ROYAL COLLEGE OF PSYCHIATRISTS

Faculty of Liaison Psychiatry Newsletter

Winter Edition 2022

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In this issue:

Contents

Editorial

Dear colleagues,

Welcome to the winter edition of the Liaison Faculty newsletter. It is long overdue. Thank you for your patience.

Many events have occurred since the last edition, including the change in our Monarch, Prime Minister and the economy. These are difficult times for all, and the most vulnerable, including our patients, are often the most affected.

This newsletter reflects the experiences of those working in liaison psychiatry.

A survey of patients' perspectives on the language used to describe functional neurological disorder sheds light on the stigma associated with the condition. In terms of service and workforce development, the findings of a survey of trainee experiences in paediatric liaison highlights the impact of availability and quality of training on offer. A cross-sectional study reports the prevalence of anxiety and depression in patients with coronary artery disease and the impact of this on quality of life. An article on equality and race highlights its impact on the workforce and provokes thought on how to address it. The legacy of the global pandemic on working practices, virtualisation, has been investigated in our final piece.

We rely on your support to continue publishing this newsletter. This is neither a peer review process nor a scientific publication but a space to share. Please consider sharing your research, projects, experiences, innovations and good practices.

If you would like to send us your work, please email Stephanie.Whitehead@rcpsych.ac.uk using "Liaison Faculty Newsletter" as the subject line. Articles should be no more than one to two pages long. Please include your name, title, place of work and contact details.

I want to thank Stephanie Whitehead for her support in preparing this newsletter. If you are interested in becoming a co-editor for the newsletter, please get in touch with Stephanie. It will help to speed up the process of producing the next issue!

Have a peaceful Christmas and new year.

Dr Deepti Desai
Stephanie Whitehead

Chair's Report

Dr Annabel Price
Liaison Psychiatry Faculty Chair

Dear Liaison Faculty colleagues,

2022 has been another year of continual change and challenge in healthcare. Within the liaison faculty we have been very active in contributing to work on policy, legal reform, service development, workforce recruitment and retention, and clinical standards. Thank you to everyone who has contributed directly to the work of the faculty in 2022.

We have been working on a liaison faculty strategy this year and have renewed our focus on how we truly represent the diversity of our specialty. It is very pleasing therefore to see this represented in the pieces published in the winter newsletter. We are working hard to represent the diversity in our specialty in all our events: the recent Trainees, New Consultants, Nurses and Allied Health Professionals conference attracted a broad range of professionals from a range of countries and we are looking forward to our 2023 Liaison Faculty conference running both face to face and online in a hybrid format to maximise opportunity to attend. We also recently joined forces with the Old Age faculty to run a conference focusing on the needs of older people in the acute hospital and plan to run more of these events in 2023. Do keep an eye on the events webpage

This is your faculty, and the executive is here to represent you as members in all the areas in which we work, be that the emergency department, inpatient services, specialist services, or primary care. Elections for a number of faculty executive positions are taking place in Spring of 2023 so if you would like to get more involved in the work of the liaison faculty please do consider seeking nomination

We are also recruiting for patient and carer representatives in January 2023 so please spread the word in your PPI networks. The advert will be available early in the new year.

We are looking for a 2023 Psych Star: a medical student who has an interest in liaison psychiatry who will be supported to pursue their interest in the specialty through personalised mentoring and financial assistance. Please do let your medical students know about this opportunity

I hope you have a chance to enjoy some well-earned rest and recuperation over the festive season. Enjoy reading the newsletter and consider contributing your own piece to a future issue! A big thank you to our newsletter editor Dr Deepti Desai for putting together the winter edition and to our Faculty Manager Stephanie Whitehead for supporting its production.

What are patients’ opinions on the terms used to describe Functional Neurological Disorder (FND)?

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Introduction

A positive diagnosis of Functional Neurological Disorder (FND), together with a clear non-judgemental explanation of the condition is vital in improving patient experience, trust in the healthcare system and healthcare utilisation [1]. Without this, many patients with FND have negative experiences [2] and describe themselves as being dismissed, disbelieved or not having been given a diagnosis at all [3].

