DIGITAL
SPECIAL INTEREST GROUP

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DIGITAL IN MIND

INSIDE

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ROYAL COLLEGE OF PSYCHIATRISTS

DIGITAL
SPECIAL INTEREST GROUP

Dear Fellow SIG Members,

Welcome to the inaugural edition of our newsletter, **Digital in Mind!** Our SIG is now one year old and during this time we have taken our first baby steps into the world. Our membership has grown to over 600 members and we have become active on Twitter with a similar number of followers.

We hosted our first event back in March 2021 on the theme of digital inclusion. For those of you who could not attend it can be viewed here. Over the past year we have spoken at the International Congress, the Private and Independent Practice SIG and many other great conferences with the aim of engaging as many people interested in digital technologies and innovation within mental health. Our website is up and running and if you are reading this and not a member, you can join our SIG there, we would love to have you on board.

Now that we have our feet under the table, we have some ambitions to create more content in the following 12 months. We would like to substantially increase the content on our website, including sections on useful resources and hot topics such as digital phenotyping and virtual reality. We will be producing more newsletters in due course and we also have plans for a podcast and events to bring us together in the next year.

Thanks to all who contributed to this newsletter, we have some fantastic content in these pages.....

We are really looking forward to building a community interested in digital technology, and innovation within our field. Please do get in touch, share your work, your thoughts, we would love to hear from you! We want to engage with our members as much as possible, so if you would like to contribute to future newsletters, the website, or perhaps you have come across something interesting and relevant you want to share with us, please do not hesitate to contact us.

Finally, we have two committee spaces currently vacant: Finance Officer and Events rep. If you are interested in joining, drop us an email!

chair.digitalsig@rcpsych.ac.uk.
Dr Romayne Gad el Rab and Dr David Rigby
Co-chairs Digital SIG

Have you attended a MS Teams meeting in the past year?
Have you sat for any of the College exams in the new online format?
Have you been using one of the video platforms for patient consultations in your clinic?
If you did any of that, digital technology has already made its way into your psychiatric career and practice. And by now, we all know it is here to stay. From reducing resources including time spent on travel, to making it possible for a carer to join a consultation from their workplace there is no doubt blending technology within psychiatry has its perks. There are challenges as well, for example, ensuring confidentiality for our patients and security of clinical data.
Use of technology in mental health care in the UK is in its early stages, and though its growth was accelerated by the pandemic it is fair to say that there is still a lot to be developed in this field. Our Digital SIG is the place where we would like to brainstorm with like-minded people to bring about some of these developments in the future. So, if you feel digital in mind and want to join us, share your work and ideas, or just want to stay abreast with the evolving world of digital psychiatry, do join us and send in your articles for the upcoming newsletters.

Bijal Sangoi
Newsletter Lead
for Digital in Mind

Time to get specific – an interview with Dr Linda Kaye on Gaming Disorder

Authored by Dr Stephen Kaar

A couple of years have passed since Gaming the Mind last published an article on gaming disorder, so I spoke to Dr Linda Kaye a specialist in Cyberpsychology at Edge Hill University, and Chair of the British Psychological Society's Cyberpsychology Section, to get her take on the issue. She has published on social identity within games and gaming culture, alongside other things, and was one of the voices on the disorder-critical side of the gaming disorder debate.

Kaye doesn't believe that much has changed in the field since the gaming disorder debates occurred prior to gaming disorder's inclusion in the ICD-11. Several issues still need refining, and she feels the diagnosis has led to a confirmation bias in research, rather than encouraging academics and clinicians to understand the problem on a deeper level. She worries that, for many people, their first exposure to gaming research will be negative, because there is more visibility to research that suggests problems with games; anyone doing an online search into gaming addiction is likely to come across a huge amount of information that supports gaming as being a problem, so they are unlikely to see the positive side of gaming or the on-going debates around the diagnostic labels.

The World Health Organisation (WHO) uses the broad term 'gaming' in its the ICD-11 gaming disorder diagnostic criteria. For Kaye this leads to issues with specificity and shows a lack of understanding of games on part of the WHO. She states that this is a phenomenon that also occurs in the gaming disorder research world: very different games are lumped together as if they're one homogenous category. Even the term 'online-games' can arguably include anything, from a puzzle game on a mobile phone, to a game where the basis of play involves meeting up in online social spaces such as in massively multiplayer online games (MMORPGs). Kaye suggests that to understand someone's gaming behaviour, it is critical to clearly establish the types of games a person is playing and what their patterns of play are. She believes that some games seem very unlikely to cause problems with control over use, whereas those with loot box or other gambling-like mechanics are more likely to be problematic. Yet even when there are elements within the games clearly designed to keep people glued to them, many people will have a healthy engagement with those games.

Moving on from diagnosis to treatment, Kaye believes it would be hard to recommend a treatment to someone experiencing problems with their gaming, until the constituent behaviours of such game play are known. Different games will elicit different gaming behaviours, so clinicians need to understand specific patterns for specific games. For example, how does the person feel invested in the game? Monetarily? Socially? As a coping strategy? What are the game's structural components, such as reward systems? Some games are going to lead to more engagement by the very nature of how they are played. One example that Kaye gives is an MMORPG which might involve membership of a guild, where loyalty and a meaningful contribution to the guild's goals are critical. So, the thing that keeps a player playing is being with friends and gaining a sense of belonging, achievement, and mastery. A player might feel they will let their guild down if they leave the game right in the middle of a big raid. What needs further exploration are the factors driving a player's participation in such games, how they affect engagement, and the presence of risk factors for gaming behaviours to become problematic.

"Time is a game played beautifully by children."
-Heraclitus, Fragments

For Kaye, many of the perceived problems with technology including gaming, start from how some of us choose to spend our time and how society believes time is best spent. There is often concern from parents about the quantity of time spent online or playing a game, but the function of that time is disregarded. Kaye suggests that simply looking at limiting gaming time isn't the best way to set boundaries. Time is an easy target because it's quantifiable but understanding the quality of gameplay is more challenging. On a surface level, a player may seem to be playing a game for hours on their own, but they might be exhibiting more functional and adaptive behaviours than parents might believe. Kaye highlights the positive reasons why someone plays games: to stay in contact with friends; to meet new people; to build social networks and social capital around games. Such factors aren't relevant for every type of game, but for some, they're key.

