



West Midlands Division Newsletter

Summer 2020

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Editorial

Dr Nilamadhab Kar, Editor



Coronavirus disease 2019: mental health implications

The outbreak of Coronavirus disease 2019 (COVID-19) is a stressful event that is affecting people all over the globe. Not just the physical health of the infected individuals and their management, mental health of the wider community is also affected considerably.[1] There are various multifarious reasons. Besides the dread of contacting the virus and its consequences, people are worried about arranging basic necessities of life, their work, family members especially those are elderly and away, and the community. With scarce information about the new disease, there are lot of rumours circulating through the social media; which are increasing the anxiety, and in some instances providing false reassurances with many funny and fictitious remedial measures. In spite of the availability of reliable resources for information, people do get influenced by these rumours. In these stressful scenarios, individual and community behaviours change; alongside charitable and altruistic actions, there are hoarding and greed observed in a proportion of people.

Stress can manifest in various ways and it is extremely important to recognise this and manage, before it starts affecting self.

Usual manifestations of stress include the worry over one's own health and that of the family; it may affect concentration, sleep, appetite, substance use, and existing health conditions. Emotional exhaustion, frustration, hopelessness, fear of death and panic may be observed. These may get further complicated if secondary stresses such as joblessness, loneliness and bereavements due to COVID-19 add up. Older persons, children, persons with psychiatric illnesses are more vulnerable to stress, even the health care providers including medical staff treating patients with COVID-19.

Most of the increased stress symptoms in general population can be managed by reliable information sharing,[2] availability of the adequate support systems in the form of medical and social care and reassuring measures from authorities and government. However, it is expected that a proportion of individuals in the community would need help from mental health professionals. In addition, the presentations of many patients with mental illness may change or exacerbate in these prevailing conditions requiring more intense interventions.

There are various supportive resources on stress management available in the Internet, especially from professional bodies.[1,3,4] Finding suitable relaxation technique for one's own self, taking regular breaks from work and usual routine, finding time to engage in different activities, connecting and communicating with close people are some of the general principles.

There are lot of proactive actions being taken by the government and organisations to take care of health and economy, to manage and limit the consequences of a global issue.[5,6,7] Remaining updated with these measures, supporting the process individually and as a community may help to tide over the crisis. Of course, the decisive factors for controlling the disease would be the effective treatment and preventive method, which will be available at some time. At this moment managing mental health of the affected individuals, their families and community at large is a pertinent issue.

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Welcome

Dr Ignasi Agell, West Midlands Division
Chair

Welcome to the summer newsletter. Please accept my apologies on the delay of its publication that was in part due to my having to complete my welcome. I have, like all of you, navigating in a sea of uncertainty that could not have been predicted and could not find the right words to express my thoughts and feelings. And this is from someone that finds himself at ease in chaos and uncertainty. The reality is that I still cannot find the right words. Something that has helped me is kindness, and perhaps this is the simplest words to say, just be kind, to yourselves and to others.

I hope that you would find the College as another point of support and that you are all keeping safe and well during these times.

Cancelled events

Due to COVID-19 the College has cancelled all face to face events for 2020.

Mental Health Act Training Courses

The College has been working closely with the regional approval boards and has created online [Section 12 \(2\) Induction course](#) and [Approved Clinician Induction courses](#).

Refresher courses: if your Approved Clinician or Section 12 approval period is due to expire before 31 January 2021, you will be granted a 12-month extension period. Read further details on the [temporary extension](#).

Academic Meetings

The 2020 summer and winter academic meetings have also been cancelled. We apologise for any inconvenience and hope that you understand.

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@ignasiagell

Committee Meetings

All committee meetings are being held remotely until further notice.

Recent appointments to the Executive Committee:

- Dr Muhammed Gul, Vice Chair
- Dr Laura Cogan, Eating Disorders Regional Specialty Representative

Mentoring

Please continue your engagement with [mentorship](#). The Mentoring Meetings organised by Geoff Marston have been taking place at 7.15-8pm and more frequently during April-July to provide extra support during the pandemic. The meetings return to the usual time slot of 2-5pm via teams on 9 Dec.

West Midlands Independent Psychiatrists Group (WMIPG)

The WMIPG meet 3 times a year and the next meeting date is 6 Nov (10am-1pm) via teams/teleconference.

The West Midlands branch of PIPSIG provides a network for independent psychiatrists, promotes responsible practice in relation to appraisals and revalidation and acts as a source and resource for continuing professional development. Anyone interested can be added to the contact list.

Twitter @rcpsychWM

Do use our Twitter account @rcpsychWM to communicate with your peers, share best practices and raise the profile of psychiatry in the West Midlands, currently with 1096 members.

Please email westmidlands@rcpsych.ac.uk for further information.

Psychiatrists Support Service (PSS)

We understand that during these challenging times, you may feel more overwhelmed and stressed than usual. We are here to support you and are in the process of expanding our [Psychiatrists Support Service \(PSS\)](#).

The PSS provides free, rapid, high quality peer support by telephone to psychiatrists of all grades who may be experiencing personal or work-related difficulties.

To contact the support service

- Call our dedicated telephone helpline on
020 7245 0412
- Email us in confidence at pss@rcpsych.ac.uk

Service Evaluation of the Dudley and Walsall based Adult ADHD Autism Service (AAA) - Focus on the Autism Service

by Dr Thushara George, ST6, Dudley and Walsall Mental Health Partnership NHS Trust

Background

In 2009 Consultant Dr Renju Joseph felt there was a gap in service provision for patients with Autism and ADHD. He was supported by Jacky O'Sullivan (Clinical Development Director) and together they wrote several business cases that were taken to the Trust and their host CCGs. Eventually the Trust supported the establishment of the service 'at risk'. Challenges included convincing colleagues, managers and commissioners about the importance of this service and getting support from GP's around prescribing. Two full time Band 6 nurses, including one nurse prescriber, were appointed in January 2017: with the addition of a full time Consultant Psychiatrist in August 2017. The 16+ service currently provides diagnosis for those suspected of being on the Autistic Spectrum, and diagnosis and management of those with ADHD. Over 20 commissioners are involved, all accessing care on a spot purchase basis. The service has so far won 2 awards: Best Mental Health Support Services Centre – West Midlands in the 2017 Social Care Awards DWMHT staff awards – Front line team of the year 2017.

Aims

To discover what diagnostic appointments the service was able to provide. To assess the positive diagnostic rate of those seen and evaluate the Service Evaluation Feedback forms, which were started in April 2019.

Method

Data was accessed via Clinician's diaries and OASIS (electronic patient information system) to look for outcomes. The service evaluation survey forms, which consisted of 8 questions with 4 different responses ranging from definitely disagree, slightly disagree, slightly agree, definitively agree were also evaluated.

