



Psychiatry

The Northern and Yorkshire Division eNewsletter

Editorial

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Hello and welcome to our second edition of the Northern and Yorkshire Division Newsletter.

We are so pleased to showcase a broad range of interesting articles, which we hope you will enjoy reading as much as we did.

We have two fascinating historical pieces on the evolution of RCPsych and British psychiatry, with a beautifully northern focus in the latter, to celebrate our College’s 180th birthday. In no other specialty is it more important to regularly look to the past for both inspiration and caution in what we do.

We get to hear from Dr. Sumeet Gupta about his work as Academic Secretary for the Division, while our bursary recipient and Core Trainee member, Dr. Stephanie Velential, tells us about her time at International Congress.

There are two excellent pieces from third sector organisations, **Arttherapy** York and Being Woman, working hard in our communities to help people through art therapy and advocacy respectively. Hopefully these will provide us all with some food for thought in terms of our own services and practice, and also increase awareness of those non-NHS organisations that are fighting the same battle facing us, and how we might better collaborate together.



These are joined by some stellar pieces of quality improvement work and audit, looking at medical seclusion reviews in Humber and dementia diagnoses in Teeside. Our impressively environmentally conscious members, Dr. Gabrielle Farrar and Dr. Guy Harvey, educate us on improving the feasibility of cycling to work and how to reduce the carbon footprint of our practice; both timely pieces to read.

As ever, if you have any exciting initiatives, projects, studies, or general news from your locality, please do get in touch and consider submitting an article for our Spring newsletter. We are particularly keen to hear from the types of organisations included in this edition, and also from service users and carers; if you are aware of anyone from these areas, who may wish to contribute, please connect them with us too.



Division Updates and Events

The good, the bad, and the kidney: Upcoming webinar on Bipolar Disorder

The Northern and Yorkshire Division are pleased to welcome Dr David Cousins, Professor Heinz Grunze, M.D. and Dr Jonathan Murray to their Webinar discussing Bipolar Disorder.

What will the event cover?

How confident are you in diagnosing bipolar disorders? Professor Grunze will be discussing the focus on boundaries of bipolar disorders – atypical manifestations, bipolar NOS and comorbidities.

Dr Cousins will then discuss Lithium treatment – theory and practice: An update on the current use of lithium, focusing on optimal prescribing and the management of common side effects. Future directions informed by the latest understanding of the actions of lithium.

Consultant Nephrologist Dr Jonathan Murray will share his expertise on patients being treated with Lithium who are often referred to nephrologists if their kidney function deteriorates. This presentation will discuss issues to consider during such circumstances.



REGISTER NOW



Our Division

The Northern & Yorkshire Division supports members in the North, West and East of Yorkshire and the North of England. The Division is run by an Executive Committee which consists of:

Dr Paul Walker—Division Chair
Dr Sunil Nodiyal—Vice Chair
Dr Kedar Kale—Financial Officer
Dr Sumeet Gupta—Academic Secretary—Joint

As well as Regional Advisors, PTC Reps, ETC Reps, Mentorship Leads and Patient and Carer Reps.

We always want to hear from our members. If you would like to get in touch with the committee, please email: nothernandyorkshire@rcpsych.ac.uk

Division Vacancies

Academic Secretary, (Shared role)
Regional specialty rep roles as below:

- Child & Adolescent: North East Region
- Child & Adolescent: Yorkshire Region
- Academic: Division Wide
- Neuropsychiatry: Division Wide
- Perinatal: Division Wide

[Click here to see full role description and how to apply](#)



The origins of the RCPsych

Professor Nicol Ferrier

2021 has been the year we have celebrated 180 years since the foundation of the Association of Medical Officers of Asylums and Hospitals for the Insane, the first predecessor organisation of the Royal College of Psychiatrists, and 50 years since the latter was established. This article looks back on the aims and objectives of the Association as it was formed in 1841 and enquires to what extent we have lived up to them. The notable contributions of some of the early pioneers who hailed from our Northern and Yorkshire Region will also be highlighted.

Alexander Walk and Lindsay Walker, in their detailed history of the Association in 1961 in the *Journal of Mental Science*, as the *British Journal of Psychiatry* (BJPsych) was called until 1963, put the idea of whether we have lived up to the Founders' ideals more elegantly, saying it "may give us some refreshment and inspiration to recall something of our origin and of the principles and ideals of our Founders." One of the lessons of the study of history is that much of it chimes with the adage that it "was ever thus" and one can see that despite changing circumstances, public attitudes and prevailing ethics, many of the issues that our Founders grappled with such as stigma and parity of esteem, are the same ones we have to tackle today.

The first meeting: participants, some ideals and some outcomes

The first meeting to discuss setting up the Association was in Gloucester at the Gloucestershire General Lunatic Asylum in July 1841. There were only 6 participants. A letter from Dr Samuel Hitch, an energetic Physician Superintendent in Gloucester, had stimulated the meeting. His letter made the plea that alienists, as psychiatrists were then called, should communicate their individual experience to each other. His letter and the subsequent first minutes of the Association made this the central objective. There was a need, in their words, to "unite talents and forces". The College continues to be a very important vehicle for this purpose. Mental Health is a difficult field, and problems and experience are best shared.

The original 1841 minutes proposed that one of the key features of the Association should be the collection of information.

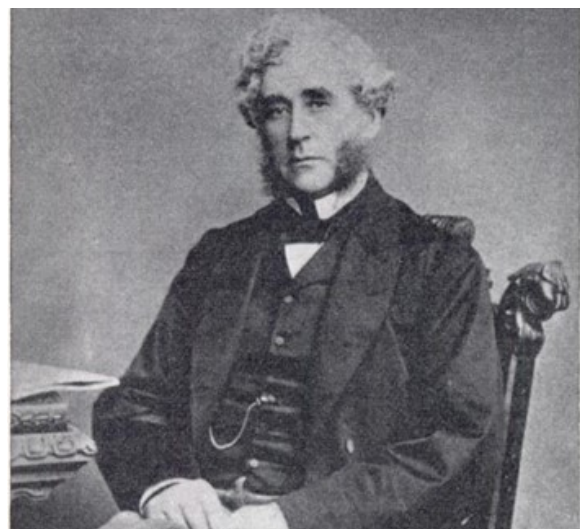
Alexander Walk and Lindsay Walker, "Gloucester and the beginnings of the RMPA." *Journal of Mental Science* 107 (1961): 603-632.

John Thurnam, *Observations and Essays on the Statistics of Insanity: Including an Inquiry into the Causes Influencing the Results of Treatment in Establishments for the Insane, to which are added the Statistics of the Retreat, Near York* (Simpkin, Marshall, 1845).

However, the Founders emphasised that this needed to be done with care and, in their words, "precaution". It is fitting that the first paper read at the Association by John Thurnam (pictured below) was entitled "On the Precautions Necessary in Reporting Statistical Observations". Thurnam had been Resident Medical Officer at the York Retreat since 1838 and was 30 years old in 1841. His zeal and ability are well shown in the publication a few years later of his work, "Statistics of Insanity". He was a keen archaeologist, and as Walk and Walker note, this interest had perhaps been "stimulated by the existence of a large prehistoric barrow in the grounds of the Retreat". This interest may also have motivated his move to Devizes in 1849 as the first Medical Superintendent of the Wiltshire Asylum, as here, besides growing his reputation as a thoughtful alienist, he found more scope for his antiquarian research. The College encourages audits and they are to be welcomed but I wonder if, collectively, we haven't collated information as usefully and as powerfully as Thurnam and others would have hoped.

One of Thurnam's major areas of enquiry was into the issue of asylum mortality. One reason behind the growth of County Asylums from the 1840s onwards was the assumption that the very high mortality rates often seen in establishments for the insane in the early parts of the nineteenth century (sometimes as high as 30% per annum) would decline in public institutions. **Fig 1. John Thurnam**

Fig 1. John Thurnam





This objective was one of the remits of the Commission in Lunacy which was established in 1845. Thurnam argued that mortality rates were a reliable “test” to evaluate success or failure of an asylum and a “much less fallacious standard of comparison” than recovery. External circumstances were not enough to excuse high death rates, and instead the asylums’ management and inadequate diets and poor hygiene were blamed. By contrast, Thurnam pointed to the York Retreat as a prime example of success. Mortality rates at the Retreat had remained at around 4.7 per cent per annum from its opening in 1792 to 1845.

Thurnam argued that such low mortality rates showed “the advantages to be derived from increased accommodation for the insane” and “the beneficial effects that would attend a more extended application of moral treatment”. Such apparently objective information made a case for the extension of public asylum provision with an emphasis on cure. However, it needs to be said that using mortality rates as a yardstick of quality became, in turn, a crude stick to beat Physician Superintendents of Asylums with, particularly as the case mix and age distribution of asylum populations were not properly considered. Thurnam’s original initiative brought benefits but his measure failed to adapt to new circumstances.

Another of the attendees at the first meeting of the Association in 1841 was Samuel Gaskell (pictured below). Gaskell was then 34 years old and had been Resident Superintendent at Lancaster Asylum since the previous year. A visitor from abroad recorded the improvements which he had at once brought about there; the abolition of most forms of restraint, the creation of a patients’ library and the encouragement of mutual assistance among patients.

