Dear Colleagues,

I feel honoured to welcome you all to another thought-provoking, interesting and useful newsletter presented by our innovative, enthusiastic and energetic young editor colleagues. I am also happy that this is the 1st newsletter since I have taken over as chair of the Trent division. I sincerely hope that by working together, we could strive to improve the current situation prevailing amongst us, in the mental health services. There is a lot of enthusiasm and innovative practices tried to improve the recruitment and retention of psychiatric trainees in our region. I understand that the uptake of trainees for this term is better than last year and I hope this trend continues. It would be helpful to find out the efficacy of various initiatives for recruitment and to see which one is best in terms of value for money and best outcome. I hope any of the higher trainees could look into this as a project and our division would be willing to support in doing this project.

The mental health act refresher training is held jointly by Trent and West Midlands divisions and is very popular. Thanks to these courses, our financial reserve also is looking better than before. I understand that if any of the Trust wants to hold this locally, it could be discussed and supported.

There are lot of changes and significant transformations happening in mental health services across the country as a result of diminution in resources and cuts in funding. To add to this unstable situation, newly introduced Sustainable Transformation Projects are diverting resources away from mental health services, although this is not mentioned in any of the documents.

Let us hope the future is going to be better and we could all work together to make it more fruitful to our members and helpful to our patients and their carers. We welcome all new faces in the Trent division executive committee and thanks to you all for spending your time to fulfil the objectives of our College and Division. I would welcome our carer representative, Rachel Bannister to the executive committee, appointed recently.

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Editorial: Summer 2017

Dear colleagues

We hope this newsletter finds you well and that you are all enjoying the last remnants of British summertime.

We have a new addition to the editorial team - Lesley Thoms, a Core Psychiatry Trainee from Leicestershire Partnership Trust.

Together we have enjoyed reading the varied articles that have been submitted into this edition and thank those who have contributed. We are confident you too will find this edition of particular interest and invite you to take a look.

Highlights include:

- Evaluation of the Flexible Assertive Community Treatment service
- Elective report on the Betty Ford Centre for addiction
- Research into folic acid deficiency in community rehabilitation
- ECT 4,970m above sea level
- Regional conference and essay prize announcements

Forthcoming editions:

As always, we are keen to receive your contributions which may include, but are not limited to:

- Reviews of recent literature
- Past and upcoming events within the Trent Division
- Opinion pieces and/or reflections
- Creative contributions (i.e. photographs, artwork, poetry)
- Research/Audits/Quality Improvement projects
- Special interests within Psychiatry

Certificates for accepted articles can be made available upon request.

Finally, in a continuous effort to ensure this newsletter best reflects your interests, we welcome any suggestions for improvement. Please do get in touch using the details below.

With thanks and best wishes,

Sam and Lesley

Editors of the RCPsych Trent Division Newsletter

Please submit your contributions and suggestions to:
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Lesley Thoms, Core Psychiatry Trainee

Service Evaluation of Newark Flexible Assertive Community Treatment Team

Introduction

The Flexible Assertive Community Treatment (FACT) team is a new model of service provision implemented on 1st July 2013 to provide secondary mental health services within the Newark and Sherwood area of Nottinghamshire. FACT replaced the pre-existing Community Mental Health Services in the Newark and Sherwood locality with the aim of streamlining pathways of patient care and assessment which traditionally existed between separate teams – such as Assertive Outreach (AO), Early Intervention in Psychosis (EIP), Community Mental Health and the Crisis Resolution and Home Treatment Services. Where patients would previously need to be assessed individually by the aforementioned teams, there would now be a single team approach covering the entire patient journey while assessed and treated in the community.

The FACT team was developed in order to provide a needs-led service with a recovery oriented clinical case management model. It emphasises flexible service provision utilising a series of pathways (EIP Pathway, AO Pathway, Flexible Support Pathway/Duty Team, Short and Long-Term Treatment Pathway, Personality Disorder, Distress Management and Deliberate Self-Harm Pathway) to a provide a range of treatment packages dependent on the needs of the service user. One of the service objectives amongst several others included provision of intensive home treatment, where indicated, to try to reduce admissions wherever possible.

The FACT model was originally developed in the Netherlands. Prior to its implementation the most severely ill psychiatric patients living in the community were served by Assertive Community Treatment (ACT), a multi-disciplinary service focussing on those at risk of relapse and hospital readmission.[1] It is estimated that this target group constitutes 20% of the long-term mentally ill persons in the population.[2] The remaining 80% of more stable long-term mentally ill were served by case management teams and often problems were encountered when they became unstable or required more support leading to increased admissions. It was felt that the differences between the two groups pertained only to the intensity of care and treatment at a particular point in time. In order to ensure continuity of treatment, care and rehabilitation, teams would be created focussing on both the 20% and 80% group, incorporating ACT as one function in multi-functional 'FACT' teams. Indeed it was found that in 80-90% of cases a client's need for more intensive services is temporary rather than permanent.[1]

After FACT teams were set up a gradual decrease in admission days was seen.[1] Bak and others (2007) published pre-post comparisons of the introduction of FACT in the south of the Netherlands. They found that the proportion of patients transitioning to remission increased from 19% in the period before the introduction of FACT, to 31% in the period with FACT (OR = 2.21, 95% CI 1.03-4.78). They went on to state that FACT may bring improvement to the lives of patients living in countries characterised by fragmented and hospital based mental health services.[3] van Veldhuizen (2007) concluded that FACT seems to be a model which can address the fragmentation of the Dutch system and provide stepped care to all long-term patients outside the hospital.[1]

The aim of this study is to evaluate the effectiveness of this new service by examining a series of parameters which were deemed to give an indication of performance.

Method

In this retrospective study, patients open to the FACT Team who were involved in the EIP and AO pathways, at the point of implementation of the FACT team (on the 1st July 2013) were initially identified. For each patient, data was collected from their electronic records concerning a series of parameters, over the one year period prior to 1st July 2013 (pre-FACT) and over the one year period after this date (post-FACT).