Results

AAA Service Total Referrals from August 2017 – March 2019: 1432
New diagnosis of Autism: 453
No Autism diagnosis: 65
DNA's for both services and ADHD Referrals: 914

Service Evaluation Survey: April 2019 – Dec. 2019 (56 forms)

1. Environment was suitable and appropriate for my needs: 86% definitely agree, 11% slightly agree
2. Staff were welcoming and helpful: 93% definitely agree
3. The assessment process was explained to me: 89% definitely agree, 9% slightly agree
4. Staff took time to understand me: 93% definitely agree
5. Staff helped me to feel comfortable and put me at ease: 96% definitely agree, 2% slightly agree
6. The next stage of the process was explained to me: 88% definitely agree, 9% slightly agree, 2% slight disagree
7. I would recommend this service to family and friends: 96% definitely agree, 2% slightly agree

8. Overall Experience: 84% Excellent, 11% Very good, 2% Good

Additional comments:

- "A fantastic and much needed service!"
- "Staff are very friendly and welcoming."
- "I felt quite at ease and was given time to answer questions and explain myself"
- "The lady who we had the appointment with was really lovely. My daughter was extremely anxious and she put her at ease".
- "Lady made my partner really comfortable, always making sure he was ok".

Conclusion

By optimizing clinician's time, whilst still providing a multi-disciplinary approach, the team has been able to assess and diagnose a large number of patients from across the wider West Midlands. Some salient suggestions from patients on the survey form were, to have support groups guided by the AAA service, to have text reminders for appointments and to raise general awareness about the service. Currently the service only offers a diagnostic assessment for those suspected of being on the Autistic Spectrum; follow-up appointments are not offered. Hence, from my point of view, a time limited post-diagnostic support should be considered e.g. occupational therapy which can offer support with e.g. employment and day-to-day activities or speech and language therapy, psychological support or some group support.

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A Pilot Clinic Where Liaison Psychiatry Joins Emergency Medicine to Manage Frequent Attenders. A Review of the Outcomes

by Dr S Arnold, Dr G Andrews and Dr M Jorsh

Background

The core 24 model is the framework being used to develop liaison psychiatry services nationally. A comprehensive core 24 model is described as a service which, in addition to delivering 24 hour psychiatric services, provides enhanced expertise and input to planned care pathways, including assessment and treatment for conditions such as chronic pain and medically unexplained symptoms¹.

Mental health care is often disconnected from the wider healthcare system and artificial boundaries between services mean that many people do not receive co-ordinated support for their physical and mental health². With the comprehensive core 24 service as something to aspire towards, there is scope for integrated service development.

The Royal College of Emergency medicine defines a very high frequent attender as a patient with 30 or more attendances per year to the emergency department. Frequent attenders tend to have higher rates of hospital admissions, greater burden of chronic disease and a higher mortality³. The most common reason for frequent attendance to the emergency department is an untreated mental health problem¹.

A pilot liaison psychiatry clinic was created for patients who frequently attended the emergency department, to see if co-working between liaison psychiatry and the emergency department could help reduce hospital attendance.



Dr S Arnold

Aim

An integrated psychiatry and emergency medicine clinic was established specifically for very high frequent attenders to the Royal Stoke emergency department, with the aim to reduce admissions as well as providing a more consistent management approach when the patient did attend.

Most importantly the clinic aimed to address the underlying reason why these patients attend the emergency department with the hypothesis that if the underlying psychiatric condition could be addressed then their attendance would reduce.

Method

Patients who fitted the criteria of a very high frequent attender were invited to attend the frequent attenders clinic.

Consultations took place by a psychiatrist from North Staffordshire Combined Healthcare, in an allocated part of the emergency department, as the setting was familiar to the patients. A full psychiatric history was taken to help identify reasons for attendance to the emergency department, and following the initial consultation a care

plan was agreed between the psychiatrist, patient and an emergency medicine nurse. The care plan was then implemented in future attendances to the emergency department.

The care plan remained within the emergency department so that it could be accessed when required, as well as an electronic management plan being created.

Retrospective data was collected electronically for the 12 months before the clinic was established and for the 3 months afterwards.

Results

A total of 7 patients were invited to attend the frequent attenders clinic as part of a pilot. Combined these 7 patients had attended the emergency department 369 times in the 12 month period before the clinic was established. Abdominal pain and musculoskeletal pain were the most common presenting complaint, followed by psychiatric disorders, including deliberate self-harm and medication overdose. The outcomes of patient visits were monitored, and out of the 369 attendances 286 resulted in hospital discharge, 48 admissions to hospital, 5 clinic follow ups, 2 transfers to the 136 suit and 28 self-discharges.

The average attendance 3 months before the clinic was set up for the 7 patients was 6.14 attendances a month (range 2-8), and 3 months after the clinic was set up, the average attendance reduced to 3.83 times a month.

One patient was visiting multiple hospitals for analgesia, following clinic attendance it was agreed that they would only attend 1 emergency department, and thus an increased attendance to our emergency department was seen. If this patient was excluded from the data, attendance to the emergency department for the remaining 6

patients reduced even further to an average of 1.80 times a month.

The pattern of attendances for all patients followed the same trend. Patients initially had an increase in attendance to the emergency department in the first month after their initial assessment in clinic, with an average attendance of 7.29 times a month, and then the data showed a gradual reduction in attendances over the next 2 months.

At the first appointment patients underwent a full psychiatric assessment, as well as creating a care plan for use within the emergency department. For many of the patients discussing past experiences and triggers for emergency department attendance was stressful, and initially caused the increase in attendance in keeping with the associated emotional state. As the patients became accustomed to the clinic and care plans were implemented, attendance to the emergency department reduced.

The numbers included in this pilot are too small to draw statistical conclusions, but it does demonstrate that attendance to the emergency department can decrease when underlying issues are properly addressed. The initiation of a care plan for use in the emergency department helped patients receive a consistent approach. Subsequently these patients knew what to expect when they attended, resulting in fewer unnecessary investigations and in some cases inhibited drug seeking behaviour.

Patients who were seen in clinic all had different underlying problems requiring an individualised management approach, including addiction, post traumatic stress disorder and anxiety. Some of the patients have subsequently been followed up by secondary mental health services, including general adult psychiatry, addiction psychiatry and liaison psychiatry with positive results.

Future development

Liaison psychiatry services are developing nationally, and with the aim of having comprehensive core 24 services there will be more scope for jointly led clinics with other specialities to help address the complex health needs of our population. Further pilot clinics within local areas should be considered to promote further service development.

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Conclusion

Regular attenders to the emergency department account for a large proportion of the workload, with subsequent financial burden due to associated investigations and hospital admissions involved. Improved joint led medical and psychiatric care could reduce frequent attendance with subsequent savings for the health service.

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Reflections on Facilitating a Hearing Voices Group in an Acute Psychiatric Hospital

by Fauzia Khan, Dr Neeti Gupta and Samina Allie

Acknowledgements

We would like to express our deepest gratitude to the Voice-Hearers at Hallam's Hearing Voices Group, past and present, without whom we would not have a group to run; and to our colleagues who have shown a great interest in the group and in doing so made a difference to the lives of the people they have supported through it.

Summary

The present paper provides a reflective account from an ST6 Psychiatrist and Psychologists facilitating a Hearing Voices Group in an acute psychiatric setting. The paper explores the psychiatrist's experience of co-facilitating the group the ways in which this informed her clinical practice. The Psychologist facilitators also reflect on their experience of co-facilitating a hearing voices group with a Psychiatrist and their anxieties and observations throughout the process.