Gaskell was especially interested in the “idiot” children, who at that time were admitted to the adult asylum, and he successfully placed some of these children under the individual care of female patients. He strived to provide separate accommodation in the Lancaster Asylum for people with intellectual disability in an effort to reduce abuse to them, a strategy which, as we have seen, has not always been successful. He advocated for specific training in intellectual disability long before that became accepted practice. He was made a Commissioner in Lunacy in 1849 where he promoted the restoration of voluntary admission. He died in 1886, and the College’s Gaskell Medal and Prize were founded in his memory.

Walk and Walker, “Gloucester and the beginnings of the RMPA,” 620.



Fig 2. Samuel Gaskell

An early stated aim was for the Association to be a lobbying body. The view was expressed that alienists had not been active enough in involving themselves with those who made mental health policy. It created a Committee to give them notice of when Parliament had relevant proceedings. Our College today plays a very important role in continuing to do this. As the Founders said, decisions about Psychiatry need expert input and this is pivotal in reducing stigma, a perennial problem and one which also exercised the Founders a great deal.

The tenor of the first minutes of the Association which later became the Medico-Psychological Association (in 1865) and then the Royal College of Psychiatrists (in 1971) was that, as a group, psychiatrists should be sceptical. The minutes of the 1841 meeting emphasised the importance of innovation and encouraged asylum doctors to test theories by doing trials which were to be reported on at subsequent meetings. Dr Hitch himself was a great innovator.

He instituted trial leave and the idea of female nurses looking after male patients. He was a strong advocate of moral restraint that he felt came with having good nurses, and was opposed to mechanical restraint.



His Asylum had the best recovery rates in England at the time. The Asylum Journal, a forerunner of the BJPsych, was set up in 1853 to foster this aim. Innovation with care and discussion and the carrying out of trials remain important ideals for all of us, though often relegated as they are perceived as too difficult in the light of service demands.

From the first official meeting of the Association in November 1841, the attendance at the irregularly held meetings rarely reached double figures. Not ever thus! However, in 1851, under the influence of one of the original members, John Conolly of Hanwell, Middlesex, a meeting at the Freemasons' Tavern in London drew an attendance of 26 and this was followed by an even more successful meeting a year later in Oxford. Since 1854, the sequence of annual meetings was unbroken until the pandemic affected one in 2020.

Discussion

The original participants established important principles for the Association and for individual doctors within it. The current College aspires to these ideals, particularly in its guidance for training, which is one of

Digby Tantam, "Samuel Gaskell, distinguished psychiatrist, and his family," *Transactions of the Unitarian Historical Society* 19 (1990): 228. ; Digby Tantam, "So you've heard of the Gaskell medal: but who was Gaskell?," *Psychiatric Bulletin* 13 (1989): 186-188.

Peter Tyrer and Nick Craddock, "The bicentennial volume of the British Journal of Psychiatry: the winding pathway of mental science," *The British Journal of Psychiatry* 200 (2012): 1-4.

Over the last two hundred and fifty years there have been developments in the care of the mentally ill in Yorkshire which have been of national and in some cases international significance. Rollin and Reynolds went so far as to write of the 'Golden Triad of York, Wakefield and Leeds.' There is considerable substance to their assertion.

its great successes. The original objectives are important templates for us all in our striving to improve mental health outcomes but, of course, neither the Association/College nor its membership has always lived up to these ideals. At times across this history, it has and we have been influences for and supporters of negative practices. Andrew Scull argued that the Association and its members were principally self-serving and agents of social control, though John Crammer penned a vigorous riposte. However, it could be argued that the College was initially slow to adapt to various issues such as the importance of the patients' voice and gender and racial inequality. We must also recall that history is not a forward march of continuous improvements by "Great Men" but a description of links in a chain which, at least, serves to highlight the debt current practitioners owe to others from the past. John Bucknill, an influential alienist, writing in the first edition of the Asylum Journal pointed out that "The struggle to overcome problems of the insane will not be gained in one battle; the struggle will be carried on with undulating success". Perhaps this is the most important lesson of all for us to take onboard in considering this history.

Andrew Scull, "Psychiatry and social control in the nineteenth and twentieth centuries," *History of Psychiatry* 2 (1991): 149-169; John Crammer "English asylums and English doctors: where Scull is wrong," *History of Psychiatry* 5 (1994): 103-115.

Anon, Prospectus, Asylum Journal, 1 (1853) : 1. Anon., Prospectus

Care of the mentally ill: Yorkshire's special

In the eighteenth century asylums for the care of the mentally ill were established in many large towns financed from legacies or public subscription. [Norwich, 1713; Dublin 1746; St Luke's, London, 1751; Manchester, 1766; Montrose, 1782; and Liverpool, 1792 .] Bethlem Royal Hospital had arisen from the monastery of St Mary of Bethlehem founded in 1247. The York County Asylum was founded in 1774, financed by public subscription and opened in 1777.

It was accommodated in a splendid building designed by the prominent local architect, John Carr, in the style of a grand country house. This was quite different from the earliest asylums and more were to follow in this style.

The establishment of the York County Asylum led to unexpected but important developments in York. A member of the Religious Society of Friends, died in the York Asylum in 1791 and was thought to have been neglected.

Under the leadership of William Tuke, The Religious Society of Friends of York resolved to build their own asylum which would employ gentler methods of care than was then customary. The Retreat, designed and built by John Bevans, opened in 1796.[Fig.1]. In 1813, Samuel Tuke, grandson of the founder of the Retreat, published a report on the work of the asylum in its first fifteen years.



The County Asylums Act of 1808 which permitted local authorities to use public funds to provide care for the insane led to the building of a number of asylums around England. At their meeting in October 1814 the Visiting Magistrates of the West Riding of Yorkshire resolved to build an asylum for the County, they established an architectural competition, and asked Samuel Tuke to advise on accommodation for the asylum. Tuke's recommendations were furnished to architectural practices which expressed interest in the project. Tuke's advice was subsequently published by the architects and became widely known.

The architects, Watson and Pritchett of York were judged to have presented the best proposals and were engaged to oversee the building of the asylum. In their design the architects came under several important influences. In 1787, the philosopher, Jeremy Bentham, had proposed a principle of building which he recommended for institutions such as factories, prisons, schools and hospitals, where the inmates and staff required supervision. Bentham called his principle 'the panopticon' and believed that its adoption would lead to the better conduct of institutions to the benefit of inmates. This principle had been employed by James Bevens in the small 'Lunatic House' at Guy's Hospital, opened in 1797 but had been used by the Scottish architect, William Stark, for his much larger cross-shaped asylum in Glasgow in 1810. Watson and Pritchett proposed an H-shaped building with wards in the vertical elements, staff accommodation in the horizontal with observation towers at the inter-sections. Extension of the hospital could be achieved by adding extra wards blocks on each side using the same system of observation. The architects used the layout of the gallery ward which had been introduced by Robert Hooke at the Moorfields Bethlem Hospital in 1676. The towers contained a spiral staircase which had a crow's nest look-out at each level giving an unobstructed view of each ward allowing senior staff to observe the wards without themselves being seen. The asylum opened in 1818. [Fig.2]. A number of asylums employing the panopticon principle were built around Great Britain.

He describes the events leading to the establishment of the asylum, details of funding, the regimen of care employed, an analysis of the types and numbers of patients treated, factors influencing progress and outcome and accounts of problems which had arisen. This is a truly remarkable book and was enormously influential in disseminating Quaker ideas of how people should behave towards each other irrespective of sex, social class or of mental illness. Tuke's account shows that details of the social background of patients were routinely sought, together with the family history and occupation. Observations of the mental state of patients at various stages of their illnesses were recorded together with the outcome of care. This information enabled Tuke to categorise patients in the diagnostic terms of the day and to make observations on the management of patients. Somewhat surprisingly Tuke was a layman with no training in medicine. The physical health of patients was dealt with by a visiting physician but the hospital was run by a lay committee. The Retreat had broken away from the methods of management of insanity then widely employed by doctors which had proved to be so unsatisfactory. Many hospitals were established and conducted on the lines of The Retreat but its early influence came in part from Tuke being invited to advise on the design of the new West Riding [WR] Asylum for pauper lunatics at Wakefield.

