PICU
QUALITY NETWORK FOR
PSYCHIATRIC INTENSIVE CARE UNITS

ISSUE 2, June 2019

This Issue

WELCOME

Welcome to the summer edition of the Quality Network for Psychiatric Intensive Care Units' newsletter. We have an excellent collection of articles for you, as well some fantastic artwork. Thank you to everyone that made a contribution to this edition.

Since the last newsletter, we've launched a developmental membership option. This is for services that would like to engage in a supportive review process without having to achieve accreditation status. We currently have five services participating in this cycle and we will be rolling this out more widely from 2020.

At the beginning of this year, we hosted a special interest day on staff support and wellbeing. We had excellent presentations, including: Faye McGuiness, Mind, on workplace wellbeing; Hannah Andrews on the experience of self-care and self-compassion from the University of Warwick; Liz Allen, founder of See Think Act, on relational security; and Louise Hall, University of Leeds, on the importance of support for staff wellbeing.

Due to the popularity of this event, we have started a staff support and wellbeing group. The group is supported by Faye at Mind and is designed to help service managers track progress on items relating to wellbeing. More information is available inside on how to be involved.

Also included in this edition are top tips from the Quality Network on how to complete your service's evidence bank. Take a look at those services that have recently been awarded accreditation. Huge congratulations to them; we know how much hard work and dedication goes into obtaining the award!

Finally, we're currently planning our 2nd QNPICU Annual Forum in October. Please get in touch if you would like to showcase your service's good practice as a workshop or poster presentation!

Megan Georgiou, Programme Manager and Kate Townsend, Deputy Programme Manager, QNPICU

The Power of Twitter and a WI Group

Coming up to Christmas 2017, Dr Kate Lovett retweeted a post from Glenbourne unit requesting donations of gifts for Christmas presents for the patients who would be on the ward at Christmas. Having a grandson with what is described as "a severe and enduring mental health illness", my mum, like the rest of my family have had our values and priorities challenged over recent years. We are more aware of what it means to live with the stigma and every day difficulties that people like my son experience.

We've also become acutely aware that many people whilst in hospital do not have family and friends who are able to visit, causing added distress. My mum, like me, just wanted to help and this seemed like a good opportunity for her to involve her local Women's Institutes (WI) group. The group had a collection and it went very well; the ward staff were overwhelmed with the presents they were then able to pass on to the patients.

Easter 2018, the Down Thomas and Heybrook Bay WI initiated another collection of chocolates, colouring books and magazines—which again was very much appreciated. In July 2018, after hearing about a young man being sent out of area with no possessions and not even being

offered a toothbrush and toothpaste after four days of being on an acute ward, and that many admissions are unplanned and belongings not readily available, I suggested that my mum's WI contact the ward and ask if they could help with admission packs. This idea was gratefully received. Items were suggested and advice given on what patients could and couldn't have on the ward and what would be really helpful. The group were shocked to learn that sanitary products were needed desperately. Any donations not suitable they take to a local homeless centre so there is zero wastage.

There is a team of women who meet in my mum's sitting room, filling bags with collected welcome goodies and a little note to show the patients on this unit that someone cares. Again, in 2018, they took in lots of presents at Christmas and recently supported the repurposing of a new room through donations of games, jigsaws, magazines etc. They have an update at each WI meeting on the links with the ward and really enjoy hearing about what they can do to help and how well their support has been received and appreciated by patients there.

The group had an article recently in the national WI magazine encouraging other WI groups to think about supporting a local ward with admission packs. They have been contacted by various WI groups nationally who are keen to help. They recently promoted this at an annual WI Devon event where they had a stand to share their story and collect donations. They were overwhelmed with the donations: two car

loads. Twenty packs have since been dropped off to The Cedars and The Junipers, with WI groups now in contact.

We are hoping that all inpatient wards will have links with a local WI group and currently there are further donations of admission packs across Devon being prepared to be dropped off.

Tracy Lang
Family and Friends Representative
QNPICU

Health Promotion Group Pilot - January to February 2019

The Psychiatric Intensive Care Unit (PICU) at Leverndale Hospital in Glasgow is a 12-bedded unit which accepts admissions from general psychiatry and patients within the judicial and custodial settings. Patients are usually detained under the Mental Health Care and Treatment Act (Scotland 2004) or Court Order under the Scottish legal system. The multidisciplinary team includes psychiatrists, nurses, pharmacists, occupational therapy, dietetics and physiotherapists.

The majority of the patients are diagnosed with severe and enduring mental health conditions such as schizophrenia, bipolar affective disorder and schizoaffective disorder. Most patients are prescribed antipsychotic medication during or prior to their admission to PICU.

People with a diagnosis of a severe and enduring mental illness, such as schizophrenia and bipolar affective disorder, are at an increased risk of a variety of physical illnesses and conditions. These can include coronary heart disease, diabetes, infections, respiratory disease and greater levels of obesity. They are almost twice as likely to die from coronary heart disease than the general population, and are four times more likely to die from respiratory disease (Wellbeing and mental health: Applying all our health gov.uk 2018). Patients can have limited access to exercise due to the nature of the environment and potential restrictions placed on them.