So, rather than talking about gaming as an umbrella term, there needs to be advice around specific games and specific behaviours. Kaye likes to remind us that many video games are just a contemporary versions of the games people played in the pre-digital era, like board games. Such games are unlikely to be problematic, despite the moral panics

they have provoked along the way. On the other hand, some online games offer sophisticated social elements or are fully integrated into existing social media platforms. There can be a synergism between online marketing and game design which may drive engagement and lead to problems with control. Such games are qualitatively different from discrete, predominately offline, gaming experiences. Again, there needs to be more focus on the structural components in games e.g., online elements.

For Kaye, the online social aspect of certain games generates further important areas for research. What do we mean by being social in online gaming? How can we understand levels of socialness? Being social looks different in online gaming spaces compared to the traditional physical world, so there needs to be a better understanding of what's healthy and what isn't. Kaye suggests we should be curious about the different kinds of social behaviours players engage in when they play specific games. For example, the pro-social role of spectatorship in Twitch streams is a new and under-researched phenomenon, and is similar, Kaye believes, to the kind of community people get from watching and supporting their favourite football team. Kaye points out that playing and watching a game gives an easy common topic to talk about and can reduce perceived stakes in social interaction. She believes it can create a social glue which leads to commonality within broad communities. Kaye agrees that, despite considerable reluctance from some to agree that gaming disorder, as it stands, is a valid diagnostic entity, most people would agree that a minority of players can develop problems with their gaming use. However, for Kaye, most of those players are likely to have a primary problem, of which disordered gaming is a secondary manifestation.

Gaming disorder research needs to improve in quality; Kaye believes the field relies too heavily on self-reported data and often gaming behaviours can be quite impulsive or unconscious, so the player might not be aware of doing them and hence find it difficult to report. To get round this problem she believes the field needs to develop implicit measures of game-related biases, such as game cues which promote attentional bias over others. Knowing whether there are certain game-related cues which draw attention, promote expectancies, and in turn, encourage engagement can be a basis for understanding how these vary for different types of games, structural components and different types of players. Kaye feels strongly that gaming companies should grant researchers access to data concerning patterns of play that might be deemed excessive or problematic. This would help to address the issues with self-report, as a more objective measurement of behaviour. In the future, a clinician might be able to use metrics from a patient's play data to monitor aspects of their well-being. Another key issue with gaming research, highlights Kaye, is that despite the concerns around the effects of gaming on children, proportionately less research is done with them compared to adult populations, and even less so in co-creation with them.

WHO's criteria?

In January this year, a study was published in the journal Addiction using a Delphi method to review the clinical utility of the criteria for diagnosing Gaming Disorder. This included a panel of 29 experts, 11 of whom were on the WHO ICD-11 Gaming Disorder Committee, who were asked to judge the DSM-5 'Internet Gaming Disorder' (IGD) criteria and the ICD-11 'Gaming Disorder' criteria according to clinical relevance. Four criteria, all from the ICD-11 diagnosis, were deemed to meet high clinical relevance: loss of control, gaming despite harms, conflict/interference due to gaming, and functional impairment. However, three of the DSM-5 IGD criteria (tolerance, deception, and escape/mood modulation) were felt to be unhelpful. I asked Kaye what she thought of these findings. She agrees that the tolerance criterion for the DSM-5 IGD diagnosis has limited validity, as people can engage healthily with games in an intense fashion. This suggests that the application of such new diagnostic criteria needs to be conducted by specialists in the field with sufficient knowledge of games, gamers and addictions and an awareness of the limitations of the current evidence base for the disorder.

Several key messages are worth highlighting from our conversation. Firstly, Kaye believes the ICD-11's description of gaming is too broad and lacks game reference points, which leads to the second issue that we need to be specific about what types of games are problematic, perhaps even down to the level of particular games. If we focus in further, we need to understand which elements within games are problematic and why. Time isn't the only way to establish a boundary, and when anyone has problematic gaming behaviours, we need to carefully describe and explore the function of those behaviours without resorting to unnecessary pathologisation.

You can find out more about Gaming the Mind, a registered charity that works at the intersection of gaming and mental health at our RCPSych Blog, Twitter, and website.

GAMING THE MIND

When public announcements impact on mental wellbeing: Insights from Shout 85258 (a digital mental health text service)

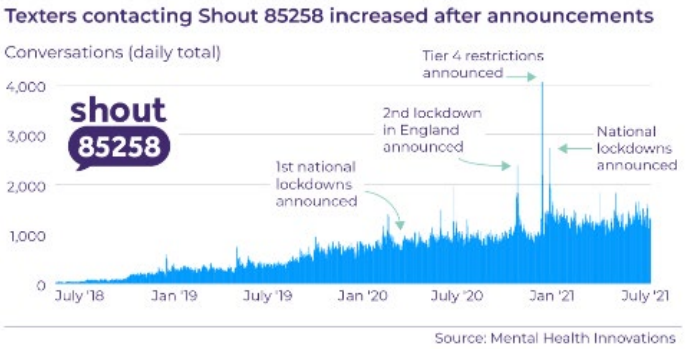
Shout 85258 is a pioneering free text support service that has been providing 'in the moment' mental health support to the UK population since May 2018. The service is powered by the charity, Mental Health Innovations and delivered by a team of trained volunteers supported on and off the sophisticated digital platform by clinical supervisors and coaches. Due to the 24/7 nature of the service and the need to ensure the platform is well staffed after midnight, Shout also has volunteers and clinical supervisors in New Zealand.

Since its launch in mid-2018, Shout volunteers have held over 800,000 conversations with 325,000 texters!

Our data is rich with insight, for example:
Around 75% of the conversations are held after 5pm, through the night, until 9am, at a time when other services might not be available.
65% of texters are under 25 years old; 7% are 13 or under, even late at night.
34% of the conversations are about suicide.

Volunteers are trained to conduct a structured risk assessment, help texters de-escalate, and consult with the clinician supervising them on the platform, who make the clinical decisions. On average, fewer than 2% of texters are referred to the emergency services.

One of the insights we have gained since the first COVID-19 lockdown on 23rd March 2020 is how public announcements about COVID-19 can impact on mental health. We gathered this information by analysing both the number of texters who contact Shout and the issues they present with at the time these announcements - some expected, some unexpected - are delivered.
The graph below shows use of the service around four time-points between March 2020 and January 2021 when announcements about COVID-19 related lockdowns were made.