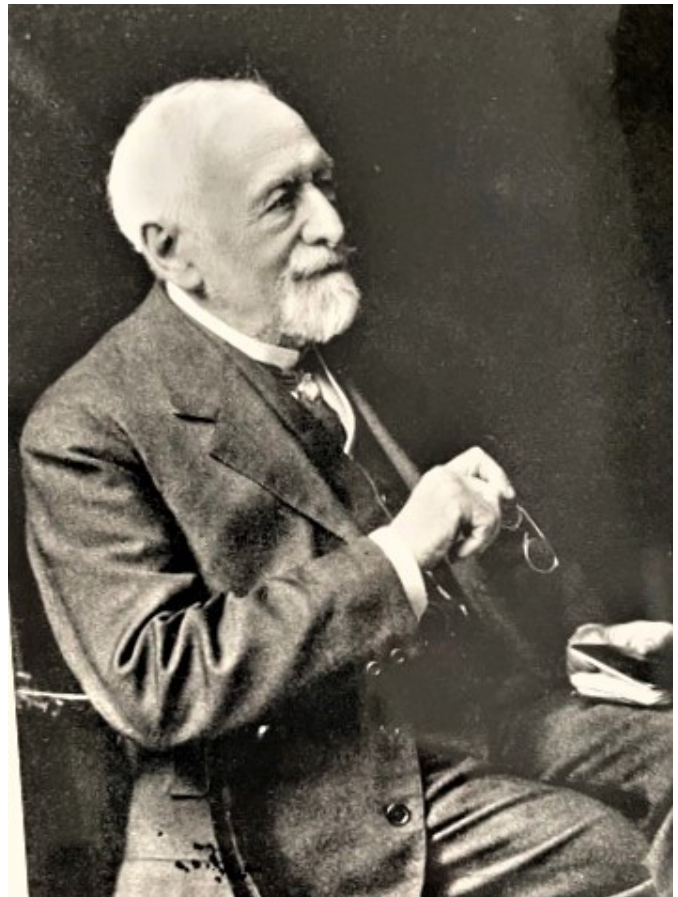




The WR Asylum was not only innovative in its design but was able to appoint very able staff. The first Medical Superintendent was Sir William Ellis [1818-31] who later became the first superintendent of the Hanwell Asylum, Middlesex, then the largest in the country. Dr. CC Corsellis, [1831-53], oversaw a major expansion in the hospital's work. Henry Maudsley, [1857-8], who came from a farming family in the west of Yorkshire and had qualified in medicine at University College Hospital, worked there in his first post in psychiatry. He was later to establish the Maudsley Hospital which became a leading centre of treatment, training and research in psychiatry. Sir James Crichton-Browne, [1866-1876], promoted teaching and research at the asylum at a time when research in medicine was still in its infancy. He made arrangements for Sir David Ferrier to conduct research into the localisation of brain function which in turn led to the hospital reports becoming the neurological journal *Brain*. Professor Bevan-Lewis, who conducted research into the pathology of mental illness, and was a teacher at the Leeds School of Medicine, became the first professor of mental diseases in an English medical school shortly after the Yorkshire College, a constituent part of the federal Victoria University, became an independent university in 1904. Professor J Shaw Bolton recounted the history of the hospital in his Presidential Address to the Royal Medico-Psychological Association in 1928. John Hughlings Jackson and Charles Darwin took note of the work carried out there. The arrangement that the Medical Superintendent of the WR Asylum would hold a senior appointment in the University of Leeds continued until the establishment of the full-time Nuffield Chair of Psychiatry in 1946. The early date of the asylum, the development of teaching and research and its association with the University of Leeds led to many of its trainees moving to senior posts in other asylums as they were opened.

An increase in the population of the County due to industrialisation led to an increase in demand for places in mental hospitals. At this time the WR included the cities of Leeds, Wakefield, Sheffield and Bradford as well as several large industrial towns. Three further large asylums were built to serve the WR. A similar pattern was seen in the East Riding and in the North Riding.

The introduction of teaching in mental illness to medical undergraduates in the Leeds School of Medicine was in part due to the influence of Sir Clifford Allbutt [1836-1925]. [Fig.3.] He was born in Dewsbury, attended St Peter's School, York, qualified in medicine at Cambridge University and St George's Hospital, London in 1859 and returned to Yorkshire to work as a physician in Leeds. He became enormously influential. Among other things he promoted the use of the clinical thermometer and the ophthalmoscope in clinical practice



He had a sustained interest in mental illness and served as visiting physician to the WR Asylums, served on the Board of Management of the Wakefield Asylum and was on the building committee for the construction of the WR Asylum at Menston. He gave evidence to the London County Council Committee of 1890 established to consider the establishment of a 'hospital' for the insane to work alongside the existing asylum system. He introduced teaching in mental illness to the undergraduate curriculum in Leeds and enjoyed a personal friendship with Crichton-Browne. After almost thirty years in Leeds in 1889 he became a Commissioner in Lunacy and moved to London where he also engaged in medical practice. In 1892 he was appointed Regius Professor of Physic in the University of Cambridge. Throughout his career he showed concern for improvements in the care of the mentally ill and remained a friend to the emerging speciality of psychiatry.

One might ask how did these developments come about and why did they occur in Yorkshire? During the eighteenth century a groundswell of public concern over the care of the insane had emerged. In Norwich, then one of the largest cities in England, Mary Chapman established a small charitable asylum for the insane as early as 1713. Thomas Guy included care for the insane in his new hospital founded in 1721.



Northern and Yorkshire— Psychiatry in the North East

There was dissatisfaction with the existing arrangements leading to a number of initiatives around the country such as the work of Andrew Duncan, in Edinburgh and John Storer in Nottingham, both physicians, to establish asylums for the insane in their own cities. The recurring mental illnesses suffered by King George III brought the care of the insane to public attention and during the century many towns and cities erected asylums for the care of the insane by public subscription.

The developments in York can be seen as part of these trends but there was also a distinct contribution to the understanding of the needs of the mentally ill. The regimen of care at The Retreat was not based on theoretical understanding of mental illness but rather on an empathic understanding of the distress caused to patients and to their relatives and of methods of reducing it. Samuel Tuke did not claim to have found solutions to the cure of mental illness, indeed he repeatedly states that cures for mental illness were not available. The approach adopted at The Retreat was a system of care rather than of curative treatment. The Retreat was run by a lay committee but the role of the medical attendant was greatly valued.

I have been working as a consultant psychiatrist since 2005. I have always been interested in practicing and teaching evidence-based medicine and management of affective disorders. In the past I had also worked in Tees, Esk and Wear Valleys NHS Foundation Trust's Specialist Affective Disorder Services. I have been very fortunate to work with very able and like-minded colleagues who had specific interests and expertise and learnt a lot from them.

This is shown in Tuke's warm remarks about the Retreat's first medical attendant, Dr Fowler, at the time of his death. Tuke not only contributed to the design of the WR Asylum but much of the approach to care at The Retreat was incorporated in the instructions to the staff of the WR Asylum.

The work of the WR Asylum was seminal in many ways but most importantly it developed a programme of research into mental illness, initially in the field of neuropathology, and recognised a need for the training of doctors to specialise in the care of the insane. Allbutt and others saw the need for all doctors to have instruction in the care of the insane. Amongst these influences it is clear that the care of the mentally ill was not solely the province of doctors nor was it understandable simply in medical terms. At the end of the nineteenth century the need was for truly effective treatments for the mentally ill.

I am grateful to : The University of Glasgow, Archives and Special Collections, for permission to use an illustration from Samuel Tuke's Book ;

The West Yorkshire Archive Service for permission to use the engraving of the Wakefield Asylum by John Landseer, c1818;

The University of Leeds for permission to use the photograph of Sir Clifford Allbutt.

My role on the Northern & Yorkshire Executive Committee

Dr Sumeet Gupta

As a clinician I believe and practice of lifelong learning to improve our patients' clinical outcome and experiences. Over the years, I have attended many local, national and international conferences and courses to further enrich my knowledge. The decision to attend a specific course/workshop /conference was driven by multiple factors, mainly conference programs, speakers, convenience or on a few occasions under the influence of peers. However, the most important factor has always been clinical relevance of the topics covered in the conference/ course.





I am of the view that the local conferences provide an invaluable opportunity for broadening one's knowledge base. Apart from leaning and networking, it also provides a platform for sharing and exploring new ideas across different localities within a trust and amongst different trusts in the region. In addition, these interactions should be an enjoyable experience for the participants. Surely these add exciting breaks from working in isolations and hence provide stress busters to all. I always found local meetings more useful and relevant to my practice, as the evidence gathered from national and international sources are discussed in context to the local practice. Therefore, when expression of interest was sought for the academic secretary of Northern and Yorkshire Division of Royal College of Psychiatrists, I opted so as to share my experience and knowledge in developing an interesting and thought provoking programme for my peers. Prior to me embarking on this new venture I spoke to Drs Ann Aboaja and Baxi Sinha, previous academic secretaries. They both were very pleased with the role and had found the job very satisfying. Dr Paul Walker and Dr Sunil Nodiyal, chair and vice chair of the division are also keen to enhance the quality of conferences/courses provided. My aim is to involve all members of the division, including members of the executive committee to decide the programs, speakers, and topics for the conferences, so that the local conferences are more pertinent and clinically useful to psychiatrists of all grades and subspecialties.

I would like to see the local conferences not only providing updates about clinical issues, but also informing /educating us about relevant issues about medical education, national policies and legal framework. If possible, I would encourage local speakers, both young and experienced clinicians and academics to participate more actively. At the same time, I will endeavour to invite national and international speakers as well.

The pandemic has forced many of us to learn in virtual setting, though I am sure younger generation has always been wired to learn from screens. Call me old generation, but I would still prefer face to face conference. Having said that most of us are getting used to learn from screens. Due to the pandemic, our next conference about bipolar disorder will be online, but I am hoping that in future we might have both types of conferences. Please do register for the online conference and I am sure you will find the conference very useful and relevant to our clinical practice.

I am writing this column to request you to send me your interests. Also, ideas and suggestions about topics, speakers and in fact if you would like to come and speak at the conference about your area of interest or expertise. Please give us feedback about the events, as it will help us immensely to improve the quality of conferences and make it more useful for all of us.

My time at International Congress

Dr Stephanie Velential



The current Covid-19 pandemic has changed the landscape of training in psychiatry dramatically; affecting all aspects of patient care, research, teaching as well as trainee wellbeing. The RCPsych International Congress 2021 themed 'psychiatry in changing times' was an opportunity to continue to spark enthusiasm for the speciality and drive career progression in unprecedented times.