Subsequently, there is now strong evidence for the inclusion of exercise and physical activity programmes within inpatient mental health settings, such as PICUs, in order to help address some of the above issues. Interventions with a focus on lifestyle choices - including physical activity, diet and behavioural choices, have been recommended in guidelines such as the SIGN guidelines for the Management of Schizophrenia (SIGN 131 2013). The QNPICU (2017) also state that *'patients are offered personalised healthy lifestyle interventions such as advice on healthy eating, physical activity and access to smoking cessation services'* as part of their Quality Network standards.

In considering the above, a multidisciplinary discussion took place regarding the most suitable delivery of health promotion within the ward. A prior health promotion group had been delivered in 2015 however the format (mainly an educational style) had not been suitable within the environment. Therefore, ideas around which format promoted involvement and sharing of information was discussed.

A group of various members of the team including nursing, occupational therapy and physiotherapy explored this further and a decision was made to commence a six week pilot from January to February 2019. This would follow a format whereby physical exercise activity (graded circuits) would be facilitated by physiotherapy staff alongside another session, (during and afterwards), which will focus on healthy snacks, educational quiz and provision of information will be offered. A group protocol and risk assessment was completed by occupational therapy and physiotherapy staff.

A consultation with patients (through patient questionnaires) was carried out. They were asked what areas of physical health/ health promotion would be beneficial. Patients were offered suggestions such as smoking

cessation, sexual health, exercise and substance misuse but were also offered the opportunity to request any specific information. Patients were also given the opportunity to set goals in relation to their physical health. Written information including illness specific leaflets and resources was collated, and a directory of local community services was also compiled. The rational for this was to provide information which patients can take and access even after discharge from PICU and any other services.

Through physical activity screening questionnaires, it was established that the majority of patients were not achieving the physical activity recommendations of 150 minutes of moderate intensity exercise a week (https://www.gov.uk/government/publications/uk-physical-activity-guidelines) Almost all patients described walking at a slow or average pace as their only form of physical activity.

The sessions began on 23 January and continued until 27 February 2019, until now the sessions have been well received within the ward. The sessions are led by physiotherapy and occupational therapy staff and supported by nursing staff.

Approximately three patients are engaging in the exercise session each week and approximately five-six are engaging in the healthy snack and information session. The physical activity sessions use exercises which require no equipment bar a chair. There is a cycle of 10 different exercises completed for 30 seconds with 30 seconds rest in between and this cycle is repeated twice. Each participant reports their mood and anxiety on a visual analogue score pre- and post-exercise. For those scores indicating a change there is a reduction of anxiety by 1/10 and an improvement in mood by 2/10. Verbal feedback from nursing staff report no negative effects from the introduction of exercise.

Patients are asked about healthy lifestyle choices and considered future plans, they are also given the opportunity to speak on their own with a staff member regarding any physical health problems that they may have. These sessions have included participation by staff. Several outcome measures are being used including the Model of Human Occupation - Volitional Questionnaire and Anxiety and Depression Scales.

It is hoped that future sessions continue to be well attended and received by the patients and a full evaluation including review of outcome measures will be completed. It is then hoped that from the evaluation that a longer term implementation of health promotion continues with PICU.

Lindsay Noble
Specialist Occupational Therapist
Psychiatric Intensive Care Unit
Leverndale Hospital

Follow us on Twitter **@ccqi_ @rcpsych**

And use **#qnpicu** for up-to-date information.

Staff Support and Wellbeing: themes and recommendations

During QNPICU's first annual forum in October 2018 it was apparent that supporting staff's health and wellbeing is high on people's priority, and a growing concern for team leaders. This topic appears to be a top of the agenda for NHS at the moment, following the publication of NHS Staff and Learners' Mental Wellbeing Commission in February this year. This details the scale of the current problem within the NHS, reporting that sickness levels are estimated to cost the NHS £1.1 billion per year. This report also provides 32 key recommendations for NHS services.

QNPICU held an event on 24 January 2019 focussing on this issue. Staff sickness and high turnovers are regularly a focus on QNPICU accreditation visits, and understandably a particular issue when caring for people who are so acutely unwell. Throughout the day we had an array of fantastic speakers explaining the reasons behind staff sickness rates and providing practical and useful tips on creating a better workplace environment for both staff and patients. There were a few key themes that came up throughout the day; including the fact that mental heath workers are particularly bad at looking after their own mental health. This article will summarise the final workshop of the day, where we asked three important questions:

- How do we measure staff wellbeing?
- What resources do we need/do we have?
- What are the good practice examples that can be shared?

How do we measure staff wellbeing?

Due to the subjectivity of wellbeing, measuring it on a larger scale is not a particularly easy thing to do. The consensus during the workshop was to introduce a measurement scale, such as Professional Quality of Life Measurement tool, introducing regular staff satisfaction surveys, or 'Rate your Wellbeing' initiatives.

