us' principle helps keep our language compassionate and respectful, less objectifying, and ensures we maintain high levels of trust with those we are working with.

We have been busy building capability and capacity in the UK in relation to the approach over the last few years as well as undertaking new research. The ODDESSI study, one of the largest mental health trials currently underway nationally, has finished recruiting its 500 participants and will be set to publish its two year follow up data towards the end of 2023. I was lucky enough to be involved in the setup and delivery of Open Dialogue at the Haringey trial site.

Since I began working in this very different way I have been bowled over by the feedback from service users and families. They are very positive about the experience they have had; it's the kind of feedback I never received before I began to work this way. Even if ODDESSI were to show equivocal outcomes compared to treatment as usual I would still continue to advocate for learning from the Open Dialogue approach as it is far more humane, respectful and loved by those we care for.

I have since moved into leadership positions with an interest in developing an understanding of how we learn from the Open Dialogue approach in the care we deliver. In my own organisation, CNWL, we are investing in sending 120 staff this year on Open Dialogue training.
The NHS Long Term Plan and the Community Mental Health Framework have set out a great vision for the future of our services. They have centred us around place and community, essential for addressing long entrenched inequalities in our system. They have brought much needed investment into under-funded services. They have diversified our workforce, illuminating our teams with lived experience and community connectors. However, there is a problem in the middle of all this transformation. It is not yet clear to me how the clinical practice at the heart of these transformed services will change. This is where Open Dialogue offers some timely lessons on how we can re-orientate our practice to deliver on the aspirations we have set for ourselves, but often struggled to realise.

Some key learning for this area is:

- Prioritise the allocation of a named key-worker and maintain the continuity of their involvement through a person's journey with services.

- Be inclusive of social network, even if that is just with questions (e.g. what would mum be saying now if she were part of this meeting?)

- Invest in training for staff. They need time to reflect on their practice and grow, particularly in relation to the emotional processing involved in all our work.

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