The first lockdown announcement on 23rd March 2020 was widely anticipated and the Shout service did not experience a significant increase in number of texters. There has been speculation that the lack of an increase in people seeking support at this time point might be attributable to the novelty of the first lockdown, a 'we're all in this together' experience, and the increased public focus on mental health generally. The second lockdown announcement on 31st October 2020 saw texter numbers increase from around 1,000 conversations daily to double that number, suggesting that perhaps people were starting to struggle with restrictions.
However, it was on 19th December 2020, when the Government announced a new level of restrictions just before Christmas that we saw our daily conversations peak to just over 4,000, followed by a smaller peak when the national lockdown was announced on 4th January 2021.

Some interesting insights emerged:
In these periods of increased activity, we see a surge in the proportion of new users and, once the peak passes, our daily average settles at a higher level; During the peaks associated with lockdown announcements, there was a decrease in risk suggesting that new users presented with less risk than perhaps expected;

There were some common presenting issues during these peaks, notably an increase in anxiety, texters talking about the impact of lockdown on their lives, and school/tertiary students worried about the impact on their studies and lives; and
Conversations about suicidal ideation, depression, relationships, self-harm, loneliness and isolation were also common.

Digital health provision is growing rapidly and has been particularly critical during the COVID-19 pandemic, when demand for many mental health services outstripped provision. Shout 85258 is part of the tapestry of mental health services available to the public, offering a first step for people to take whenever they need support, no matter where they are, particularly during times of unprecedented public health challenge.

Dr Fiona Pienaar (Senior Clinical Advisor, Mental Health Innovations/Shout 85258) Dr Mark Ungless (Director of Data Insights, Mental Health Innovations/Shout 85258)
Dr Jean O'Hara FRCPsych Honorary Consultant Psychiatrist (SLaM) and Visiting Senior Lecturer (IOPPN)
Trustee at Mental Health Innovations (Shout 85258)
Trustee at British Institute for Learning Disabilities (BILD)

What is clinical safety and why should I care about it?

Dr Iain Grant
MBChB, DLshipMgmt, CMgr, MCMI, MRSB, MRCPsych, NHSx Liaison and Clinical Safety Advisor

Clinical Safety may not sound sexy, but it's the thin barrier protecting millions and you should pay attention.

Information technology should make our lives easier. Today it is almost unfathomable to consider being able to see and treat patients without computers being involved in one stage or another – be this booking and arranging the appointment, holding electronic notes, ordering and reviewing investigations or typing a clinic letter; health is now digital and is here to stay but several bad experiences can ruin its reputation and have catastrophic consequences on patient care.

When we get a mismatch of top-down managerial requirements, poor user-interface design and unconsidered developing; we get an information-hungry, repetitive, infuriating, clunky system that doesn't work, doesn't talk to one another and makes us want to bury our head in the keyboard and scream – sound familiar?

Projects for health ought to be designed with clinicians at the centre, software that does not incorporate the front-line staff throughout the development process is inefficient, difficult to use and can be frankly dangerous for patients. Step forward - Clinical Safety.

Any software that aims to operate within the health sector of the UK must have an appointed Clinical Safety Officer (CSO). A CSO is a qualified and experienced clinician with professional registration (GMC) and training in digital risk management; they are responsible for approving that a health software is fit for purpose and is compliant with the mandatory NHS digital standards (DCB0129 and DCB0160).

A CSO is often employed, or at least paid by, the software company they are signing off (marking your own homework are we?) and will try to demonstrate the safety of their product through "deliverables", that is, a group of documents, including a Clinical Risk Management Plan (setting out how your software will work and how it will remain safe with the right checks), a Clinical Safety Case Report (evidence showing that you have done what you said you would do) and a Hazard Log (a list of anything that has gone wrong in the past and why). A software company will give these documents to any prospective client in a "handing over of the baton" (read: responsibility). It generally then falls to the Chief Clinical Information Officer (CCIO) of a receiving Trust or CCG to navigate the jargon, critically appraise and scrutinise these safety documents to make sure everything is above-board and is truly as safe as it claims to be.

Through experience or training, being suspicious and having a high degree of scepticism is a natural trait of most doctors, but just as that shiny Double-Blind RCT may look good on-paper; the devil is in the detail (and the funding).

Patient safety is held by us all and we all deserve software that works with us and for us.

Clinical Safety is the process of holding software developers and electronic healthcare systems to account to ensure that they are fit for purpose and are safe to use and it should have your attention.

Remote consultation: 10 years in 10 weeks?

Dr Lesley Haines PIPSIG past-Chair

On 22 July 2021, the Private and Independent practice special interest group 'PIPSIG' hosted (via the digital platform Zoom) the delayed conference on remote consultation, postponed since July 2020 on account of the pandemic. This was a follow-up to the first PIPSIG telepsychiatry conference in 2015, but what a massive leap forward in use of remote consultations since the postponement!

Speakers at the conference included the General Medical Council, the Medical Defence Union, as well as clinicians from services that were undertaking remote consultation in the NHS and private sector (both long-standing and new) and experience of undertaking remote therapies. The Digital SIG and Dr Ed Clark, winner of the PIPSIG bursary, presented ways that remote technology can move beyond remote consultation.

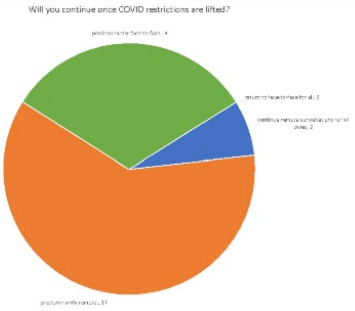
Major highlights include:
Just because a consultation is remote, doesn't mean you can stop being professional. Boundaries, thoroughness, record-keeping, verification and appropriate prescribing do not cease to be relevant just because the patient is not in the room with you.
Both clinicians and patients have accepted remote consultations and, on the whole, have been surprised at how positive the experience has been, although video consultations were deemed far superior to telephone contact.

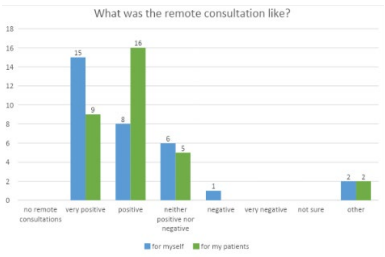
On the whole, rapport across a remote platform was not difficult to establish, and in some cases (anxiety, OCD, autism spectrum) may be easier via video.
Be aware that others may be in the room, and that Alexa/Echo or similar voice-activated internet-connected devices can hear everything that is said; this includes your environment in addition to that of the patient so be sure to check.

It isn't a panacea and doesn't work for all. However, for every delegate who raised a concern about a particular group of patients or conditions, there was another who had found remote consultation to be just as effective or better. That included adolescents, patients with eating disorders, patients on the autism spectrum, patients experiencing psychotic symptoms and those with cognitive impairment.
It appears to be here to stay!