There are a lot of tools available to help measure staff satisfaction, but it is important to adapt the tools to fit your service and environment, as there are many tools available that might not be appropriate.

There are also a number of indirect measurements you can look at, such as staff sickness rates, complaints, high turnover rates, exit interviews and engagement levels. Conduct supervision audits to see if staff are receiving regular support from their line managers. These are all good indicators of the levels of support and wellbeing experienced by staff.

Before embarking on a staff support programme, it is important to get a baseline understanding of where your team are on the 'satisfaction scale', as this will inform you of future improvements. This will also help you to understand what is working well/what is having less of an impact when implementing any improvement measures.

What resources do we need/do we have?

Something that was interesting to learn during the event was how beneficial it is for staff to have their own dedicated room, away from the patient areas; the staff room! Having a space to make a cup of tea and have a five-minute talk with colleagues can make a big difference to the daily pressures. Other tips and suggestions included: implementing a health and wellbeing lead, regular supervision and reflective practice, implementing team away days and team bonding activities, promoting good physical health (yoga and gym sessions), and ensuring staff can consistently take their breaks.

There are many recommendations produced by the people who attended the event, and there will be staff within your service who have fantastic ideas of how they can better be supported. Utilise your staff and get them involved.

What are the good practice examples that can be shared?

Being in the fortunate position of visiting

many different PICU services, I have seen first-hand the effects of good staff support, and the impact it has on patient care. I have split some good practice examples into themes:

Culture/leadership: When staff members are well supported and encouraged to look after their own wellbeing, it can help create a culture within the service of openness and honesty. Positive leadership with an 'open-door' policy can lend well to this, as well as management being hands-on enough to allow staff breaks. Regular supervision, particularly if newly qualified or in training can have a positive effect on staff retention rates. Implementing reflective practice, ideally by an external lead, will promote this further.

Empowerment: Utilising your staff team to create new initiatives and innovations. There is a new era of quality improvement initiatives that is growing due to the fact the ideas are coming from frontline staff, who lead on the initiatives with the support of management. Empower staff and encourage them to follow through with their ideas. The positive impact it will have on their confidence and enjoyment at work will be huge.

Safety/Openness: Implementing a speak-up guardian, who can raise issues on behalf of staff. Encouraging staff to comfortably challenge decisions and raise concerns should they have any. Promoting a place of safety for staff within the workplace.

Benefits: Advertising any NHS other discounts and try to provide an opportunity to socialise within the team. Where possible promote healthy physical activity such as a walking/running club, utilising access to a gym area or providing yoga classes. Consider flexible working arrangements or rotations to make the roles more appealing.

It is vital that staff are supported and feel valued to ensure the continuing care is given to the patients. There are many resources available, and the QNPICU network has started a staff support and wellbeing working group to help managers and people working within PICUs implement tools effectively. This group includes staff satisfaction surveys and practical recommendations and tools to use. This group also provides a network of support to help with the implementation of tools. If you are interested in joining this group, please contact a member of the PICU quality network team.

Kate Townsend, Deputy Programme Manager, QNPICU

Standards for Psychiatric Intensive Care Units (2017)

Available online:
www.rcpsych.ac.uk/picu

Do you want to be involved in a staff support and wellbeing group?

Following on from our special interest day in January, and in collaboration Mind, we are looking for expressions of interest to become part of a staff support and wellbeing working group.

The group is a supportive network to help teams in providing a positive working environment for their staff, increasing staff morale and enabling colleagues to better look after their own mental health and wellbeing. Using guidance from Mind, NHS and Health Education England (HEE) the wellbeing working group is a network of support during the implementation of wellbeing tools.

Please see below for a timeline of the process:

Stage	Scheduled
Stage 1	First conference call and staff satisfaction survey for baseline
Stage 2	Second call and discussion of tools (this may be done individually to each patient)
Stage 3	Implementation of tools and monthly conference calls for feedback of tools
Stage 4	Second satisfaction survey

If you are interested in finding out more information, please email kate.townsend@rcpsych.ac.uk.

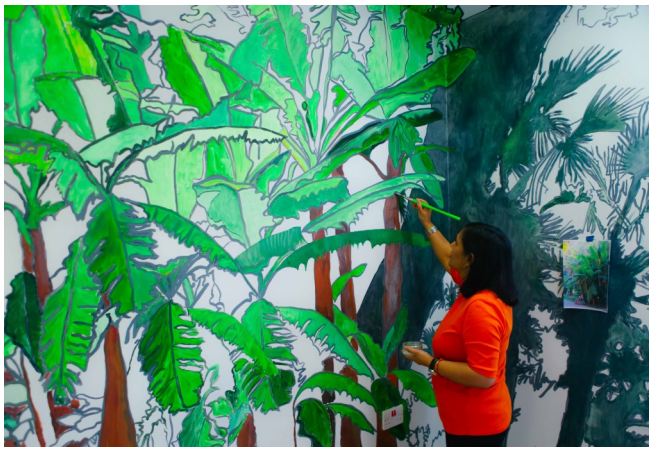
If you are interested in seeing the slides from the event, they are up on our online platform: Knowledge Hub. Please contact PICU@rcpsych.ac.uk for queries on how to join if you are not already a member!