Declaration of Interest: None

Author Contribution Statement

Fauzia Khan – Khan made a significant contribution to the present paper, primarily to the psychologists reflective account. Khan offered feedback and support to other authors on the structure of their testimonials. Khan also reviewed drafts and edited the present paper, as well as completing referencing and collating the paper. Neeti Gupta – Gupta made a significant contribution to the psychiatrists reflective account in the present paper. Samina Allie – Allie contributed to some sections in the present paper and also offered some feedback to other authors.



Dr Neeti Gupta

Background

I am a Speciality Trainee in General Adult Psychiatry, and in my clinical practice, I have encountered patients who complain of symptoms that are sometimes resistant to medical treatments. One such symptom includes auditory hallucinations (AH), where 25-50% of people continue to hear voices despite taking antipsychotics. [1]

As psychiatrists, we feel pressurised to increase medication or to change it altogether when these patients present in crisis. Despite change of medication, some patients continue to experience AH's and this leads to a feeling of desperation for patients and clinicians. It was this desperation that led me to explore alternative ways of working with AH's.

The Hearing Voices Group

The HVG is a facilitated support group, which is open to patients that hear voices and have other experiences such as visions and tactile sensations. The group is underpinned by the Hearing Voices Network, which was founded by Romme and Escher.[3]

The movement endorses the acknowledgment of diverse reasons for the causality of voice-hearing and considers voices a meaningful experience that can facilitate self-discovery and change.[4]

Challenges

I had a number of anxieties in co-facilitating the group. One such anxiety was difficulty relating to patients with lived experience of voices. I had never co-facilitated such a group and felt deskilled in how I could support these individuals. I had worries that exploring the content of the voices could increase distress.

The premise of the group was such that the voice-hearers in the group held the 'expertise' in the room. As a clinician I struggled with grappling dual roles, the patients see me as an expert in my field where I make decisions about care in ward review, however in the group I found that at times I struggled with the power imbalance. In ward reviews I would hold the decision-making power, however in the group the ownership of decision-making was held by group members.

Learning and Development

Co-facilitating the HVG allowed me to cultivate a better understanding of the patients' narrative and the way in which the voices were perceived. The group taught me the importance of validating and normalising the experience for the individual.

It strengthened my clinical management skills further by helping me widen the treatments that I could offer my patients and I no longer find myself rushing to find a 'quick fix' to patients' problems. I feel that this is because I am no longer restricted to solely prescribing medication but I can empower patients by offering them alternative strategies to cope with their

experiences. I now provide my patients with information on trying out alternative strategies, which we can discuss and explore in further reviews.

In follow-up consultations, patients report that they have found the information and strategies helpful and they too can now play an expert role in their experience.

Future Implications

I believe that psychiatrists can benefit greatly by co-facilitating HVGs, particularly in the current climate where there is increasing demand on NHS services with often-limited resources and where waiting lists for psychological therapies are ever growing.[6] Involvement with HVGs will help psychiatrists cultivate a greater understanding of the psychopathology of the individual and help them develop the necessary psychological skills in working therapeutically with patients, both on inpatient wards and in clinics. However, I believe that for this to be successful on a more macro level, there needs to be more emphasis in psychiatry training on working closely with psychologists in delivering group based psychological interventions.

Psychologists' Reflections

The HVG at Hallam Street Hospital is a well-established group that has been running since 2007. [5] Throughout the years, we have had a number of multidisciplinary colleagues co-facilitate the group with us including OT and nursing and we have observed many benefits of having their involvement.[5] It was refreshing to have a medic show an interest in developing her clinical practice around working with this presentation.

Historically there has been a conflict within the traditional psychiatric and psychology paradigms in understanding the nature of voices and treatment

approaches. We were initially anxious in working alongside a Psychiatrist as we felt there may be a clash of approaches. However, we saw this as an opportunity to support our colleague to develop her skills and knowledge base so that she may in turn act as an advocate for the Hearing Voices Network approach within her discipline. [8]

Initially when the Psychiatrist joined the group, we noticed that her approach was very medicalised, from the language she used to her focus on medication as a treatment approach. We noticed that at times she struggled to switch from her role as a Psychiatrist to her role as co-facilitator. However over time we observed her style evolve. Initially, she would refer to voices as AH's, which was something we did not sit comfortably with. As noted above, our group is underpinned by HVN principles where voices are not referred to as AH's as the term implies that the experience is unreal which can be invalidating. [8] However, through the course of her involvement, we noticed a change in her language. We noted that when she first joined the HVG, her focus was on the pathology of the experience, however, over time we observed a shift from this and she was more open to explore what the experience symbolised, which then allowed us to work more creatively. This also helped us strengthen connections with the wider psychiatry team and help them understand the psychological formulation, which helped us work more effectively as an MDT.

About the authors

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Psychiatric Pain Management for Elderly Inpatients and Outpatients suffering from Mental Health problems or Dementia

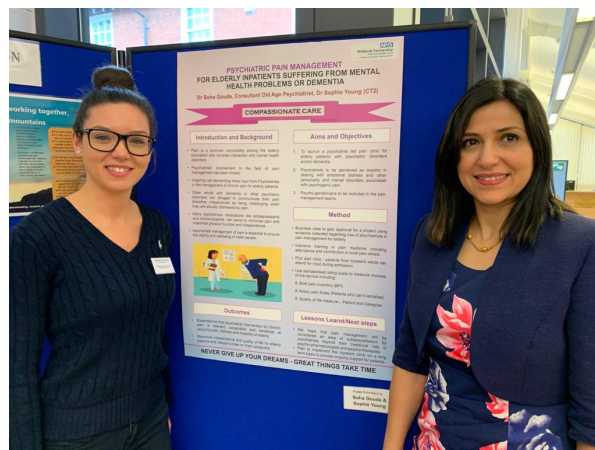
by Dr Soha Gouda, Consultant Old Age Psychiatrist, Dr Sophie Young (CT2 Psychiatry)

Pain is a common symptom experienced by older adults; it can result in distress and can negatively impact on quality of life for both the patient and their carers. The relationship between psychiatric illness and pain is a complex one requiring a multidisciplinary approach to management.

Older adults with dementia often struggle to communicate pain to those around them and may instead present with behavioural changes such as restlessness and agitation. This can result in their pain not being adequately addressed. As a result of this there are many older adults with mental health issues or dementia who are struggling with unmanaged pain. This in turn affects many aspects of their lives and can result in ongoing low mood and social isolation. (1)

The aim is to overcome these barriers to pain management for older adults in psychiatric inpatient settings, promoting well being and dignity for our patients (2). To achieve this we plan to launch a pilot psychiatrist led pain clinic for inpatients on the older adult wards with coordination with carers and other members of the multidisciplinary team such as nurses, physiotherapists and geriatricians. (3)

The method is to gain approval for the clinic to cover both the organic and functional older adult wards. This would be led by a psychiatrist who has received specific training in pain



Dr Soha Gouda and Dr Sophie Young

management through teaching and attendance at local pain clinics in the general hospital.

