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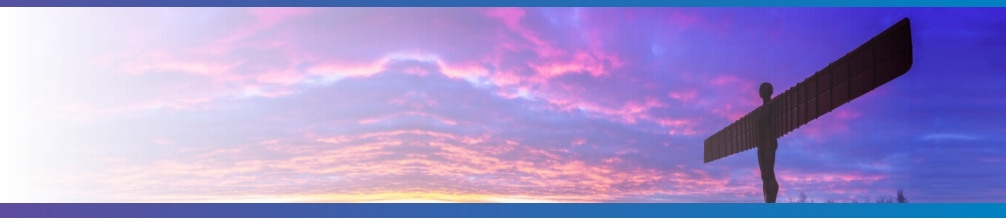
Psychiatry

The Northern & Yorkshire Division eNewsletter



Editorial

In this issue:

Welcome to the Summer edition of the RCPsych Northern and Yorkshire Division eNewsletter. I am delighted to be the Guest Editor of the newsletter and am grateful to all the authors who have contributed to this edition.

I have learnt a lot from these articles about how we can improve our practice and lead fulfilling careers. It has been inspiring and educational. Our chair begins with a divisional update. Dr Nazish Hashmi, Dr Elizabeth Edwards, Dr Betsy Babu and Bal Dosanjh share the valuable benefits reaped from a Diverse Mum's support group in Leeds. This is followed by a timely project where Dr Bhowmik considers why patients miss appointments in Children and Young People's Services.

In her article Dr Ranjita Howard highlights the importance of encouraging help seeking, particularly through examples from leaders. Dr Sana Fatima and Dr Deepak Moyal report on a vast quality improvement project aimed at changing an organization's culture towards sustainability. Dr Gbolagade Akintomide shares an innovative approach to reducing enhanced observation levels on PICU wards across the Cygnet hospitals. Dr Sumeet Gupta, Dr Sayeed and Mat Croft share an update on the use of Clozapine. Dr Lauren Unsworth, Dr Gwen Collin and I discuss an evaluation of a mentoring scheme for higher trainees. Dr Anne Alase reviews "The Body Keeps the Score," a widely praised book on the theme of trauma but one not for the faint hearted.

We hear from Dr Gwen Collin, reporting on the inspiring RCPsych Annual Trainees conference where she played a key organizational role. Dr Gupta reports from the division Spring Conference. Dr Ben Dempster and Dr Grace Bretnall report on the Great Northern Psychiatry Summer School, an innovation of hybrid event styles.

I am particularly grateful to our Divisions Committee Manager, Moinul Mannan, and Cheryl Hatwell, Divisions Administrator. They are vital to the work of the division and the production of the eNewsletter.

Those who submit articles to our newsletter are entered for our best article prize. Congratulations to Drs Fatima and Moyal who are this edition's winners of the £100 prize with their vital work on sustainability. Please submit articles of 500-1000 words' length by 15th November 2024 to: northernandyorkshire@rcpsych.ac.uk.

Dr Sarah Orr, Editor, Northern & Yorkshire Division

Chair's Column

By Dr Sunil Nodiyal

Welcome to the latest edition of the newsletter for the Northern and Yorkshire Division of the Royal College of Psychiatrists. Here, you can find updates, news, and information about activities of our division and the field of psychiatry in our region. My name is Dr Sunil Nodiyal, and I am the new Chair of the division. I have taken over from Dr Paul Walker who was our very able chair for the last 4 years. I hope to continue doing all the great work he undertook.

Our division is dedicated to promoting excellence in psychiatry and mental health care, and we strive to support our members in their professional development and practice. Through this newsletter, we aim to share insights, resources, and opportunities to facilitate learning and collaboration among our members.

We have had a successful academic year so far with several webinars and conferences that we ran. These included our webinars Prescribing GMC guidance and medicolegal aspects, The Use and Misuse of the Mental Capacity Act and our Spring Conference which focused on new treatments in psychiatry.

Dr Sumeet Gupta (our new vice chair), Moinul Mannan, our divisional administrator and I recently have met with a couple of Integrated Care Boards from our divisional area. One of them was North East and North Cumbria ICB and the other was the West Yorkshire ICB. They were both very good meetings with productive discussions as to how the division can support the local ICBs in maintaining and improving standards in mental health. The leads of ICBs shared their areas of concerns and where they may need support from the college as an expert body. We in turn offered our expertise from our membership and invited them to attend our executive committee meetings. We agreed to have regular meetings in the future to keep communication open. We are hoping to meet all the ICBs operating in our divisional area to keep the channels of communications open and invitation has been sent to the remaining ICB leaders to meet with us.

We encourage you to check back regularly for updates and to engage with the content by commenting and sharing your thoughts. We also welcome contributions from members who wish to share their expertise, experiences, and perspectives on topics related to psychiatry and mental health care in our region. I am particularly excited to inform you all about the upcoming autumn conference. It is titled "Triumphs Amidst Trials: A Local Showcase" on 27th September 2024, at Holiday Inn, Scotch Corner, Darlington. This year, we are going to focus on local mental health services. Our division covers six mental health trusts and many private providers. Come and learn, from our local leaders, about how local mental health services are coping and excelling despite ongoing service pressures and challenges. Also hear about regional specialist services for best practices in their specialist areas (substance abuse, neuropsychiatry and chronic fatigue services). It's a fantastic opportunity to connect, learn, and share insights with colleagues. For Students, Foundation year doctors, trainee doctors and middle grade doctors, there is time to enter the poster competition where we have increased the amount of money for the prizes in each categories.

Also look out for vacancies in the division (see page 29). It is a fantastic opportunity to be involved with the functioning of the division. Taking on a role in the division opens opportunities to take on further roles within the division or within the college nationally.

Thank you for viewing our newsletter, and we look forward to connecting with you as we work together to enhance the quality of mental health care in Northern and Yorkshire region. I wish you a pleasant summer.

Dr Sunil Nodiyal
Chair of the Northern and Yorkshire Division

An evaluation of a Diverse Mum's Support Group developed within the perinatal mental health service in Leeds

By Dr Nazish Hashmi, Dr Elizabeth Edwards, Dr Betsy Babu, Bal Dosanjh

Background

Evidence demonstrating ethnic inequalities in mental health is accumulating and has created a drive for culturally competent services to be delivered. Women from ethnic minorities are disproportionately affected by perinatal mental illness yet despite this, they are less likely to access services.[1,2,3] Albeit limited, research has suggested that possible explanations for this are multifactorial and may be due to; experiencing more discrimination and isolation; having less awareness of perinatal mental illness; and complex cultural and religious beliefs around mental illness, including stigma.[4] Data exploring experiences of women from diverse ethnic backgrounds has highlighted that lack of culturally appropriate services are a factor in the under representation of ethnic minorities receiving mental health care. [5]

In view of this data, using co-production, a Diverse Mums' Group was set up to support women under perinatal mental health services from diverse and ethnic minority backgrounds. The aim of this was to create a culturally specific support group that creates an inclusive culture, breaks down barriers through open discussion, reduces stigma, creates a sense of shared identity and belonging, and improves wellbeing and recovery among women from diverse backgrounds.

Methodology

Women from diverse ethnic backgrounds who were under the care of perinatal community services in Leeds and expressed interest in the group were sent an initial questionnaire to identify specific needs. The responses were evaluated and a co-produced schedule for the group was created. This aided the development of a six-week trial whereby feedback from participants was collected using a questionnaire.

Results

The data corpus for the analysis consisted of questionnaires completed by 10 members of the diverse Mums' group, and thematic analysis followed the 6 steps outlined by Braun and Clarke (2006). An inductive (bottom-up) approach to analysis was conducted to provide an overview of the data. The analysis identified 3 themes and 6 sub-themes. A summary of each theme is provided below.

Theme 1: Psychosocial factors

The first theme was related to psychosocial factors and had two sub-themes: overcoming anxieties, and shared experiences.

Quotes regarding psychosocial benefits of the group included:

"Improved self-esteem, positivity"

"I absolutely love the Diverse Mums Group but I could never share this with my mum or sister. They would think I have a Jinn inside me."

"We are like a little family and care about one another, our feelings are acknowledged and understood because we all come from similar backgrounds".

It was felt by the participants that being within a group of women from diverse backgrounds was an opportunity to offer and receive support from individuals with shared experiences:

"Talk about motherhood, depression, share personal experience."

"This group is a safe platform to share what I am going through. There is no taboo here: every story matters, everybody matters."