Hospital Rooms

"Hospital Rooms commission world class artists to work with mental health patients and staff to radically transform locked and secure mental health units with museum quality and compliant art.

Our artists work in partnership with patients, staff and the wider community through art workshops, events and discussions.

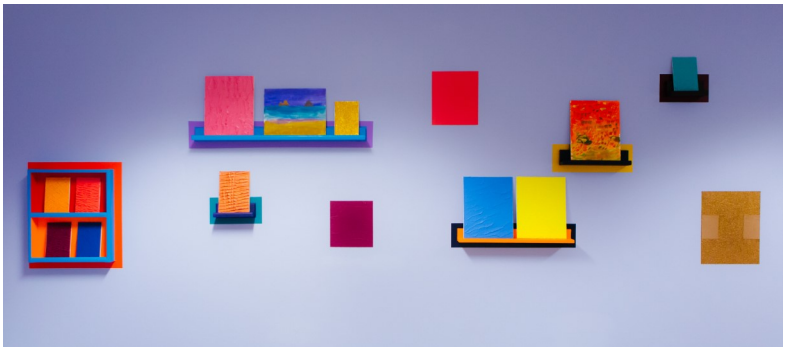
Together, we make challenging clinical environments imaginative, thoughtful and rejuvenative."



Sutapa Biswas, Women's Lounge Garnet Ward, Camden and Islington NHS Foundation Trust

Tim A Shaw, Recovery College, Springfield University Hospital, South West London and St George's Mental Health NHS Trust

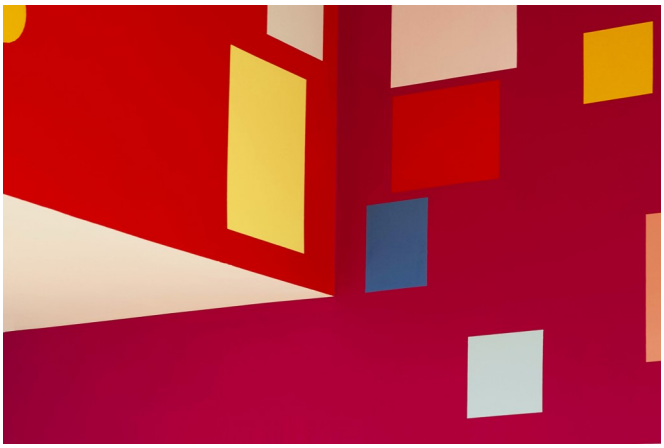
Jon Emmony



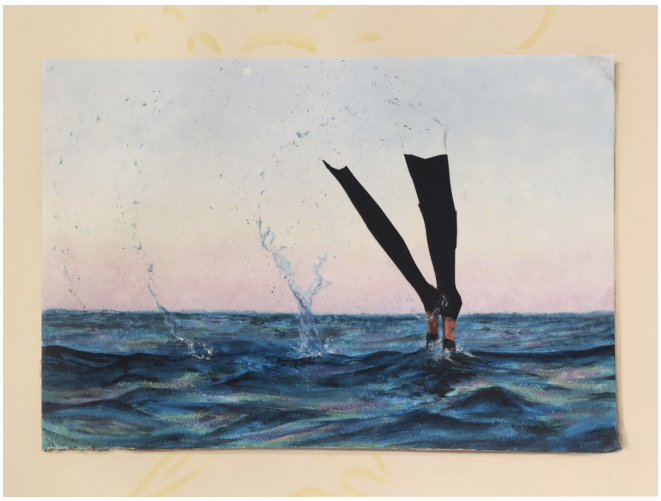
Richard Wentworth, Lothar Gotz, Hannah Brown, Sophie Clements and Tim A Shaw, Hellingly Centre, Sussex Partnership NHS Foundation Trust

Rachael Champion, 'Tropospheric Terrestrial Bodies', Telephone Room, Bluebell Lodge, CNWL