The focus would be centred around a detailed assessment of the patient's recent symptoms or behaviours, with emphasis on the effect that this has on their presentation, functioning and mood. Following assessment in the clinic a management plan would be offered. Both non pharmacological and pharmacological support would be considered while also using this as a platform to educate staff and carers regarding the non verbal signs of pain in patients with dementia.

A holistic care plan considering additional treatment such as physiotherapy and massage would also provide a means of relaxation for the patient when they are distressed and would avoid polypharmacy where possible (3).

The patients would be followed up after the clinic to gain feedback from them, staff and their carers using standardised rating scales such as The Brief Pain Inventory, Quality of life measure and the Abbey pain Scale for patients who are unable to verbalise. We also plan for patients to be followed up after discharge into the community to ensure continuity of care.

The expected outcome is that patients, carers and staff will find the clinic beneficial and this will improve the mood, quality of life and social interaction for patients with a reduction in challenging behaviours on the ward. We hope that this would also raise awareness among patients, carers and other professionals regarding the role that psychiatrists can play in the management of pain in older adults with mental health problems or dementia.

Moving forward there would be a plan for a regular psychiatrist led pain clinic to take place where staff can refer patients or patients can self refer for advice and support in regards to pain management allowing a holistic and compassionate care approach for our patients. (4)

Acknowledgements:

Poster 'Psychiatric Pain Management for elderly patients suffering from mental health problems or dementia' was presented at Acute Mental Health Inpatient Conference on Compassionate Care, 10th December 2019 at St George's Hospital, Stafford. Midlands Partnership Foundation Trust.



Pain management
poster for submissic

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Reflections on Co-facilitating a Mindfulness Group at an Acute Psychiatric Hospital

By Fauzia Khan

Abstract: The interview below was conducted by Fauzia Khan, Assistant Psychologist, at Hallam Street Hospital, Black Country Healthcare NHS Foundation Trust. The interview explores an ST6 Psychiatrist's experience of co-facilitating a Mindfulness group in an acute psychiatric hospital setting. The psychiatrist shares his experience as a co-facilitator of the group and also discusses how it has changed and shaped his practice.

Fauzia: Hi David, thank you so much for agreeing to this interview. Would you like to introduce yourself for the readers, and just tell us a bit about your role and what your role as a co-facilitator of the mindfulness group has entailed?

David: My name is Dr David Pang. I am a ST6 psychiatrist in my final year of training and took the opportunity to co-facilitate a Mindfulness group for inpatient psychiatric patients at Hallam Street Hospital in Birmingham. Of course being new to mindfulness, initially I participated in a few sessions first to get my bearings before feeling comfortable to co-facilitate. My role involved introducing and covering the basics of mindfulness, carrying out exercises with the patients, being aware of the group dynamics and giving feedback to patients based on what thoughts or sensations they experienced.

Fauzia: So, David, tell us a bit about your experiences of Mindfulness. How did you first hear about mindfulness?

David: I first heard of mindfulness 3-4 years ago, when I noticed that patients and nurses were starting to mention mindfulness in outpatient clinics. This was in the context of when asking patients about what techniques or skills were useful to them to help them cope better with their mental health difficulties.

Fauzia: What did you know about mindfulness?

David: Not much at all, only what patients had told me, that it helped them to relax. It is not part of our training curriculum and certainly was not covered

in any of our membership examinations - unlike CBT, which is covered in some detail.

Fauzia: Did you hold any pre-conceived ideas about the practice of mindfulness?

David: I thought that it was a technique to learn to help people relax and manage anxiety, much like breathing exercises.

Fauzia: What got you interested in co-facilitating the mindfulness group?

David: Simply that I have noticed it has gained more popularity, that patients have found it helpful and that I didn't know much about it.

Fauzia: What were your first impressions of the mindfulness group?

David: That it actually works (I was a participant for the first few sessions). I then downloaded a mindfulness app, which helped me to remember to practice mindfulness outside of the group sessions.

Fauzia: Did you have any preconceptions or anxieties prior to supporting the group?

David: That I would not "get it" and therefore be a terrible co-facilitator!

Fauzia: Did the group challenge any pre-conceived ideas you may have held?

David: I thought that meditation was a practice for spiritual or religious people, but actually I now know that mindfulness is all inclusive, whatever culture, religion or spiritual beliefs you have.

Fauzia: What have you learnt from supporting the group?

David: Awareness of group dynamics, their interactions and the suitability of patients is very important for the group to run successfully. It has helped develop my skills and confidence in facilitating group sessions.

Fauzia: Has the group changed the way you think about mindfulness interventions? And if so, in what way has it changed your thinking?

David: Yes it has! Having experienced and delivered mindfulness, I am definitely much more enthusiastic about promoting it to patients as I am able to talk in confidence about what it entails but also my own experiences.

Fauzia: Has the group changed or shaped your practice at all? And if so, in what way has it changed or shaped your practice?

David: The group has definitely changed and shaped my practice. With the strain on NHS resources and long waiting times for psychological input, I have found myself recommending self-help CBT, support groups, workshops and such which patients can access in a timely manner. Now I have added mindfulness to this list that I recommend to patients in clinic (sometimes to a mixed reception), but if I can get even a few patients to try out and persist with mindfulness then I consider that a success.

Fauzia: Would you recommend mindfulness interventions to your patients?

David: Yes, I most definitely would!

Fauzia: What advice would you give to other psychiatrists or healthcare professionals about the practice of mindfulness?

David: Try it yourself if you get the opportunity to attend a group or download a mindfulness app if you have a smartphone. The apps are very accessible and easy to use. You may be pleasantly surprised with how

applicable and beneficial it can be to our own professional and personal lives and not just for patients!

Over the last few decades, the practice and concept of mindfulness has become increasingly popular in healthcare settings, and as such has received substantial attention in clinical literature. There is increasing evidence suggesting the efficacy of mindfulness meditation for a range of mental health problems, such as major depression, and anxiety disorders (Schreiner and Malcolm, 2008).

The Mindfulness group at Hallam Street Hospital is a weekly facilitated practice group in which patients are introduced to the concept of mindfulness practice, its associated benefits and patients are given an opportunity to practice a range of formal meditation practices such as mindfulness breathing, body scan, and conscious observation exercises, among others. Although, the group is set out primarily as a therapeutic group for patients, from time to time we have interest from psychiatry and medical colleagues who also attend the group. Over the years, we have had interest from a number of psychiatrists completing their speciality training, who have a specialist interest in mindfulness and these colleagues have been involved in participating and then co-facilitating the group with us. This has been greatly beneficial for both our patients and our colleagues, and has helped to further strengthen connections between psychology and psychiatry within our service.

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Academic meetings

Report from winter meeting



Prof Saeed Farooq, Academic Secretary

The winter 2019 academic meeting was held at the St John's Hotel, Solihull.

This was a popular meeting with 116 delegates who registered for attending. We had an excellent line up of speakers. These included eminent academics from the leading academic institutions.

The conference received excellent feedback with high ratings of good or very good and participants found the programme relevant to their professional development needs. The conference generated an income of £10,170.

