Winter Edition, 2024 | Issue 4

Psychiatry

The Northern and Yorkshire Division eNewsletter

Editorial

In this issue:

Welcome to the 2024 Winter edition of the RCPsych Northern and Yorkshire Division eNewsletter! I'd like to start by offering a special thank you to all the authors who took the time to write and send in their contributions; we were sorry not to be able to accept all of them. I'd also like to extend my gratitude to our division secretary Moinul Mannan and the rest of the RCPsych team working behind the scenes, without whom the newsletter and smooth organisation of our regional events would not be possible.

This edition has a variety of diverse articles including reflective pieces, audits, service evaluations and event reports from across the region! We start with Dr Nodiyal who writes an update on recent division activity in his role as Chair of our regional RCPsych Executive Committee. We hear from Dr Chaplin on her career changing learning disability placement and from Dr Hayes who has written a perceptive piece on psychedelics in the clinical setting. Medical student Francesca Best and Dr Dakroury present a service evaluation investigating a local perinatal service's referrals and attendance, and Dr Williams reflects on Erving Goffman's Betrayal Funnel in 'Psychiatry and Race, My Race...'.

Dr Appuhamy and colleagues audit lithium levels in bipolar disorder for those at risk of relapse, and Dr Bezzina and Dr Ramaswamy report on their ward-embedded case-based teaching programme to both educate and replenish empathy on acute inpatient wards. Dr Syed tells us about a successful Transcultural psychiatry workshop that they co-organised, and Dr Dempster and Dr Bretnall reflect on their experience of 'reimagining' the yearly Great Northern Summer Psychiatry School event.

It's been a delight to have the opportunity to edit this newsletter as part of my role as one of the region's Psychiatry Trainee Committee representatives. I've particularly enjoyed getting a sneak peek at all the different events organised by members across the region and it's been inspirational to see all the different ways colleagues have taken up opportunities to improve our local services for our patients.

Those who submit articles to our newsletter are entered for our best article prize. Congratulations to Dr Williams who is this edition's winner of the £100 prize with their insightful reflective article on 'Psychiatry and Race, My Race'.

Please submit articles for the summer edition of the N&Y Newsletter by 30th May 2025 to northernandyorkshire@rcpsych.ac.uk. We look forward to another packed edition next year!

Dr Emily Jackson, Editor, Northern & Yorkshire Division eNewsletter

Chair's Column

By Dr Sunil Nodiyal

Welcome to the latest edition of the newsletter for the Northern and Yorkshire Division. We had yet another successful academic year with several webinars and conferences that ran. We recently had a very successful Autumn conference titled "Triumphs Amidst Trials: A Local Showcase" on 27th September 2024, at the Holiday Inn, Scotch Corner, Darlington. This was a face-to-face event and I was delighted to see the full capacity crowd at the venue. There were excellent presentations from three different medical directors within the region and other showcases of available expertise in our division. Our division covers six mental health trusts and many private providers. The highlight of the event was about how local mental health services are coping and excelling despite ongoing service pressures and challenges. We also heard about regional specialist services for best practices in their areas (addictions psychiatry, neuropsychiatry and chronic fatigue services). I enjoyed attending the conference a lot and the feedback has been very good too.

We had an executive committee meeting at the venue the day before followed by the executive dinner which went down very well. This is something we would like to make a tradition. Please look at the division vacancies and join the executive committee to be involved not only in the day-to-day functioning but also fun events like executive dinners, conferences and benefit from specific discounted rates to attend events. It is a fantastic opportunity to be involved with the functioning of the division. Taking on a role in the division opens opportunities to take on further roles within the division or within the college nationally.

We had an online webinar of CTO practices where interesting and contrasting cases were discussed and very different approaches to managing them. This was followed by legal views from Helen Kingston who a lot of you may know if you have completed your S12 induction in the North East. It was very well received.