Data on following parameters were collected:

1. Gender
2. Team/FACT pathway (Assertive Outreach or Early Intervention in Psychosis)
3. Number of inpatient admissions
4. Length of stay of in-patient admissions
5. Mental Health Act status on admission
6. Number of Community Treatment Order (CTO) recalls
7. Whether subject to CTO
8. Number of referrals to Crisis Resolution Home Treatment (CRHT) team
9. Number of CRHT contacts
10. Duration of CRHT referrals
11. Number and details of 'Serious untoward incidents' (SUI'S)
12. Number and nature of complaints
13. Number of contacts with Consultant
14. Number of contacts with care co-ordinator
15. All contacts

Results

A total of 99 patients were identified as being open to the EIP and AO pathway of FACT on the 1st July 2013. Of these 55 were open to AO and 44 were open to EIP. 59 patients were male and 40 were female.

In order to compare quantitative data between the pre and post FACT implementation periods, the Wilcoxon rank-sum test was used. This is a nonparametric statistical test that compares two paired groups.

First of all the numbers of admissions in each period were compared. There were 45 admissions in the twelve month period prior to FACT implementation and 22 admissions in the twelve months after implementation (Table 1). The significance statistic using the Wilcoxon Signed Rank Test was found to be 0.022, which was below the significance level of 0.05 (at the 95% level). It can therefore be said that there was a statistically significant difference in numbers of admissions between the two periods.

Next, the total length of stay (cumulative number of admission days over the period) was compared for each period. The total length of stay across all patients prior to implementation of FACT was 2732 days compared to 1101 days post FACT (Table 1). The significance statistic using the Wilcoxon Signed Rank Test was found to be 0.008 which was below the significance level of 0.05 (at the 95% level). It can therefore be said that there was a statistically significant difference in total length of stay between the two periods.

The numbers of referrals to the Crisis Resolution Home Treatment Team were compared for each period. The number of referrals pre-FACT was 34 and the number post-FACT was 32 (Table 1). The significance statistic using the Wilcoxon Signed Rank Test was found to be 0.864 which was above the significance level of 0.05 (at the 95% level). It can therefore be said that there was no statistically significant difference in the number of referrals between the two periods.

The number of CRHT team contacts was compared for each period. The number of contacts pre-FACT was 196 and the number post-FACT was 108 (Table 1). The significance statistic using the Wilcoxon Signed Rank Test was found to be 0.964 which was above the significance level of 0.05 (at the 95% level). It can therefore be said that there was no statistically significant difference in the number of contacts between the two periods.

The duration of referrals to the CRHT team (cumulative number of days under CRHT over the period) was compared for each period. The cumulative number of days under CRHT was 1438 pre-FACT versus 1665 days post-FACT (Table 1). The significance statistic using the Wilcoxon Signed Rank Test was found to be 0.858 which was above the significance level of 0.05 (at the 95% level). It can therefore be said that there was no statistically significant difference in duration days between the two periods.

Tests were carried out using the same parameters as above but looking only at those open to EIP and for each parameter it was found that there was no statistical difference between pre- and post-FACT Team data.

Tests were also carried out using the same parameters as above separating out by gender. For each parameter it was found that there was no statistical difference between pre- and post-FACT Team data within each gender category.

Table 1 Number of admissions, length of stay; CRHT referrals, contacts and duration – pre and post FACT

	Pre-FACT	Post-FACT	Wilcoxon Signed-Rank Test Statistic
Admissions	45	22	0.022*
Length of Stay (days)	2732	1101	0.008*
CRHT Referrals	34	32	0.864
CRHT Contacts	196	108	0.964
CRHT Duration (days)	1438	1665	0.858

*denotes significant difference at 5% level

Additionally, the number of Consultant contacts was compared for each period. The number of consultant contacts pre-FACT was 242 in comparison to 233 post-FACT (Table 2). The significance statistic using the Wilcoxon Signed Rank Test was found to be 0.635 which was above the significance level of 0.05 (at the 95% level). It can therefore be said that there was no statistically significant difference in consultant contacts between the two periods. This held when separating out by gender as there was no significant difference in consultant contacts in males (0.653) or females (0.843) between the two periods. No significant difference was also found when separating out by ‘pathway’ (EIP 0.793; AO 0.693).

The number of care co-ordinator contacts was compared for each period. The number of contacts pre-FACT was 1429 in comparison to 1450 post-FACT (Table 2). The significance statistic using the Wilcoxon Signed Rank Test was found to be 0.750 which was above the significance level of 0.05 (at the 95% level). It can therefore be said that there was no statistically significant difference in care co-ordinator contacts between the two periods. This held when separating out by gender as there was no significant difference in care co-ordinator contacts in males (0.439) or females (0.774) between the two periods. No significant difference was also found when separating out by ‘pathway’ (EIP 0.273; AO 0.167).

The total number of contacts was compared for each period. The number of contacts prior to FACT was 4489 compared to 3305 post-FACT (Table 2). The significance statistic using the Wilcoxon Signed Rank Test was found to be lower than the significance level of 0.05 (at the 95%

level). It can therefore be said that there was a statistically significant difference in the total number of contacts between the two periods.

The total number of contacts was broken down by gender. When looking at males only, the significance statistic using the Wilcoxon Signed Rank Test was also found to be lower than the significance level of 0.05 (at the 95% level) at 0.004. There was therefore a significant difference in the total number of contacts of males between the two periods. When looking at females only, the total number of contacts was also significantly different between the two periods (0.004). This significant difference held when separating out by 'pathway' (EIP 0.001; AO 0.011).

Table 2 Number of Contacts by Consultant, Care-Co-ordinator and All Contacts – pre and post FACT

	Pre-FACT	Post-FACT	Wilcoxon Signed-Rank Test Statistic
Consultant Contacts	242	233	0.635
Care Co-ordinator Contacts	1429	1450	0.750
All Contacts	4489	3305	<0.001*

*denotes significant difference at 5% level

Table 3: Mental Health Act status on admission of those admitted in the period before and after FACT implementation, with the corresponding percentage figure of the total for each period in brackets.

	Pre-FACT	Post-FACT
Informal	21 (46.67)	13 (59.09)
Section 2	15 (33.33)	5 (22.73)
Section 3	6 (13.33)	1 (4.55)
Section 4	1 (2.22)	0 (0)
CTO recall	1 (2.22)	1 (4.55)
Insufficient/ill-defined data	1 (2.22)	2 (9.09)
Totals	45	22

The number of informal admissions was compared for each period (Table 3). The significance statistic using the Wilcoxon Signed Rank Test was found to be 0.523 which was above the significance level of 0.05 (at the 95% level). It can therefore be said that there was no statistically significant difference in the number of informal admissions between the two periods.