Being the first time that the Congress was held on an online platform there was uncertainty amongst trainees as to whether the event would provide the same academic value as previous face to face events. The Congress did not disappoint however and was full of stimulating educational material such as Professor Wendy Burn's talk on 'The Art and Science of Deprescribing Psychotropic Medications', engaging debates on 'Social Media and Mental Health in Young People' attended by a social media influencer with lived experience as well as key updates on college examinations from the Chief Examiner Dr Ian Hall.

I had the privilege of attending with the Northern & Yorkshire Division bursary which allowed me to view as well as present my own projects as part of the Rapid Fire Posters on consent to treatment within forensic inpatient units as well as the monitoring of metabolic side effects of antipsychotics. As an added benefit this year successful abstracts were published in the special supplement of the BJPsych Open.

I look forward to attending next year's Congress and would urge trainees to apply for the bursary and register to attend, whether it's to update your clinical knowledge, showcase the work you have completed or simply to network with your peers and colleagues.



The Importance and the Hurdles of providing Mental Health Care to ethnically Diverse communities and minority groups, including Asylum seekers and refugees

Imran Zahid, Mahnoor Shakir, Nour Al Huda Al

Note: The names of service user/users have been anonymised to protect identities.

Being Woman is a charitable, incorporated organisation based in Northumberland. Our aim is to promote good mental health, self-esteem and emotional resilience of women, girls and the wider community through supportive interventions. We empower them with the skills and knowledge to challenge all forms of discrimination in society. As a charity, we are approached by a large number of service users who come from ethnically diverse backgrounds. Being Woman was founded with a single aim; to eliminate inequalities that exist between communities. Established by Fareeha Usman in a single room, with a small team of only 3 people initially, it has now carved a niche for itself. Being Woman promises quality service to its users and pledges to help everyone in need, without discrimination. We support growth, equality, inclusion, and respect for all.

Being Woman's Efforts to Promote Mental Health and Wellbeing:

As part of our services, we offer them early mental health interventions when needed, as our staff has undergone Mental Health First Aid Training. Being Woman has so far supported 10 of its employees and trustees to become Mental Health First Aiders from Mental Health First Aid England. We also refer them to appropriate professional organisations such as Talking Matters and Connected Voice. For our employees, our organisation regularly holds meetings and training to look out for any issue that they might have. We also have a strong complaint-handling system that protects employees from any prejudice or discrimination. Other than that, we offer a safe space for all our employees and trustees to express themselves without the fear of being judged.

For our service users, we have an up and running platform called CupShup. It is a safe space for our service users where they can come and talk about their journeys, their worries and also learn about different problems surrounding mental health and how to cope with them.

During the lockdown, we also initiated a live show for mental health and positivity which reached out to thousands of people and became a ray of light in those hard times. In addition, we have a free and confidential helpline as part of our service, called RAIN, to support people with early mental health intervention support.

The Challenges and the Needs:

Despite numerous advances in the study and treatment of mental health, many minority groups consider it to be a taboo and weakness, to be healed by a higher power. From our own experience, we know that minorities receive a poor quality of mental health care. Mental health does not discriminate. Irrespective of a person's background, gender, or sexuality, mental health support must be available for all.

To live happier and to have access to support is every citizen's right. However, due to unmet needs and lack of knowledge about mental health, many people from ethnically diverse communities can experience severe conditions including depression, PTSD, and suicidal behaviors.

According to a mental health charity, England is facing a mental health "pandemic". Analysis of NHS estimates by the House of Commons Library shows 12.8% of adult GP patients in Northumberland had a diagnosis of depression in 2019-20 – higher than the 11.5% national average. The area with the highest rate in the county was Newbiggin where 18.7% of patients were depressed (1).





Northern and Yorkshire— Psychiatry in the North East

We feel that mental health in the North East is underdeveloped, and there is very little awareness and publicity around mental health. An improvement we would like to see is hospitals and GP practices becoming more open, and advertising that mental health is as important as physical health, to make this less of a taboo. There is already a stigma attached to mental health in many cultures, but particularly for minorities in the North East and within the UK.

After speaking to some of the people we support, it seems that there is little to no knowledge about symptoms of mental health disorders or warning signs of crises like suicide or panic attacks as an example. Some people do not even know of the many different mental health issues, and it varies from eating disorders to depression to bipolar disorder. Lack of awareness impedes seeking support, and this can result in deterioration of any mental health condition. Therefore, educating people about mental health is very crucial and should be embedded in educational institutions' curriculums and charities.

The Cultural Impact:



Every culture is unique and approaches mental health in various ways. For instance, some cultures consider mental health issues as an excuse to shun away someone who is struggling with a mental health problem because they see that person as broken. Conversely, some other cultures are more open and supportive.

It is also important to look at the representation of ethnic minorities in the mental health sector. There are not many counsellors, psychiatrists, psychologists, or psychotherapists who can understand the need or represent the ethnically diverse communities in the North East. This inequality may make it more difficult for minorities to approach or even consider talking to someone about their struggles and the issues they have faced. Likewise, some people may want to talk to someone outside of their community for fear of people finding out.

This lack of choice is an area of concern for many patients. On top of this, there are long waiting lists for patients to be seen, and this can take months or even a year due to the recent pandemic. If there were more mental health workers in the field to see patients, this would be less of a problem; so perhaps more jobs should be created to keep up with the demand of patients.

Meeting the needs of minority groups:

The 2014 Adult Psychiatric Morbidity Survey displayed that prevalence of common mental health disorders does not vary significantly for men (10.5-13.1%) from different ethnic groups but white non-British women (15.6%) are significantly less likely to have a common mental health disorder than white British women (20.9%), while these disorders were more common in Black and Black British women (29.3%). Due to the small numbers in the survey, the prevalence of mental health disorders in different ethnic groups cannot be disaggregated to a regional level.

People from ethnic minorities are more likely to experience mental health issues, particularly if they are refugees or asylum seekers as they may have gone through the trauma of war, violence, domestic abuse, or similar circumstances back in their home countries. Due to these circumstances, their mental wellbeing becomes a sensitive topic, and so the way mental health support workers offer advice or support must be individually tailored.

To achieve this, a model named "Frame of Reference" should be focused on when training mental health support workers. This model takes into account all factors of an individual's background, such as gender, race, age, religion, etc., and their influence on one's perceptions and judgments. Training will help workers to become more aware of these factors when supporting people.

The Generality:

Often, people from minority backgrounds experience mental health issues because of their families and household problems in some cultures. For instance, it is common in Asian households to expect women to do everything for their children and for men. This patriarchal structure is so embedded in their culture that the process of unlearning must be taught.

Mental health problems are more commonly found in areas of deprivation and the North East has a relatively high proportion of these areas. Compared with England as a whole, both Northumberland and North Tyneside are less deprived but Middlesbrough and Hartlepool have some of the most substantial concentrations of deprivation in England(2).



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Therefore, many areas of the North East are deprived and this must be taken into consideration when looking at mental health with the people who live in these areas. There should be more concern and focus on these deprived areas, in addition to reforming mental health in the North East as a whole.

People visit psychiatrists when their mental health condition gets severe or when it is long-lasting. Although psychiatrists are of great support and help for their patients, there are still some missing aspects that are worth talking about. People visiting psychiatrists wish they are given more time, because what they mainly need is to be listened to genuinely. One thing that might annoy patients is being asked the same typical questions every time with a lack of focus on what the individual is experiencing. Here we come to another point, which is relying completely on diagnostic tools (like ICD: International Classification of Diseases or DSM-5) when diagnosing a patient.

A patient mentioned that she felt like an “object” and not a human. She reported that she was misdiagnosed for years with a personality disorder. She said: “In order to capture the full mental state of someone you need to focus more on the patients and what they say and feel, and not depend only on written criteria for diagnosis”.

Some psychiatrists just follow diagnostic guidelines by checking what applies in order to set a diagnosis, and although it is very important, they should increase their attention and focus on the patient as a human and not a number. These two points are strongly connected; as the psychiatrist spends more time listening deeply to a patient, more information will be gathered and in addition to the given standards, a psychiatrist will come to an accurate diagnosis.

Looking forward:

A better and improved service provision system can be shaped if MH Services focused on molding themselves to meet the needs of the minority groups that exist in the area. Tackling language barriers can be the first step as many people feel safer and more understood when they are allowed to express themselves in their own language. A few suggestions that we have gathered to promote a mentally healthy, happy and safe environment for everyone are as follows:

- Incorporating mental health and its importance in curriculums
- Easy to access services for all, in multiple languages for ease
- Providing routine therapy checkups, free of cost
- EDI and MH training of employees at the workplace to reduce stigma and stress around work
- Free of cost workshops and webinars on how to manage mental health

The Conclusion:

Only an individual who suffers from a mental health issue can understand what it means to not be understood properly and moreover do not have the ease of discussing their problem in the language they are fluent in. We realise that the mental health support workers are doing the absolute best that they can in the area, but it does not diminish the fact that a huge gap still exists in providing the right care. We are dealing with people who have already gone through traumas; just imagine the horror of coming to access support and feel as if you are not even being heard on top of that. But, all is still not lost; many people are gaining awareness about the significance of good mental health. We wish to live to see the day when the stigma around this aspect will be eliminated completely and we dream that one day, acceptance and care for all will be the reality of our society. The path to achieving these goals is no doubt very hard but it is never impossible and we must keep going because “difficult roads often lead to beautiful destinations!”.