"This group is important because people don't realise the country you come from is important. I am isolated, don't have friends. We can share our views and backgrounds together."

Theme 2: Cultural factors

The second theme considered factors associated with cultural considerations of the support group. For this theme, there were two sub-themes: Cross-cultural awareness, and Overcoming stigma.

Regarding cross-cultural awareness, respondents saw the group as an opportunity to recognise differences and similarities amongst the group:

"Learn about cultural beliefs and the difference between Culture and Religion and the emotional impact this has on people from different communities."

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The second sub-theme which arose from the data was overcoming stigma. A number of respondents saw the group as an opportunity to discuss topics such as gender roles, religion and self-determination within their culture:

"Mental health is not a Christian/African thing. It's seen as a new thing that's happening in Europe."

"I've stopped talking to my friends about my illness, they don't get it."

"There's too much stigma and shame about mental health in my community which is an every day challenge for me and I don't have the energy to fight back."

The group was seen as an opportunity to talk through issues surrounding pressures and understandings of their cultural background in order to confront and understand stigmas.

Theme 3: Attendance factors

The final theme focused on the issues surrounding attendance of the group and what obstacles the respondents recognised in continual support. Two sub-themes were identified; physical attendance, and perceived benefits.

Capacity of service users to attend the group was primarily dependent on childcare and whether this was obtainable. Anxiety over issues related to Covid-19 was also a significant determinant, with users split between a preference for socially distanced meetups or virtual support groups.

The final sub-theme was related to whether respondents felt the support group would be beneficial to them. Some service users who had initially expressed interest decided against utilising the service. Interest was increased when they could suggest what they would prefer to gain from attendance.

Discussion

Our evaluation looked at the experiences of service users from ethnic minorities suffering mental health disorders during the perinatal period and the experience of being part of a culturally tailored support group. Having a group where they could meet other women with similar experiences helped many women overcome their anxiety and improve their self-esteem. The group also provided the opportunity to address awareness and stigma around mental health within their culture and across other cultures.

Strengths and Limitation and future directions

Evaluation was limited by the low number of participants. It was also conducted during the COVID-19 lockdown which brought challenges around face to face contact. Inclusion of more service users would provide more insight into perinatal experiences of mental illness and enable further research and development of groups. Generalisability is limited as it was conducted within the perinatal cohort. It would be interesting to see how a diverse support group in general adult services would compare.

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An evaluation of a Diverse Mum's Support Group developed within the perinatal mental health service in Leeds

By Dr Nazish Hashmi , Dr Elizabeth Edwards, Dr Betsy Babu, Balvinder Dosanjh

Dr Elizabeth Edwards
CT3, Leeds and York Partnership NHS Foundation Trust

Balvinder Dosanjh
Clinical access, engagement and inclusion coordinator, Leeds and York Partnership NHS Foundation Trust

Dr Betsy Babu
Specialty Doctor, Leeds and York Partnership NHS Foundation Trust

Dr Nazish Hashmi
Consultant Perinatal Psychiatrist, Leeds and York Partnership NHS Foundation Trust

A Service Evaluation Report of the cases who were discharged from services for non-attendance (DNA) in the Northumberland CYPS (Children and Young People's Service)

By Dr Kalpasree Bhowmik

Introduction:

The terms 'Did Not Attend' (DNA) or 'Was Not Brought' (WNB) referred to appointment outcomes recorded in patient's notes when a patient missed their clinical appointments offered within the NHS. The Outpatient Recovery and Transformation Programme (NHS England) noted that during 2021/2022, approximately 7.5 million of appointments were missed by patients.[1,2] Missed appointments cost CYPS over £45 million per annum[3] It has been often debated amongst professionals whether "DNA" was an appropriate word to use in this context, as the majority of CYPS service users are generally dependant on their carer to bring them to appointments. The term "WNB" (Was Not Brought) for the appointment may be more appropriate to service users who are of an age where they require parental/carer assistance to attend appointments. The UK children's charity, NSPCC (National Society for Prevention of Cruelty to Children) further argue that a change in terminology matters, as it might encourage the professional involved with the young person to question safety and reasons for non-attendance.[3,4,5] Research has shown that factors including younger age group; deprived population; human factors; therapeutic relationship; and communication between provider, clinician and service user also influence attendance.[3] Reducing missed appointments helps ensure that clinical time is used effectively for good clinical care.

Scope of Work undertaken:

Title: Service evaluation of the cases who were discharged from the services for non-attendance (DNA) in the Northumberland CYPS.

Time period covered- 31/10/2021 to 31/10/2022

Aim of the project: To improve the quality of delivery of service and to identify any modifiable cause of young persons not brought to the appointment (and thus being discharged under the heading "Did Not Attend" or "DNA" in the trust electronic documentation system (Rio)). This is a quality improvement project aimed to improve the quality-of-service delivery and to understand trends and reasons for non-attendances in CYPS.

We aim to gain insight to the issues in accessing services and any known reasons for discharge due to non-attendance.

Methodology:

The discharge case load of the Northumberland Children and Young Person's Services (CYPS) were examined for the above study period.

The patient's electronic notes were examined to identify any possible reasons for non-attendance in appointments outcomed as 'DNA' (Did Not Attend).

Results:

Demographics:
Table 1

Demographics	White British (%)	Other (%)	Total
Male	13 (61%)	0 (0%)	13 (61%)
Female	7 (33%)	1 (4.7%)	8 (38%)
Other gender	0 (0%)	0 (0%)	0 (0%)

Age group:
Table 2

Age group (years)	Number (%)
5 to until 12	8 (38%)
>12 to until 16	3 (14%)
>16	10 (47%)

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Diagnosis:
Table 3

Problem/Diagnosis	Number	Percentage
ASD (Autism Spectrum Disorder)	3	**14%**
ADHD (Attention Deficit Hyperactivity Disorder)	3	**14%**
Intellectual disability (ID)	1	**4.7%**
Mental health problems	9	**42%**
Mental health problems with ASD/ADHD/ID	1	**4.7%**
Alcohol and Substance misuse	2	**9.5%**
Incomplete assessment	1	**4.7%**
No diagnosis	1	**4.7%**

Health care professionals involved as care co-ordinator at the time of discharge:
Table 4

Care co-ordinator (CCN)/key worker	DNA number	DNA %
Community Psychiatry Nurse (CPN) or Nurse medical prescriber (NMP)	12	57%
Psychologist or therapist	4	19%
Doctor	3	14%
Occupational therapist	2	9.5%

Methods used to inform carer/young person/key worker/GP regarding appointments

Table 6

Contact	Yes	No	Unclear from case notes	Disputed by carer
Appointment information (Phone, text, email, letter, verbal)	**18 (85 %)**	**-**	**0 (0%)**	**3 (14%)**
Telephone Contact with carer/ young person or the other key agency Following WNB	**14 (66 %)**	**3 (14%)**	**2 (9.5%)**	**2 (9.5%)**
Opt-in letter sent out:	**12 (57 %)**	**9 (42%)**	**0 (0%)**	**0 (0%)**
Discharge letter completed	**21 (100 %)**	**0 (0%)**	**0 (0%)**	**0 (0%)**

Discussion:

The CNTW (Cumbria Northumberland Tyne and Wear) NHS trust policy on non-attendance Recommends that in accordance with national reporting requirements, appointments cancelled by the service user within 24 hours of the booked time should be recorded as DNA. The policy also advises that prior to discharge following DNA, CYPS professionals contact the carer/client and the other key workers involved in care of the young person before sending out an opt-in letter and discharging them.[4]

Case notes revealed there was a trend of multiple DNA and previous discharge due to DNA in some cases. Contributing factors included issues in receiving communication; human factors (such as carers forgetting about the appointments); therapeutic relationship factors

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(such as the carer/service user attributing positive change to other factors rather than medications or the carer not agreeing with the management plan proposed by the keyworker) and other patient factors (including conduct disorder, addiction issues, being unwell or work commitments).

Good Practice:

Nevertheless good practice was identified in two areas; following the trust policy by contacting the carer or the young person (66%) and completing a discharge letter for all patients (100%).

Conclusion

Recommendations:

1. Clinicians to consider contacting the carer following all non-attendance, including those for initial appointments, and to record this in the electronic record.
2. To re-evaluate DNA cases in the service in 12 months' time.
To consider the use of questionnaires (with consent) in future studies to further our understanding.