The number of formal admissions (grouped together due to low numbers) was also compared for each period (Table 3). The significance statistic using the Wilcoxon Signed Rank Test was found to be 0.210 which was above the significance level of 0.05 (at the 95% level). It can therefore be said that there was no statistically significant difference in the number of formal admissions between the two periods.

5 patients were subject to a CTO in the period pre-FACT implementation and there were also 5 patients under CTO post-FACT. There was one CTO recall pre-FACT and also one post-FACT (Table 4).

There were found to be zero 'serious untoward incidents' (SUI's) prior to FACT implementation and 3 post-FACT (Table 4). The 3 SUI's included a 'healthcare associated infection' in one patient and 'physical assault' and 'attempted suicide' both involving an individual patient.

There were 2 complaints pre-FACT and 2 post-FACT (Table 4). Pre-FACT this included: 'medication/prescribing, communication',' medication/prescribing, adequacy of treatment, consent to treatment, bed management'. Post-FACT this included: 'bed management/availability', 'medication/prescribing'.

Table 4: Number of patients subject to CTO and CTO recalls; Number of complaints and SUI's – pre and post FACT

	Pre-FACT	Post-FACT
Patients subject to CTO	5	5
CTO recalls	1	1
Complaints	2	2
Serious Untoward Incidents	0	3

Discussion

The results showed a significant reduction in the number of admissions and length of stay in the post-FACT period compared to the pre-FACT period. It could be proposed therefore that the implementation of the new model has had a positive impact in terms of preventing admissions and also by reducing the total number of days spent in hospital. It is difficult, however, to definitively state the mechanism behind this trend, which is beyond the scope of the study. One also needs to bear in mind that there may be other factors which may account for the trend including significant bed closures across the locality over this time period.

The numbers of referrals to the CRHT Team, CRHT Team contacts and total number of days spent under this team was not significantly different between the two periods. It would appear therefore that the new team model had no effect on this parameter, with broadly similar outcomes.

The results showed a significant reduction in the number of 'all contacts' in the post-FACT period compared to the pre-FACT period. This significant difference did not hold when looking at the numbers of consultant contacts and care co-ordinator contacts only. It is possible that the new FACT model has had a direct impact on the total numbers of contacts although one cannot definitively state why this is so. One possibility is that the amalgamation of specific teams into an overall FACT team has led to healthcare workers having less availability to make contact with certain patients as they must work across different 'pathways' as opposed to just one specific team.

The numbers of patients subject to a CTO were the same in both periods. Likewise the number of CTO recalls was the same between the two periods indicating that the new model had no effect on this parameter. One should apply caution in interpreting these results however due to the low numbers involved.

The numbers of complaints was the same in both periods although whilst there were 3 SUI's post-FACT there were none prior to its implementation. Due to the low numbers involved it is difficult to state whether this is statistically significant and therefore it is difficult to definitively state whether this is an effect of the new team model.

Looking at the Mental Health Act status on admission before and after FACT implementation shows an increased proportion of patients admitted on an informal basis. Of those admitted post-FACT implementation, there were proportionally fewer detained under Section 2 MHA (33.33% vs 22.73%) and Section 3 MHA (13.33% vs 4.55%). These differences, however, were not found to be statistically significant when looking at informal admissions and formal admissions grouped together. Patients detained under the Mental Health Act tend to be more unwell compared to those admitted informally, being unable to consent to admission. It could be said therefore that not only have the numbers of admissions reduced post-FACT but those requiring detention under the Mental Health Act have reduced proportionally indicating less severe or reduced psychiatric

morbidity since implementation of the new model. As mentioned previously however these differences were not found to be statistically significant.

Overall, in spite of significant changes to service configuration, it appears that the effectiveness of the service has been maintained and even improved when looking at the various indicators of performance measured. Certain areas indicate an improvement including a significant reduction in admissions, length of stay and the proportion of those admitted under the Mental Health Act (albeit not at a statistically significant level). Other areas have indicated that the new model has had no effect including referrals, contacts and duration days under CRHT, numbers subject to CTO and CTO recalls. The only negative trend found was a significant reduction in the numbers of overall contacts although it is unclear as to what impact, if any, this has had on patient well-being. There were also more SUI's post-FACT although due to the very low numbers, the significance of this cannot be statistically confirmed.

Conclusion

One could conclude, particularly given the reported reduction in running costs, that the FACT model has been successful in terms of the performance indicators measured within this study. Indeed no areas revealed a deterioration of service with certain areas showing improvement when measured against the performance indicators.

Limitations

In terms of limitations, the study did not take into account a reported transition period between the old and new models. Indeed it is reported that the new model was not fully implemented on the official start date of the 1st July 2013 but instead gradually phased in over the first few months. Furthermore the periods under study were generally short and it would be useful to expand the time frame to look at a broader period. The study looked at various performance indicators (e.g. admission numbers) although it is unclear how much of an effect confounding factors had on these (e.g. bed closures). Certain areas measured revealed low numbers which meant that the statistical significance of any changes was impossible to ascertain. Furthermore, the study relied on accuracy of data of the computerised notes system, which is dependent on the reliability and quality of data input. The study exclusively examined quantitative data which were deemed to give an indication of team performance. Any future study on this topic may wish to look at more qualitative data, including service user and healthcare worker feedback of their experiences of the new team.

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Together We Will Overcome Addiction – My week at the Betty Ford Centre

I had an interest in the Disease of Addiction since a placement on the Liver Ward at the Royal Derby Hospital during my first clinical placement at medical school. I found working with the certain alcoholic demographic – often low socio-economic status, disenfranchised and at the edge of society, extremely rewarding. Typically they were complex patients with a variety of co-morbidities, often accompanied with mental health issues and harrowing backgrounds. As I researched more about alcoholism I learnt that it actually reached all corners of society, not purely a disease of the poor and 'down and out' but could equally affect high-functioning members of society. A further placement on a drug and alcohol rehabilitation centre in Nottingham furthered my interest.