Poll results:

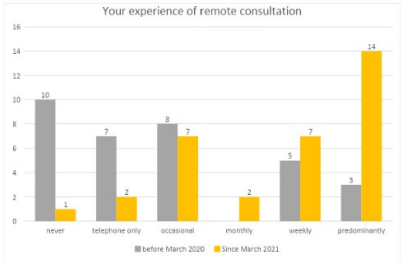
Five polls were undertaken during the conference. The audience was clearly a selected sample and the questionnaires were not standardised or validated. There was a spread of experience and practice across the NHS and independent sector, but unlike many PIPSIG conferences, few in the audience were retired.

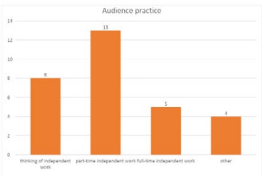


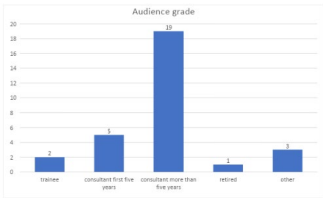


There was a debate as to how much touch, taste and smell added to the assessment of the mental state.

It seems that remote consultation is something that will continue to be offered, but the conference was clear that both patients and clinicians should have a choice as to the mode of assessment.







Further reading:
GMC prescribing guidance:
https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-practice-in-prescribing-and-managing-medicines-and-devices

College guidance on digital communications during the COVID restrictions:
https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians/digital-covid-19-guidance-for-clinicians

Video consultation information for NHS Trusts and Foundation Trusts
https://www.england.nhs.uk/coronavirus/publication/video-consultations-for-secondary-care/

Introducing telepsychiatry into routine practice in an emergency department psychiatric service
https://www.health.org.uk/improvement-projects/introducing-telepsychiatry-into-routine-practice-in-an-emergency-department

Development of a remote memory clinic pathway in Surrey

Dr Rajesh Abraham, Consultant Psychiatrist, Guildford and Waverley CMHTOP Dr Philip Slack, Consultant Psychiatrist, Surrey Heath CMHTOP

The coronavirus pandemic brought about a major shift in the way patients are reviewed especially given the guidance during the lockdown period and social distancing. This affected the older adults more, especially the ones shielding. Patients were advised to self-isolate and socially distance themselves in all but few situations. This was necessary to reduce the chances of transmission of the virus by reducing face-to-contacts. At the same time it is vital that the people who use mental health services get the care and treatment that they need. Remote assessments using virtual technology could be used to make contact and provide care for our patients.

The information commissioner has made it clear that data protection and electronic communication laws do not stop us from using the latest technology to facilitate safe and speedy consultations and diagnoses. (1) The advice from NHS Digital regarding video conferencing states "We encourage the use of video conferencing to carry out consultations with patients and service users. This could help to reduce the spread of COVID-19. It is fine to use video conferencing tools such as Skype, WhatsApp, Facetime as well as commercial products designed specifically for this purpose." The advice also suggested that the consent of the patient or service user is implied by them accepting the invite and entering the consultation. It did stress the importance of safeguarding personal/confidential patient information in the same way as any other consultation.(2)

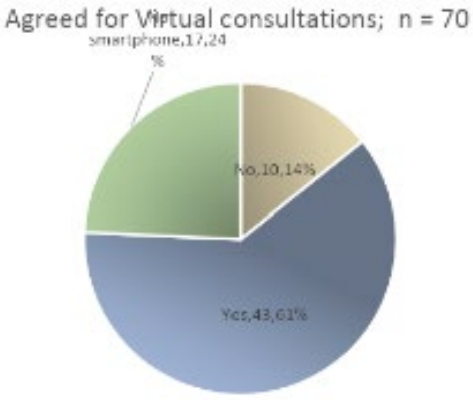
Surrey and Borders Partnership NHS Foundation trust advised its clinicians to use any available virtual means to contact patients including telephone. In terms of video consultation, SABP introduced Attend Anywhere (AA), a remote consultation platform to assess and review patient to inform management and care. AA has been use in Australia since 1998 and adopted by NHS Scotland in 2016 and NHS Wales in 2018.(3)

Guildford and Waverley Community Mental Health Team for Older People (CMHTOP) and Surrey Heath CMHTOP teams decided to pilot this mode of consultation to understand its appropriateness especially in the older adult population who may not be technologically-able to engage in video consultation and to help inform the subsequent development of a new remote assessment memory pathway.

Results of our pilot

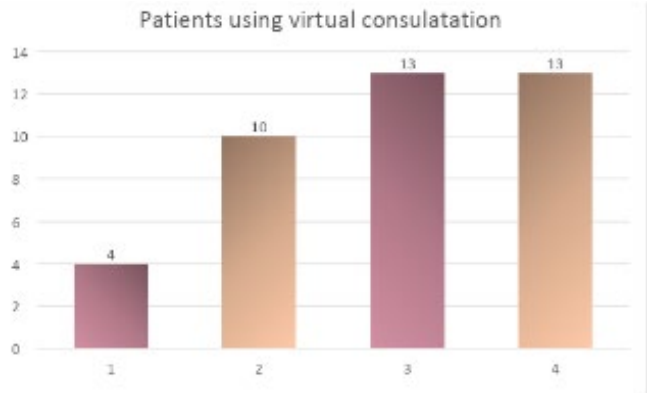
A total of 70 consultations were included in the pilot. The new patient referrals were from the GP surgeries and acute hospitals. The reviews were taken from the existing caseload of the teams.

All included patients were offered virtual consultations using the AA platform. About 62% of the patients agreed for virtual consultation, 14 % declined and 17% did not have access to appropriate technology including smartphone, tablets, laptops etc.

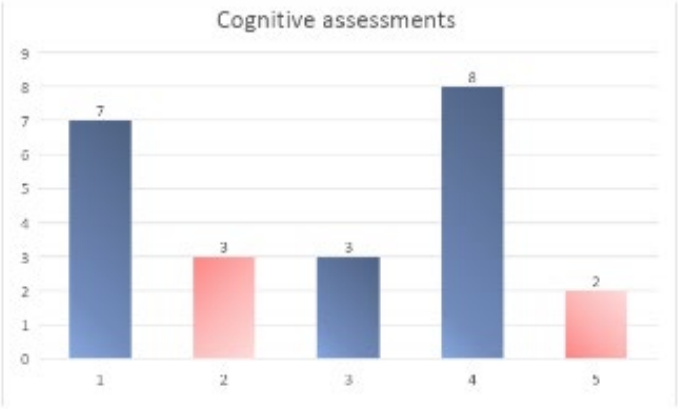


Consultations were conducted from clinic bases and from homes of the clinicians. There were more reviews conducted (63%) in comparison to new patient assessments (37%).