Limitations of this study:
Limitations of the study included lack of information on the specific reasons for non-attendance leading to discharge; lack of information onthe economic background of service users and a lack of feedback from services users/carers.

Conflict of interest:
None to declare.

Acknowledgments:

1. Information analytics, CNTW NHS FT
2.Dr Jeremy De Bono (sponsor), consultant psychiatrist, Northumberland CYPS, CNTW NHS FT

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Dr Kalpasree Bhowmik
Specialty Doctor, Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Addressing help-seeking barriers for trainees and students: The importance of senior physician wellbeing role models.

By Dr Ranjita Howard

Introduction

"Lunch is for losers" and "You can sleep when you're dead", are sentiments that still typify the work ethic philosophy of many physicians within our profession[1]. Although in my experience such views no longer predominate, their impact endures given that the capacity to cope with the pressure, managing long hours, and maintaining the professional identity of infallibility and perfectionism[2] all reflect the cornerstone of cultural value within the field. It is therefore unsurprising that such a cultural environment often results in trainees and students choosing not to seek help for health problems, leading to high levels of presenteeism, burnout, depression, anxiety, and suicide[3]. Fears of being seen unfavourably by others (stigma), concerns about the career implications of disclosing an illness (discrimination), the guilt of burdening peers with added workload (psychological factors), not having time to access resources (such as seeing a GP), or being unaware of available resources (such as wellbeing clinics), all serve as possible explanations as to why low levels of help-seeking behaviour exist amongst trainees and students despite evident need (Box 1)[4].

Box 1. Barriers to help-seeking for trainees and students

- **Stigma**
  - Potential of being seen less favourably by colleagues
- **Discrimination**
  - Potential implications on career/ opportunities
- **Psychological factors**
  - Feelings of embarrassment, fear, guilt
- **Time constraints**
  - No time to access resources
- **Awareness**
  - Unaware of resources available

Addressing help-seeking barriers for trainees and students

Addressing barriers to help-seeking for trainees and students may offset a lot of the negative consequences of this perfectionist work ethic. Given that these barriers are generally embedded within the culture itself, it seems logical that addressing culture should be central to any organizational change initiative. Previous attempts at changing culture within large organizations has generally considered the workforce homogeneously, prioritizing hyper-cultural change that reflect the corporate narrative or structural activities of an organisation[5].

Contemporary efforts, however, are acknowledging the deeper, more phenomenological realities occurring within the workplace, and that culture is shaped via the everyday language, beliefs and meanings held by organizational members. To achieve profound change, any cultural change program should therefore be implemented from the bottom-up, based upon the understanding that true change is contingent upon change in the individuals that make up the organisation[5]. Interventions that encourage use of cultural change-facilitating language; appraisal systems that reward expression and implementation of wellbeing principles; and championing those who symbolize or advocate self-care; have all been proposed as means through which such positive cultural change can manifest.[6]

Senior physician wellbeing role models
Accessing non-discriminatory wellbeing support

Consistent with the medical adage "see one, do one, teach one,"[7] it is unsurprising that the involvement of senior physician wellbeing role models is positively associated with help-seeking amongst trainees and students. Access to senior physicians who offer non-discriminatory wellbeing support, for example, has contributed to the 'normalization' of self-care, enabling juniors to 'open up' and become more amenable to seeking further support if needed. Indeed, peer-to-peer support that advocates the importance of accessing self-care resources (e.g. the Doctors Support Network) or provision of mentoring/ coaching has been shown to be effective in facilitating help-seeking behaviours.[8] To offset the 'command and control' culture in favour of a less discriminatory environment that promotes self-care and collective problem solving, Tees Esk and Wear Valley (TEWV) NHS Foundation Trust, has also endeavoured to train and

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sponsor development of Physician Master Coaches and accredited Physician Cognitive Behavioural Therapists, through their ThinkOn solution-focused coaching programme, and Value-Adding Professional Activities for Trainees (VAPA) initiative. Such trust initiatives are proving fruitful, demonstrating increased trainee self-care, self-confidence and wellbeing. Indeed, being a recipient of CBT sponsorship myself and having supported several trainees and students during my training, I have been able to build rapport by facilitating a non-discriminatory safe space which encourages open dialogue and emotional transparency, leading to increased self-care amongst all my clients.

Exposure to those who self-disclose overcoming mental health challenges

Exposure to physicians who self-disclose overcoming their own mental health challenges has also helped offset barriers to help-seeking. Martin et al (2020), for example, in their randomized study of 43 medical students found that those exposed to physicians with self-disclosed histories of overcoming mental illnesses were more likely to access care if they needed it[7]. It is encouraging that more trusts, medical conference organizers, publishers and royal colleges are seeing value in such findings, and are now inviting senior doctors who have faced mental health challenges to openly communicate on how they overcame them. Dr Rebecca Lawrence - a trailblazer in self-disclosure of living with a mental illness as a physician – was a keynote speaker this year at The Royal College International Congress 2024. Her contribution has also been recognized by Cambridge University Press in her memoir 'An improbable Psychiatrist,' and by the Royal College of Psychiatrists who shortlisted her for Psychiatric Communicator of the Year. Continued championing and promotion of individuals who symbolize self-disclosure will no doubt go a long way towards shifting medicine from a culture that values infallibility and perfectionism to one that emphasizes acceptance and compassionate self-care.

Culture eats strategy for breakfast

Despite well-intentioned interventions it is important to remind ourselves that, unless implemented as part of a broader cultural change initiative, they are at risk of having little effect on processes they intend to change. Worse still, they risk reducing terms such as self-care, compassion, and wellbeing to nothing more than buzzwords. Within the context of the medical field, I think the notion that "culture eats strategy for breakfast" explains why a lot of the initiatives pushing the wellbeing narrative may not have the impact intended. However results may be fruitful if we proceed with caution, adopting the most appropriate and timely interventions as part of broader cultural change. Research suggests that early involvement of senior physician wellbeing role models in any wellbeing cultural change initiative is fundamental, and it is pleasing to see that trusts including TEWV are taking heed, with positive results. If we continue to scaffold wellbeing programmes with measured organizational cultural change theory[5] we may soon witness a cultural shift towards one that values non-discriminatory, self-care practice. And, with that, the realization that lunch is in fact not for losers, and sleep is most certainly for the living, as both encapsulate a physician's capacity to look after oneself so that they can give their absolute best when caring for others.

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Dr Ranjita Howard
ST6 (CAMHS), NHS Education North East

Sustainability and Planetary Health: A Quality Improvement Project to assess Medical Staff's awareness and involvement in S&PH initiatives in Bradford District Care NHS Foundation Trust

By Dr Sana Fatima, Deepak Moyal, Sarfaraz Shora, Apostolos Bardis

Introduction

Sustainable healthcare practices have become imperative for addressing environmental challenges and promoting planetary health. Bradford District Care NHS Foundation Trust (BDCT) actively engages in Sustainability and Planetary Health initiatives, primarily run by a dedicated BDCT Sustainability department. The Royal College of Psychiatrists has advocated for Sustainability and Planetary Health and encouraged clinicians to actively engage in such initiatives. Recognising the importance of integrating sustainable practices into mental health care, the College's Sustainability and Planetary Health Committee emphasises a holistic view of sustainability, encompassing not only environmental concerns but also social justice and workforce sustainability. Key principles include prioritising prevention, empowering patients and staff, delivering high -value care, and considering carbon emissions.

Aims and Objectives

Focusing on our medical workforce, this project sought to examine the engagement of medical staff from BDCT in environmentally sustainable practices and identify ways to empower them for more effective contributions. The objectives included assessing the current knowledge and understanding of Sustainability and Planetary Health among medical staff at BDCT. Additionally, the project aimed to evaluate the level of participation of medical staff in ongoing Sustainability and Planetary Health initiatives within the NHS and Bradford District Care NHS Foundation Trust, while also examining the obstacles and constraints associated with these initiatives.

Methodology

This project adopted a mixed-methods approach, encompassing both quantitative and qualitative research methods. We developed a short survey questionnaire which was disseminated among the entire medical workforce in Bradford District Care NHS Foundation Trust. The target respondents included Consultants, Trainees, SAS/ Trust Grade and LAS doctors. The questionnaire comprised of 18 Questions on 3 Key Themes. These themes were:

- Staff: Staff Knowledge and Awareness S&PH
- Service Users: How do staff facilitate service user's awareness of S&PH
- Workplace: Access to green spaces

The survey required 5-10 mins to complete. The limitations included Conflicting priorities, survey fatigue and other barriers to survey responses.