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Art Therapy York

Peter Brown. MA, Dip.DL., Senior Art Psychotherapist/Director

ArttherapyYorkshire based in Scarborough was founded in 2012 and quickly built a reputation for providing professional, appropriate, beneficial therapeutic support for a complex and vulnerable section of the local community. In 2016 it became a registered charity (Registered charity number 116957).

All our therapists are qualified, experienced Art Therapists, registered with BAAT (British Association of Art Therapists) and HCPC (Health & Care Professionals Council).

From our studios in Scarborough, or within the community, ArttherapyYorkshire aim to provide Art Psychotherapy to children, young people and adults who may need support with their issues.

As may be expected, our clients come to us with a wide spectrum of complex psychological and emotional presentations. Invariably, the initial presenting issue will be a symptomatic response to much deeper and more complex issues, some of which may have a diagnosis while others, resulting from unexplored trauma and abuse, continue to disrupt daily life on many levels.

Prior to any intervention, each client will be asked to attend an initial assessment meeting with one of our Art Psychotherapists, ideally accompanied by the parent or other referrer. This initial assessment allows all those involved to gain an understanding of the art psychotherapy model. Within this scenario, it is possible to establish whether the client can engage with the art therapy process and, importantly, to discuss and set some achievable aims and objectives within what is, essentially, a time-limited intervention. Whether working 1-1 or in a group setting, our established model is to offer an initial programme of 10-12 one-hour weekly sessions, effectively as on ongoing assessment, then review to establish individual needs. These needs may be met by an extension to the art therapy programme or signposting to further support from the community or other specialist professionals if appropriate. Clients' progress is recorded within our bespoke assessment and outcomes tools.

As we make clear, there is no need for any previous experience or knowledge of art making; the majority have often not touched art materials since primary school. The model offers the spectrum of art making and creative media, which allows an individual to explore and express feelings and emotions through their innate creativity, guided throughout by their art psychotherapist.

This therapeutic relationship gives the individual (or group) the opportunity to gain a better understanding

of their issues and to develop new, less damaging behaviours. This in turn engenders self-confidence and self-esteem. This model can be particularly effective where individuals struggle to verbalise their issues; cases of chronic and enduring trauma and abuse where shame, guilt and fear are so deeply embedded that they are too difficult to speak out loud. The art making process allows the unspoken to materialise within the artwork or indeed the art making process itself. Whether embodied figuratively or in the form of symbol or metaphor, with the guidance and support of an experienced art psychotherapist, these issues can be seen and processed from a different perspective giving the opportunity develop a more positive understanding of self and self-management. As this short case study illustrates....

James A. (Not client's real name; this case study is presented with his knowledge and consent)

James is a quiet man in his 40's, married with a daughter and a teenage daughter from a previous relationship. James was aged 3 when his father went for some cigarettes and did not return to the family for 30 years. James has now assumed some responsibility for his father who is in poor health, but he understandably struggles with this. His school days were unhappy; casually labelled as autistic, he was mainly side-lined as a low achiever. Aged 35, on his way to work, James suffered a catastrophic panic attack, with intense anxiety and barely controlled rage. He was unable to return to work, resulting in the loss of his job and self-esteem. Other losses and changes occurred, but he found a secure base in a local church where he began to rebuild his confidence, married, and became a voluntary caretaker and team member. Fears of recurrent panic attacks and continuing deep anxiety and ongoing depression lead James to seek help, other than medication, resulting in his referral through Social Prescribing earlier this year.

At first, James was extremely anxious, perspiring and trembling, showing visible signs of distress. I gently explained the process – what Art Therapy entailed and how it may be able to help, and James showed me part of his collection of meticulously painted model soldiers, particularly his favourite who famously held the bridge at Arnhem.

Figure 1 session 2 charcoal sea battle





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Although not a requirement, a client's wish to share their creative endeavours shows a willingness to offer some starting point, a positive first step in the therapeutic experience.

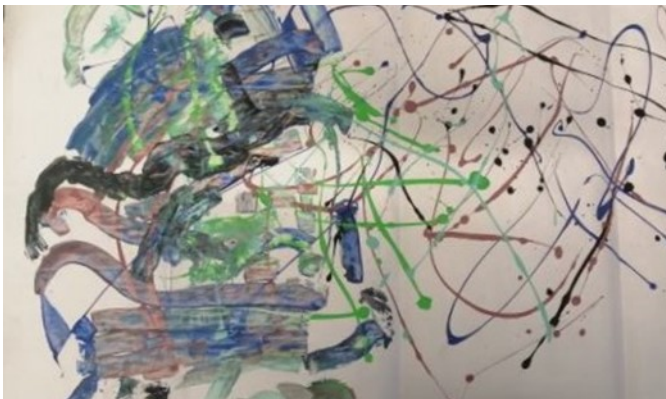
Our first task was to alleviate anxiety and involved pouring and manipulating sand together as he spoke. The story of his childhood abandonment, loss of status, the family home, was profound and deep.

In our second meeting he was invited to choose materials and create what he wished; he depicted a sea battle in charcoal which picked up the patina of the table. Normally he would have hated that incursion, but he liked the unexpected effect, creating the sense of depth. The sea battle raged on the far horizon, whilst the big, flag-bearing ship sailed away, leaving only wreckage in its wake.

I later wondered if those were small ships seemingly floating further apart or figures in lifeboats.

To further alleviate anxiety, I suggested working big and pouring paint. James accepted my suggestion and created a large image, again creating a work of two halves as he worked into the wet paint, blurring and playing with it, fascinated to discover the traces of the poured paint remaining after considerable activity on the surface. It was messy but somehow satisfying. "I am here", he said, indicating the lower left parallel lines (pencil to indicate scale).

Figure 2 session 3 large, poured paint



He worked with soft wet clay to form an oval bowl, struggling at times to manage the collapsing edges, strengthening and building up the edges so they would maintain the structure, adding the two handles. He was satisfied with the construction which I felt strongly resembled an infant's training cup.

The next week he decided to paint the hardened clay, and we both wondered what it may hold – or need filling with.



Figure 3 sessions 3-5 pot

In the wide-ranging conversation with the cup before us, James spoke of his workroom and what he described as the model makers 'Pile of Shame'; things started and left unfinished or yet to begin – left on a pile - we both looked at the cup and he said, "that's my pile of shame". He proceeded to paint it again, notably leaving a dividing line – but in this case he described it as the good stuff starting to seep through into the cup from outside.

Recently James reports feeling more relaxed and at ease, his relationship with his teenage daughter is less pressured and secure. He no longer feels responsible for caring for his father any more than he can manage. His most recent work was made with oil pastels, started with the tree and a green pasture. This depicts a picnic blanket, a couple of footballs, and a row of flowers – the dividing line is now a flowing stream.

I invited him to construct a plasticine figure to show where he would be in the scene; he is on the picnic blanket with a hamper, and a rugby ball.

Considering this scene James declared "I am not there yet. – But I've got my coat on and the door is open".

Figure 4 session 8 crayon & plasticine





I believe this series of images shows a clear journey from the despair and abandonment carried through a lifetime to a found sense of hope for the future; a letting go of a burden that he did not have to carry and a recognition of the possibility of a joyful future with his own young family. It has been his own journey, facilitated and witnessed by his art therapist, as they travelled through his lonely past together into the recognition of his own strengths, where he is now.

As a so-called non-talking therapy, the Art Psychotherapy model can be effective in many areas of mental health where communication is one of the challenges. Children and young people often respond to this model as their emotional and psychological vocabulary has not yet developed, and it can also appear less confrontational than some 'talking' therapies. PTSD and CPTSD are good examples of where this model can be effective in allowing individuals to explore and develop new and more positive approaches to managing their issues whilst gaining self-confidence and self-esteem. Our group work often extends these benefits beyond the individual allowing a sense of social awareness

Do you need to do more about problem drinker and drug users?

Dr. Duncan Raistrick, Consultant Addiction Psychiatrist and Dr. Gillian Tober, Consultant Addiction Psychologist, both formerly of the Leeds Addiction Unit, have created a website called [result4addiction](https://www.result4addiction.net), which may help you. Colleagues will be aware that NHS addiction services have been much reduced over the last decade and the website is designed to help plug this gap. The site...

- Is free and anonymous to use
- Has six self-assessments of addiction problems
- Provides feedback to the assessments, which includes an action plan
- Is an ideal supplement to prescribing plans and dual diagnosis management
- Is handy for learning more about addiction

We suggest giving patients 'homework' tasks from the website. This makes for efficient out-patient consultations, whether on Zoom or face to face, and is consistent with best practice.

The site contains a wealth of learning materials. While these are pitched at a level suitable for some of the general public there is much for psychiatry trainees to explore about addiction including a pretty difficult MCQ exercise and video demonstrations. The site cannot compensate for the lack of NHS addiction placements for trainees but should help.

Visit RESULT at <https://www.result4addiction.net>

and community to group members. finding positive change for our mutual clients.

To date, we have had little interaction with the local psychiatric support team although several of our clients are registered with the team. Naturally we would welcome the opportunity to develop a working relationship wherein the two disciplines could work and support each other in

Our growing reputation continues to bring enquiries from organisations, institutions and individuals across Yorkshire, looking for support or collaboration on some level, and where we can fund the work we will, now being able to offer some group work and 1-1 remotely, as the Covid pandemic taught us.