Bob and Roberta Smith, Family Room, Bluebell Lodge, CNWL



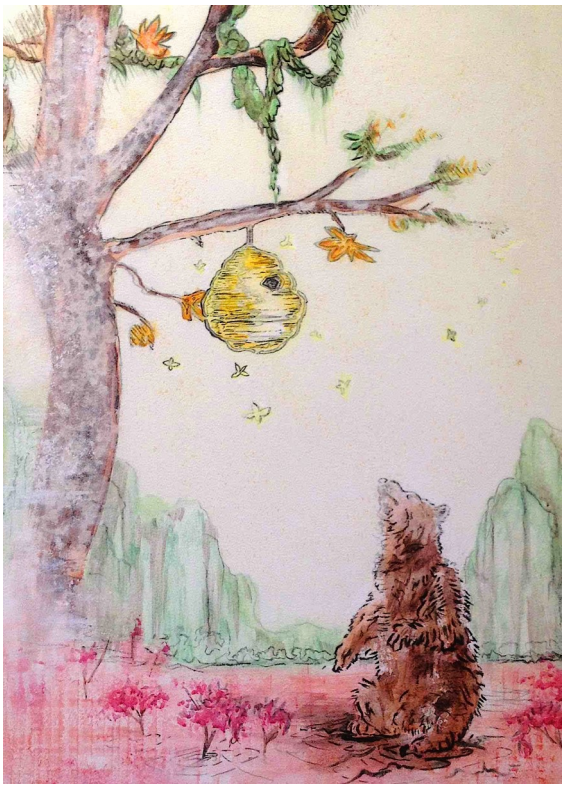
Tim A Shaw, Artwork for the Hospital Rooms project at the Phoenix Unit at South West London & St. George's Mental Health NHS Trust



Michael O'Reilly, Artwork for the Hospital Rooms project at the Phoenix Unit at South West London & St. George's Mental Health

Tamsin Relly, Pink Shadow, Hospital Rooms project at Eileen Skellern 1 psychiatric intensive care unit at South London & Maudsley NHS Foundation Trust

Sophie Clements, Shall I This Time Hold You? Hospital Rooms project at the Phoenix Unit at South West London & St. George's Mental Health NHS Trust



Michael O'Reilly, Front Mixam, Artwork for the Hospital Rooms project at the Phoenix Unit at South West London & St. George's Mental Health

Pavilion Ward PICU development

Pavilion Ward has undergone drastic improvements in the last year. The ward has recently been accepted to be involved in the National Quality Improvement project for reducing restrictive interventions as part of the National Collaborative Centre for Mental Health (NCCMH) following concerns of high usage of restrictive practices. In December 2017 seclusion, the Place of Safety and the Calm Room were all being used as seclusion simultaneously. There were 11 episodes of seclusion totalling 354 hours. In comparison, in December 2018, there were three episodes of seclusion totalling 15 hours. With this amazing reduction we thought we would see an increase in rapid tranquilisation or restraint, but we have managed to reduce this also.

How? Firstly a change in leadership has led to a change in culture. A new leadership team and ward manager who works shifts in the numbers and has an open-door policy, is passionate about staff wellbeing, has helped to flattened hierarchy and empower staff via a 'leader-leader' approach. Our new leadership team has created an open and transparent environment where staff feel able to challenge each other's practice and raise concerns during regular supervision as well as calling safety huddles on shift.

The 'leader-leader' approach has been implemented on Pavilion which aims to give control to all members of the team no matter their band, give them the skills to be competent in achieving tasks, gives clarity with a shared vision and goal, and to have the courage to not fall back in to the 'leader-follower' model. This gives all staff a sense of ownership and responsibility in the care of their patients.

An example of this is, instead of a healthcare assistant approaching the nurse in charge to ask to take a patient out on section 17 leave, the healthcare assistant, following all the checks, tells the nurse in charge why they believe from their risk assessment that a patient should or should not go out on leave, therefore holding a level of responsibility.

This might seem like a small change but it is one that has allowed everyone, no matter what their banding, to be part of clinical decision making surrounding risk management. Staff at all bands now suggest de-escalation options, calls safety huddles and post incident reviews and are able to recognise when a patient is becoming distressed and take action to support the patient.

Another major driving force has been the dramatic increase in activities that are carried out on the ward. We noticed that when our occupational therapy colleagues went home that there was increased boredom and agitation which resulted in incidents and we realised there was a huge need for nurse-led activities at evenings and weekends. As soon as we started to implement these, staff noticed how much of a positive impact this had on alleviating patients' boredom on the ward as well as a therapeutic distraction technique. We now have a nurse-led activity time table as well as three nurse-led activity leads within the team and we hold on average the highest number of activities weekly throughout our hospital. We have varied activities such as tie-dyeing t-shirts, cooking new and exciting meals (spring rolls went down a treat), movie nights, and a new favourite – decorating welcome boxes for new patients.

When incidents are occurring it can be difficult to facilitate activities, however we have continued to encourage this. At times when there have been incidents we have had a member of staff in our art room doing a group with five of our 10 patients. This has actually increased the safety of the patients on the ward as they would not be involved in, or exposed to, the incident.

We have also removed 'blanket bans' from the ward. We wanted to change the perception of a PICU which was seen as a restrictive place where people were nursed when they were violent, to a therapeutic environment where engagement is at the heart of what we do.

Our patients are all individually risk assessed for items previously banned on the ward such as mobile phones, belts and phone chargers. Why would you remove all these items if someone is not at risk from them? Surely

removing all these items and potentially a patient's only means of communication with loved ones would be upsetting and not supportive?