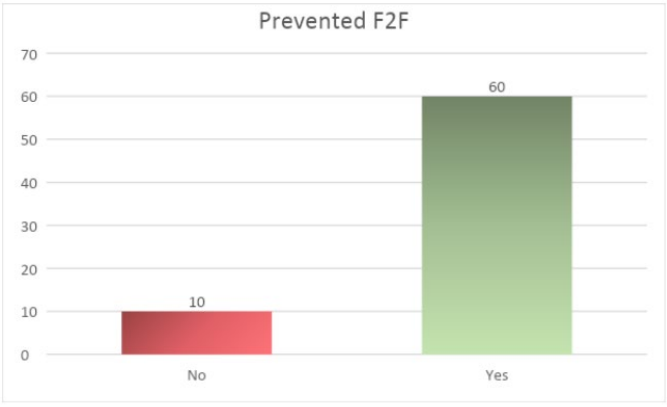
Of the 43 patients who agreed to use virtual consultations 40 agreed to use AA. The others chose to use WhatsApp and Zoom as they were using that platform already and were comfortable using it. Out of the 40 AA consultations 26 (65%) were successful and 14(35%) were unsuccessful. 42% of the AA consultations were new patient assessments (NPA) and 23% were reviews. A higher number of AA consultations were successful when compared to the unsuccessful ones.



Cognitive assessments were done using cognitive tools such as remote Addenbrookes Cognitive Exam (ACE III), Montreal Cognitive Assessment (MOCA), and MOCA blind. Remote ACE III and MOCA were done when there was successful audio-video link and MOCA-blind was used for telephone assessments. A total of 23 cognitive tests were completed successfully. Out of 25 NPA, 10 patients had their cognitive test completed. The others were done with review patients.



We also considered how many consultations resulted in coming to a working diagnosis and informed management plans without the need to wait for a face-to-face (F2F) assessment to become possible. About 60 (86%) of the patients did not require further face-to-face reviews and 10 (14%) needed further contact to establish working diagnosis and management plans.



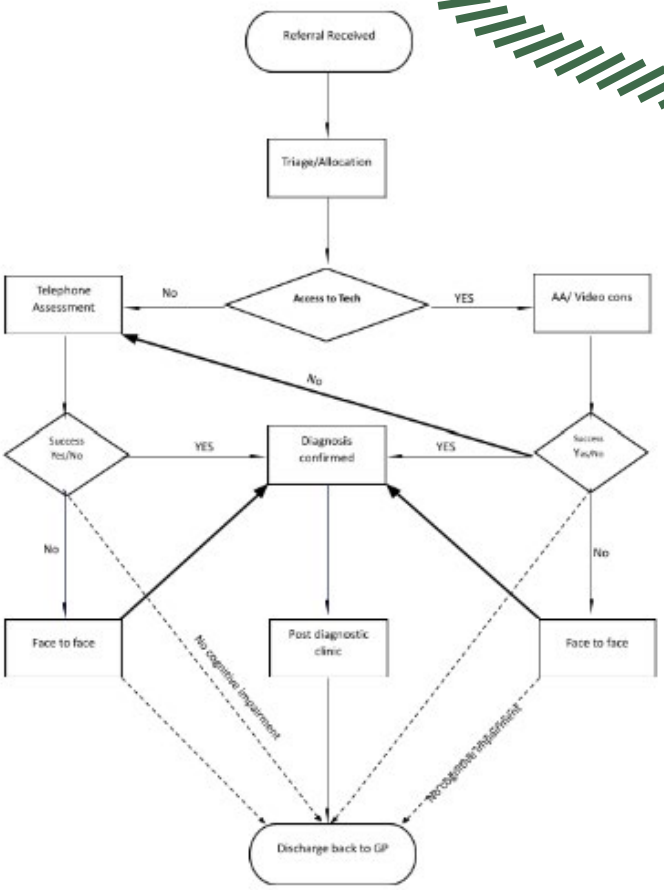
In terms of arriving at a diagnosis, 86% of the successful AA NPA had a working diagnosis helping to plan further management.

Discussion of our results

The results of our pilot clearly indicated that more patients were willing to engage in new technologies including video consultation as opposed to those choosing not to do so. Lack of appropriate technology including smartphones, tablets, laptops prevented approximately a fifth of the consultation to be conducted over newer platforms, this is a smaller cohort than we would have expected but is still vital to be aware of. While we move towards newer technologies we need to ensure equality of access to care and to avoid digital exclusion becoming a problem. Video consultations work well if there is good connectivity and appropriate technology available. Sensory impairment also affects the quality of assessment and this needs to be screened before conducting any remote assessments. We could do remote cognitive testing including remote ACE III and MOCA using screen share facilities reducing the need for any face-to-face consultations to do cognitive tests. Interpretation of the cognitive tests needs to be carefully considered as we are using these tests outside of the realm that they were validated for use in.

During our pilot period the AA platform was down at times and the consultations were then converted to telephone consultations. We found that remote consultations reduced the need for face-to-face in 86% of the consultations which had a significant impact on saving time and associated travelling costs.

In terms of patient experience, they were mixed. In cases of successful consultations feedback was generally positive with emphasis on convenience and travelling. It was also



possible to do conference calls with the patient and families from different locations helping to keep social distancing in this time of pandemic. In unsuccessful consultations, patients reported that it was anxiety-provoking and confusing.

The limitation of our pilot included both clinician and patient factors. Clinicians involved in the trial were more comfortable using technology and as such this may have an impact on the success of virtual consultations in a wider community health setting. Equally technology savvy patients were more successful in completing the consultations. Patient factors including sensory impairment were not tightly controlled and this may have impacted history taking and cognitive assessments. This was minimized by good collateral history but not eliminated.

Despite the small sample size our pilot does show that virtual consultations are promising and further data is needed. Virtual consultations can be used in a hybrid model where virtual consultations could be offered as a choice to patients especially those who are affected by frailty and mobility issues. This pilot was completed during the height of lockdown and shielding and we are now moving towards a blended approach of virtual and face-to-face reviews.