We (Dr Sumeet Gupta, our vice chair, Moinul Mannan, our divisional manager and I) have been meeting with some ICBs from our divisional area. One of them was North East and Cumbria ICB and the other one was West Yorkshire region ICB. The West Yorkshire ICB leads also attended our last executive meeting. The meetings were very good with productive discussions as to how the division can support the local ICBs in maintaining and improving standards in mental health. The leaders of ICBs shared their areas of concerns and where they may need support from the college as an expert body. We in turn offered our expertise from our membership and invited them to attend our executive meetings. We are hoping to have the North East and Cumbria ICB leads attend our executive meeting in the new year to have further discussions with us. We agreed to have regular meetings in the future to continue the exchange of ideas. We are hoping to meet all the ICBs operating in our divisional area to keep the channels of communications open and invitations have been sent to the remaining ICB leaders to meet with us.

We encourage you to check back regularly for updates and to engage with the content by commenting and sharing your thoughts. We also welcome contributions from members who wish to share their expertise, experiences, and perspectives on topics related to psychiatry and mental health care in our region.

In the new year, we are going to focus on mental health of women in a series of webinars. The first one in the series is Hormones and Women's Mental Health (PMDD) on Wednesday, 29th January 2025.

I must commend Dr Emily Jackson on the success of the autumn newsletter. We have received quite a few articles for publication and it was not possible to publish all of them. It's a fantastic opportunity to connect, learn, and share insights with colleagues so please do contribute to our newsletters and remember that there is a prize for the best article too.

Thank you for viewing our newsletter, and we look forward to connecting with you. I wish you all a merry Christmas and a very happy New Year.

Dr Sunil Nodiyal
Chair, Northern & Yorkshire Division

Northern & Yorkshire Autumn Conference Poster Winners

- Best Medical Student/FY1 Poster Prize: Dr Mays Al-Waeli
- Best FY2/Trainee Poster Prize: Dr Mehmet Zahit Serefoglu
- Best SAS Doctor Poster Prize: Dr Henrietta Emedo

New Northern & Yorkshire Division Members

- Dr Shaharyar Alikhan - Regional Specialty Representative, Rehab & Social
- Dr Gbolagade Akintomide - Regional Advisor, North East
- Dr Jennifer Gilligan - SAS Rep
- Dr Claire Lister - Regional Specialty Representative, General Adult
- Dr Ewa Young - Mentoring Lead
- Dr Theresa Ugalahi - Equity Champion
- Dr Murtaza Naqvi - Regional Specialty Representative, Child & Adolescent
- Dr Saman Ahmed - Academic Secretary

New Northern & Yorkshire Fellows

- Gbologade Akintomide
- Shaharyar Masood Alikhan
- Charlotte Deasy
- Rashmi Dixon
- Julie Hankin
- Uma Ruppa Geethanath
- Pratish Thakkar
- Rachel Voller

Northern & Yorkshire Division Vacancies

- Academic: Division-wide
- Child and Adolescent: North East region
- Eating Disorders: Division-wide
- General Adult (shared role): Division-wide
- Intellectual Disability: North East region
- Old Age (shared role): Division-wide
- Deputy Regional Advisor: North East/Yorkshire
- Workforce Lead
- Recruitment Lead

Psychedelics in the Clinical Setting: The Potential for Harm and the Promise of Healing

By Dr Caroline Hayes

The psychedelic renaissance is well underway, with hundreds of clinical trials currently looking into a plethora of different mental health conditions. I was a sub-investigator on a clinical trial researching a psychedelic study drug to treat depression, but I have since stepped back from psychedelic clinical trials due to personal ethical concerns about the way the field is evolving. Despite the seemingly boundless optimism for their potential as pharmacological treatments, there are a number of unique issues that psychedelics present in a clinical setting that are yet to be adequately addressed. I believe it is essential that these issues are rectified to minimize the potential harm to those desperately seeking relief from their mood symptoms.

Many subjects self-refer into trials having seen the extensive positive coverage in the lay media. Although this may help with recruitment, it can have a problematic effect on the data. Participants attend with a firm set of expectations about the study drug and the impact it will have, often pinning all their hopes on it alleviating symptoms that have caused suffering for many years. This creates an expectancy bias, which means that there is an inflated difference between the relative treatment effects of the active and the placebo arms[1]. This is not helped by the inherent difficulty in blinding psychedelics. This may have the overall effect of making the study drug seem more effective in the trial data than it may be in practice.