Ward Vision
"Together we will create a supportive, encouraging and inclusive community where our wellbeing can flourish to become our happiest, strongest and wisest selves."

Jodie King
Ward Manager
Pavilion Ward

Accreditation Awards

The QNPICU team congratulation the following wards for their hard work at achieving accreditation from the Royal College of Psychiatrist's Centre for Quality Improvement:

Name of Ward	Date of Accreditation
Chaucer ward, Greater Manchester Mental Health NHS Foundation Trust	26 November 2018
Denholme ward, Cygnet Healthcare	26 November 2018
Caspian ward, Central and North West London NHS Foundation Trust	26 November 2018
Jade ward, East London NHS Foundation Trust	20 February 2019

Top tips for the evidence bank

The evidence bank can often be the most difficult part of the self-review process, so we have provided some top tips to help support you in capturing the evidence required to meet the standards.

Top tip 1: Refer closely to the wording of the standard.

e.g. *'There is a minuted community meeting that is attended by patients and staff members. The frequency of this meeting is **weekly**, unless otherwise agreed with the patient group.'*

You should provide **3x examples** of community meeting minutes to evidence it occurring on a weekly basis. Do not just submit one example.

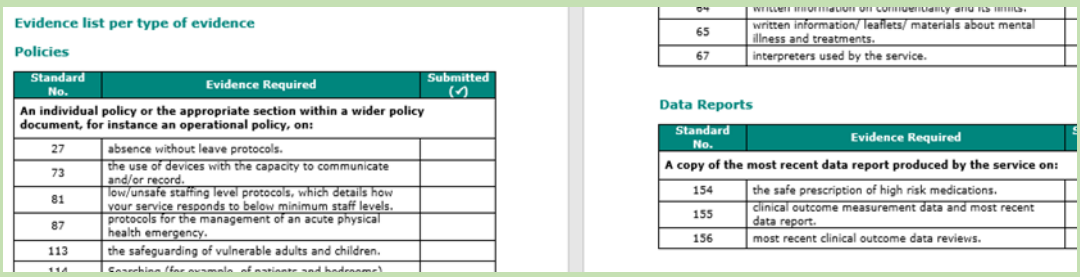
Top tip 2: Read the standard in full.

e.g. *'An audit of environmental risk is conducted annually, and a risk management strategy is agreed and acted on.'*

The review team will be looking for **all points in the standard**; that the environmental audit is done annually **and** there is a comprehensive and proactive management strategy / action plan that follows.

Top tip 3: Consider the *type* of evidence needed.

The evidence bank checklist is a helpful resource. This is sent to you during the self-review, and the peer-review teams will refer to it on the review day (for accreditation reviews). It will describe which standards need policies, written information (e.g. welcome pack given to patients), data reports, patient/staff or environmental records.



Evidence list per type of evidence

Policies

Standard No.	Evidence Required	Submitted (✓)
An individual policy or the appropriate section within a wider policy document, for instance an operational policy, on:		
27	absence without leave protocols.	
73	the use of devices with the capacity to communicate and/or record.	
81	low/unsafe staffing level protocols, which details how your service responds to below minimum staff levels.	
87	protocols for the management of an acute physical health emergency.	
113	the safeguarding of vulnerable adults and children.	

65	written information/ leaflets/ materials about mental illness and treatments.	
67	interpreters used by the service.	

Data Reports

Standard No.	Evidence Required
A copy of the most recent data report produced by the service on:	
154	the safe prescription of high risk medications.
155	clinical outcome measurement data and most recent data report.
156	most recent clinical outcome data reviews.

Top tip 4: Prepare the evidence.

Make sure you label and mark **all of the evidence** by the standard number. When given multiple documents it makes it a lot harder for the review team (and project team) to go through and work out which policy/ document is for which standard. When it is not clear to the team this may result in them not being fully informed and marking standards as Not Met.

When evidence is fully labelled, the project team are able to go through the evidence robustly, ensuring useful feedback is given before the accreditation visits. Time is tight on the review day, clearly labelled evidence will ensure enough time to go through all documents.

Anonymise all of the evidence before being sent through to the Quality Network team.

Top tip 5: Check the dates.

If policies are out of date or in draft format this will affect the scoring of the standard. Make sure policies are in date and ratified.

Top tip 6: Utilise the Quality Network!

The project team are here to help and have a good understanding of what evidence is needed. Utilise their expertise and ask questions if you have any!

QNPICU Standards Consultation

08 October 2019

at the Royal College of Psychiatrists

Updates from the Quality Network:

Knowledge Hub

Knowledge Hub is a free to join, online platform which allows you to be part of various groups. The Quality Network for Psychiatric Intensive Care Units (QNPICU) has created their own group to facilitate discussions around psychiatric intensive care units - you will only be able to join if you work within a service which is currently a member of the network.