I would like to thank Ignasi Agell for chairing the afternoon sessions and Dr Adrian James for chairing the Presidents Lecture and introducing Dr Derek Tracy.

A big thank you to Alfred White for being our photographer for the day and to the West Midlands division team for their efforts.



Dr Ignasi Agell

On behalf of the West Midlands Executive Committee I would like to thank Prof Saeed Farooq for arranging another successful event.

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Prof James H MacCabe, Professor of Epidemiology and Therapeutics, Kings College London



Dr Derek Tracy, Consultant Psychiatrist & Clinical Director, Oxleas NHS Foundation Trust; Senior Lecturer King's & University College London



Prof Shanaya Rathod, Southern Health Foundation NHS Trust



Dr Carol Kan, Clinical Lecturer Kings College London



Dr Gabrielle Milner, Deputy Chief Medical Member FTT Mental Health England, Independent Psychiatrist, Honorary Consultant Midlands Partnership NHS Foundation Trust



Dr Ahmed Hankir, Academic Clinical Fellow, South London and Maudsley NHS Foundation Trust



Dr Adrian James, RCPsych Registrar

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Prizes

Clinical Audit / Quality Improvement Prize Winner

The 2020 Clinical Audit / Quality Improvement prize was awarded to Dr Sarah Fynes-Clinton for; 'Improving knowledge and confidence in the acute management of eating disorders and resulting complications'.



Dr Sarah Fynes-Clinton and Dr Ignasi Agell



Further details about [divisional prizes](#) can be found on the website or by contacting the divisional office.

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Clinical Audit / Quality Improvement Prize Abstracts

Improving knowledge and confidence in the acute management of eating disorders and resulting complications

Dr Sarah Fynes-Clinton (CT3)

Project Contributors: Dr Maisha Shahjahan (F1), Dr Brendan McKeown (Speciality Grade Doctor), Dr Clare Price (Consultant Psychiatrist - Joint Supervisor), Dr Louisa Beckford (Consultant Psychiatrist - Joint Supervisor)

A recent survey found just 1% of doctors have the opportunity for clinical experience in Eating Disorders. Anecdotally, several junior doctors within our trust had mentioned that they felt unsure when asked to manage patients with Eating Disorders during their out of hours shifts.

This project therefore aimed to improve the knowledge and confidence of doctors at all levels when managing patients with Eating Disorders whilst on call.

A survey was sent to 97 doctors (from foundation to consultant level) working in a Mental Health Trust in order to ascertain levels of confidence when managing patients with Eating Disorders, as well as to collect suggestions for improving confidence. The response rate was 37.11%.

The survey found that doctors lacked confidence in the management of common conditions that arise in patients admitted with Eating Disorders. Refeeding syndrome was identified as a particular area of concern, both due to its clinical significance, and low level of confidence reported.

Three interventions were designed and implemented to improve the identified areas of concern:

1. Direct lectures. 5 multiple choice questions (MCQs) was given out before and after the lecture to assess its impact.
2. Creation of an educational poster highlighting pertinent information. This was displayed in key clinical areas.
3. Creation of an information booklet covering key clinical information. This was made available to all on call doctors.

The MCQ scores were compared, and showed a clear improvement in overall knowledge, with results going from an average score of 56.6% to 80%.

Multiple methods were implemented to improve the confidence of doctors when treating Eating Disorders whilst on call. Lectures were shown to improve overall knowledge in the short term. Easy access to important information in the form of visual posters and printed booklets aims to support this improvement in the long term.



3 Abstract (1).pdf



3a Supplementary Document.pdf



3b Supplementary Document.pdf

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Audit of the use of zaleplon, zolpidem and zopiclone or the shorter-acting benzodiazepine hypnotics (loprazolam, lormetazepam and temazepam) or other drugs for the short-term management of insomnia

Dr Nilamadhab Kar, Consultant Psychiatrist; Dr Jasmin Mahil, FY1; Dr Lakshmi Radhica Ohri, FY1; Dr Sorina Merlici, FY1

Supported by: Natalie Jackson, Clinical Effectiveness Lead, Mental Health Division. Black Country Partnership NHS Foundation Trust -Wolverhampton

Acknowledgements

All consultants and colleagues contributing to data collection.

Background

Z drugs are benzodiazepine agonists, which act specifically on the alpha-1 subclass of GABA-A receptors to produce hypnotic effects [1]. Developed in the 1990's to optimise the pharmacological benefits of benzodiazepines, they are now the most commonly prescribed hypnotics in the UK.

Their succession of the older benzodiazepines has mostly been attributed to their greater efficacy and safety profile, particularly in the elderly. The ones licenced for the treatment of insomnia include: zaleplon, zolpidem, zopiclone and eszopiclone.

Z drugs produce a quicker clinical effect and have a more rapid rate of clearance compared to benzodiazepines. Their better pharmacodynamic and pharmacokinetic profiles, attributed to a smaller receptor occupation minimises their scope for drug abuse. They are less harmful in overdose, eliminate the

potential for daytime sedation and reduce the risk of developing tolerance, dependence and withdrawal symptoms.

Adverse effects of the Z drugs and benzodiazepines are comparable, however are far less common and severe for Z drugs. Z drugs do have the potential to cause psychomotor and cognitive impairment as well as unpredictable paradoxical reactions. Respiratory depression is a concern as well as an increased risk of falls in the elderly.

The prolonged use of Z drugs can reduce the hypnotic effect and create a degree of dependence. Hypnotics with the shorter half-lives tend to be safer but do have higher risks of withdrawal.

All hypnotics should be used short-term or intermittently and be reviewed regularly. The mechanism of action as well as the cautions and side effects of the prescribed hypnotic should also be explained to the patient to limit abuse potential of the drug.

Objectives

1. To explore the safe use of Z-drugs locally, in the short-term management of insomnia using NICE guidance.
2. To identify which pharmacological agents are being used in clinical practice for the treatment of insomnia.
3. To explore if the Z drugs are being utilised on a short-term basis as recommended.

Standards

The standards used to compare clinical practice against, are outlined in the NICE guidance published in 2004 [2]. The standards state that only after careful consideration of non-

pharmacological interventions should pharmacological agents be prescribed for a short period of time as per their licensing agreement in all patients treated for insomnia. Secondly, the most cost-effective pharmacological agent should be prescribed. Thirdly, a service user should not be prescribed any other hypnotic agent if they have not had any clinical effect from the initial one. If, however, the patient considers adverse effects to be attributable to the initial pharmacological agent prescribed then switching to another hypnotic is feasible.

Methods

The audit included out-patients seen within one week period who were prescribed hypnotic / sedative drugs (n=50). Information for previous one year (letter from GP and Handwritten file) was checked, in order to assess the total length that the patients took the sedative treatments. Data collection was done in Mid-2019 in Adult and Older Adult Teams of Black Country Partnership NHS Foundation Trust.