Furthermore, there is a striking lack of diversity amongst subjects partaking in psychedelic clinical trials. In the vast majority (70.6%) of psilocybin trials, 75% of participants were white[2], and have been described as 'Often mainly Caucasian, highly educated living in major urban centres with access to tertiary medical care.'[3]. The significance of this is that the promising results lauded by both the media and sponsors of clinical trials simply may not apply to a more diverse population. Additionally, this population does not necessarily reflect the population who are seen by secondary care psychiatry for treatment-resistant depression, a condition that is more prevalent amongst those of a lower socio-economic status[4]. Although lack of diversity in clinical trials is an issue in other fields, it is particularly pertinent to psychedelics, as psychedelic experiences can be both deeply personal and culturally specific[2]. We must also consider whether or not there is actually much interest in psychedelics as pharmacological treatments outside of this vocal demographic in the broader population, especially if they are not already participating in clinical trials.

Psychedelics present a challenge to clinicians trying to gain informed consent, one of the founding principles of research ethics; participants in clinical trials must have a full understanding of what it is they are agreeing to. The mystical experience that is often a part of the psychedelic experience, and in fact tied to more positive clinical outcomes[5], is where the complexity lies. The Mystical Experiences Questionnaire (MEQ30) is used in psychedelic clinical trials and boils this historically and culturally ubiquitous human experience down to four domains. These are a sense of unity with all that exists, a sense of sacredness, noetic quality, deeply felt positive mood, transcendence of time and space, and ineffability[6]. It is the ineffability, or inability to put the experience into words, that presents the issue. If I as the clinician consenting a participant cannot fully convey the backbone of the psychedelic experience in words, then how can I possibly get consent that meets the robust medico legal standard? Consent is even more of an issue in the clinical setting than in the naturalistic setting due to the asymmetry in the relationship between doctor and patient, and people who just want some relief from their symptoms are all too ready to accept something that they are told may help from someone in a position of trust.

Perhaps the most concerning issue bubbling to the surface is that of suicidality. In the recent Compass Pathways study looking at psilocybin for treatment-resistant depression, there were 3 patients in the group receiving the highest dose (n=79), 25mg, who reported suicidal behaviour and were classed as "non-responders" to treatment[7]. There was no suicidal behaviour in either the 1mg (n=79) or the 10mg (n=75) groups. This is concerning to see in subjects who have been heavily screened to minimise such outcomes, and we have to ask whether this rate would increase in an unscreened population? It is disingenuous to label these participants as "non-responders" as they have certainly responded to the study drug, just not in a positive manner. Was the "pearl of wisdom"[8] that the participants found during their journey too much to bear? It seems naïve to assume that new insights will always be helpful and easily integrated.
Even if participants feel that psychedelics have had a positive effect on their mental health, they may find that

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this effect is much more short-lived than they were led to believe. Good mental health isn't simply a headspace, but rather a lifestyle. Psychedelics aim to provide rapid relief of symptoms that may have been present in some for many years. This rapid change means that people may not have the time to make the lifestyle changes to maintain the positive impact, and so could return to being depressed relatively soon after. The process of getting better and unwell again quickly can be very traumatic and destabilising for participants, and begs the question as to whether it would have been less distressing to have had no intervention at all.

Psychedelics still have a long way to go before becoming licensed medications, and it remains to be seen whether they will live up to the brouhaha and find a role in psychiatric care. Upcoming phase three trials have a responsibility to address these issues to ensure minimal harm to research participants and potential future patients.

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Caroline Hayes
Senior Teaching Fellow, Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

My experience of the psychiatry of Learning Disability: an unexpected career goal

By Dr Emma Chaplin

As CT2 approached along with the training requirement to undertake a developmental rotation, I chose a learning disability post on little more than a recommendation from a colleague that it was a well-supported role. At that point I had thoughts of completing it and moving back to requesting general adult jobs in readiness for higher (general adult) training...