Joining Knowledge Hub will allow you to:

- Share best practice and quality improvement initiatives
- Seek advice and network with other members
- Share policies, procedures or research papers
- Advertise upcoming events and conferences

For more information or if you wish to join, please email PICU@rcpsych.ac.uk.

QNPICU 2nd Annual Forum

Save the date! The QNPICU Annual Forum will be held on 15 October 2019.

It will be an interesting day full of presentations, workshops and networking - including sharing good practice! If you have any good practice that you would like to share in the form of a workshop or poster presentation, please contact PICU@rcpsych.ac.uk.

Upcoming reviewer training dates:

Thursday 07 November, 14:00-17:00
Royal College of Psychiatrists, London, E1 8BB

The training is a great learning experience for those who are interested in participating in external peer-reviews of mental health services in prison.

The training will give potential reviewers the opportunity to gain practical knowledge about how to conduct a peer-review visit.

The training day will involve presentations, discussions and workshops created to develop the skills of a reviewer.

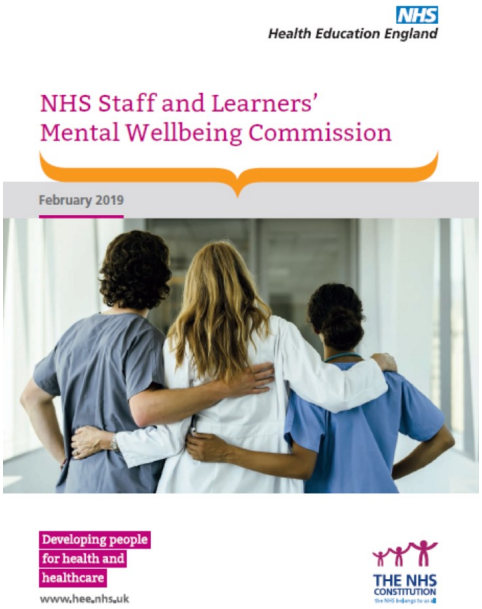
Should you or a colleague wish to book a place, please email **kate.townsend@rcpsych.ac.uk**

For further information on our event locations and booking enquiries, please visit

www.rcpsych.ac.uk/picu

College Reports and Publications

NHS Staff and Learners' Mental Wellbeing Commission: NHS and Health Education England published February 2019



This NHS Staff and Learners' Mental Wellbeing Commission has set out to discover and review evidence of good practice where the mental health and wellbeing of staff and learners in NHS organisations has been made an organisational priority.

HEE recognises its central role in supporting the current and future workforce to deliver high quality, safe care and the Commission has examined successful interventions from around the country, to identify what has worked well and what could be adopted widely.

Our aim is to see an NHS where staff and learners are happy and feel fulfilled in their work, where they look forward to going to work and are proud of the care they provide to their patients.

Managing Transgender patients within a single gender psychiatric intensive care unit (PICU)

There have been three reported suicides of transgender patients within prison services over the past year. There is limited evidence available beyond anecdotes, related to experience of managing transgender patients within services. Are providers of psychiatric services appropriately resourced to manage gender variant patients?

Alysium Healthcare have published a poster on this topic. Please find out more information at: https://www.elysiumhealthcare.co.uk/wp-content/uploads/2019/01/RCPsych.pdf


Elysium Healthcare

Managing Transgender Patients Within a Single Gender Psychiatric Intensive Care Unit (PICU)

Dr Kazeem Owodunni, Specialist Doctor; Dr Henjeet Bhograth, Consultant Forensic Psychiatrist; Dr Amit Chatterjee, Consultant Forensic Psychiatrist
The Royal College of Psychiatrists International Congress, Edinburgh, June 2017
Thornford Park Hospital, Crookham Hill, Thatcham, Berkshire, RG19 8ET
For additional information please contact: Dr Kazeem Owodunni Kazeem.owodunni@elysiumhealthcare.co.uk

Aims and Hypothesis:

There have been three reported suicides of transgender patients within prison services over the past year. There is limited evidence available beyond anecdotes, related to experience of managing transgender patients within services. Are providers of psychiatric services appropriately resourced to manage gender variant patients?

RELEVANT LAW

Equality 2010 Act – Given equal protection of all 7 equality strands: AGE, DISABILITY, GENDER, GENDER IDENTITY, RACE, RELIGION, SEXUAL ORIENTATION
Sex Discrimination Act 1975 (as amended) – Protects against discrimination and harassment in Employment, Vocational Training and Good & Services
Gender Recognition Act 2004 – Protects people whom intend to live in a particular gender for the rest of their lives
Data Protection Act 1998 – 'Sensitive' records such as health records must not be divulged unless consent is sought (unless significant threat to life and to protect vital interests of the person)
Any disclosure of confidential information should be in accordance of Caldicott Principles 1) Justify purpose 2) When absolutely necessary 3) The minimum that is required 4) Access should be on strict 'need to know' basis 5) Staff must understand their responsibilities 6) All staff must understand and comply with the law.