Results and Analysis

56.% of respondents were working in inpatient settings while 33.3% were in the community, 2 respondents were working on other settings. A majority of respondents, 13/18 (72%) were working full time. Only a small percentage of respondents had awareness about sustainability champions within BDCT (22%) and the BDCT Green Plan (29%).

67% of respondents said there were Green Spaces at their workplace, but only 44% had access to them. The respondents suggested flower beds, use of hospital grounds, structural changes, planting orchards as potential improvements. Encouragingly, 89% of respondents were able to appraise the positive effects of nature on the mental well-being of patients, but only a minority (17%) had discussed them with their patients. Despite this, there were many interesting and feasible suggestions including: recycling options; arranging walks; teaching sessions; organising hiking trips; and awareness talks.

Sustainability and Planetary Health: A Quality Improvement Project to assess Medical Staff's awareness and involvement in S&PH initiatives in Bradford District Care NHS Foundation Trust

By Dr Sana Fatima, Dr Deepak Moyal, Dr Sarfaraz Shora, Dr Apostolos Bardis

Recommendations

We shared the findings with the trust's Sustainability and Planetary Health Department as well as with Medical Education department. We shared the following set of recommendations which helped engage stakeholders and continue to inform ongoing S&PH initiatives within the trust.

1. Improve Clinical workforce's engagement.

- Increased awareness using – teaching, emails, desktop reminders.
- More focused work on S&PH targeting the areas highlighted in this work with designated Roles and Responsibilities
- To Develop specific role i.e. Sustainability Lead) to encourage clinical workforce engagement.
- Recommendations to reduce staff commuting carbon footprint and promote sustainability-informed flexible working.
- Develop strategies to improve clinical staff's involvement in these initiatives.
- Review barriers and develop strategies to mitigate these.
- Realistic goal setting
- Ongoing collaborative work between Clinicians, Sustainability Department and other stakeholders

2. Facilitate Patients' relationship with nature.

- Encourage staff to use evidence-based insights to suggest strategies for medical staff to facilitate patients' relationship with nature, linking it with mental health benefits.
- Social prescribing

3. Workspaces

- Discussion with stakeholders to develop strategies to incorporate green spaces in the workplace and facilitate staff access and utilization of these areas.

Reflection and Limitations

This project has provided a valuable opportunity to contemplate and consider sustainable clinical practices within our trust. The emphasis on engaging clinicians and the medical workforce was the first project of its nature and highlighted scope for further work in the area. The project elicited genuine interest and a positive reception. In terms of specific challenges encountered during this project, we gained awareness of conflicting priorities, clinical workloads, and survey fatigue, among other factors. We acknowledged how despite its significance, the subject matter remains relatively underexplored and poorly understood, particularly within healthcare. We were also able to acknowledge how the project was a welcome first step in a wider culture shift, and in order to achieve long term outcomes, we will require ongoing advocacy for sustainability within the field of psychiatry, a focus on education and training, as well as collaboration with experts in environmental sciences, healthcare and sustainability.

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Dr Sana Fatima
ST6, Leeds and York Partnership NHS Foundation Trust

Dr Deepak Moyal
ST6, Leeds and York Partnership NHS Foundation Trust

Dr Apostolos Bardis
Consultant Psychiatrist, Bradford District Care Trust

Dr Sarfaraz Shora
Consultant Psychiatrist, Bradford District Care Trust

7Cs Enhanced Observation Review Protocol

By Dr Gbolagade Akintomide

Introduction

The use of enhanced observation (EO) in psychiatric inpatient wards is common. Between 8 and 23% of adult inpatients in the UK are under EOs, with the goal of supporting patients to reduce risks of harm to themselves and/or others. (1). EOs are estimated to cost the NHS £35 million annually(1).

EOs can be perceived as intrusive and might result in distress for patients. It is a form of restriction that should to be used for the minimum time possible. Other disadvantages include; taking staff away from providing therapeutic activities for other patients, increasing patients' dependency on staff, disempowering of patients, institutionalisation, exposure of staff to assault from patients , staff boredom and increased risk of allegations against staff (1). Moreover, evidence for enhanced observation reducing suicide is limited, and at best mixed. (1)

Alternatives to Enhanced Observation

Several alternatives have been attempted to either improve quality and safety of enhanced observation, remove or replace it, or, reduce frequency of it. These measures could be divided into two categories:

a) Changes to enhanced observation practice: such as daily review of EO by the team; senior nurses being empowered to make changes to observation in the absence of medical staff; case-based approach; staff education and training; and involving patients (for example patients contributing to discussions about their observations, and suggesting interventions to be used when adapting enhanced observations).(1, 2).

b) Organisational changes on the ward: such as staff focusing on positives about patients; patients being encouraged to contribute to care plans and risk assessments; encouraging regular patient meetings to support positive interpatient relationships; patients co-designing activities to be conducted on the ward and the use of sensory modulation tools and toys(1, 2).
Interventions which made adjustments to teamwork skills had the strongest impact on patient and staff experience; reducing frequency and length of EO; and reducing the cost of EO. (1, 2)

7Cs Enhanced Observation Review Protocol – Development

The 7Cs Protocol was developed by Cygnet but pioneered and developed in 2022 by the team on Franklin ward. Franklin ward is a 10 bedded female psychiatric intensive care unit (PICU) that cares for NHS patients referred directly from acute wards, A&E, PICU services, step downs from secure services and from prisons. The 7Cs protocol was first used on Franklin ward in June 2022. It underwent a Quality Improvement workshop in September 2022, following which the other 2 Cygnet PICUs in the Northeast adopted it.

Principles behind 7Cs Enhanced Observation review Protocol

The 7Cs protocol combined the two broad approaches of improving quality and experience of enhanced observation: a) changes to enhanced observation practice and b) organisational changes on the ward. The core principles of the 7CS are:

1. That EOs do not have inherent therapeutic value unless purposeful.
2. That EOs are a form of restriction that should be for the minimum time possible.
3. Working collaboratively with patients and agreeing a SMART objective on what to achieve in order to exit from the enhanced observation.
4. The 7Cs are a combination of 4 positive practices to do (4Cs) and 3 negative practices (3Cs) to avoid by the team and the patient. The 4Cs are that EOs should be a) Consistent (agreed by the MDT), b) collaborative (agreed with patients), c) Clear rationale (why and what to achieve with it), d) Clear exit Criterion (should be kept to and not subjected to review, most critical to success). The 3Cs to avoid are: EOs should not be due to a) Lack of Confidence in staff, b) lack of Capability (training) of staff, c) lack of Capacity (to increase number of staff on duty)

Operational procedure

Before commencing enhanced observations, the 3 negative Cs are discussed openly amongst staff to ensure that they are not the reasons for EO. Then the 7C form is completed to ensure the positive 4Cs above are kept to. In addition staff have to justify why EO is the least restrictive alternative. Then it is care planned and communicated with patients, and a copy provided to the patients.

The exit criterion must be a SMART (specific, measurable, achievable, realistic and time bound) goal and it must

7Cs Enhanced Observation Review Protocol

By Dr Gbolagade Akintomide

include the next planned level of observation. The observation is reviewed at least once daily by the MDT, with a focus when the clock restarts if there is an incident during the EO, and on when the exit criterion would be achieved. This is also communicated at handovers.

Alongside the above, discussions are had with the patient about the exit criterion and how to achieve it. Moreover, specific biopsychosocial activities to reduce challenging behaviours are agreed and implemented during and after EO. This is captured on a Service user involvement card that is given to the patient.

Once the exit criterion is met, the nurse in charge reduces the EO to the next planned level of observation without further review with medical doctors

Results

With the use of the 7Cs EO review protocol there has been a reduction in the duration of EO lasting more than 72 hours on Franklin ward from 100% to 30.8%. A similar reduction was noted in other units that adopted 7cs. Please see figure 3:

Observation level lasting more than 72 hours

PICU Ward	Pre 7Cs	Post 7Cs
Cygnet Hexham - Franklin ward	(July 2022) 100%	(August 2022) 30.8%
Cygnet Appletree - Pippin ward	(June 2023) 66%	(August 2023) 14%
Cygnet Victoria House Albert ward	(June 2023) 67%	(August 2023) 25%

Conclusion

The 7Cs EO review protocol has increased collaborative working between patients and staff, reduced durations spent on EO and improved dynamics by removing interpersonal differences around when EOs should be reduced. It has increased nurse autonomy whilst allowing the MDT and Responsible Clinician to retain accountability. Most importantly it has made our PICU wards patient centred, safer and non-discriminatory to patients of any diagnosis

Further development:

It is being adopted Cygnet wide and we are beginning to train NHS Trusts in the 7Cs. The Health Service Safety Investigation Body (HSSIB) also considered it for their May 2024 report. The protocol undergoes continual monitoring and tracking.