I knew that for my elective I wanted to learn more about addiction and the people that it could effect. The name "Betty Ford' to me was synonymous with recovery from chemical dependency and was the world renowned centre for treating the disease of addiction. A simple Google search alerted me to the Summer Institute for Medical Students (SIMS) programme, a fully funded scholarship to attend a week long immersive programme at the Betty Ford Centre (BFC) in Rancho Mirage in California.

Figure 1: Betty Ford Centre, Rancho Mirage.

The application process was relatively straight forward. It required two letters of recommendation supporting your application as well as a short essay on your personal or professional experience with addiction. I was thrilled to be awarded a place and in mid-June I flew from Manchester to Los Angeles, eventually arriving in Palm Springs 15 hours later to a balmy 49 degree heat. The SIMS programme is fully funded by donors to the Hazelden Betty Ford Foundation and on our first day I met with the other 14 medical students, 13 from other Universities throughout the US and 1 from Canada, all at various stages of their medical school career.

The BFC adopts a 12-step philosophy of Alcoholics Anonymous and assumes an abstinence approach. This is quite a traditional treatment model but the BFC believe wholeheartedly the 12-step model works. The abstinence approach particularly applies to drug recovery - currently no medication, such as methadone or buprenorphine, is used to control cravings. Instead the BFC believe that abstinence from all drugs results in a more successful recovery in the long term.

Figure 2: The Medical Students were from all over the US and Canada.

Following detoxification, patients undergo treatment and relapse prevention involving a fully holistic approach covering a range of behavioural treatments. These include CBT, meditation, anger management and AA or Narcotics Anonymous meetings as appropriate, all individualized for each patient. We were given the opportunity to sit in with small group therapy sessions during our week on the programme. This gave us the chance to interact on a more personal level with the patients and begin to understand their backgrounds as well as their continual struggle with cravings. We also attended daily lectures on a variety of subjects including courage, how medical professionals are taught to understand addiction and family therapy. We learnt about the idea of the 'Disease of Addiction' and how it is in fact a disease of the midbrain resulting in a defective decision making process – essentially making addiction 'a disease of choice'. Addicts may be able to modify their behavior but cannot change their physiological response to the drug (i.e. the craving). At times their cravings may become overwhelming, hence why the addicted individual may relapse. Through therapy it is believed that the brain can be re-wired to help diminish these cravings.

What struck me most about the BFC was the obvious demographic of the patients that attended the facility. These people did not look like the addicts I was used to seeing in Nottingham or Derby. They appeared too healthy – they did not appear malnourished, had no visible signs of liver disease and had a full set of sparkling white teeth despite often heavy addictions to large quantities of crystal meth and heroin. They were predominantly white and appeared relatively affluent. However we were informed that the patient population has changed vastly over the past few years. Once a celebrity haunt where Steven Tyler, Lindsey Lohan and Sir Anthony Hopkins could be seen walking the halls, previous residents had to self-fund the $2400 a day treatment plan. Now, 85% of residents are funded by insurance. This results in a more representative population but as Insurance is provided by those in employment, it results in the poorest addicts not being reached. Due to government regulations the BFC are unable to take any Medicare patients who must attend the drastically underfunded public programs instead. In addition the BFC was unable to take addicts with primary co-existing mental health issues or those that did not want to undergo treatment. This resulted in a patient group who were motivated, educated and willing to change. It would be interesting to see if their programme, heavily structured around group therapy and lectures, would work for those less-educated, lower classed individuals.

Being able to hear first-hand people's stories that were at various stages of their recovery – from day one to people who had been clean for decades, was a great privilege. The week was very emotive and I do not think I was fully prepared for how life changing it could be for both the patients and myself. The stories of the people I will never forget, from the banker who narrowly missed out on 9/11 and resulted in spending the remaining noughties in a cocaine fuelled haze, the college professor who used to drink Listerine if he couldn't get served alcohol, the meth addicted teacher with HIV, the 60 year old alcoholic housewife, the broadcast journalist self confessed party girl, the airline pilot who believed if he still could get up for work he did not have a problem and the pharmacist getting high off her own supply, every story was so different.

The SIMS programme is a fantastic opportunity to see inside the leading Chemical dependency treatment and recovery centre in the world. It really helped me understand more about addiction, how to discuss addiction with my patients and how to support and treat addiction in the future. 1 in 10 people are said to suffer from some form of addiction and yet our understanding of the disease and how to manage it is limited at best. Addiction carries with it a great social stigma that you wouldn't get from diseases such as diabetes or cancer. I feel that now I have attended the SIMS programme I will be better able to deal with addicted patients throughout my medical career. For a truly immersive, life changing experience in the field of addiction I cannot recommend the SIMS programme enough.

Rebecca Bennett - University of Nottingham Medical School

More info about the SIMS programme and how to apply can be found here: http://www.hazeldenbettyford.org/education/medical-professional-education/summer-institute-medical-students

Folic acid deficiency in patients on a Community Psychiatric Rehabilitation Unit

Introduction

Folic acid and vitamin B12 are vitamins which are obtained from the diet and are necessary for good health[1]. People suffering from severe mental illness are at risk of chronically poor diet, and therefore may be more likely than the general population to suffer vitamin deficiencies. Such deficiencies are associated with a wide variety of symptoms, including neuropsychiatric ones; Vitamin B12 deficiency is associated with paraesthesia, visual disturbance, depression, psychosis and dementia, whereas folic acid deficiency is associated with anaemia, lethargy, weakness and depression[2]. Folic acid and vitamin B12 deficiency are also associated with schizophrenia – an effect that seems to be independent of antipsychotic treatment[3]. The symptoms mimic or exacerbate the disabling "negative" symptoms of schizophrenia[4]. Several authors have reported that negative symptoms improved in patients treated with folic acid and vitamin B12 supplements[2, 5, 6].

In this study we aimed to quantify the prevalence of serum folic acid and vitamin B12 deficiency in patients in a Community Psychiatric Rehabilitation Unit.

Method

Twelve out of fourteen inpatients in a Community Psychiatric Rehabilitation unit agreed to take part. Informed consent was sought for blood testing. All results were anonymised. Two patients declined to participate.

Blood samples for estimation of folic acid and vitamin B12 levels were taken from the twelve inpatients. Samples were taken between 12/10/2016 and 16/01/2017 as part of routine monitoring (for physical health conditions, to monitor medication side effects, or statutory full blood count monitoring associated with clozapine). Folic acid and vitamin B12 levels were identified using immunoassay. Serum vitamin B12 levels below 197 ng/ml or serum folic acid level below 3.9ng/ml were taken to represent vitamin deficiency.