Results

More than half of the patients included in the audit were females (56%). The primary diagnoses were: depressive disorders 20%, psychotic illnesses 16%, mixed depressive and anxiety disorder 12%, and emotionally unstable personality disorder 10%. Less than half of all patients (44%) had a second diagnosis. Only a small proportion of patients had a third psychiatric diagnosis (16%). Nearly half of the respondents 23 patients (46%) reported a substance use, half of them were smokers and alcohol consumers, and in a smaller proportion (20%) used cannabis. Twenty-two patients (44%) had a history of a physical illness, ranging from metabolic-related problems such as diabetes,

hypertension, to chronic pain syndromes (fibromyalgia, sciatica) and lung problems (asthma and COPD). In 84% of cases, insomnia or any sleep problems were documented in the medical notes.

Non-pharmacological options were offered in 54% of cases, and were represented by psychoeducation (42%) and sleep hygiene (24%).

In terms of pharmacological treatment for sleep disorders, the most frequent choice was zopiclone, being prescribed to 56% of patients, followed by a promethazine (26%), and benzodiazepines, such as diazepam and lorazepam, with 16% and 14% respectively. In 70% of cases the hypnotics and sedatives have been prescribed PRN. All the doses corresponded to the BNF recommendations. In the majority of cases (68%), the patients were taking only one hypnotic drug, and in smaller proportions a combination of medications was observed. In terms of the main treatment prescribed, almost half of all patients (42%) were taking an antipsychotic, followed by antidepressants, taken by 32%.

Only 10% of doctors were aware of the cost of sleeping tablets. In 76% of cases there was no reason specified as to why a specific drug has been chosen. In 12% of the patients hypnotic drug was changed to another, due to adverse effects. In 34% of cases the duration of the treatment was specified. And it was less than 2 weeks in 12% of cases, 8% less than 4 weeks, 4% for a period of 1-3 months and 10% over 6 months. A considerable proportion of patients took hypnotics for more than a month and some for years. This needs reviewing in order to prevent abuse, dependence and further burden of the mental health services.

Conclusions

To conclude, this audit demonstrated the partial adherence to NICE guidelines on the use of pharmacological agents in the management of insomnia. In particular, this audit highlighted that the majority of patients did not require a change in their medication as they were content with their current dose. Majority (89%) of patients were prescribed pharmacological agents as PRN, and not as regular administration.

Furthermore, all patients within this audit were prescribed drug therapy for longer than a month and some longer than the maximum duration of licensed medications. Large proportions of patients had been advised to undertake non-pharmacological measures before the introduction of drug therapy for insomnia. There was no clarity about why certain medications were chosen over the other. In many of the case notes there was a lack of reference to weaning patients down; and no patients were redirected to non-pharmacological measures such as good sleep hygiene/psychoeducation after being initiated on pharmacological agents. Most (67%) patients had co-morbidities which are known to have insomnia. Moreover, there was no suggestion of CBT being offered to service users for insomnia which may be due to lack of resources.

Recommendations

1. Non-pharmacological interventions need to be offered [current rate 54%] and documented.
2. Psychoeducation [currently 42%] should be utilised more.
3. Sleep hygiene [currently 24%] should be utilised more. A Leaflet on sleep hygiene should be given.
4. Specific duration of the hypnotic prescription [currently recorded only in 36% cases] should be noted.

5. Hypnotics should be prescribed for short duration, according to guidelines and the period of prescription reviewed regularly.
6. If a medication is being prescribed for insomnia, the indication (insomnia) needs to be recorded [current rate 84%] /specified.
7. The reason why a specific hypnotic was chosen should be recorded.
8. Only 18% of doctors knew that drug with lowest cost is chosen, 90% medics did not know about the cost of hypnotic medications. It is recommended that the NHS cost of these medications should be provided periodically.
9. When there is a switch from one hypnotic to other reasons should be noted.
10. Regular use of lorazepam or diazepam can be further decreased.
11. Dosage has been within BNF dose, which need to be adhered.
12. Re-audit annually

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An audit cycle into the physical health monitoring of patients with severe mental illness

Project Leads on An Audit into the Physical Health Monitoring for Patients with Severe Mental Illness: Dr Felicity Jones (Core Psychiatry Trainee) and Dr Lenia Constantine (Consultant in General Adult Psychiatry).

Name of Originators/Authors for Shared Care Protocol for Antipsychotics: Dr Felicity Jones (Core Psychiatry Trainee) and Dr Louisa Ward (Core Psychiatry Trainee)

In January 2018 I had the opportunity to complete an audit cycle into the physical health monitoring of patients with severe mental illness. Physical health monitoring is an integral part of caring for patients with mental health problems. It is proven that serious physical health problems are more common among patients with severe mental health illness (SMI) [1]. Antipsychotic medications increase this risk further [2].

The main contributing factors are individual lifestyle choices, side effects of psychotropic treatment, and disparities in health care access, utilization, and provision [3]. The mounting evidence of the risks makes regular physical health monitoring of great importance for early detection and management of any problem.

The National Institute for Health and Care Excellence (NICE) guidelines recommend physical health monitoring for patients on antipsychotic medications; weight, waist circumference, smoking and lifestyle status and blood pressure, fasting blood glucose, HbA1c and blood lipid levels [4]. The following six parameters are recommended to be monitored annually

in all adults with psychosis and schizophrenia who are taking antipsychotic medication.

In concordance with the Royal College of Psychiatry; The Lester UK Adaptation: Positive Cardiometabolic Health Resource was formulated⁵. This framework for patients with psychosis on antipsychotic medication now features within the Worcestershire Health and Care NHS Trusts policy and uses the same six parameters as the NICE guidelines.

I was tasked with designing an audit that would assess whether a community mental health team was achieving adequate physical health monitoring of patients with severe mental illness in accordance with NICE guidance. During the month of January 2017 all patients on a community psychiatrist's case load within Worcestershire Health and Care Trust with a formal diagnosis of schizophrenia or psychosis were assessed. Online and physical notes were reviewed to see if the six domains for physical health monitoring had been carried out. If evidence was not seen within the electronic documentation system (Carenotes); either in clinical reviews, the physical health form or in correspondence, the use of the online tool ICE comms was used to analyse whether blood monitoring had been carried out.

This audit was then repeated one year on in January 2018. However in this cycle an addition to data collection was made. Besides the six parameters stated by NICE guidelines two further parameters were measured separately as per Maudsley guidance. These being Electrocardiography (ECG) monitoring and documentation of side effects from the psychotropic medication [6].

Data analysis in January 2017 showed that Audit standards were not being met for any of the six parameters. It was found that the most highly monitored parameters were blood lipids and glucose regulation (87.5%); least monitored parameter was lifestyle (62.5%).

Following this recommendations were made to educate healthcare staff and provide a specific weekly physical health check clinic within the community that would enable patients to be referred via community nurse practitioners as well as through team doctors. Here patient's would have access to weight, blood pressure and blood monitoring as well as a trained professional to give lifestyle advice including diet, exercise and smoking cessation.

The audit was repeated in January 2018 to see if these recommendations had been fulfilled and whether there was an improvement in the monitoring of physical health in patients suffering from severe mental illness.