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Dr Gbolagade Akintomide
Consultant Psychiatrist, Cygnet Health Care Limited

Clozapine: A brief Update

By Dr Gupta, Dr Sayeed and Matthew Croft

Clozapine is the most effective antipsychotic medication and the only one licensed for treatment-resistant schizophrenia (TRS).

The US Food and Drug Administration (FDA) also recommends clozapine in schizophrenia/schizoaffective disorder with suicide risk.

Over 40% of TRS patients respond to clozapine (>20 % improvement) vs. about 5-7% for other antipsychotics.[1,2] Clozapine is effective in reducing episodes of aggression & violence and substance abuse.

Clozapine is also associated with a reduction of all-cause mortality, despite a high risk of metabolic syndrome.[2]

Clozapine dosage and therapeutic drug monitoring (TDM)

The dose of clozapine is usually 200–450 mg daily, max. 900 mg/day according to the BNF, but does not distinguish between acute treatment and relapse prevention. Additionally, the suggested therapeutic levels between 0.35–0.5 mg/L are based on acute psychotic symptoms rather than maintenance of schizophrenia. If a patient is asymptomatic and/or is experiencing adverse effects, then dose reduction should be considered (aiming for the lowest effective dose). Moreover, a few patients might also respond to lower or higher than the recommended therapeutic plasma levels hence the dosages should be decided based on response and adverse effects.[2-4]

Standardised titration charts should not be followed blindly. Dose increments should be personalised depending on adverse effects to promote tolerability. The suggested dosages, based on gender and smoking status, can result in highly variable plasma levels, therefore TDM is important to establish the target oral dose.[2,3]

Managing Side Effects

Hypersalivation Possibly dose-related, and tolerance may develop over time. Avoid systemic anticholinergic drugs, such as hyoscine, as these might worsen constipation. Consider localised treatments such as sublingual atropine. Regularly review ongoing benefit of anticholinergic drugs and consider trial discontinuation to confirm effectiveness. The decision to treat should be informed by sleep disturbances and a history of chest infection (aspiration pneumonia), due to hypersalivation.[5]

Constipation Common and dose-related adverse effect. Regularly enquire about bowel habit in detail. Keep a low threshold for prescribing laxatives and consider prophylactic use. Prefer Macrogol osmotic laxatives (i.e. Cosmocol, Laxido, Movicol), stimulant laxatives (i.e. Senna, Bisacodyl) and avoid bulk laxatives. Severe constipation can be life-threatening.[2,6]

Managing Side Effects – continued

Sedation Dose-related and common adverse effect. One of the common reasons for patients to discontinue clozapine and should be taken seriously. Dosages up to 500 mg/day can be taken as a single nighttime dose or divided dosages with a higher amount given at nighttime.[2,7]

Fever A common and usually benign adverse effect. However, if it persists and is associated with other adverse effects then myocarditis, NMS, infection, and neutropenia should be ruled out.[2,8]

Seizure Dose-related adverse effect. Possibly linked to rapid rises in clozapine level such as during titration, smoking cessation or during infections. The risk of seizure, even on high dosages (>600 mg/day), is about 5%) making primary prophylaxis unnecessary in the majority of cases. In contrast, the risk of seizure on any antipsychotic is about 1%. Avoid Valproate – increased the risk of agranulocytosis and myocarditis and consider the recent MHRA guidelines.[2,9]

Chest Infection Inflammation during serious infection inhibits clozapine metabolism, which can cause toxicity and is the most common fatal adverse effect of clozapine. If a patient develops a chest infection, consider clozapine dose reduction (25-50%), arrange the clozapine level and explain to the patient about signs and symptoms of clozapine toxicity.[10]

Myocarditis Idiosyncratic reaction, within the first 8 weeks Clozapine treatment. If Troponin levels are elevated seek urgent advice from a cardiologist and withhold clozapine.[11,12]

Managing Side Effects - Continued

Clozapine: A brief Update

By Dr Gupta, Dr Sayeed and Matthew Croft

Prolonged QTc Uncommon adverse effect. However, most patients on clozapine suffer from tachycardia and Bazett formula (used by ECG machines) might show prolonged QTc inaccurately. Recalculate QTc by Fredicia formula (QT Calculator or MDCalc). If the QTc interval is prolonged then consider reducing the dose of clozapine and stopping other medications which might prolong the QT interval.[11,12]

Neutropenia Red results refer to mild neutropenia. Most cases of mild neutropenia might not progress to severe neutropenia (Neut $<0.5x10^9/L$ = agranulocytosis). Most cases of clozapine-induced agranulocytosis (CIA) occur within the first year of the initiation of clozapine. After 12 months, the risk of CIA is similar to any other antipsychotic drug. Around 80% of clozapine rechallenges after a red result (off-license) are successful. Enhanced care is required in cases of clozapine-induced agranulocytosis. Always seek guidance and involve a haematologist.[13-17]

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Dr Sumeet Gupta
Consultant Psychiatrist, Tees, Esk and Wear Valleys NHS Foundation Trust and Vice Chair, Northern & Yorkshire Division

Dr Abdullah Sayeed
Senior Registrar, Tees, Esk and Wear Valleys NHS Foundation Trust

Matthew Croft
Advanced Clinical Pharmacist, Tees, Esk and Wear Valleys NHS Foundation Trust

Mentoring Specialty Trainees in North, East and West Yorkshire

By Dr Lauren Unsworth, Dr Sarah Orr and Dr Gwen Collin

Introduction

- Mentoring is a partnership in which a more experienced mentor provides support and guidance to someone less experienced who is in a similar role to themselves, supporting them and helping development. It is encouraged by the Royal College of Psychiatrists at all stages of a doctor's career.
- A peer mentoring scheme has been running in the North, East and West Yorkshire General Adult and Old Age Psychiatry higher training schemes since August 2020, following a successful pilot study in early 2020.
- New starters, or those returning from leave, are offered a mentor who can be matched to them based on various criteria (for example, experience of the same trust). Following introductions, the mentor and mentee are free to meet as often as they wish, with support or guidance available as required.
- An initial evaluation of the scheme in 2021 demonstrated that both mentors and mentees had benefitted from the scheme.
- Based on feedback from this evaluation, a training session for mentors was provided. We hope to repeat this for future cohorts.
- In February 2024 we surveyed past and current mentors and mentees to evaluate the scheme and guide its further development.

Aims

To review how the mentoring scheme is organized, to determine if it remains beneficial, and to determine if further improvements can be made.

Method

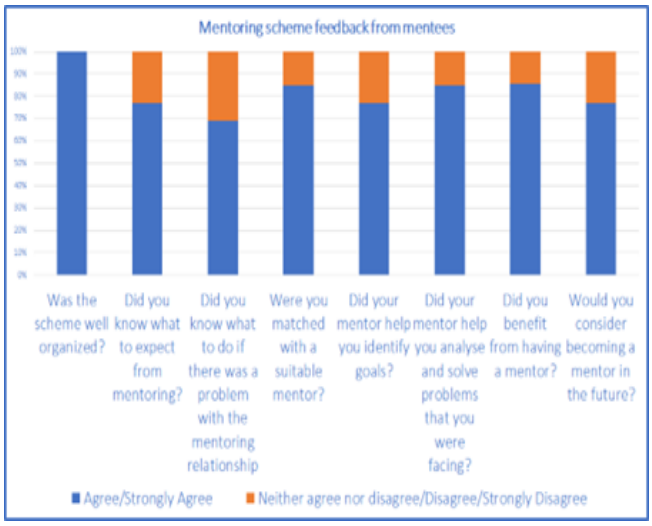
A questionnaire was distributed to all current and previous mentors and mentees via email and through the higher trainee WhatsApp groups.

Questionnaire

- The questionnaire consisted of 10 questions largely with 5-point Likert options for answers.
- Question themes for both mentors and mentees included organisation of the scheme, suitability of the matching process, availability of support and benefits of being a mentor or mentee.