Dr Rajesh Abraham, Consultant Psychiatrist, Guildford and Waverley CMHTOP
Dr Philip Slack, Consultant Psychiatrist, Surrey Heath CMHTOP

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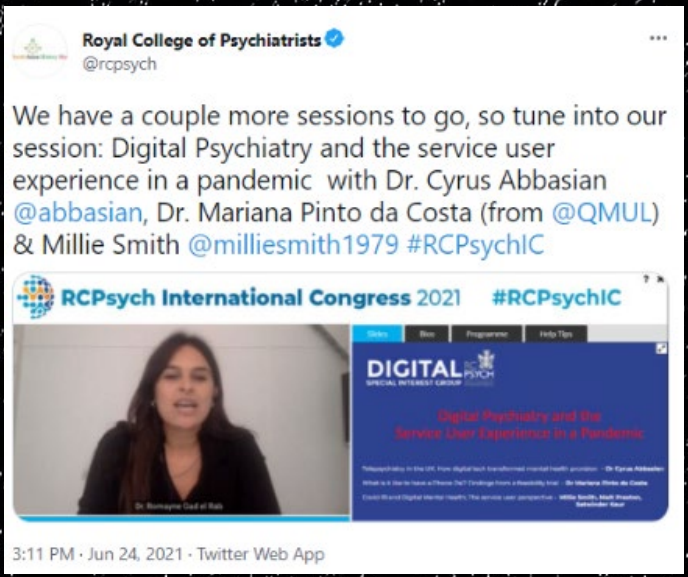
https://www.nhsx.nhs.uk/covid-19-response/data-and-information-governance/information-governance/covid-19-information-governance-advice-health-and-care-professionals/
https://www.attendanywhere.com/journey.html

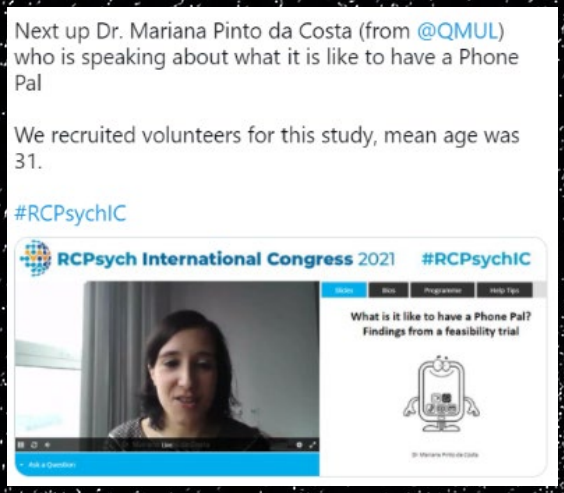
Digital Psychiatry and the RCPsych International Congress 2021

The RCPsych Digital Psychiatry SIG had the pleasure of contributing to the RCPsych International Congress on the 24 June, 2021 with a session on Digital Psychiatry and the service user experience in a pandemic.

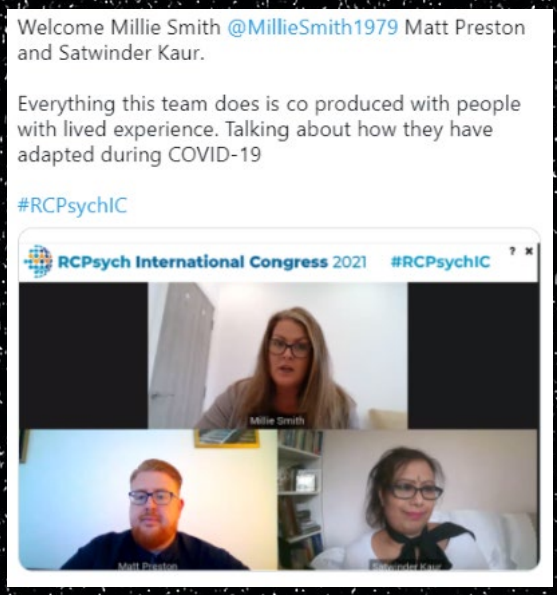


The first talk was by Dr Cyrus Abassian from St George's University of London on "Telepsychiatry in the UK: How Digital tech transformed mental health provision". It provided an overview on how technology has transformed mental health provision, and the impact of the "internet age" in mental health care.

The second talk by Dr Mariana Pinto da Costa presented the findings from a feasibility study conducted at Queen Mary University of London on "What is it like to have a Phone Pal?" The talk covered the findings of a clinical trial with London-based patients and volunteers from across the country. The study showed that it is feasible, acceptable and safe to connect patients and volunteers remotely through smart-phones and participants not only seem to like the intervention, but also benefit from it.



The final talk was by Millie Smith, Matt Preston and Satwinder Kaur who discussed "COVID-19 and Digital Mental Health; the service user perspective". This team with expertise in co-production at East London NHS Foundation Trust described that changes to online consultations occurred quickly, and it was necessary for service users to learn quickly how to use technology, which led to a number of service users digitally excluded. We also heard how the move online facilated creativity in a pandemic and the group shared poetry created online.



These talks were followed by an interactive discussion with the audience on digital mental health aiming to promote user inclusion.
We look forward to continue engaging in these discussions with you all!

Summary by Dr Mariana Pinto da Costa.

Top 5 things you need to know about DATA as a psychiatrist

By Asif Bachlani + Ayesha Rahim.

DATA!

We all know we need data in order to make decisions about care, be that data from research trials to inform our intervention decisions, or data about how our services are performing. But what about these buzz words that keep being bandied around? "Big Data", "data science", even #DataSavesLives?

What does this mean for your practice?
Read on for the top 5 things you need to know about data in mental health.

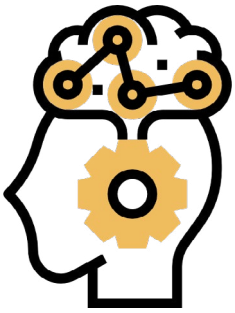
1. Examples of existing dashboards [ie what you can do if you have data in the care of specific patients; the SWLSTG timeline stuff would be a great example]

2. College MH watch https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/mental-health-watch [for more regional comparisons]

3. NHS benchmarking data ["ask to see your trust's data to compare nationally"]

4. RCPsych data conference [to dip your toe in the water]

5. Further resources/courses/reading [to skill up further]



1. Within healthcare organisations we are constantly collecting information about patients be their demographics, ethnicity, diagnosis, rating scales and outcomes. For most of us collecting the data is less of a problem but what we are not so good at is collecting data that is relevant to patient care and presenting this data to clinical teams in a manner that is meaningful, supports patient care and quality improvement.