I was allocated to my chosen rotation which was within an adult community learning disability team. I had previously had very little experience of working with patients with an intellectual disability either during my CT1 year or as a Foundation Doctor where I can count on one hand the number of patients with an intellectual disability I had looked after in an acute setting. In short, I did not know what to expect.

I was lucky enough as a LTFT (Less Than Full Time) trainee to be granted the opportunity to spend a further six months in the post. After a year I was left sad to leave and with a well-formed plan to pursue higher training in the Psychiatry of Intellectual Disability. So, how did this turnaround happen?

In addition to a very well supported placement with a very welcoming team there were themes that really stood out for me.

Working with patients and their families – more than any of the other training roles I have had, this post enabled me to build strong relationships with both the patient and their relatives or (often long term) carers. This allowed for rich histories from those attuned to subtle changes in their relative's mental state. I found that if a patient could not tell me what was going on for them, I was able to get a very reliable description from their family or long-term carer. An example of this was a patient on my caseload who presented as very settled when I saw her yet was experiencing significant new onset nightmares and night wandering that she was unable to describe however her relative was able to paint a vivid picture of what was now occurring every night.

Communication can pose more challenges for people with a learning disability. I learned there are more ways than I thought to enhance and aid communication so that people are given the best opportunity to receive and understand information and thus partake in their own care. I have used the skills and knowledge from this in other areas of my practice, for instance using easy read documentation such as medication guides has helped in subsequent CAMHS work. Avoiding jargon and rephrasing have helped when working with patients for whom dementia affects their comprehension and understanding.

The MDT – if any rotation taught me about the expertise of the MDT it was this one. Without the help from our speech and language therapists I would not have got to the bottom of an unusual somatic presentation I had initially put down to a patient's anxiety which was in fact a dermatological complaint. We were able to arrange treatment for this via the GP and in turn reduce medication dose – something the STOMP (Stopping Over Medication of People with a learning disability and autistic people) campaign advocates.

Advocating – more than any other role, I have understood the importance of and need for advocating for my patients. I arranged investigations for suspected malignancy, I saw colleagues arrange emergency alternative accommodation on the same day of reviewing a patient and instigate urgent safeguarding processes when concerns were raised.

Working with uncertainty – I soon learned that there are a significant number of things that can present as a mental illness in people with an intellectual disability and how vital it is to systematically consider each possible cause. Pain, loneliness, grief, constipation, abuse, and more can present as depression, dementia, anxiety, or psychosis. I realised the importance of revisiting and reviewing a diagnosis regularly when a patient who appeared to be presenting with a dementia was experiencing abuse which transpired to be the cause of their symptoms.

My experience of the psychiatry of Learning Disability: an unexpected career goal

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Media coverage shows these events are still sadly occurring yet I hope that highlighting the need to consider all causes of a presentation may go towards enabling us as clinicians to recognise possible signs of abuse or to avoid prescribing psychotropics when other management strategies are more appropriate.

My message to anyone considering applying for a rotation in intellectual disabilities is to go for it – you may find you change your career goals, if not, you will certainly develop invaluable skills, and hopefully be better equipped to advocate for those with an intellectual disability.

Dr Emma Chaplin
Core Trainee, Cumbria, Tyne and Wear NHS Foundation Trust

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An Evaluation of Referrals and Attendance at a Perinatal Specialist Mental Health Service

By Francesca Best and Dr Menna Dakroury

Introduction

Perinatal mental health services cater to individuals experiencing mental health issues during the critical period of pregnancy planning, pregnancy itself, and up to one year postpartum. These services are crucial for providing timely support and care to promote both maternal and infant well-being.

The need for perinatal mental health services cannot be overstated. Suicide and other psychiatric conditions are leading causes of death between six weeks and one year postpartum. Research highlights that up to 90% of individuals stop taking prescribed mental health medication after discovering their pregnancy, often without professional guidance. This places them at risk of deteriorating mental health during a pivotal time in their lives.