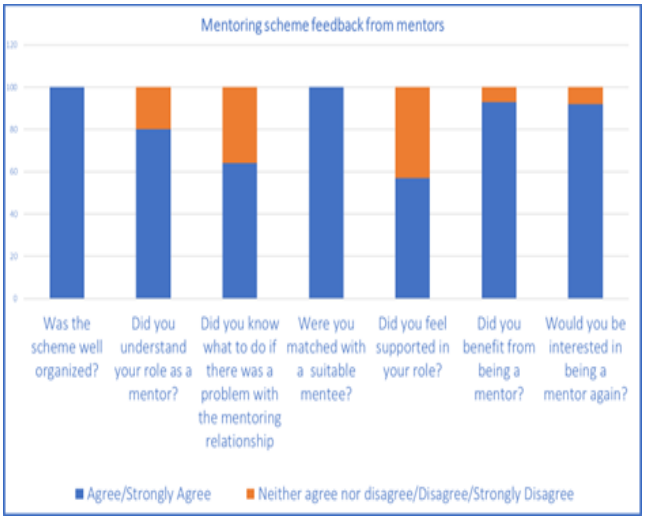
Analysis

Responses from Mentees: 13 responses received.



- 84% of mentees had requested a mentor because they were starting a new ST4 post. 8% were returning from a period of extended leave and 8% were new to the region.
- Themes from comments about how mentees had benefited included support settling into role/easing transition, practical advice, sources of support, and confidence.
- Some comments noted limited engagement from mentors and difficulties getting in touch.
- Suggestions for improvement included providing more guidance and expectations for mentors and mentees, ongoing mentoring training, increasing awareness on benefits of mentoring, and more communication with the mentoring coordinator.

Responses from Mentors: 15 responses received.



Mentoring Specialty Trainees in North, East and West Yorkshire

By Dr Lauren Unsworth, Dr Sarah Orr and Dr Gwen Collin

- 53% of mentors had previously been mentees themselves.
- 57% had mentored 1 trainee. 43% had mentored 2 trainees.
- 33% of mentors had accessed e-learning, 22% had attended the teaching at the Higher Trainees' Committee and 33% had accessed other written information.
- Themes from comments about how mentors have benefited included developing mentoring skills, getting to know colleagues, sharing insights, increased knowledge of expectations of new STs,

Conclusions and discussion

- Overall, the mentoring scheme is currently functioning well and is valued by both mentors and mentees.
- This evaluation has helped to guide future directions for the mentoring scheme and helps to inform how to best support future mentors and mentees.

Recommendations to improve the scheme include:

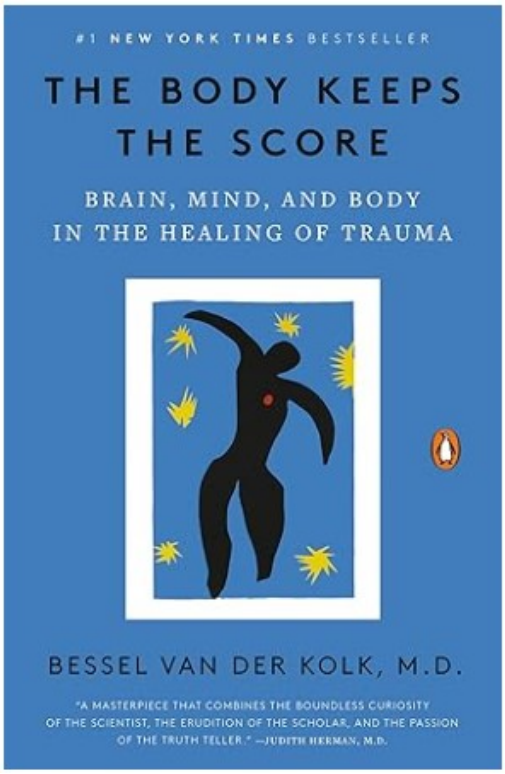
- To run an introductory training session to set expectations for mentors and mentees.
- To provide clear guidance about how and when to access support with mentoring.
- To provide ongoing access to mentoring training.

Dr Lauren Unsworth
Consultant Psychiatrist, Leeds and York Partnership NHS Foundation Trust

Dr Sarah Orr
ST6, Insight, Early Intervention in Psychosis Team, Wakefield, SWYT

Book Review: The Body Keeps The Score: The trauma book every psychiatrist should read?

By Dr Anne Alase



A search for trauma focused books easily reveals The Body Keeps The Score (TBKS) by Bessel van der Kolk. Written by a renowned psychiatrist based in the USA, TBKS generated attention in its first days but made an even bigger comeback during the pandemic, a period of collective trauma. Despite its provocative title, I didn't read TKBS at first sight even after it was picked by our higher trainees' book club. Bessel's powerful descriptions of the impact of trauma is not a light-read. Yet, this is the reason psychiatrists should read TBKS.

It's hard to decide what TBKS is. A memoir, or trauma text? Though sprinkled with research, TBKS could pass as a first-hand account of Bessel's 40yr work with trauma survivors. But beyond this, TBKS shows us Bessel's journey as a psychiatrist. First, a newly minted and wide-eyed psychiatrist; then a curious psychiatrist crossing disciplines to understand trauma; and now a twilight psychiatrist who has seen enough of psychiatry's political machinery and earned the right to criticize it. Though TBKS is set in the USA, it resonates with many by provoking thoughts about the universality but uniqueness of trauma. The book shows how trauma results in post-traumatic stress disorder (PTSD), self-harm, substance misuse, and other symptoms that we often see. Bessel does a good job of relying on work done by Sigmund Freud, Pierre Janet, Jean-Martin Charcot, William James, and John Bowlby. However, TBKS is a long read at about 140000 words, 400 pages, 20 chapters and 5 parts. Maybe Bessel should have gone the way of a bite-sized Sushi roll instead of a baguette with TBKS.

In the first part, "The Rediscovery of Trauma," Bessel gives account of trauma in war veterans, referencing his work with America's veteran affairs (VA) department. The classical symptoms of PTSD come to the fore here. This part then shows the effect of trauma on everyday people. Bessel tells the story of Laura and her husband after they had a life-threatening car accident. Using their example, Bessel shows how we react differently to trauma and how neuroimaging can help us understand trauma's effects on the brain. The amount of neuroscience in TBKS is surprising as Bessel explains how the brain is affected by trauma. We see how hypofunction or hyperfunction of these brain areas could explain the spectrum of trauma related symptoms. For example, anterior cingulate cortex dysfunction is associated with emotional stress dysregulation while brainstem dysfunction is associated with hyperarousal, and autonomic system abnormalities.

With the book's second part, "This is Your Brain on Trauma," we see the responses to trauma: flight, fright and freeze. Bessel shows how interpersonal chronic trauma such as childhood abuse and domestic violence are often more complex than acute traumatic experiences such as car accidents and robbery attacks. Here we see how interpersonal trauma disrupts attachment, mind-body connections, brain development, emotional regulation, and body physiology. We hear about Tom, a man abused by a catholic priest as a child whose traumatic memories were often triggered by his intimate relationship. By showing how trauma results in dissociation, impaired interoception, difficult relationships, narrowed physical activities in a state of freeze, sensation seeking, and relieving of traumatic experiences, one could see how trauma sometimes lead to a vicious cycle of intergenerational trauma.

Bessel entitled the third part, "The Minds of Children," and focused on how trauma affects a child's development. Here, TBKS shows how behavioural, emotional, and physical symptoms seen in children and adolescents can arise from childhood trauma. With Alex's, Julian's, and Eliza's stories we see how behavioural issues, fragmented incoherent memories, 'challenging' and defiant behaviour could develop from trauma. The

Book Review: The Body Keeps The Score: The trauma book every psychiatrist should read?

By Dr Anne Alase

book describes the 'hidden epidemic' of childhood abuse in America, social drivers of trauma and how population-based approaches can help. Bessel leaned on widely acclaimed findings from the adverse childhood experiences (ACE) study to show the impact of childhood adversity on health outcomes. It's not all gloom however, as TBKS highlights the power of resilience in children and how nurturing environments in school, home and community settings can overcome trauma. Here we see how therapies using play and art can help survivors.