Psychiatric diagnosis was established by a consultant psychiatrist (Dr Matthew Allin) using criteria from the International Classification of Diseases, version 10 (ICD-10) based on case note review and face-to-face interview. Positive and Negative Symptom Scores (PANSS) were rated on each participant.

Results

Demographic characteristics and diagnoses

Twelve out of a total of fourteen patients completed the study. Seven were male and five were female. Their ages ranged between 32 and 65 years (Mean 41, Range 33). Seven of the patients were Caucasian, three of Black Afro Caribbean descent, one of Asian Bangladeshi ethnicity and one patient of Persian ethnicity. Six patients had an ICD 10 diagnosis of paranoid schizophrenia and six had a diagnosis of schizoaffective disorder. Three of the twelve patients had a comorbid Depressive Disorder, one had a comorbid Panic Disorder, one had comorbid Obsessive Compulsive Disorder and one had comorbid alcohol dependency. All patients were taking medication, with a majority (8 out 12) being on clozapine (Table 1).

Folic acid levels

Serum folic levels ranged from zero to 14.8ng/ml, with a mean of 5.8ng/ml. Five out of twelve patients (42%) had low levels of folic acid. In three cases (25%) the level was so low as to be undetectable by the assay. One of these patients had comorbid alcohol dependency.

Vitamin B12 levels

No patients had vitamin B12 deficiency. Eleven out of the twelve patients had normal levels, and one person had raised vitamin B12. This patient had been taking vitamin B12 supplements as part of treatment for co-morbid alcohol dependency.

Table 1: Demographic characteristics, diagnoses, PANSS scores, medication and serum vitamin levels of participants

ID	Sex	Mental Health Diagnosis	PANSS positive	PANSS negative	PANSS general	Psychotropic medication	Serum folic acid (ng/ml)] (Normal range: 3.9 - 20)	Serum B12 (ng/ml) (Normal range: 197-771)
1	M	Paranoid Schizophrenia Mild OCD	19	31	42	Clozapine	0	454
2	F	Schizoaffective Disorder Panic Disorder	36	31	67	Zuclopenthixol Decanoate depot	0	501
3	M	Paranoid Schizophrenia Alcohol Dependency Depression	28	32	51	Olanzapine	0	783
4	F	Paranoid Schizophrenia	11	17	22	Clozapine	2.6	367
5	F	Paranoid Schizophrenia Depression	24	33	37	Clozapine Amisulpiride	2.4	375
6	M	Schizoaffective Disorder	21	23	33	Clozapine Sodium valproate	6.5	619
7	M	Schizoaffective Disorder	26	56	38	Clozapine Sodium Valproate	4.9	543
8	F	Schizoaffective Disorder	26	23	29	Clozapine Sodium Valproate	6.9	509
9	F	Paranoid Schizophrenia	23	42	31	Clozapine Amisulpiride	13.5	270
10	M	Paranoid Schizophrenia	13	15	32	Haloperidol Sodium valproate	4.1	764
11	M	Schizoaffective Disorder Depression	10	32	32	Clozapine Sodium Valproate	14.8	294
12	M	Schizoaffective Disorder	29	33	39	Aripiprazole depot	14.1	677

Discussion

We found folic acid deficiency to be common among patients at this Community Rehabilitation Unit. Vitamin B12 levels, however, were normal for all our participants (save for one person who was on vitamin B12 supplementation). This was of potential clinical relevance, as this might have been contributing to negative symptoms of psychosis and thus been an unsuspected barrier to moving on to independent living. Several authors have reported the benefits of folic acid supplementation in patients with chronic schizophrenia. For example, Hill et al[6] reported significant reduction in PANSS (Positive and Negative Symptom Scale) scores following supplementation of folic acid and B12 in patients with schizophrenia.

Vitamin B12 is available in the diet in meat, liver, fish, eggs and shellfish. Folic acid is available in green leafy vegetables, fruits, nuts and meat and eggs. None of the patients were vegans (a group at high risk of B-vitamin deficiency – especially B12). However, it is possible that dietary intake of green leafy vegetables was lower than the optimal. Folic acid supplementation has subsequently been provided to those who had low levels.

Folic acid levels may be affected by other environmental exposures – for example, tobacco smoke. All 12 of the participants of this study were cigarette smokers. Several authors have reported lower folic acid concentrations in smokers compared to non- smokers[7, 8].

Another possible explanation of the low folic acid levels is the effect of antipsychotic medication, which is known to affect the absorption of dietary nutrients. Eren et al[9] found that serum folic acid levels were negatively correlated with antipsychotic dose (lower folic acid at higher antipsychotic doses). However, the participants in their study were all taking first-generation antipsychotics, whereas the majority of the patients in our study were taking clozapine or second-generation antipsychotics.

Folic acid is required for key cellular processes, including gene transcription, homocysteine metabolism and synthesis of neurotransmitters[10]. The bio-availability of folic acid is subject to considerable inter-individual variability, linked to the activity of the enzyme methylenetetrahydrofolate reductase (MTHFR). This enzyme activates folic acid by catalysing the reduction of the precursor molecule. A single nucleotide polymorphism in the MTHFR gene (leading to a low-activity form of the enzyme) is over-represented in patients with schizophrenia, and is associated with negative symptoms[5].

Limitations

This was a small sample (12 participants). No definite conclusions can be drawn without further replication by highly powered studies. Our study is rather like a pilot to create the basis for funding a more elaborate and significantly powered study. Nevertheless, it does represent a “real-world” study, of a relevant clinical population.

We were unable to account in detail for participants’ dietary habits. All had access to a budget, and nursing support, to enable them to buy and prepare food. No patients were detained under the Mental Health Act (1983, revised 2007), and all were able to leave the unit at any time.

Recommendations:

1. Serum folic acid deficiency was found to be highly prevalent in our sample group, consistent with other studies. Serum vitamin B12 and serum folic acid determination should be part of the routine screening in Community Psychiatric Rehabilitation units.

2. It might be worth considering prophylactic folic acid supplementation in patients with chronic Schizophrenia, especially if they also smoke cigarettes.