The presence of a range of diagnostic terms used can make understanding the condition more challenging for patients and has implications on offering consistent treatment, standardised services and conducting further research. Using consistent diagnostic terminology is an important first step in managing stigma and improving access to treatment for patients with FND [5]

We undertook this study to explore patient views about different diagnostic terms used for FND. This work adds to the Butler et al 2021 [6] survey of FND patients by the focusing on the impact of differing FND terminology.

Method
The cross-sectional survey took place February 2021 in conjunction with FND Hope UK, a charitable organisation. The survey questionnaire was published online through the FND Hope UK website and social media pages.

Results

The majority of the respondents to the survey were female (87%) and 95% were between 18 and 65 years old. 62% of participants were diagnosed 1-5yrs ago. 75% of participants were diagnosed by a Neurologist in a secondary care setting (see figure 2).

The main symptoms experienced were weakness/paralysis (11.8%), involuntary movements (10.2%) and gait/balance problems (10.0%). The main associated symptoms were fatigue (20.9%) and pain (17.5%).

Impact of Terminology
95% of participants diagnosed with FND felt that their treatment was affected negatively by the label given for their medical condition. Patients felt that there were negative connotations associated with being diagnosed with terms other than FND (see figure 4).

In this study the term with the most positive impact was FND (71.3%). Non epileptic attack disorder (53%). Not having a label (40% positive impact) was the next most positive response (see figure 1).

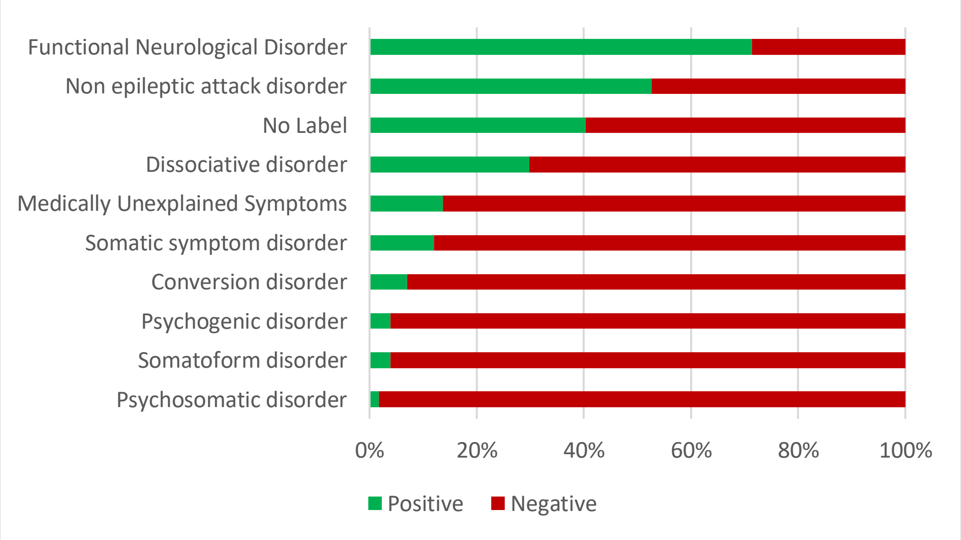

Figure 1 showing which labels were offered to patients and what proportion of these participants had a negative or positive impact from the use of that label.

Discussion

The overwhelming majority of participants (95%) diagnosed with FND felt that their treatment was affected negatively by the label given at the time of diagnosis for their condition.

They felt that diagnosis precluded them for further sought investigation and that referral to psychological therapy may have been motivated by professionals being unbelieving in their symptoms. For this reason, a preferred diagnosis in this study (40% positive impact) was “no label” possibly as it prevented stigmatisation. This highlights the further stigma around mental health conditions as a whole and may be partly conceptualised as internalised stigma amongst those with FND.

Our survey found that FND was the preferred terminology for diagnosis. Participants felt that this was the most positive and normalising. Whereas the other diagnostic labels suggested that it was not a “neurological” condition.

These results highlight the challenge of informing, empowering and sensitively communicating with patients with functional neurological disorder. Clarity and uniformity in diagnostic terminology would surely be beneficial in this process.