In "The Imprint of Trauma," the fourth part, Bessel revisits the long-term effects of trauma on the body and brain of survivors. He looks again at how traumatic memories are stored in the brain, and shape the survivor's worldview, self-perception, and self-unity. This could lead to a lifetime of guilt, low self-esteem, and unworthiness. We hear about Marilyn, a victim of childhood abuse who developed dissociative identity disorder, a heavily debated condition. This part reminds us that while trauma may be universal, the symptoms are infinite. Again, Bessel shows how the power of interventions using eye movement desensitization reprocessing (EMDR), psychodrama, arts, music, neurofeedback, and internal family systems can be powerful to overcome trauma. Here he emphasizes what psychiatrists know about trauma and that medications have limited roles.

Rightfully, the concluding part of TBKS is titled "Paths to Recovery." Here, Bessel delves into a wider array of therapies. Body-oriented therapies like yoga and body awareness exercises can help survivors attune to their body and regain control. Bessel describes internal family systems (IFS) therapy as one where survivors learn how to integrate their fragmented memories and sensations as well as become self-compassionate. These fragments might have been initially created as a self-preserving escape from trauma. The book also shows that neurofeedback and EMDR help survivors by working to integrate traumatic memories, body sensations, and brain activity. Martial arts and equine therapies are activity-based and can help survivors rebuild confidence, control, and trusting relationships with others. Bessel reminds us that creating structured routines and radical personal choices are good places to start the recovery journey after trauma.

Undoubtedly, TBKS is an invaluable body of work that shows us the often-intertwining journey of a psychiatrist and his patients. Yet, some questions are left unanswered. For one, is there really a cure for the life-changing impact of trauma?

Dr Anne Alase
ST5, South West Yorkshire Partnership NHS Foundation Trust

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RCPsych National Trainees' Conference 2024

By Dr Gwen Collin

We were delighted to host the RCPsych National Trainees' Conference 2024 in Leeds on 24th and 25th April. This is the first time that the conference has been held in the region; we were thrilled to welcome trainees from across the country to the vibrant city of Leeds.

The conference is a key part of the RCPsych Psychiatric Trainees' Committee (PTC) calendar; after a highly successful conference in Cardiff last year the committee was keen to build on this to deliver an engaging and exciting programme. Dr Becky Long (PTC higher trainee representative for the London Division) and myself took on the role of conference co-organisers, supported by the PTC executive committee (chaired by Dr Laura Thorn) and the wider committee. We were also fortunate to work with some of the fantastic College staff on the project, who are experienced in delivering large events.

A theme of "Next Generation" was chosen. This was based on consultation with trainees about what is important to them currently, and what topics they would like covered. Central to the theme was what future patient care will look like, alongside the changing role of psychiatrists in the coming decades. We also felt it was important to focus on how psychiatry can be made a rewarding and sustainable career right through to retirement. On both days there were keynote speakers and workshops; four different workshops running simultaneously allowed for more intimate and interactive sessions. The keynote presentations and workshops included: innovative treatments in psychiatry, including the role of digital technologies; emerging sub-specialities; research that informs and improves patient care; incorporating nature-based activities and sustainability into clinical practice; and navigating a dynamic and diverse career.

In the run up to the conference we used several strategies to publicise the event. This included a "Twitter-takeover" (on the platform now known as X) of the PTC account a few weeks before the conference. Dr Daniela Borges also organised a podcast where some of the speakers were interviewed about the conference themes. Costs were kept as low as possible, and all the conference activities were linked to curriculum HLOs.

The conference was held in the historic Cloth Hall Court, a fitting venue to welcome visitors to the region. Nearly 180 delegates attended the two-day conference. There was a diverse group of speakers and workshop facilitators from a range of backgrounds, disciplines, and regions/nations. We were particularly pleased to welcome SAS colleagues and third sector organizations to present. It

RCPsych National Trainees' Conference 2024

By Dr Gwen Collin

felt imperative that issues relating to equality, diversity and inclusion were featured, and that individuals with lived experience were able to contribute. The programme was supplemented by fringe events which included early morning yoga, a guided run, a relaxed social over drinks, and a learn to crochet session.

Speakers came from across the country (including the devolved nations) to contribute to the event, with good representation from the local area. The academic Professor Peter Coventry from York University gave a talk on nature-based interventions in mental health, considering how research evidence could be used to influence clinical practice. Dr Felicity Wood who works in Palliative Psychiatry in Leeds emphasised the importance of good mental health care provision right until the end of life. Dr Wendy Burn, emeritus College president and consultant working in older age services locally, opened the second day of the conference and gave an insightful overview about the future of psychiatry.

Dr Charlotte Heaps, a consultant liaison psychiatrist, gave a candid interview about her experiences of returning to clinical practice after nearly a decade, and how this informs her role as a training programme director for less than full time and flexible training. Dr Heaps is now based in the Midlands, having previously trained in West Yorkshire; it was great to welcome her back. We also enjoyed hearing from Dr Benji Waterhouse, an alumnus of Leeds Medical School - now an award-winning comedian as well as NHS psychiatrist. He read some humorous but highly poignant sections from his new book about the challenges of working in mental health services, whilst also struggling with your own mental health issues.

We were pleased to have several local clinicians delivering workshops. Two consultants based in Yorkshire, Dr Nazish Hashmi and Dr Christiana Elisha-Aboh, facilitated a workshop entitled: "Transcultural Psychiatry: Celebrating Our Differences and Sharing Our Similarities." They were joined by a panel which included service users; personal stories helped to emphasise the importance of transcultural issues for everyone's practice. Dr Philippa Mason and Sophie Bracewell (Lead Gender Outreach Worker), based at the Leeds Gender Identity Service, ran a thought-provoking workshop entitled "The role of psychiatrists in gender healthcare". Dr Matthew Gaskell, lead for the Northern Gambling Service, led an engaging session on the public health crisis of gambling. We were also pleased to welcome Anne Burghgraef from the charity Solace, which provides psychotherapy and support to the survivors of persecution and exile in the region. Two doctors from the SAS committee, including Dr Jeniffer Gilligan, based in York, delivered a popular session entitled "Flexible, integrated and inclusive careers and the alternative pathway." Dr Natalie Cook, also based in North Yorkshire, considered the important topic of sustainability in healthcare.

The conference ended with a panel of experienced psychiatrists discussing "A life in psychiatry," chaired by the RCPsych Treasurer, Professor John Crichton. The panel was made up of Dr Pearl Hettiaratchy, Dr Jan Birtle and Professor Femi Oyebode. Hearing about the panel members' journeys through psychiatry was an inspiring and uplifting end to the conference.

Overall, we were very pleased with the conference and came away feeling enthused about the future of the specialty and the next generation of psychiatrists. It was a privilege to be involved in organising the event and I would encourage other trainees to take opportunities be involved in future conferences and events. Although it involved a significant amount of work, it has furthered my management skills and gave me a greater insight into the work of the College and the events they deliver.

Dr Gwen Collin
ST5, General Adult Psychiatry Trainee, Leeds and York Partnership NHS Foundation Trust
PTC Rep for Northern and Yorkshire Division and RCPsych 2024 National Trainees' Conference Co-organiser

Spring Conference 'A trio of novel treatments in psychiatry'

By Dr Sumeet Gupta

On 26th April 2024, the Northern and Yorkshire Division held a webinar about the new treatments in psychiatry. We had three eminent speakers to talk about recent updates on neuromodulation, pharmacological treatments of antipsychotic-induced weight gain and insomnia.

Dr Julian Mulz provided a comprehensive account of recent updates about using neuromodulation, especially rTMS, in psychiatry. He told us that evidence about the effectiveness of Repetitive Transcranial Magnetic Stimulation (rTMS) in depression and bipolar disorder is gradually growing. There are still uncertainties about the treatment protocols and hopefully, soon refinement of treatment protocols will make rTMS more effective. He also gave an overview of Transcranial Direct Current Stimulation (tDCS) and a recently NICE-approved device. In our area, only Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust provides rTMS services. Other trusts are likely to follow.

Dr Artemis Igoumenou, Consultant Psychiatrist gave an excellent lecture about a common problem faced by all of us i.e. antipsychotic-induced weight gain. Mostly it is regarded as an inevitable adverse effect of antipsychotic medications. Most of us know that behavioural interventions lead to desirable outcomes for most patients. A large-scale randomised trial in this country has also suggested this. The best evidence is for Metformin. It can lead to weight loss and improvement of other metabolic issues. Recently GLP 1 agonist has revolutionised the treatment of diabetes and morbid obesity. There are a few small-scale studies in patients with severe mental illness suggesting a positive impact. NICE has approved Semaglutide and can be accessed through weight management clinics. Currently, it is offered to patients with BMI of > 35 kg/M2. She is hopeful that GLP 1 agonist will be used more in NHS for patients with severe mental illness.