3. A more elaborate and significantly powered study studying folate deficiency and the benefits of folate supplementation in patients with Chronic Schizophrenia should be considered.

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Dr Nicholas Taylor is a Consultant Forensic Psychiatrist at Arnold Lodge, and the Training Programme Director for Forensic Psychiatry in the East Midlands. He was brought up in Manchester and trained as an undergraduate in Bristol, before training as a psychiatrist in the West Midlands. His special interests include medical education and medical management.

1. **Tell us something about yourself that most people don't know.**

Whilst working full time in the NHS in the years after I qualified, I spent 6 years as an Officer in the Royal Naval Reserve. This led to the most exciting job I ever had, working as a Medical Officer on board a Royal Navy fleet submarine (HMS Turbulent), living entirely under the sea for several months. There's very little medicine to be done down there, so I was briefly an expert at submarine navigation, periscope watchkeeping and a range of other skills which, although thrilling at the time, I am unlikely to use again. I prefer being on the water now, rather than under it, and spend much of my free time in the summer driving a ski boat.

2. **What trait do you deplore in others?**

We all face any number of professional and personal challenges on a daily basis but we are professionals - I don't think there is any justification for losing your temper in the workplace.

3. **Tell us about either a film or a book that left an impression on you?**

The Ordeal of Gilbert Pinfold is a short story by Evelyn Waugh from the late 1950s. Few people have heard of it, but it's freely available online and has been dramatized on radio many times over the years. It is a short, funny and compelling story worth 20 minutes of any psychiatrist's time. It has direct relevance to the modern clinical world in which we all work - you should read it!

4. **When not being a psychiatrist, what do you enjoy?**

I've been a huge fan of all forms of technology for many years. I enjoy seeing what the latest technologies have to offer and I'm very much an "early adopter". I have my sights set on a VR headset in the near future.

I also breed peacocks every summer, with varying degrees of success. I have quite a setup with several incubators, hatchers and a range of enclosures and pens, which I have built myself. This is enjoyable when things go well and there are little chicks running everywhere, and heartbreaking when things are not going well. I did not have a good year in 2017, with only a handful of new birds to show for it, but have sought expert advice and have high hopes for 2018!

5. **Which people have influenced you the most?**

My career was strongly influenced by Dr Paul Hogbin, an old age psychiatrist in Cornwall. I was assigned to him as an undergraduate, and had never considered psychiatry as a potential career until that point. Seeing a really well led, effective multidisciplinary team making a huge difference to people's lives inspired me to pursue a career in psychiatry. I am also a huge fan of David Allen and his *Getting Things Done* approach. I buy the book for every one of my trainees.

6. **If you were not a psychiatrist what other profession would you chose?**

I could easily have ended up as a GP, which would have been a mistake for me. If circumstances had been different, I would have loved to have pursued a career in submarines, but I would miss the rest of the world too much and it would be difficult to reconcile this with a relationship or a family.

7. How would you like to be remembered?

I think the only way any doctor should want to be remembered is as having been effective at helping their patients. I hope I have helped my patients over the years.

I benefitted hugely from inspirational teaching, training and guidance throughout my education and training, and I hope that I have been able to help other medical students and trainees from time to time. It would be great to think that I had helped at least one medical student or junior doctor to make decisions about their future career in the same way that others helped me.

Regards

Nick Taylor

Reflecting on my Work Experience in the Psychiatry of Intellectual Disability

(Agnes Unit, Leicestershire Partnership Trust)

I was enlightened. This past week has truly changed my perspective of the human brain and of people and how different lives can be, due to mental illnesses. Throughout this week I had experience not just in how mental illness can impact on the lives of people with intellectual disabilities, as well as neurodevelopmental conditions such as autism. This allowed me to witness the struggles and disadvantaged lives of those with intellectual disabilities, which can range from mild to severe in severity. I am grateful for the opportunity I received; as it has aroused my interest further and has shown me that I want to study medicine and go into psychiatry, to then help others.

What first interested me to pursue psychiatry was that one of my friends became ill with depression and I thus saw the profound impact this can make on someone's life. I observed the help from mental health services that was given to them and how they benefitted from it. I now want to be able to provide this kind of support and care myself, to others that need it. Working as a psychiatrist, as part of a multidisciplinary mental health team, will help me to achieve this.

People with intellectual disabilities and mental illness should be given every opportunity to have the best quality of life possible. When we have learnt about mental illness at school, the focus is generally on brain biochemistry and physiology, which is imperative, but equally important is the impact on patient's behaviour, social functioning and overall quality of life. Seeing these patients gave me greater insight into what it's actually like for the people with intellectual disabilities affected by mental illness. I want to be able to pass on this enhanced understanding to my peers, but also understand that I am at the start of my prospective career and still have much to discover and learn.

I was very moved by the patients I met. As well as meeting patients and understanding what is wrong with them, I have learnt how psychiatrists treat people with mental illness, including the pharmacological options and potential side effects. Psychiatrists need to be able to accurately weigh up the risks and benefits of treating patients with these medications, and communicate this back to the patient in a way they can easily understand, to help mutually negotiate a way forward. Additionally, I realise that medications form only a part of the management plan for many patients, and that a collaborative approach, involving the utilisation of skillsets of numerous different professionals (including psychologists, nurses, occupational therapists, speech and language therapists, physiotherapists and many others) is often required in order to provide high quality patient care.

Throughout the week of work experience, I also discussed with a qualified psychiatrist about how to approach my medical school interview and how best to present myself. He also told me what to expect at medical school and what it is like. For me this was very important and extremely helpful as he was the first person to give me such an insider's viewpoint. I am now already starting to feel more confident for the future and know that, to achieve my goal I must also work extremely hard.

Miss Simrun Chauhan, A-level student, Leicester

Update on the RCPsych International Congress

New beginnings seemed to be the theme of this year's International Congress, which was held in the beautiful historical city of Edinburgh. Whilst it marked the end of Professor Sir Simon Wessely's term as College President, we welcomed Dr Wendy Burn as new captain at the helm. We also met the new College CEO and came across the newly launched quarterly magazine, RCPsych Insight. However, Congress was more than just marking the advent of transition, it also marked the celebration of psychiatry's contributions, successes and future potential.