ATY has big ambitions and continues to punch above its weight. We have been successfully involved with 'Action Towards Inclusion' since its inception, working alongside other organisations locally, supporting a significant number of vulnerable individuals in the community.

As a small local charity our activities are only limited by our funding levels, all of which are currently managed in-house, along with the management of the organisation. This, in effect, depends on two main practising art psychotherapist/directors, supported by two other art psychotherapists, all of whom are self-employed and a small team of trustees, dedicated to providing professional affordable or funded psychotherapeutic support to our local community.

For more information please visit www.arttherapyyorkshire.org.uk



QI Project: Improving the Quality of Medical Seclusion Reviews at Humber Teaching NHS Foundation Trust

Dr Shumaila Shahbaz (MRCPSyh), Core Psychiatry Trainee at Yorkshire and Humber Deanery, Department of Psychological Medicine, Humber Teaching NHS Foundation Trust, Hull.

Introduction

Seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the containment of severe behavioural disturbances which is likely to cause harm to others(1). The Mental Health Act 1983 Code of Practice provides guidance on how to manage people with disturbed behaviour that may present a particular risk to themselves or others.

Management of mentally unwell, agitated, and aggressive patients is a very important part of psychiatric practice and sometimes, we use seclusion rooms to de-escalate the situation for the safety of the patients and others. Medical seclusion reviews provide the opportunity to evaluate and amend seclusion care plans. They should be carried out in person and should include, where appropriate, a review of the patient's physical and psychiatric health, assessment of any adverse effects of medication, a review of the observations required, a reassessment of medication prescribed, an assessment of the risk posed by the patient to others, an assessment of any risk to the patient from deliberate or accidental self-harm, and an assessment of the need for continuing seclusion, whether it is possible for seclusion measures to be applied more flexibly or in a less restrictive manner (1). These all help to prevent harm to our patients as a result of seclusion.

The National Institute of Clinical Excellence (NICE) also provide recommendations for this area, with an emphasis on the individual needs of the patients and safe care following rapid tranquillisation (2,3). Similarly, General Medical Council (GMC) guidance emphasises that is the responsibility of the prescriber to have adequate knowledge of their patient's health and the prescriber must be satisfied that the drugs serve the patient's needs.

Quality improvement projects relating to the quality of medical seclusion reviews have previously proven effective (5).

Background

We completed an audit of 50 medical seclusion reviews in July 2019 across Humber NHS Foundation Trust to establish the extent to which medics were following Trust Policy when conducting medical seclusion review. On average, there are approximately 13 patients nursed in seclusion each month in the Trust. We collected retrospective data from the last 6 months for general adult wards of the Trust.

We identified good documentation by medics in the following areas:

- Time of seclusion review (within the first hour or when required).
- Record keeping (accurate time and place for clinical notes).
- Plan for continuing need for seclusion.
- Good documentation of risk to self and risk to others.
- Good documentation of mental state examination.

Comments on physical health although it can be improved.

We also noticed that the following areas could be improved:

- Prescribed medications
- Medication side effects
- Physical observations

Audit standards

For re-audit standards in 2020, we used Trust guidelines, results of the last audit, and a template that had been designed and discussed with medics following the previous audit. This template had then been incorporated into the existing document of medical seclusion review on the electronic patient record. The headings of the template were as below:

- Time of review
- Reason for delay if applicable
- Reason for seclusion
- Duration of seclusion
- Psychiatric diagnosis
- Patient's capacity to understand why they are in seclusion
- Mental State Examination
- Physical health (including physical observations)/ Environment



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- Medication (prescribed, rapid tranquilisation, side effects, or adverse effect)
- Risk (to self, deliberate self-harm, or accidental, risks to others)
- Plan (frequency of physical observation, medical review, management, restrictions, exit plan for terminating seclusion, patient's capacity to understand the plan)

Methods

Data collection: Carried out retrospectively from 01.03.2020 to 30.08.2020 by examining 25 medical notes of seclusion medical review.

Sample selection: We had approval for general adult wards across the Trust (acute assessment unit, treatment unit, psychiatric intensive care) and it was the same as our previous audit. We had a list of patients who were nursed into seclusion during the above specified time. We randomly selected patients for the re-audit using a computer-generated list to get a mixture of different wards, and different times without looking at the reviews ourselves, to avoid bias. This list was based on similar localities and times to those included in the first audit in 2019. Data was obtained by reviewing the seclusion medical review template from the electronic patient record.

Data analysis: Carried out using Microsoft Excel on our work laptops and we followed information governance policy for it. We used descriptive statistics for data analysis.

Results

We noted 100% compliance in the following parameters: Name and role of the reviewer, time of review, reason for seclusion, mental state examination, physical health (including physical observations)/environment, risk to self and/or others. There was also full compliance with documenting a plan, including elements such as frequency of physical observations and medical reviews, clinical management, any restrictions, and an exit plan for terminating seclusion.

96% of reviews from our audit sample commented on psychiatric diagnosis and medication including prescribed medication, rapid tranquilisation, and side effects or adverse effects of medication. The patient's capacity to understand the reason for seclusion and duration of seclusion was documented in 92% of cases.

Comparison from the last audit

There was a significant improvement in physical and mental health monitoring (100 % from 82 %). It also improved for prescribed medication/rapid tranquilisation/side effects/adverse effects (96 % from 40%).

Physical observation records, risk assessments, and plans were available for 100 % of patients (was 60%, around 85%, and 90% respectively). Similarly, good documentation was found for the prescribed medication (96% from 62%). All reviews were done on time in both audits (100%).

Conclusion

We noticed a remarkable improvement in the quality of medical seclusion review following introduction of a template for it. This is based on Trust guidelines, which in turn are based on the Mental Health Act's Code of Practice, and ultimately helps us to provide person-centred care. There were no major concerns identified during the re-audit.

Clinical Implications of re-audit

This Quality Improvement Project helped us to improve our clinical practice for medical seclusion review. It helped medics to identify, escalate, and manage urgent medical issues during seclusion. Due to good record-keeping, all medics were able to see any changes in physical and mental health or prescribed medication. It particularly helped doctors in training (especially those who are just doing psychiatric rotation) to learn and improve their clinical skills around these areas.

Key actions following the audit

- We presented the results in our clinical network meeting.
- We continued to use the template for seclusion medical review which has shown good results and helped us to provide good patient care.
- We continued to provide training for doctors about seclusion review as part of our post-graduate teaching programme and induction programme.
- We presented its posters to various other training conferences (School of Psychiatry Conference and Royal College of Psychiatrists Conferences).

This quality improvement plan inspired nurses in our Trust to review and improve nursing seclusion reviews.

Acknowledgments

I would like to thank Dr Richard Ward (Consultant Psychiatrist) who supervised the quality improvement (QI) project. The Audit department, IT department, Clinical Network Team and our medical and nursing colleagues in Humber Teaching NHS Foundation Trust also supported and helped us to complete the project. I would also like to thank Haley Jackson (Clinical Effectiveness and Research Nurse) who helped us with sample selection for this project.

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The Carbon Footprint of Psychiatric Medicines

Dr Guy Harvey

Later this year, world leaders will gather in Glasgow for the 26th United Nations Climate Change Conference of Parties (COP26) to discuss how to avert another worldwide health crisis. Three degrees of global heating will be a catastrophe for humanity and the natural world that we love. Two degrees will likely lead to large parts of the world becoming uninhabitable and all that will involve. We are already seeing the effects of one degree of heating. As scientists, many doctors understand the importance of minimising their personal carbon footprints but few appreciate how much the care they provide and especially their prescriptions contribute to global heating.

Health and care services produce around 5% of the UK's total CO₂ and the largest part of this comes from medicines and equipment. The Sustainable Development Unit (now called The Greener NHS) has produced estimates of the carbon cost of the different healthcare specialties¹. This identifies 'hotspots' that need to be the focus of our initial efforts to combat this.

You may be relieved to hear that mental health services' medicines carbon footprint is relatively modest (40 ktCO₂e), compared to primary care (3619 ktCO₂e), for example. But this does not mean that we are off the hook. A large lump (around one eighth) of primary care's carbon footprint comes from psychiatry either directly or indirectly. Often, drugs are prescribed by GPs on the direct instructions of psychiatrists, or arise from GPs' psychiatric training experiences and psychiatrist-produced guidelines. So if we accept the 12% of the primary care medicine's footprint onto our account, then mental health's contribution multiplies eight-fold. This is a hotspot for which we must take responsibility.

But what do we know about the carbon footprint of the medicines we prescribe? The only ones where this has been extensively studied are aerosol inhalers and anaesthetic gases. We don't know which of our regularly prescribed drugs are the least damaging to the environment. There are ways to calculate it but they rely on data provided by the manufacturers. Without that, the best we can do is use cost and quantity as a proxy measure.



For instance, each pound spent on pharmaceuticals is estimated to produce one sixth of a kilogram of CO₂e.

We do know that worldwide the pharmaceutical industry produces huge amounts of CO₂, even more than the automotive industry. A study by Belkhir and Elmeligi (2019)² calculated the carbon production of 15 of the largest pharmaceutical manufacturers worldwide. It showed huge differences between different companies. The authors looked at how each company was progressing towards their Paris Climate targets. It found some were doing well and were already there, whereas others were way off and going in the wrong direction. They also compared carbon production with profitability and found, contrary to the belief that going green costs money, that the best performing manufacturers were also the most profitable.