Limitations

We received 176 responses to this survey which is a relatively small number, and the survey was open for one month. Views of terminology change over time so a snapshot of views may not be entirely reflective. The study was also distributed through FND Hope UK and consequently was targeted at individuals who already had links with FND Hope UK or had some sort of awareness of FND. Therefore, the sample may favour FND terminology and those not told they had FND may not have even found the FND Hope UK site. Another limitation was the validity of FND diagnosis of the participants who took part.

Implications

FND can be a challenging diagnosis to conceptualise and communicate. The range of different diagnostic terms used to describe the condition has implications for patient and professional understanding, as well as service development and allocation. In this survey we have attempted to identify which term may help to foster an improved patient experience and doctor patient relationship. From our survey, we recommend the use of Functional Neurological Disorder (FND) as a uniform terminology.

Acknowledgements

The authors would like to thank Professor Jon Stone for his support in the preparation of this work.

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This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors. There were no competing interests.

Paediatric Liaison Network, PLN, Trainee Survey 2022

Dr Ashy Rengit
Paediatric Liaison Network

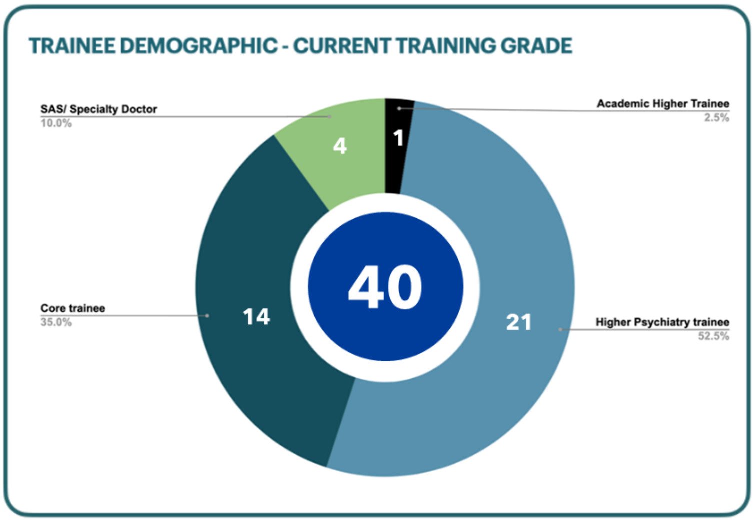
With thanks to the PLN Executive Committee: Dr Virginia Davies, Dr Sophia Williams, Dr Ashley Liew, Dr Ruth Garcia-Rodriguez and Dr Isabel Paz

Introduction

Objective

This project aimed to gather information from psychiatric trainees across England, Wales, Scotland and Northern Ireland, regarding their experiences and views of training in paediatric liaison psychiatry.

The PLN Trainee Survey



The survey was open between 29 November 2021 to 17 January 2022 with trainees from the RCPsych Liaison Psychiatry and Child & Adolescent Psychiatry faculties invited to participate.

Overall, 40 trainees across the UK completed the survey detailing their views and experiences of paediatric liaison psychiatry training.

Key themes

Awareness

Most respondents (85%) were aware of paediatric liaison psychiatry as a specialty, regardless of whether they had been able to access experience in this field. A minority of those surveyed were aware of previous collaborative initiatives between paediatricians and psychiatrists working in young people’s mental health (9 out of 40 respondents)

Availability

The availability of training appeared to be highly dependent on the quality of investment into local paediatric liaison services, with most formal training posts and departments (including child & adolescent psychiatry input) being based in London. Less than half of the respondents (47.5%) were in training programs which included paediatric liaison psychiatry experience.

Trainees also highlighted particular difficulties with working in paediatric settings due to organisational differences (i.e. in terms of local Trusts or training providers) and/or disorganised clinical service structures. This raises concerns regarding disparity in:

a) Training - for psychiatrists with limited opportunities in their localities due to the lack of adequately resourced paediatric liaison services. This is also especially difficult for trainees with other personal commitments e.g. childcare, who find it difficult to travel out of area to access desired training opportunities available elsewhere.

b) Quality of care - for young people, who would benefit from a system of care that gives equal priority to their physical and mental health.