Directly comparing the original 6 Physical Health Parameters for monitoring there has been an improvement since the previous Audit in 2017. We are now achieving 100% monitoring for 2 out of the 6 parameters. Within the previous Audit the least monitored parameter was lifestyle; however this time the least monitored within the six original domains was BMI. Despite this we are still achieving above 90% within each of the six domains which is a vast improvement from last time. Within this re-audit we are achieving an average of 96.25% monitoring within the six parameters which is an improvement of 18.75%.

Analysing our additional two parameters of ECG monitoring and Side Effects of medication we can see that there is work that needs to be done with only 75% of baseline ECGs being carried out. This may be due to lack of guidance regarding monitoring these additional parameters and health care practitioners may be more familiar with NICE guidance rather than The Maudsley.

Overall the recommendations following the previous Audit in 2017 have contributed to a vast improvement in physical health monitoring. I feel that an increase in staff awareness and an uptake in responsibility from the multidisciplinary team has influenced the good outcome. The use of weekly Physical Health Clinics are now being utilised well by all members of the team.

A negative point to be made through data analysis is that the key information regarding the physical health parameters measured is not clearly documented within Carenotes. Despite an accurate pro forma being available results were recorded in various places on the system and proved difficult to find at times. Another concern was that it was difficult to ascertain who was responsible for monitoring patients in those services that do not have access to their own physical health clinic. Many relied on utilising the patient's general practitioner to obtain physical health monitoring but sometimes this proved difficult with no specific policy or guidance available for them.

As a result I designed a poster based on this completed audit and presented it at the Royal College of Psychiatrists International Congress in Birmingham 2018 as a way to further educate colleagues on the importance of the

need for physical health monitoring and compliance with NICE and Maudsley guidance. Following this myself and a colleague have gone on to design a formal physical health monitoring policy which includes evidence from the audit and recommends a shared care agreement between general practitioners and members of the psychiatric team to enable us to pull resources and together care for patients who require regular physical health monitoring. We are currently waiting to present the shared care agreement at the Area Prescribing Committee meeting in December 2019.

I am also in the process of re-auditing the physical health monitoring of patients with severe mental illness. This time I am collecting data from an alternative community setting that does not have access to a physical health clinic to see whether there is a significant lack of documented monitoring. Through the data collected already I can foresee that there will be a major difference between physical health monitoring for patients with access to a physical health clinic and those without. This furthermore provides evidence for the need of a shared care agreement between general practitioners and members of the Psychiatric team to improve monitoring and together aim to prevent adverse physical health conditions from developing.

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Documentation of psychiatric history and clinical examination – a quality improvement project.

Authors: Dr Muhammad Shoaib Talib, Dr Habibat Salawu, Dr Nneamaka Asiodu, Dr Divyanish

People with severe enduring mental illness have a significantly reduced life expectancy about 2-3 times, and this excess mortality, while due to many factors, is mostly accounted for by a higher prevalence (60% more) of physical health disorders than the general population.

This translates to a shortened life expectancy of about 13-30 years, creating a mortality gap in people with mental illnesses.

The importance of accurate and legible documentation during a medical consultation cannot be over emphasized. It is the source of information that guides present and future treatment planning, serves as prognostic indicator and the meter by which wellness is indicated.

There is evidence to suggest that 80% of diagnoses may be made on the basis of history alone (Hampton et al, 1975). In psychiatry, it could be argued that the history provides 100% of the diagnosis, if the mental state examination is included as part of the history.

These facts drove the efforts to narrow and hopefully eliminate the mortality and morbidity gap by being more proactive in managing physical health problems and documenting these efforts actively.

The Royal College of Psychiatrists' standards for inpatient mental health services (Second edition, 2017) state that within the first 24 hours of admission, patients should have a comprehensive physical health review.

The Royal College of Psychiatrists: Good Psychiatric Practice book states that a psychiatrist must be competent,

- In obtaining full and relevant history that incorporates develop-mental, psychological, social, cultural and physical factors.
- Undertaking a comprehensive mental state examination and in evaluating and documenting an assessment of clinical risk, considering harm to self, harm to others, harm from others, self-neglect and vulnerability.
- In determining the necessary physical examination and investigations required for a thorough assessment.

Bearing this in mind, we pioneered an audit in 2017 to look into the quality of our documentation of inpatient admission assessment, trust wide. At the time of admission, it is assumed that a patient is most unwell and the clinician has the rare opportunity to review a full picture of the physical and mental wellbeing of a patient.

We aimed to determine if documentation standards, using the Royal College of Psychiatrists Code of Practice as a guideline, were achieved at first contact with patients. This involved looking into the documentation of a comprehensive psychiatric history, physical examination including ECG and blood tests and mental state examination at the time of first consultation for inpatient admission.

On determining these, we made sure to provide a structure and appropriate recommendations, if standards were not being met. Also to re-audit in 2019 after implementing the recommendations and to improve the quality of inpatient admissions and care provided.

There are no specific standards from the royal college of psychiatrists regarding the content of psychiatric clinical notes. Therefore a standard was constructed using the new oxford textbook of

psychiatry (a widely used and respected source). All aspects of History should be document-ed completely (standard of 100%)

In 2017, we collected data across the 3 hospitals in the trust. We did a retrospective review of 84 randomly selected inpatient admission notes. A proforma was developed for this audit which covered 16 main areas of history (a total of 26 sub headings),

- Patient identification (name, age, marital status, occupation, ethnic background, legal status)
- Presenting complaint
- History of presenting complaint
- Psychiatric history
- Medical history
- Family history (parents, Siblings, medical history, psychiatric history)
- Social History (Financial, Support structures, living Arrangements, hobbies)
- Personal History (birth, development, Education, Occupational history, Relationships, children)
- Forensic History
- Pre-morbid history
- Drug and Alcohol History
- Risk assessment
- Mental State examination (Appearance and behaviour, Speech, thought form and content, Mood and affect, perception, Cognition, insight)
- Physical examination, reason if not performed
- Differential diagnosis
- ECG

Results were shown as green (95-100% compliance), yellow (85-94%), amber (65-84%), red (0-64%).

In 2017, domains such as, patient identification, presenting complaint, history of presenting complaint, past medical and psychiatric history, mental state examination and risk assessment we found that mainly the results were in green or yellow zones.

Documentation of physical examination and ECG was found to be in the amber and red zones. Personal history, social history and family history were also in the red and amber zone. It can be speculated that these areas perhaps were lacking due to technical errors or unsocial hours of most admissions.

A 2017 we also conducted a survey amongst clinical staff involved in inpatient admissions, to further examine the cause of these lapses. Survey results showed that factors such as time restrictions, uncooperative patients and faulty instruments were the main reasons why these areas were not meeting the standard of 100%.

Our recommendations to improve these outcomes were to;

Organise refresher teaching courses for history taking and physical examination. ECG training for nursing staff. Universal history proforma to be adapted trust wide. Checklist to be included in first ward review for physical examination, ECG and blood tests. Checking the ECG equipment regularly. ECG training upon induction for doctors, to learn how to use available equipment.

Some of these changes were implemented successfully, such as a ward checklist and training for nursing staff.

We did a re-audit in 2019 to complete the audit cycle, a total of 124 medical notes were reviewed retrospectively using the same proforma with the help of more data collectors.