Dr Kirstie Anderson, Consultant Neurologist and a Sleep Specialist delivered a very informative and useful lecture about the management of insomnia. She gave many practical tips to manage patients with insomnia. She was unequivocal that most patients should try CBT- insomnia, which is as effective as hypnotic medications. Promethazine is not a good hypnotic drug and there is not much evidence to suggest the effectiveness of long-term Z drugs or benzodiazepines. She also advised against using smart watches or fitness apps to monitor sleep or drinking herbal teas to manage insomnia. Lastly, she gave an overview of Orexin receptor inhibitors (Daridorexant). She has started using the above medication and was hopeful that it might be of use to psychiatrists as well.

105 delegates attended the webinar and feedback was very positive. As the academic secretary of the division, I tried to select topics relevant to practising psychiatrists. Please give us regular feedback to ensure we continue to provide high-quality and meaningful CPD activities. I would appreciate any suggestions about either topics or speakers.

Dr Sumeet Gupta
Vice Chair, Northern & Yorkshire Division

The Great Northern Psychiatry Summer School 2024: A Successful Evolution

By Dr Ben Dempster and Dr Grace Bretnall

As we set out to plan 2024's edition of the Great Northern Psychiatry Summer School (GNPSS), there was no doubt in our minds that we had the opportunity to build on several years of success, whilst also now having the time and space to innovate and re-design certain aspects of the current format.

For those unfamiliar, the GNPSS was created in 2021 during the worst of the COVID pandemic by Dr Evelyn Evans, a now -consultant forensic psychiatrist. A three-day conference for medical students and foundation doctors, GNPSS aimed to promote psychiatry as a career generally, and specifically sought to display the virtues of training in the Northeast of England. Its original format, constrained by the limitations of COVID, consisted of a three-day online only event that invited speakers (largely consultant psychiatrists) from across the Northeast to give a presentation on their particular corner of psychiatry. The central idea was to represent as wide a range of sub-specialities as possible, often overlooked in medical school, to give a much more balanced and complete view of a career in psychiatry. In the original format, GNPSS celebrated success over the last three years, attracting over fifty delegates each year with consistently positive feedback.

When it came to looking towards the 2024 edition, there was considerable momentum for a change in format. There had been challenges with engagement between speakers and delegates in online-only version, likely reflecting the world's fatigue with spending our time on Teams or Zoom in a hangover from the pandemic. Conscious that our continued success would not likely be maximised within the confines of this, we decided to change things significantly this year.

Whilst remaining a three-day event, we decided to split the conference into two virtual days and one in-person day.

Previous years had experienced issues with talks being too long, and seeing drop offs in engagement and attendance. With that, including the condensing of the virtual schedule from three days into two, we implemented a new plenary-style system, with three speakers (all along a similar theme) being grouped together before a plenary session where we aimed to have discussion between themselves and with the delegates, creating a livelier Q&A session after each period. We limited the talks, therefore, to thirty-five minutes each, to create a new fast-paced and punchy feel to the virtual days. We also managed to showcase a wide range of sub-specialties: from perinatal to forensics, to veterans and

medicolegal, there were over twenty speakers across two days. We are pleased to report the feedback from these two days has been extremely positive, with attendance at each talk averaging sixty-five delegates and over eighty attending in total.

The principal change without question was the introduction of an in-person day, aimed at giving the delegates the experience of being a core trainee for the day. It was held at St Nicholas' Hospital, Newcastle, on 5th July 2024. It was attended by sixteen foundation doctors or medical students from all over the UK, many of whom visited the Northeast for the first time.

Thinking of the unique aspects of psychiatry training, we included the opportunity to participate in a Balint group. For this, we were fortunate to have in attendance the real Balint group leaders from the core training course in CNTW, who very generously gave their time to provide an authentic experience, with a core trainee providing an anonymised case from their experience. The feedback from this was really encouraging, as was the delegates' participation in the groups. We also held talks on applying to core training, day-to-day life of core trainees, as well as a tour of the St Nicholas' Hospital site.

We also continued an ''emergencies in psychiatry'' simulation session, which had been created in previous years and delivered online. This gave the delegates a start-to-finish view of an admission of an unwell patient,

The Great Northern Psychiatry Summer School 2024: A Successful Evolution

By Dr Ben Dempster and Dr Grace Bretnall

Grace briefs the delegates for their upcoming simulation session

exploring restrictive aspects of inpatient practice. Utilising second-person view video vignettes to stimulate discussion, this session aimed to give the delegates an idea of the types of issues and ethical questions experienced day-to-day and when on-call.

Another exciting addition to this year was an interview with renowned mental health advocate, president of Mind and honorary fellow of the RCPsych, Stephen Fry, conducted by co-president Ben, recorded some months earlier. A well-known proponent of psychiatry as a career, Mr Fry very kindly provided some of his time to speak to the delegates directly and give, in his words, 'a plea' to consider psychiatry as a career, highlighting the positives including from his own experience. This was an exciting and interesting surprise for the delegates which was incredibly well-received.

Conscious to evenly represent training in the Northeast, we were fortunate to welcome four TEWV trainees and fellows on to the GNPSS committee this year. Our plan going forward is to alternate the hosting of the conference annually between TEWV and CNTW, to better represent training in the Northeast as a whole. Many of those involved have already expressed interest in ongoing involvement following their positive experience.

Overall, we feel this has been a year of innovation and experimentation that has yielded very positive, and certainly better-than-expected results. We welcomed over eighty delegates across the three days, and the online reach was international. Whilst we experienced challenges in evolving GNPSS to this format, we feel it is a welcome first step back to conference formats aimed at better delegate engagement and satisfaction.

We have been very kindly supported by the College's Northern & Yorkshire Division, which has included an expansion of funding this year, without which our evolution to an in-person day would not have been possible, and for which we are immensely grateful. We plan to present our feedback, results, and reflections at the Division's conference in the Autumn.

Dr Ben Dempster and Dr Grace Bretnall
Core Trainees in Psychiatry, Northern Deanery, Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Upcoming Northern & Yorkshire Events 2024

Friday 27 September 2024
'A Triumph amidst trials: A local showcase'
Northern & Yorkshire Division Autumn Conference 2024
Holiday Inn, Darlington, Scotch Corner, DL10 6NR

15 October 2024
Community Treatment Webinar
(Online Via Zoom)

Please visit the Northern & Yorkshire Events page for more information.

Follow us on Twitter:
@rcpsychNY

Membership Survey 2024

The College has launched a short survey to understand members preferences.

Membership survey 2024 (rcpsych.ac.uk)

We'd like to hear about how you'd like to be communicated with, and how you'd like to be involved in College activities.

Completing this survey should take no longer than 5-8 minutes and will help us shape services to suit you, our members.

Royal College of Psychiatrists
21 Prescot Street
London E1 8BB

Phone: 0208 618 4000
Email: moinul.mannan@rcpsych.ac.uk

The Royal College of Psychiatrists is the professional body responsible for education and training, and setting and raising standards in psychiatry.

The Northern & Yorkshire Division is made up of members from areas including Leeds, York, Bradford, Cumbria, Tyne & Wear and Gateshead.

We would like to thank all members for their contributions towards Northern & Yorkshire Division activities throughout the year.

Northern & Yorkshire Division Vacancies

The Northern & Yorkshire Division have a number of exciting roles to share. Please see our vacancy list below:

Regional Representatives

- Academic: Division-wide
- Child and Adolescent: North East region
- Intellectual Disability: North East region
- Old age (shared role): Yorkshire region

Regional/Deputy Regional Advisor

- Deputy Regional Advisor (North East region)
- Deputy Regional Advisor (Yorkshire region)

Executive Committee

- Academic Secretary (shared role)
- Workforce Lead
- Mentorship Lead

For more information on these roles and to apply, please click here: Northern and Yorkshire Executive vacancies (rcpsych.ac.uk)

Deadline for next edition: 15 November 2024
Submit your articles for the Winter Edition to northernandyorkshire@rcpsych.ac.uk

Royal College of Psychiatrists - Northern & Yorkshire Division eNewsletter

Editor: Dr Sarah Orr, South West Yorkshire Partnership NHS Foundation Trust
Chair: Dr Sunil Nodiyal, Tees, Esk and Wear Valleys NHS Foundation Trust
Production: Moinul Mannan, Divisions Committee Manager, Royal College of Psychiatrists