Accessibility
In addition to wider services, trainees also identified other factors influencing the quality of paediatric liaison training accessible to them:

a. Appropriate supervision - the lack of paediatric liaison psychiatrists available to oversee training was highlighted as a key issue by respondents. (This also includes areas where paediatric liaison care was delivered by community teams, or other multidisciplinary professionals.) In particular, trainees responses noted that it was difficult to identify appropriately qualified supervisors, as there was little support available for them to do so.

b. Trainee-centred approach - trainees identified a mismatch between their goals of sub-specialising in paediatric liaison psychiatry, and the support available from trainers to facilitate this process.

Anecdotes from trainees summarised negative experiences with consultants, limited scope for modifying their job plan to meet training needs, and lack of advertised paediatric liaison opportunities as key factors influencing their experiences.

Recommendations

Paediatric liaison services
The responses in this survey capture the importance for trainees of increasing the provision, and quality, of paediatric liaison services across the UK. In the absence of such initiatives at present, the following recommendations are based on trainee feedback about priorities for paediatric liaison training going forward.

Training opportunities
Survey feedback emphasised the need for increased subspecialty tasters, offered within training programmes, for promoting exposure to paediatric liaison psychiatry. The idea of gaining further accreditation as a higher trainee (ST4 - ST6) in paediatric liaison psychiatry (similar to general adult psychiatry training) was also viewed positively by respondents completing the survey.

Sub-specialty engagement
Respondents highlighted areas for meeting their training needs within paediatric liaison psychiatry - in particular, more opportunities for shared experiential learning with paediatricians in sub-specialty settings

according to special interest. The need for a wider network to advertise formal clinical/ research training opportunities and specialist learning initiatives, such as case discussions, was also conveyed by trainees during this survey.

To view the full report - please visit this link

Assessment of depression, anxiety and quality of life in patients with coronary artery disease

Abstract

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Background

Coronary artery disease (CAD) is the most common type of Cardiovascular disease. Depression and anxiety are common in people with CAD and are associated with worse cardiac outcomes. The presence of comorbidities like depression and anxiety are important predictors of QoL in patients with CAD.

Objectives

To estimate the prevalence of anxiety and depression, and to find the effect of anxiety and depression on quality of life in patients with CAD visiting cardiology outpatient at Manmohan Cardiothoracic Vascular and Transplant Center, Tribhuvan University from November 2019 to October 2020

Materials and Methods

The study was a cross-sectional design comprising a total sample size of 96. Socio-demographic and clinical profiles were obtained using a semi-structured proforma. A validated Nepali version of Hospital Anxiety and Depression Scale (HADS) was used to assess anxiety and depression. ICD-10 DCR was further used to categorize the anxiety and depressive disorders. Quality of life was assessed using WHOQOL-BREF.

Results

The majority of the participants were of the age group 40-64 years (61.5%) were males (70%) and had a diagnosis of STEMI (57.3%). Anxiety disorder was present in 27.1% and depressive disorder in 20.9% of patients with CAD. The most common anxiety disorder diagnosis was generalized anxiety disorder (11.5%) and the most common depressive disorder diagnosis was a mild depressive episode (12.5%). The WHOQOL-BREF scores were significantly negatively correlated with the HADS. A score across domain one ($p<0.05$) and domain two ($p<0.05$) and also negatively correlated with HADS D score across all four domains($p<0.05$)

Conclusion

A significant proportion of patients with Coronary Artery Disease suffer from anxiety and depression. The presence of comorbid anxiety and depression significantly affect their quality of life.

Keywords: Anxiety, Coronary Artery Disease, Depression, HADS, ICD-10 DCR Quality of life.**,** WHOQOL-BREF

Medical Workforce Race Equality Standards (MWRES). What are they and why they should matter to us all

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Introduction

I have come to this issue late in my life. I have spent most of my professional career avoiding thinking about racism, because I never ever wanted to be accused of “playing the race card”. So, I am ashamed to admit that I didn’t think about it much.

In recent years this has started to change, initially when I heard of Roger Kline’s 2014 seminal report, The “snowy white peaks” of the NHS: a survey of discrimination in governance and leadership and the potential impact on patient care in London and England. It looked into institutional racism in the NHS and described the impact of colour change of our staff as you moved from the black and brown “foothills” up to the white leadership. It articulated something that I had felt subconsciously forever, but it brought it into my consciousness. Over the past two years, Covid affecting people from BME backgrounds disproportionally more than their white peers and the Black Lives Matter movement coming into everyone's awareness has only served to cement that for me.