With 14 keynote lectures and over 70 parallel sessions, there was no end to the opportunities of learning about new advances in research, policy, clinical practice and medical education. Delegates learnt about new advancements of dementia management, future directions of medical education, psychiatry and the Prevent programme, the impact of Brexit, sleep and sleep disorders, novel psychoactive substances, telepsychiatry, functional neurologic disorders; and the list goes on.

We also heard a moving testimony of living four years with PTSD after being held hostage in a terrorist attack, and of one mother's survival of postpartum psychosis following ECT. Altogether, speakers not only provided delegates with updates and information, but also provided us with a reminder of the realities of living with a mental illness.

Aside from the many talks, there were countless posters across the four days, detailing the work of audits and QI projects, of new research findings and of interesting case presentations. As well as presenting results, these posters exhibited the celebrated successes of frontline staff, promoting their continuous efforts for improvement in science and clinical practice. In doing so, it also provided many students and trainees with a platform for professional development and cultivated a real sense of achievement and progression.

It is safe to say that Congress provides an opportunity for intellectual stimulation, challenging perspectives and keeping up to date with new advancements in psychiatry. It also offers the opportunity to unite clinicians of different specialities and grades, from different countries and healthcare systems; to learn together and to teach one another. Given that International Congress seems to outshine each previous year, with such high a standard this time around, it is exciting to know that somehow next year's Congress will be even better.

International Congress 2018 will take place in Birmingham on 24-27 June. To find out more, visit:
http://rcpsych.ac.uk/traininpsychiatry/conferencestraining/internationalcongress2018.aspx

Lesley Thoms, Core Psychiatry Trainee, Leicestershire Partnership Trust

National Institute of Clinical Excellence Updates Relevant to Psychiatry:

January – June 2017

January 2017

1) NICE and the FDA (Food and Drug Administration) are Working Together.

NICE and the FDA are working closely to help developers of medical devices, diagnostics and similar technology to gather the best evidence to demonstrate clinical effectiveness of their products. This aims to speed up patient's access to the best technologies. In the UK it is usually the NHS that pays for these.

2) Management of Co-existing Severe Mental Illness and Substance Misuse Guidelines.

People living with severe mental illness and co-existence substance misuse often experience difficulties in accessing the care and support they need. They can be excluded from Mental Health Services because of their substance misuse being their primary concern. They can then be denied Drug and Alcohol Services support because people think their mental illness should be treated first. This difficult situation is compounded and many people miss appointments which results in services not being provided. These new guidelines aims to address these problems. They promotes the need of teams to work together and consider what recovery means. It will increase the engagement and recognises the support needed by carers as well.

3) Learning Disabilities Mental Health Checks.

Mental health problems may be more difficult to diagnose in people with learning disabilities and therefore every patient with a learning disability will have their mental health checked annually. Only half of patients with learning disabilities are received a health check in in 2011/12, this is an improvement on previous years but so far is only focused on physical health care. There will be the necessity for patients to:

1. Have a Mental Health Assessment every year.
2. Make Referrals to Mental Health Services.
3. Have a Key Worker to co-ordinate their care.
4. Receive Psychological support.
5. Review Psychotropic Medication every year.

4) Transition from Children's Services to Adult Services.

This quality standard covers all children accessing Adult Services with mental health problems, disabilities, long term life limiting complex needs, those in secure settings and those under the care of local authorities.

5) Developing People Framework

NICE have also developed a developing people/improving care framework which focuses on NHS and social care developing for critical capabilities including systems leadership, established quality improvement methods, inclusion and compassion at leadership and talent management.

February 2017

1) Guidelines to Spot and Stop Abuse or Neglect of Children.

This guideline is for various professionals including Social Workers, Teachers, Police Officers and all Health Care Professionals. It identifies how we can spot the signs of abuse and how professionals should act when faced with these circumstances. These guidelines also include physical, mental and sexual abuse as well as new forms of abuse such as Female Genital Mutilation, Sexual Exploitation, Child Trafficking and Forced Marriages. There are soft signs and hard signs identified. There is a draft available for public comment.

2) Preventing Falls in Older People through Conversation.

A lot of patients have routine appointments with doctors at the hospital, GP surgery, or through visits by Social Workers. These can prevent falls by considering that in people aged over 65 we must regularly question whether our patients have had falls or have been unsteady on their feet recently. If they are deemed to be at risk then they should be referred to the appropriate service to assess and manage a plan to address their risk of falling.

3) NICE seeks to Improve Diagnosis and Treatment of Cerebral Palsy.

NICE first guideline on Cerebral Palsy aims to improve diagnosis and treatment across the country. Last year 192 of 209 CCG's did not have pathways for children with Cerebral Palsy but 114 did. The new guidelines focus on how to treat common problems such as saliva control, pain, mental health and communication issues. Recommendations include, recognising that parents and familiar carers have a key role in assessing pain, discomfort and distress in children with Cerebral Palsy and that children with delayed motor milestones should be referred to a Child Development Service for further assessment.

4) NICE seeks to support New Mother's with Mental Health Problems.

NICE is calling on General Practice staff to assess the mental health of women who have recently given birth as there are fears that some are left unsupported. Some symptoms of mental health problems such as changes in appetite and sleeping patterns may mask what is considered normal for pregnancy and post-natal women. There needs to be a routine 6 week post-natal appointment to provide the new opportunities for mother's to be asked about their mental health. It is estimated the one in eight women experience anxiety or depression whilst pregnant and one in five do so in the first year after child birth. The plan is for women to have referrals to Psychological Therapies within six weeks.

5) NICE's Relationship with the Life Sciences Industry.

NICE is continuing to work with the industry and the government to develop innovative approaches to evaluate new technologies such as the Ease Early Access to Medicine Scheme and the Reformed Cancer Drugs Fund. NICE has dedicated scientific advice program and the Office of Market have also created new opportunities to engage with the industry. NICE is reflecting on their relationship with the industry.

6) Targeted Interventions in Drug Misuse Prevention.

This guideline covers targeted interventions to prevent the misuse of drugs including illegal drugs, legal highs and prescription only medicines. It aims to prevent or delay the harmful use of drugs in children, young people or adults who are most likely to start using drugs or who are already experimenting or using drugs occasionally. The guidance does not cover broader activities at population level and those that aim to address wider determinants of health.

March 2017

1) NICE Guideline Flowchart into the Health of People in the Criminal Justice System.