BACKGROUND

Gender variant patients already suffer significant challenge in their transition which is compounded by the lack of specific service provision. A survey of 10 000 people undertaken in 2012 by the Equality and Human Rights Commission found that 1% of the adult population was gender variant. About 1 in every 30,000 people have gender dysphoria pronounced enough for them to seek medical attention. Of these, 73% have experienced public harassment including violence, and 29% have been refused treatment by a doctor or nurse, and 35% have attempted suicide at least once.

METHOD

This will focus on the experience of managing two patients, both biological females living as males, within a male PICU. We will discuss anecdotally the impact on the service with no previous experience of managing a transgender patient. Given that only two patients have been managed, there are clear limitations to this Poster, though we argue that there is value in sharing our experience, nonetheless.

RESULTS

Both patients had significant histories of mental illness with repeated presentations to the GP and then Community Mental Health Team in a state of crisis, with features of parasuicidal behaviour. Both shared histories of repeated inpatient stays for short periods and then rapid destabilisation within community following discharge. Both patients' progress to full gender reassignment was hindered by repeated attempts to self-harm, which was perpetuating the incidents of self-harm. Both had shared histories of traumatic childhood and met criteria for Emotionally Unstable (Borderline) Personality Disorder (ICD-10, F60.31).

Patient 1 was admitted to the PICU subject to s3 MHA, after a suicide attempt with externally directed aggression. There was evidence of pseudo-hallucinations that were distressing. Patient 2 was admitted after assessment in a Police Station after non-compliance with medication in the previous month and cannabis use. He presented with threats to kill and reporting hearing the voice of previous abuser taunting him. He was admitted subject to s2 MHA a year after Patient 1's discharge.

Patient 1's pathway

Staff developed specific care-plans to safely manage a transgender within a male PICU. This included how to address the patient appropriately and sensitively. His discharge was delayed significantly due to placement funding difficulties, possibly exacerbated by his transgender status. He was eventually discharged to a male adult open ward.

Patient 2's pathway

There were fewer incidents of incorrectly and unhelpfully referring to the patient as 'he'. Care plans were developed quickly to manage risk as well as the specific risks based on being biologically female, such as during restraints. The team also organised a formulation meeting led by the Psychologist where any concerns could be managed and discussed openly, with a constructive conclusion drawn. Issues were also discussed at a reflective practice meeting. Patient 2 also benefitted from having a Care Coordinator that was able to help facilitate rapid discharge after medication had been recommenced. Patient 2 was discharged after two weeks into the community.

CONCLUSION

On reflection, the experience of managing Patient 1 within the PICU helped improve the confidence of staff to manage Patient 2 as any other male patient, though with individual needs also identified. Avoiding labels and awkwardness around the use of pronouns was identified early on as a barrier to the development of a therapeutic relationship with Patient 1. Having opportunities for reflection and a formulation meeting also contributed to the improved management of Patient 2.

All UK service providers must uphold requirements of The Equality Act 2010, The Human Rights Act 1998 and The Gender Recognition Act 2004. We conclude that steps to eliminate discrimination (direct or indirect), harassment or victimisation within service provision needs to occur. Services need to re-evaluate their resources to manage this patient group in conjunction with shared learning from other services, and there needs to be further education to reduce the stigma that this group receives, as afforded to them by The European Court of Human Rights.

Reference: THOM B et al. Transgender Guide for NHS Acute Hospital Trust. Royal Free Hampstead NHS Trust

Useful links

Care Quality Commission
www.cqc.org.uk

Centre for Mental Health
www.centreformentalhealth.org.uk

Department of Health
www.doh.gov.uk

Health and Social Care Advisory Service
www.hascas.org.uk

Institute of Psychiatry
www.iop.kcl.ac.uk

National Institute for Health and Care Excellence
www.nice.org.uk

NHS England
www.england.nhs.uk

National Association of Psychiatric Intensive Care Units
www.napicu.org

Revolving Doors
www.revolving-doors.org.uk

Royal College of Psychiatrists' College Centre for Quality Improvement
www.rcpsych.ac.uk/quality.aspx

Royal College of Psychiatrists' Training
www.rcpsych.ac.uk/traininpsychiatry.aspx

See Think Act (2nd Edition)
www.rcpsych.ac.uk/sta

Contact the Network

Megan Georgiou, Programme Manager

Megan.Georgiou@rcpsych.ac.uk
0203 701 2701

Kate Townsend, Deputy Programme Manager
Kate.Townsend@rcpsych.ac.uk
0203 2701 2678

Lana MacNaboe, Project Officer
Lana.MacNaboe@rcpsych.ac.uk
0203 701 2715

Twitter
Follow us: **@rcpsych** and **@ccqi_** and use **#qnpicu** for up-to-date information

Knowledge Hub

Please email picu@rcpsych.ac.uk if you wish to join Knowledge Hub, to start discussions and share good practice.

Royal College of Psychiatrists' College Centre for Quality Improvement QNPICU

21 Prescot Street
London
E1 8BB

www.rcpsych.ac.uk/picu