Results in 2019 showed that there had been an overall improvement in the documentation of clinical history and physical examination across all inpatient admission units in the trust. However, there were still areas for improvement which had been identified such as physical examination and personal and social history.

Our recommendations included a refresher training course on psychiatric history taking for junior doctors on induction. Ensuring accurate documentation and handover of tasks are done during admission so that parent teams can complete undone tasks. Training nursing staff and HCA to do ECG for new admissions, so there are more technically skilled people therefore increasing the likelihood of such tasks to be done. A Universal history proforma to be adapted across the trust to minimize errors and omissions.

Our trust is moving towards transition to electronic notes and our hope is that this audit input would help in shaping the new history taking proforma, with emphasis on physical examination, ecg and blood tests. We hope that during induction for junior doctors in the trust, there would be a session for psychiatric history taking, which would improve the quality of documentation of history on admission in inpatient units. Hence we would see an improvement in inpatient admissions documentation and as a result eventually improve our patient's physical and mental health outcomes being in a position to plan timely interventions, practice preventative medicine and reduced the morbidity and mortality gap that exists in people living with severe mental illnesses.

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Quality improvement evaluation project to establish the standard of current practice in relation to reviewing confusion inducing drugs (CIDs) at the time of referral

Author: Dr Siddhant Hegde, FY1

Aims & hypothesis

The aim of this quality improvement evaluation project is to establish the standard of current practice in relation to reviewing confusion inducing drugs (CIDs) at the time of referral, as it has been hypothesised that there is a proposed link between these medications and their impact on memory issues. This is essential in order to establish the validity of the diagnosis processes of dementia syndrome in the memory assessment services.

Background

It has long been established that anti-cholinergic medications (ACMs) have contributed to short-term cognitive impairment in patients taking them (1)(2)(3). This is compounded with the fact that these medications may be continued, without review, for longer than was originally intended when the drug was first prescribed. However, there is little research into the cognitive effects of long-term exposure to anticholinergics. Interestingly a cross-sectional study looking at older adults with questionable cognitive impairment who were exposed to anticholinergics found that they might have higher global cognitive scores than those without exposure to ACMs (4). This was attributed to the therapeutic effects of ACMs controlling their co-morbidities, thus outweighing their adverse effect on cognition. More recently there has been a robust association made between some classes of anticholinergics and future dementia incidence (5).

The impact of polypharmacy, subsequent anti-cholinergic burden, and the overlapping presence of delirium, may call into question the validity of a diagnosis of dementia in patients who have not been correctly vetted during the course of their assessment. Therefore this quality improvement evaluation has been designed to assess whether we are adequately reviewing patient's medications before diagnosing them with a memory disorder. We will aim to focus on eliminating the possibility of drug induced delirium which may obfuscating the correct diagnosis. This is in accordance with guidance set out by the NG97 NICE guidelines, The Royal College of Psychiatrists Memory Service National Accreditation Programme (MSNAP), and the National Institute on Ageing and Alzheimer's Association (NIA-AA) (6)(7)(8).

Method

All new referrals to the memory assessment service during the months of July and August 2019 were obtained. They were then systematically reviewed by looking at each of their RIO entries to collect the relevant data which included: patient ID, GPCOG/6CIT score, final diagnosis, CID prescriptions, CID review (in the referral letter, by a dementia support worker, by ANP/medic, or in MDT/ANP supervision.) Each case was reviewed by looking at the memory referral clinical document and the rio entries dated from the first point of contact to the present day.

Results

Currently the data set is being collated and analysed with the expected date of completion being 22nd November 2019.

Conclusion

Currently evidence suggests that there is a deficiency in the clarity of documentation when reviewing CIDs of patients referred to the memory assessment service against existing guidelines for dementia from the Royal College of Psychiatrists MSNAP and the NIA-AA. There is a link between the clarity of the documentation and the accuracy of the diagnosis, therefore by improving these we would expect to see a substantial improvement in the speed and accuracy of the diagnosis, as well as the delivery and efficiency of the service, benefitting the patient and their carers.

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Executive Committee

The West Midlands Division Executive Committee meets three times a year.

Approved [minutes](#) from previous meetings can be accessed online (member login required).

The committee's next meeting takes place virtually on Friday 16 October, 9-11.30am

Find out more about our [Regional Advisors and Speciality Representatives](#) roles, including full job descriptions.

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Section 12(2) and Approved Clinician Training Courses

Refresher courses

If your Approved Clinician or Section 12 approval period is due to expire before 31 January 2021, you will be granted a 12-month extension period. Read further details on the [temporary extension](#).

Induction courses

Our current online Section 12 (2) and Approved Clinician Induction courses are now both sold out.

- Section 12 (2) Induction: [Register your interest](#) to receive updates on future dates
- Approved Clinician Induction: [Register your interest](#) to receive updates on future dates

Please note: Attending one of these courses is only part of the process to becoming accredited.

We would strongly advise you to check with your local [NHS Specialist Mental Health Approvals Lead](#) for information on the criteria for approval/re-approval, and to confirm which course is suitable for your requirements before registering for a course.

If you have any queries, please read our [Approved Clinician FAQs](#) or [Section 12 FAQs](#) . If you can't find the answer to your question there, please contact Online.Events@rcpsych.ac.uk

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Get Involved!

If you would like to submit an article for inclusion in the next edition, please email it to Dr Nilamadhab Kar (westmidlands@rcpsych.ac.uk), Editor.

The division welcomes articles of local interest relating to psychiatry. We encourage trainees to get involved as well as patients and carers.

Submissions could be along the following lines:

Interest articles

Are you personally involved in any local work that you would like to increase awareness of? Is there a topic in mental health which you find interesting and would like to share with your colleagues? Do you have a personal experience within psychiatry you'd like to share?

Event articles

Would you like to share a review/feedback from a conference or other mental health related event that you've attended?

Opinion pieces/blog articles

Are there any issues in mental health that you are passionate about and wish to discuss with a wider audience?

Cultural contributions

This could be in the form of artwork, photography, poetry or an article relating to your insights, interpretations and observations of relevant popular culture, the arts and theatre.

Research/audits

Have you been involved in any innovative and noteworthy projects that you'd like to share with a wider audience?

Patient and carer reflections

This should be a few paragraphs detailing a patient or carer's journey - you may have a patient whose story you would encourage to share; or it could be a case study including a patient's perspective. Confidentiality and Data Protection would need to be upheld.

Instruction to Authors

Please consider your articles to be as precise as possible. As a guideline, articles on interesting topics, research/audits, good practice and opinion pieces may be up to 1000-word limit which may include up to around 5 essential references. Articles on events or conferences should be within 500 words. Please follow [Instructions for Authors of BJPsych](#) for reference style. Authors must obtain written permission from the original publisher if they intend to use tables or figures from other sources, and due acknowledgement should be made in the legend.

Authors are expected to be aware of and comply with best practice in publication ethics. Please declare any conflict of interest related to the article.

Disclaimer:

[The opinions expressed in this newsletter are those of individual authors and do not necessarily represent the views of the Royal College of Psychiatrists](#)

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