This guideline covers assessing, diagnosing and managing mental health problems in adults aged 18 and over who are in contact with the Criminal Justice System. It aims to improve mental health and wellbeing in this population by establishing principles of assessment and management and promoting more co-ordinated care planning and service organisation across the Criminal Justice System. There is also a guideline on physical health of people in prison which covers mental health assessment of people going into prison and continuity of their mental health care when they are leaving. The recommendations include areas of:

1. Assessing and managing a person's mental health including assessing risks to themselves and others.
2. Planning their care.
3. Psychological and Pharmacological interventions.
4. Health Services organisation and staff training.

2) NICE Fast tracking more Drug Approvals.

Patients will benefit from access to the most cost effective treatment nearly five months faster after changes to the NICE drug evaluation process were approved. These changes will see the introduction of fast track options for appraising treatments which offer exceptional value for money which can be available a month after they are licenced. There are various other changes made which followed public consultation.

3) Burning the Bridge to Burn Out

Guidelines on Healthy Workplaces: Improving Employee Mental and Physical Health and Wellbeing.

There is a discussion about incorporating physical activity into the work place to improve mental wellbeing and reduce stress. We recommend that as doctor's that our patients engage in 30 minutes of physical activity five times a week to control their stress, however only one in

five doctors achieve this goal. There are NICE Guidelines on physical activity in the work place that highlight that people working in the NHS need to make minor changes to our daily routines to incorporate physical activity to start seeing the benefits. There are various guidelines advised. There are quality standards in the above mentioned guidelines which have been written to improve employee mental and physical health.

April 2017

1) Changes to NICE Drug Appraisals

The NHS is under unprecedented financial pressure so it is more important than ever to use the money effectively and fairly. The drugs and other treatments recommended by NICE and its Technology Appraisal Programme must be funded by the NHS by law. This is through the Funding Directive. Normally when Funding Directive is applied the NHS has 90 days to make the treatment available. Some of NICE's recommendations can cost the NHS tens of millions of pounds a year and the money has to be found regardless of other pressures and priorities. However, every pound spent means that it is not spent in other areas such as Mental Health Services or General Practice. There needs to be special arrangements put into place so that the NHS can manage the introduction of new drugs that does not impact unfairly on other services. NICE and NHS England are introducing this in two ways, the first is through negotiation to the other company to help reduce the budget impact and secondly if these negotiations cannot be resolved then there will be a phasing the cost of introducing the new treatment over a longer period.

2) HIV Testing should be Routine Practice.

There is a draft quality standard to improve the uptake of HIV testing amongst adults and young people who may have undiagnosed HIV. This would mean that they could have timely treatment and reduce the likelihood of onward transmission. The draft quality standards has a plan to reduce the burden of HIV.

3) Councils and Sexual Health Services to Consider Providing Free Condoms.

Condoms will be more readily available to reduce the rate of sexually transmitted infections. NICE recommends local authorities giving free condoms to people at high risk of getting STI's including those engaged in risky sexual activities for example having multiple having multiple partners or frequently changing partners. These condoms should be distributed through pharmacies, sexual health centres and universities as well as through health services.

4) Emerging Technology which Aims to Improve Muscle Movement is NICE's 100th Medtech Innovation Briefing.

A full body garment that aims to reduce spasticity which can occur in nerve cells which enable a person to control their limb movements that are damaged. Since the introduction in 2013 NICE Medtech Technology Innovation briefings have featured new and novel technology used in the most common care pathways. The objective is to give technology to help NHS and

Social Care Commissioners to consider using these. These briefings do not make recommendations on the use of technology.

5) Children Should Be Seen and Not Heard

There is an article against violence and abuse which recruited young people which led to NICE recommendations on guidance about how to identify warning signs and indicate if something is wrong. It is important that staff should make sure that children understand that they are being listened to and are comfortable. The care we provide is more likely to be effective when based on lessons learned in a real life situation and there will inform National Guidelines.

6) Alcohol Use Disorders Interactive Flow Chart.

This guidance covers care for adults and young people with physical health care problems that are completely or partially caused by an alcohol use disorder. The guideline includes recommendations on:

1. Acute alcohol withdrawal.
2. Wernicke's encephalopathy.
3. Alcohol related disease.
4. Alcohol related pancreatitis.

<u>June 2017:</u>

1) Measuring Quality of Life across Health and Social Care.

NICE is taking part in a project that will examine how quality of life measures are uses to evaluate health care treatment such as drugs which can be extended into social care and public health. This is a research project called "Extending the Quality Project", led by the School of Health and Related Research at the University of Sheffield. There are multiple collaborators in this.

2) New Programme Assessing how Digital Therapies Treat Anxiety and Depression.

Guided self-help which can track peoples mood and advise on breathing exercises as recommended by NICE to treat mild to moderate anxiety and depression. As part of IAPT, NICE had been asked to assess digital application or computer programmes which sit alongside face to face consultations, phone lines, and on-line therapies.

3) GP's Welcome NICE Behind Closed Doors.

NICE intends to make its guidelines better manageable for front line clinicians and the panel was set up to try and capture the voices of GP's on the ground (and not those in "Ivory Towers"). It is running a group around these issues.

4) Black, Asian and Other Minority Ethnic Groups: Promoting Health and Preventing Premature Mortality.

This guideline is in development and an update is expected.

5) Building Independence through Planning for a Transition.

A quick guide for practitioners supporting new people has been provided for young people and their families as transitioning from Children's to Adult Service can feel frustrating, confusing and difficult. The areas to consider in transition include:

1. Planning the transition from the age of 13 or 14 at the latest.
2. Providing a named practitioner a child can choose in a co-ordinating role. The named worker should be a Key Worker, Transitions Worker, Personal Advisor, Health Social Care or Education Practitioner, GP, Youth Worker, Allied Health Professional, or Nurse.
3. Transition plans will be part of education health and care planning.
4. Review and update the guideline news plans annually which can be done either in person or via teleconferencing video link or report to have a meeting to do this.
5. To consider preparing adulthood outcomes to help the young person set goals.

Dr Asha Mashru, Consultant Psychiatrist in Learning Disabilities, Leeds and York Partnership Foundation Trust (Previously Specialist Registrar in Learning Disabilities, Nottinghamshire Healthcare NHS Foundation Trust).