Aims

This evaluation focused on one Perinatal Specialist Community Mental Health Service at Cumbria, Northumberland, Tyne and Wear (CNTW) NHS Foundation Trust for the period from 1st May to 30th July 2023 with the following aims:

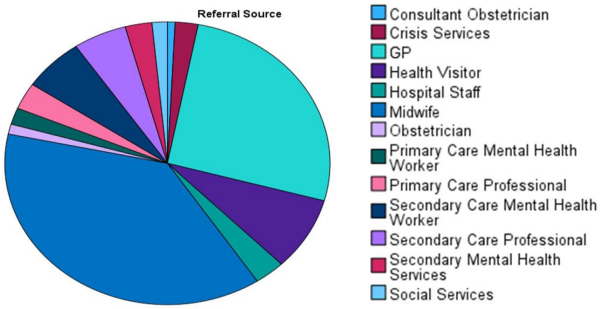
1. Breakdown the sources of referrals to the Perinatal Service
2. Calculate the waiting time from referral to an initial assessment
3. Analyse the Did Not Attend (DNA) rate for initial assessments
4. Suggest possible service improvements to cut down waiting times and DNA rates

Results

Referral Sources

The evaluation analysed 263 referrals made to the CNTW Perinatal Service between May and July 2023. The two largest referrer groups were:

- Midwives: 37.2% (100 referrals)
- General Practitioners (GPs): 26.2% (70 referrals)
- These findings underscore the significant role of midwives and GPs in identifying and referring individuals to specialist care.



Waiting Times

Timely care is a cornerstone of effective perinatal mental health services. However, the evaluation revealed:

- An average waiting time of 29.85 days from referral acceptance to assessment, which exceeds the Trust's two-week target.
- The longest recorded wait was 124 days.
- Emergency referrals were seen on the same day.
- Delays were often due to scheduling conflicts between the service and patients.

While the CNTW service fared better than some trusts with reported wait times of up to 319 days, these delays highlight a need for improvement to meet care standards.

An Evaluation of Referrals and Attendance at a Perinatal Specialist Mental Health Service

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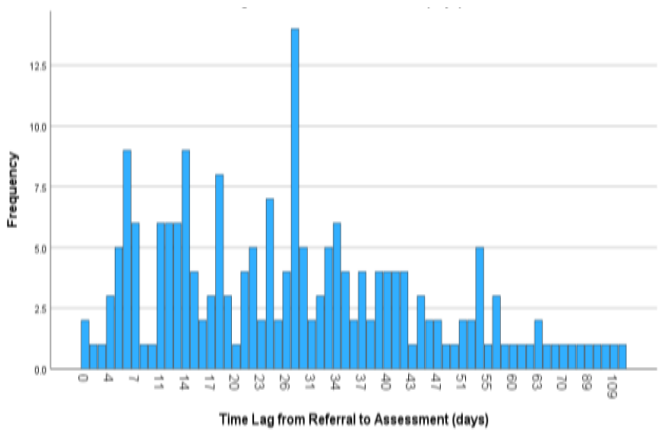

Non- Attendance (Did Not Attend (DNA)) Rates

Of the 201 patients offered assessments:

- 20 appointments (just under 10%) were not attended.
- Reasons for DNA included:

⇒ 6 withdrawals following miscarriage or a perception that specialist care was unnecessary.
⇒ 6 patients eventually attended after subsequent attempts.

- Barriers: Patients who DNA were more likely to have pre-existing mental health conditions and a history of domestic abuse (55% vs. 48% for those who attended on the first attempt).

Recommendations

Implement Tighter Guidelines for Referrals

The current referral criterion, "maternal mental health impacting on mother and baby," may capture mild cases that are more appropriate for primary care. A more stringent approach could reduce unnecessary referrals, but this must be balanced with ensuring adequate support for those who would benefit from secondary care.

Educate Referrers

Training programs for midwives, GPs, and other referrers can:

- Help differentiate cases requiring specialist care versus primary care.
- Potentially reduce unnecessary assessments and waiting times.

Tackle DNAs with a Multidimensional Approach

Strategies to reduce DNA rates include:

- Text Reminders: With 98.45% of patients agreeable to reminders, continuing their use is crucial.

- Home Appointments: Offering assessments at home can increase attendance for patients who may face logistical or psychological barriers.

- Collaboration: Working with healthcare professionals already trusted by patients can build rapport and encourage attendance.