Here are three ideas as to what we can do.

Medicines optimisation

Medicines optimisation³ includes practices that can save carbon. Structured medication reviews by trained MDT members can identify medicines that are no longer needed and can be safely stopped. Self-management enables patients to control their use of medicines which improves concordance and reduces waste. Patient Decision Aids also minimise waste by identifying patient preferences and values which may be different from the health professional. Medicines optimisation can avoid healthcare arising from adverse events and interactions. This can be as much as three million bed days a year, with estimated savings in the region of 111,000 tonnes of CO₂e⁴.



Environmental impact ratings

The NHS has now committed to procurement standards that ensure compatibility with its Net Zero target⁵. That means that within the next decade suppliers need to show how they too will achieve Net Zero. Progress towards this could be the basis of a rating system. Or, with information provided by the industry, it may even be possible to calculate the carbon footprint of each drug. Patients and prescribers could compare, as they can now with asthma inhalers, and choose.

Low carbon prescribing skills

We could think about developing a skill-set for clinicians aimed at reducing the number of prescribed items. Clinicians and service users may be particularly motivated if the result is to reduce environmental damage. These skills should include shared decision making, self-management, concordance strategies, and skills in using Patient Decision Aids. Prescribers need to know how to find and use the best evidence by using clinical decision support systems, evidence based medicine and critical appraisal. Doctors should have a good knowledge of non-pharmacological interventions such as psychotherapy, social prescribing, and green care.

Each of these has potential to reduce the carbon footprint of healthcare. Psychiatric medications are essential, life-saving, and relieve and prevent untold misery for countless people. But there is a lot we can do to reduce their impact on our environment. Prescribing must always be for the best for each patient and we don't have to compromise on quality; because often what is good for patients is good for the environment too.

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Cycling to work QI Project at Leeds and Yorkshire Partnership Foundation Trust

Dr Gabrielle Farrar

Background

The NHS Net Zero Project, that came out in October 2020, aims to provide an NHS that is in balance between the amount of greenhouse gases it produces, in comparison to the amount that it removes from the atmosphere (1,2). Specifically, it discusses the shift that will be necessary for this to happen towards sustainable methods of transport, such as cycling, walking, and away from fossil fuel emitting methods, such as private cars (1). Not only will this improve air pollution levels, carbon dioxide emissions and congestion, but also participants' physical and mental health (1, 3).

Every NHS trust is required to have a Green Travel plan, which should be encouraging green travel through targeted interventions such as provision of cycle storage and showers (1).

Leeds and York Partnership Foundation Trust's (LYPFT) 'Sustainability Policy', ratified on 22/01/21, makes no mention of cycling, or of sustainable methods to help employees get to work (4). It does, however, state that as a trust LYPFT needs to be actively engaging staff members in sustainable development. It also states that a key area for implementation is the protection of the local environment by preventing, wherever possible, pollution of these sites (4).





Aims and Objectives

The aim of this quality improvement project was to establish whether every LYPFT hospital and non-clinical sites has:

- a) Easily accessible bike storage facilities on site
- b) Provision for cyclists when they arrive at work i.e. showers and locker space

It also aimed to obtain qualitative data about bike storage around LYPFT and cycling to work. There were no inclusion or exclusion criterion, as it was desired to gain information and personal views from as many people as possible, who felt that they had something to say regarding the cycling facilities.

Methodology

This was an observational study assessing all workplaces within LYPFT. There were fifteen workplaces on a list received from an administrator. One of these was not owned by LYPFT anymore and was excluded. The workplaces included were: Newsam Centre, Becklin Centre, The Mount, St Mary's House, St Mary's Hospital, Aire Court, Asket Croft & Asket House, Trust HQ, Clifton House (York), Mill Lodge (York), Kirkstall CAMHS, Little Woodhouse Hall, Reginald CAMHS (East and ED) and Parkside CAMHS.

When this study was initially attempted, it was thought that emails would be a reasonable way to find out about the cycling facilities at each workplace. These were sent out, but response rates were poor. It was then determined that a telephone call would be made to each workplace. Reception staff members were the providers of requested information, with the rationale that:

- A) They would know the building and its facilities well
- B) They would be one of the first points of contact for potential cyclists

The qualitative part of this quality improvement project was achieved through inputting questions regarding the cycling facilities on a blanket email that is sent out weekly to all members of LYPFT staff. This email included a contact email address, details of the information we were specifically seeking, and a request for anyone with experience or thoughts about cycling to work to email the address listed.

Respondents were asked whether they agreed to have their thoughts and viewpoints published anonymously.

Results

Parkside CAMHS was unable to be contacted through telephone or email and so it was discounted from the project. Therefore, thirteen workplaces are included in the final results.

Bike Storage

92% (12/13) sites had some form of bike storage. Kirkstall CAMHS was the only place with no bike storage. Only 25% (3/12) of sites with bike storage were locked facilities. One of these locked facilities, St Mary's House, was currently unusable as staff were unable to locate the key for this. Therefore, 15% (2/13), of sites have accessible and lockable bike storage facilities.

There were also issues regarding access to bike storage facilities. For example, at Asket Croft, staff members have been reluctant to leave their bikes outside in the dedicated storage facility. This is in part due to concerns about safe storage, as the area they are supposed to leave their bikes is used concurrently by service users. Currently, the bikes brought by staff are being stored in the stairwell. This has extremely limited space, since the area is next to a fire exit.

Showers

85% (11/13) of the workplaces had showers. However, these showers were often located in areas where not all staff had access to, or where some staff felt as though it was inappropriate to go. This was the case at The Mount (showers located within the doctor's office), and at the Newsam Centre (showers located within the management suite). One location, Kirkstall CAMHS, has showers but these are used for storage.

Lockers

46% (6/13) of workplaces have lockers. However, when the project was carried out, staff members were not always certain about where these were located, and who these were for (i.e. patients, particular staff members). To mention a particular area, Asket Croft has a shower but there are no facilities for storage or drying out of wet cycling clothes or towels.



Conclusions

Although the trust performed well in having cycling bike storage, in almost all of the cases this appeared to be cycling rails as opposed to anything more substantial, such as lockable facilities. Bike theft is known to be prevalent, and keeping bicycles securely could be a barrier to some employees cycling to work.

There are some issues with the storage facilities being unusable, for reasons of inaccessibility (St Mary's House) or feeling unsure about the safety of bikes when stored there (Asket Croft).

Despite having a secure bike storage facility at the Becklin Centre, there is still an issue that was raised by a survey respondent. This bike shed requires a key to unlock them, which is kept in the reception area. This has to be signed for on every lock and unlock. Some regular users of the Becklin Centre bike facilities wondered if a card system could be put in place, as this would eliminate the hassle and the risk associated with leaving the bikes outside whilst signing for the key. One employee stated that it was difficult to imagine such a system being in place for cars.

Anecdotal evidence and results from the survey show that showers are at a premium, they are located in areas not readily accessible to everyone, and that it is not clear on speaking to reception staff about their location. One survey respondent used the word "intrusive" to describe going into the doctor's office to shower in the morning.

Not only were showers not always present, but it seems finding space, or indeed radiators, to hang up wet clothes or towels after a shower or wet ride into work was difficult. Some survey completers talked of having to put on wet clothing following a day of work.

The vast majority of respondents mentioned some of the benefits that they see to cycling in every day.

Limitations

The methods for determining the cycling facilities at each location were reliant on the knowledge of reception staff, rather than regular cyclists and facility users. Therefore some data may be inaccurate due to recall error.

This project has not established the extent of provision at each workplace. For example, where there are bike storage facilities, the number of bike spaces remains unknown. More detailed information may be required to assess the gap between existing facilities and user demand.

Further work is required to understand the level of interest into cycling to work, and perceived barriers to doing this.

Ideas for discussion

Send around a short information poster to each reception at LYPFT so they know about the locations of every cycle rack, shower facility and lockers in each workplace. This has been considered due to much of the answers and information received from various staff members regarding cycling facilities, was imprecise and vague, therefore making it difficult for people to plan how they would get to work if they were to cycle.

- Publicity, including a regular staff email including information about the cycle to work scheme and quiet routes that cyclists can take from the city centre to different hospitals, a poster campaign (including photographs of staff members and their bikes and quotations from said staff members about their commutes), a film of people cycling to work, and some form of competition.
- Fix or repurpose the facilities that are broken, and get every workplace to the same standard.
- Rethink the locking facility at the Becklin Centre to make it easier and more convenient for staff members to use.
- An "LYPFT Cycling Hub" – this would be a primarily email run service, who employees can contact with any issues, comments about provision, and questions about how to cycle in. This has been seen throughout other hospitals, for example Sheffield Teaching Hospitals, and worked to good effect. This would also provide us with a direct email address through which we could liaise with other nearby hospitals to share ideas, and come together to work with the council on improving cycling routes.
- Encouraging staff to allow different working hours to avoid commuter traffic.

Other Information

A great deal was said in the qualitative part of the quality improvement project about the lack of coherent and safe cycling routes into Leeds. Dangerous driving, potholes, and the general condition of the roads for cyclists were brought up as part of the reason why people do not cycle. This would need to have proper consultation with the council around increased cycle paths and safety on the roads. Positive changes, such as increased performance in the workplace and helping to wind down after busy days were noted from respondents.