Having explored these issues at great length over the past two years, I have come to the understanding, that for real improvement, we need levers of change, not just talk or training. Evidence suggests that training alone doesn't change behaviours. The NHS works on transactional processes and requires performance outcomes. It's human nature to work on the issues that we will be assessed on. We all know that from our day jobs.

The Medical Workforce Race Equality Standards, MWRES, was created to be that lever. It's not perfect but it's a start.

What is MWRES?

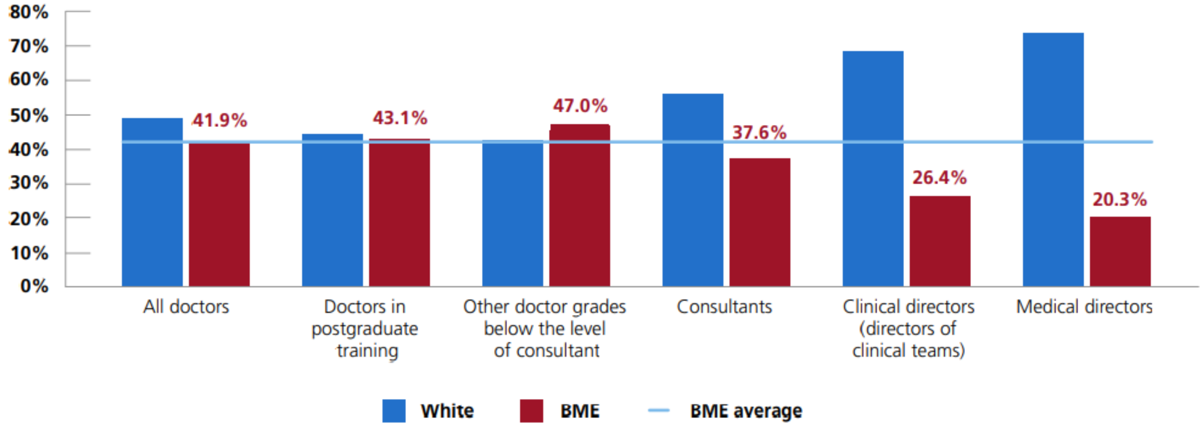
NHS Chief People Officer, Prerana Issar describes the framework much better than I can:

> "The Workforce Race Equality Standard (WRES) was launched in 2015 to document the different experience of white and black and minority ethnic (BME) staff in the NHS, and to provide guidance on how to achieve better race equality in the workforce... the medical workforce differs from the rest of the NHS workforce; hence the development of the Medical Workforce Race Equality Standard (MWRES) and its 11 indicators, introduced in September 2020. This report is the first publication of the MWRES data, and will provide baseline evidence to quantify discrimination in the NHS trust-based medical workforce at the national level, and hence identify the targets for organisations to pursue with corrective action. The MWRES is a 'world first' in creating an evidence base to expose racism and discrimination in the medical workforce at a national level." [Extract from the Foreword of MWRES Report 2020].

A picture speaks a thousand words

Below is a graph of one of the 11 indicators and how we fare in it on race equality across the UK (from the first MWRES report 2020).

Indictor 1a- headcount of BME and white doctors at each grade



In terms of career progression, you can see that the news is not good. The other indicators, recruitment, referrals to the GMC, differential attainment, bullying and harassment, discrimination by line mangers, greater difficulties in getting revalidated, all paint a similar picture. It is shocking and yet somehow validating at the same time.

Why this should matter to us all

We are in trouble. As an organisation, we are facing an existential threat at a time when

- financial resourcing is less than it was 10 years ago,
- we have increased demand, not just because of the current viral pandemic, but because of multiple other pandemics (current and future, infectious and not infectious)
- we have recruitment and retention challenges that mean we have 93, 000 vacancies with swathes of staff reporting they will leave the NHS once this crisis is over.
- public support is falling

Can we really afford to not be utilising every bit of expertise, knowledge and skills that we have at our disposal? Can we really afford to continue to keep people down who might otherwise bring diversity of thinking to find solutions to our biggest challenges? Solutions that are not mired in the groupthink that is an inevitable part of a non-diverse group?
It is not just a fairness or morality issue. It is about pure common sense. We need all of our people to be supported to be at their best to stand a chance as an organisation, of facing the challenges ahead.