One good example of clinically meaningful dashboards is from the Digital team at South West London + St. Georges Mental Health Trust who presented their dashboard which has patient level information on outcomes – HoNOS, DIALOG and clustering.

2. Another important source of data is the **RCPsych's mental health watch** which president Adrian James discussed at the RCPsych Data Conference held in May 2021. Dr James spoke about how the RCPsych prioritised vaccinations of SMI in discussions with Prof Whitty, about the value of data and how data made major improvements in cancer care where 98% of people have evidenced based care as against only 30% of people with psychosis. He also elaborated on how RCPsych is supporting use of data via the Mental Health Watch.

3. Starting off on the 'data' journey: There is no better place than the **NHS Benchmarking Network Data** set which is considered to the best mental health data set internationally.

Stephen Watkins, director of the NHS Benchmarking network discussed the impact of COVID on mental health services at the May conference, how CMHT caseloads remain 5% lower than pre-Covid times, with shift of contacts from face to face to digital or face to face. CAMHS services moved to 27% digital consultation whereas Adult services used telephone as the alternative with only 7% of appointments being digital.

For this year's national mental health NHS Benchmarking data results sign up for webinars - https://www.nhsbenchmarking.nhs.uk/events. To get your individual trust's data set ask your Trust's Medical Director.

4. 2021's **RCPsych Better Data, Better Care** conference was held on 13th and 14th May 2021. The conference was open to all members and followed the success of the General Adult Faculty conference in 2019. This year's conference focused on the value of data to clinicians, how to access the already available Mental health data sets on your local population, how to develop clinician friendly dashboards, the connection between data, digital and outcomes as well as 'real life' examples of how clinicians have used data to improve their service.

This was attended by 190 delegates which included international medical students, trainees, speciality doctors, consultants, CCIOs and Medical Directors.

This is a good time to show interest in next year's conference - #RCPsychdata22 which will be on Wednesday 27th April 2022 with RCPsych President Adrian James opening the event.

5. Other data resources that clinicians can access are:

- At Borough level – produced by Public Health England in order "To understand their local community's needs, agree priorities and encourage organisations involved in health and care to work in a more joined up way" - mental health JSNA
- At CCG level - find yours via NHS Clinical Commissioners website
- At Regional level - CQC Area profiles - https://www.cqc.org.uk/publications/themes-care/area-data-profiles
- If you are based in London: London Mental Health Dashboard
- NHS Digital Mental Health Data Hub – which is a "collection of interactive dashboards and useful links covering mental health data in England"

Dr Asif Bachlani,
Consultant Psychiatrist + Clinical Director for Acute and PICU Service Networks

Dr Ayesha Rahim,
Perinatal Psychiatrist, Deputy Chief Medical Officer, Chief Clinical Information Officer.

I am healthy now,
House trained,
Civilised.
We have days out in the sunshine,
And debate coffee tables in IKEA.
I drink flavoured lattes
And matcha green tea smoothies.
I work in job where I make a difference.
My friends are supportive and kind.
I invest and plan for my future,
I have a future.

But the chaos still calls me from the darkness,
A tiny sound, from so far away.
I can only hear it if I listen very carefully,
It has such a beautiful melody,
Hypnotic.
It sings a song of excitement, destruction, fighting, regret, guilt, sadness and panic.
Verses that remind me of who I once was
And who I could be again.
All I have to do is let go
And for the briefest, tiniest moment,
I am tempted.

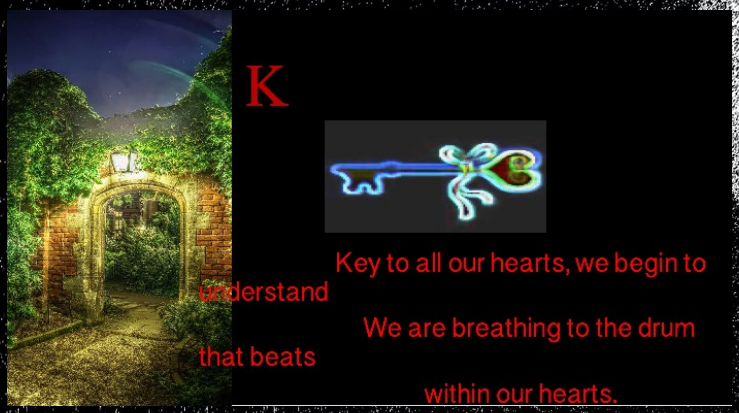
@MattPWriting

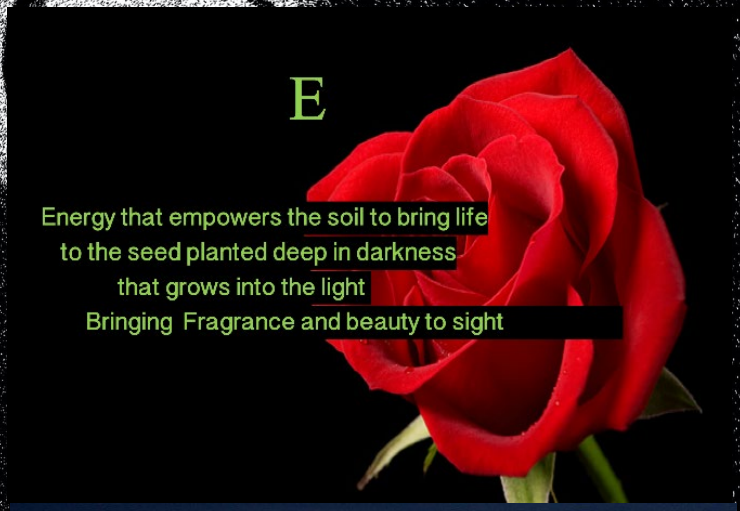
Poem by Matt Preston
Service User Quality Assurance Lead
Matt facilitates digital poetry groups