NHS Net Zero plan, section 3.2.2.
<https://www.isg.ac.uk/GranthamInstitute/news/what-is-net-zero/>
<https://www.nice.org.uk/guidance/gh4/resources/physical-activity-walking-and-cycling-pdf-1996352901061>
LYPFT's Sustainability Policy, Word Document. Published 22/01/21



Clinical Re-audit of Dementia Diagnosis across Teesside – how are diagnoses made and what treatments are offered?

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Background

An audit was carried out in 2020 which looked at the differences between memory services in Teesside in terms of dementia diagnosis. This was carried out following clinical observations that there may have been variances in practice. The audit found that across Teesside and all areas (Middlesbrough, Stockton, Redcar, Hartlepool), patients were given a dementia subtype diagnosis (where possible) in 100% of cases. Neuroimaging, clinical history and cognitive screening were considered in the vast majority of cases to make a diagnosis.

However, there was evidence of individual clinicians documenting in different ways and some clinicians appeared more cautious to prescribe medication than others. There were also some inconsistencies with offering Cognitive Stimulation Therapy (CST) at diagnostic appointments.

The findings were presented locally and nationally, which prompted multiple discussions about standardising services and how this is best done. Teaching was given around the expected standards and prescribing. A re-audit was planned to review if there had been changes following these actions.

Criteria and Standards

The following table highlights the criteria that we wished to re-audit; specifically looking at what information clinicians use when diagnosing dementia (and the type of dementia) and the treatments offered.

Standards were developed in conjunction with current NICE guidance NG97 (2018)¹ and the TEVV Person Centred Pathway of Care for Dementia document (2014)². The TEVV pathway lists cognitive stimulation therapy as an intervention but does not explicitly state this should be done at diagnostic assessment. However, local best practice is to offer this as early as possible.

Evidence base	Criterion	Standard
NICE NG97 (2018) - diagnose a dementia subtype if possible	Look to see if a dementia subtype is recorded in patient's record at diagnostic appointment	100%
NICE NG97 (2018) - consider neuroimaging / cognitive testing / history to make diagnosis and use validated criteria to diagnose dementia subtypes	Look to see what investigations have been performed, and look for documentation to see that the different investigations have been considered. If not, why not?	100%
NICE NG97 (2018) and TEVV Dementia Pathway - cholinesterase inhibitors offered to those with mild to moderate Alzheimers Disease (as well as mixed dementia, Dementia with Lewy Bodies and Parkinsons Disease Dementia). Memantine offered for those with severe Alzheimers, or those with moderate Alzheimers disease with a contraindication to cholinesterase inhibitors	Look to see if any medication has been started at initial appointments if it is indicated. If not, has a rationale been documented	100%



NICE NG97 (2018) and TEWV Dementia Pathway - cholinesterase inhibitors offered to those with mild to moderate Alzheimers Disease (as well as mixed dementia, Dementia with Lewy Bodies and Parkinsons Disease Dementia). Memantine offered for those with severe Alzheimers, or those with moderate Alzheimers disease with a contraindication to cholinesterase inhibitors

Look to see if any medication has been started at initial appointments if it is indicated. If not, has a rationale been documented 100%

TEWV dementia pathway – Cognitive Stimulation Therapy to be offered / considered to patients following a diagnosis of mild to moderate dementia

Look to see if there is evidence that this has been considered (even if felt not to be applicable) 100%

Methodology

We aimed to analyse the records of 30 patients seen for a diagnostic appointment in each of the memory services in Teesside between August and December 2020, using the trust records. The audit was conducted between April and May 2021. Data was analysed and recorded on a standardised proforma. The audit tool was designed in consultation with the Clinical Audit and Effectiveness Team of the trust, and was approved by the Mental Health Services for Older People Audit Group.

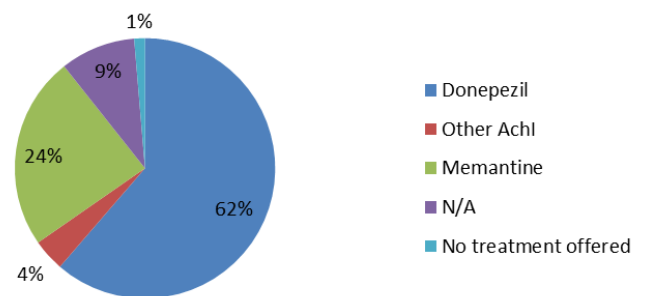
4.3. Where anti-dementia medication was indicated, the majority received donepezil (62% in 2020 data, 69% in previous audit). There appeared to be improved documentation if a medication was not offered due to a clinical reason, or if medication had been declined.

Results

4.1. As with the previous audit more women were seen in memory clinics across Teesside than men, with 58% of participants identifying as female. Most patients seen in memory clinics were aged between 80 and 89 years old. The youngest patient was 54 and the oldest 99.

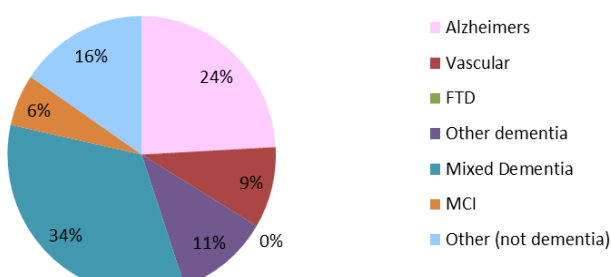
4.2. The types of diagnosis given across Teesside was similar in the 2019 data and the 2020 data, with the most being diagnosed as mixed dementia.

Medication Given When Indicated (n=75) 2020



4.4. Cognitive Stimulation Therapy (CST) was offered in only 31% of cases across Teesside, which is a decline from previous. However, it is felt that access to group therapy during the pandemic affected these results. Furthermore, some teams report that CST is not discussed at the diagnostic appointment.

Dementia Diagnosis by type across Teesside 2020





Northern and Yorkshire Quality Improvement, Research and Audit

Results – Overall Compliance with Audit Standards and Comparison with Previous Audit

Standard	Overall		Middlesbrough		Stockton		Redcar		Hartlepool	
	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020
Diagnose a dementia subtype if possible 100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Consider neuroimaging to make diagnosis 100%	91%	81%	100%	70%	100%	100%	83%	61%	100%	93%
Consider clinical history to make diagnosis 100%	94%	100%	100%	100%	97%	100%	96%	100%	100%	100%
Consider cognitive screening to make diagnosis 100%	94%	91%	100%	83%	100%	100%	92%	86%	100%	97%
Appropriate Medication offered as per NICE guidance 100%	69%	99%	38%	100%	90%	95%	70%	100%	63%	100%
CST offered 100%	61%	31%	52%	0%**	86%	83%	10%	0%**	78%	45%

*If not felt appropriate / not available / patient declined this is included as "yes" if clearly documented

** CST not available or discussed at post diagnostic appointments



Areas of Good Practice

6.1. Across Teesside and all areas, patients were given a dementia subtype diagnosis where possible in 100% of cases.

6.2. There was an overall improvement in practice of considering clinical history to make a diagnosis in comparison with the 2019 audit; this was considered in 100% of cases in all services.

6.3. There was good practice in considering neuroimaging and cognitive screening in making a diagnosis. Stockton considered neuroimaging and cognitive screen in 100% of cases to make a diagnosis.

6.4. There was an overall improvement in practice of offering anti-dementia drugs where indicated; 99% cases were offered anti-dementia medication across Teesside, with Middlesbrough's practice improving from 38% to 100%, Stockton from 90% to 95%, Redcar from 70% to 100% and Hartlepool from 63% to 100% from the 2019 to 2020 audit.

Summary of Issues Identified

7.1. This audit was limited as it concentrated solely on what was documented at diagnostic appointments.

7.2. The audited period was during the pandemic, at which time certain services such as CST were not available, and this may have influenced it being offered to [patient](#). Offering CST at diagnostic appointments reduced overall from 61% to 31% across Teesside. In Middlesbrough and Redcar from 52% and 10% respectively to 0%; this may also have been because CST is discussed at post diagnostic appointments, as reported by these teams. There was a decline in offering CST from 78% to 45% in Hartlepool and 86% to 83% in Stockton. We also did not follow up patients to see if CST was offered at subsequent appointments.

7.3. The availability of neuroimaging services was also limited during this period and may have influenced practices at the time. There was a decline in considering neuroimaging to make a diagnosis compared to the audit of 2019, which may be due to the limited availability of these services during the pandemic; overall decline across Teesside was from 91% in 2019 to 81% in 2020.

Recommendations

8.1. Ensure that appropriate patients are referred for CST at the earliest opportunity: Community team staff to review current procedures and look at pathway documentation to ensure consistency and clarity around this process.

8.2. Increase awareness of good practice across teams by presenting at locality and service meetings.

8.3. Re-audit when not in a pandemic to make more valid comparisons.

References

1. NICE Guideline (NG 97). Dementia: assessment, management and support for people living with dementia and their carers June 2018
2. Tees, Esk and Wear Valleys NHS Foundation Trust. Person Centred Pathway of Care for Dementia. 2014.
3. CQC Fundamental Standards relevant to this audit are as follows: Person-centred care



We would like to thank all members for their contributions towards Division activity throughout the year.
If you would like an article to be considered for our Spring 2022 Newsletter, please submit your articles to northernandyorkshire@rcpsych.ac.uk
The deadline for submissions is 25th February 2022