What you can do

Can you read the report? – it is short and punchy and won't take you long.

Can you experiment with one big or small thing to do differently?

- If you are white- can you use your platform to raise those who have less of a voice? Who do you most commonly like or share on social media? Can you look out for who has a seat at the table and who hasn't? Who gets airtime and whose voice is ignored or worse still hijacked and reattributed to someone else?
- If you are from a BME background and you need support, can you speak to someone in your organisation? If not, you can contact me or our Presidential Leads for Race Dr Lade Smith or Dr Raj Mohan or the NHS MWRES lead Professor Partha Kar? Can you connect with local or national groups where you can be part of a diaspora network that empowers you? Association of Black Psychiatrists UK, British Pakistani Psychiatrists Association, British Indian Psychiatric Association to name a few.

But most importantly of all, please don't let the discomfort of acknowledging this stop you from engaging in it. We need everyone to do this

A Remote Future? Physician Perspectives on the benefits and challenges to using remote consultations for general adult mental health care in the community

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In March 2020, almost overnight, GPs and community mental health services underwent a process of rapid virtualisation, with consultations being conducted remotely to fulfil the dual aim of safe service provision and prevention of SARS-CoV-2 transmission. Now, with healthcare slowly acclimatising to unusual circumstances, physicians are now in a position to decide the role remote consultations will play in the future.

Inspired, myself and my team undertook the task of investigating the benefits and challenges to the use of remote consultations for the diagnosis and follow up of general adult mental healthcare in the community. An exploratory sequential mixed methods study design was adopted, starting with qualitative data collection which then informed quantitative data collection. Data from both these methods were then interpreted together. The qualitative component consisted of GP and community general adult psychiatrist semi-structured interviews, whilst the quantitative aspect consisted of a survey.

A variety of interesting benefits and challenges were identified, of which I will be sharing a few. Firstly, it was thought that as patients did not have to leave their 'safe spaces' to talk to their doctors, it was more convenient, and encouraged some patients to open up more. Furthermore, it was commonly noted that clinicians perceived teleconsultations to be very suitable for mild-moderate anxiety and depression, but unsuitable for severe conditions, such as psychosis or the management of suicidal patients. Moreover, from an organisational perspective, a more telemedicine-focused approach facilitated efficiency as clinicians were able to see more patients in a day. However, the nature of back-to-back meetings lead to some clinicians experiencing reduced job satisfaction. Nonetheless, some clinicians found that remote ways of working improved job satisfaction as they were better able to establish a better work-life balance. On a personal clinician level, there were still some that felt their technophobia or discomfort with technology impeded their ability to fully utilise the potential of the platforms. Additionally, the absence of non-verbal cues posed a great challenge, as did the multitude of technical issues often faced, especially so with video consultations over telephone. An interesting finding to also note is the extra time taken for the set-up of video consultations when compared to telephone – this was in fact reflected as a key difference between GPs and psychiatrists. GPs tended to have a preference towards telephone appointments due to shorter appointment slots, whilst the longer appointment slots for psychiatrists facilitated the uptake of video consultations.

This remains a small glimpse into some of the benefits and challenges experienced by clinicians. There is still an untapped goldmine of research opportunity in this area. Do teleconsultations lead to better health outcomes for mental health patients? Are they cost-effective? And most importantly, what is the patient perspective? We therefore look forward to seeing what the future holds for telemental health.

Dates for your diary

Faculty of Liaison Psychiatry Annual Conference 2023

10-12 May 2023
In person (RCPsych)/Live-stream

Keep an eye on the event website for further information

EAPM conference 2023

15-17 June 2023
Wroclaw, Poland
Visit the event website for more information

LPSE6 - Final Reminder

Please can we remind all services in England to complete the Liaison Psychiatry Survey. The surveys have been a really valuable way of tracking services over time and have been a vital contributor to the enormous growth in Liaison in recent years.

If you have been sent a survey and have yet to respond, please complete it and send it to cft.lpse@nhs.net

If you haven’t received a request to respond and think you should have, surveys can be accessed by contacting Kate Welch at cft.lpse@nhs.net Kate can also be phoned on 07557 800 806.

Thanks very much everyone.