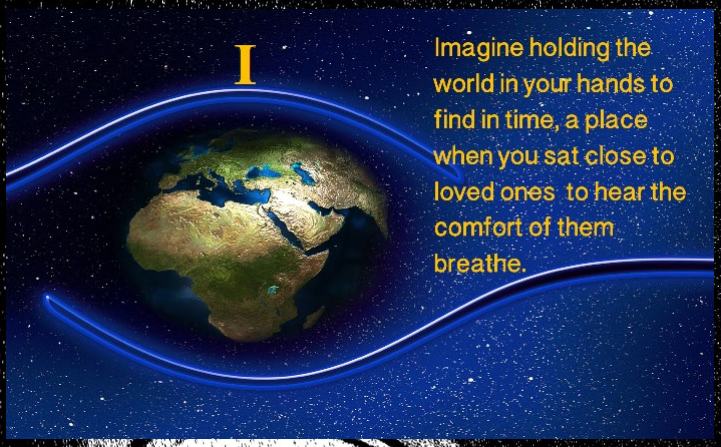
East London NHS Foundation Trust

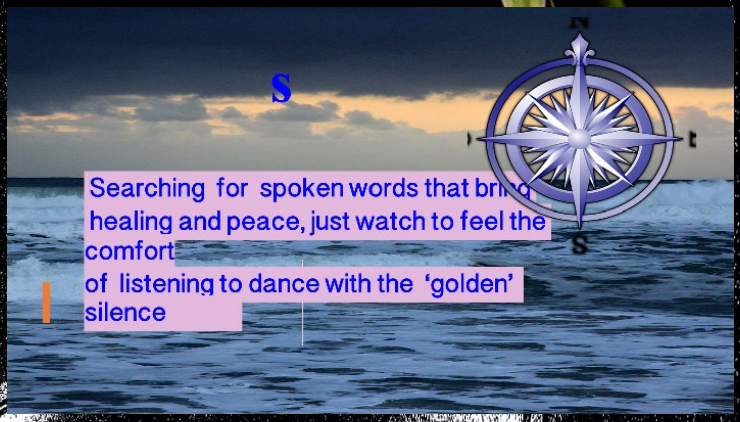
Kindness

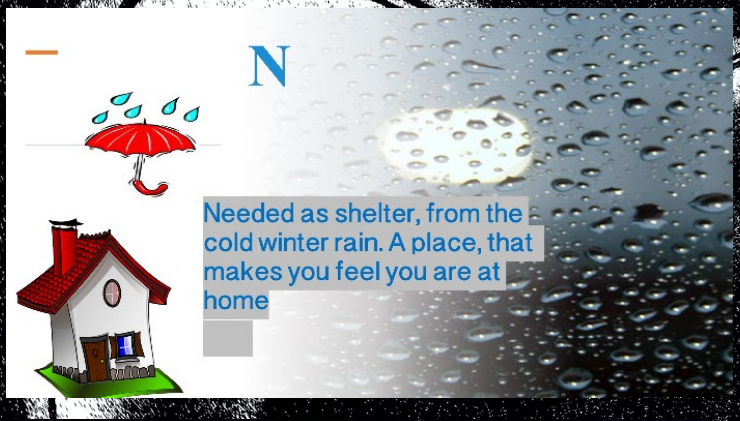
By Satwinder Kaur
Avtar Singh and Joravar Singh

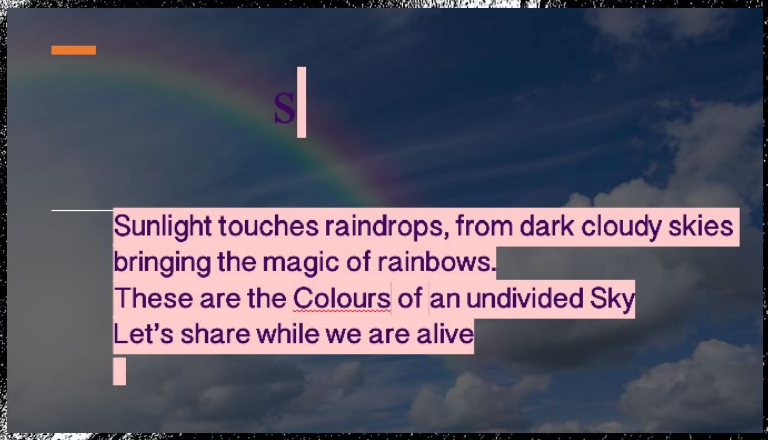


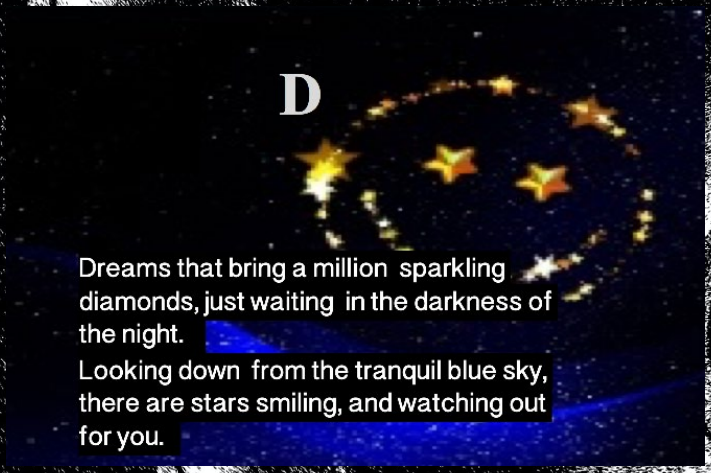












Poem By Satwinder Kaur.
Quality Improvement coach with Lived Experience at ELFT,
Expert by Experience with People participation.

OPPORTUNITIES

SHOUT- SPECIAL INTEREST OPPORTUNITY

Mental Health Innovations is the charity behind Shout 85258, a free, confidential, 24/7 text messaging support service for anyone who is struggling to cope. Shout began as a pilot in May 2018, and was launched publicly in May 2019. Shout Volunteers have taken more than 1.25mil conversations with people who are anxious, stressed, depressed, suicidal or overwhelmed and who need immediate support. As a digital service, Shout 85258 has become increasingly critical since Covid-19, being one of the few mental health support services able to operate as normal at this time. The service currently responds to between 1500 and 2000 requests for support every day.

Opportunities for Royal College of Psychiatry Trainees. There are multiple opportunities for Royal College Trainees to work with us. These include:

- Training as a Shout Volunteer and taking conversations on the platform
- Training as a Shout Clinical Supervisor, supervising volunteers on the platform
- Working with our Data Insights Team on specific, special interest research projects
- A combination of the above

If this may be of interest to you, please contact **Sarah.Kendrick@giveusashout.org** who will arrange aconversation with the most relevant person in our team to discuss the options further.

DIGITAL SIG EXEC COMMITTEE

We have two committee spaces currently vacant: **Finance Officer** and **Events Lead**. If you are interested in joining, drop us an email!

DIG SIG GROUPS

Does your Trust have a digital group, Connect with us and let us know.

RESEARCH

Add to our **research repository**
A google doc of all things technology and innovation within mental health.

Look out for our soon to launch lunhctime Digital SIG meet up session to share research and projects.

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