Limitations and Future Research

The evaluation was limited to referrals made between May and July 2023, and follow-up attendance data was not included. Attendance at initial assessments, often conducted at home, may not reflect attendance rates for subsequent clinic-based appointments, suggesting that the DNA rate for the service as a whole could be underestimated. Missing or incomplete documentation also restricted the analysis.

Future Research

Building on this evaluation, future efforts should:

- Analyse follow-up appointment attendance to gain a holistic view of patient engagement.
- Provide additional training for referrers to enhance

An Evaluation of Referrals and Attendance at a Perinatal Specialist Mental Health Service

By Francesca Best and Dr Menna Dakroury

decision-making and monitor the impact on referral quality.

- Directly engage with patients who DNA to understand their barriers to attendance and identify targeted solutions.

Conclusion

Perinatal mental health services are vital for addressing the unique challenges faced by individuals during and after pregnancy. The CNTW evaluation highlights key areas for improvement, including reducing waiting times, refining referral processes, and addressing DNA rates. Implementing these changes can help ensure that patients receive timely, appropriate care, ultimately improving outcomes for mothers and their families.

Acknowledgement

This project was carried out by Medical Student Francesca Best under the supervision of Dr Menna Dakroury. Their collaborative effort underscores the importance of continuous evaluation and research in enhancing perinatal mental health care.

Francesca Best
Medical Student, Newcastle University

Dr Menna Dakroury
SAS Doctor, Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Psychiatry and race, my race...

By Dr Jordan Williams

Like many doctors around the world, some cases stick in our minds. One such patient has been the source of a feeling within me that I have struggled to shake. It raised a fundamental question about how I decide to practise psychiatry in the UK. How does race, specifically my race, interact with the patients I treat?

I am a black British man who was born and has lived in the UK all my life, born to mixed-race parents who were born to parents from around the world. Mostly the Caribbean, Africa and the UK. This is something I enjoy because, with such a diverse heritage, I feel incredibly British. Within NHS services we quite proudly boast about our diverse workforce. The NHS workforce Race Equality Standard published in March 2024 findings that this is the most diverse NHS workforce ever. Despite such progress within the workforce, we know there is still a large disparity in outcomes from Black, Asian and Minority Ethnic backgrounds.

My patient was a young black man suffering from a psychotic episode. He had been detained due to his vulnerability. He was outside shouting, approaching people he didn't know and confronting those who questioned his behaviour. He was unwell and at risk. This was not the first time he had been unwell. He had previously spent time in the general adult wards and the local psychiatric intensive care unit.

Once admitted he presented as guarded and suspicious of staff. Disagreeing with his diagnosis, detention and overall medication plan. He had given little information to admitting doctors overnight and largely declined to engage with the ward reviews. His behaviour outside of the ward reviews was concerning. He was responding to unseen stimuli and was largely hostile to staff. This was my first job as a core trainee, and I quickly realised he trusted me.

We built a rapport over the weeks, with him telling me more and more about his world. He allowed blood tests, examinations, and ECG and once, with my reassurance, took oral medication. He explained to me his mixed heritage, working-class roots and enjoyment of his local black community. We frequented the same takeaways, knew the same streets and enjoyed similar music. We were similar, in another world the roles could have easily been reversed. When taking a social history, unbeknownst to him, we had similar experiences in primary and secondary school. Explaining teachers had said he had 'so much potential but was too disruptive'. I had similar comments made about me and could see myself at 'parent's evenings' trying to gauge how my mum felt about such feedback. The information he told me helped our formulation by unveiling how unwell he really was.

On one of the ward rounds the decision was made for depot injection. He turned to me and asked me why 'they' were doing this. With a pang of guilt, I explained I thought he was unwell and was struggling to see how vulnerable he was. He disagreed, kissed his teeth, and left the review stating 'It's always your own'. A saying my father would often say when managing the frustrations of delivering letters and parcels around a busy city centre. I moved onto an old age community job, however out of hours when called to that ward I would often see him. He remained on the ward for many months after my departure.

Erving Goffman introduced the term 'Total institution' in the book Asylums published in 1961. In this book, he describes the process of institutionalisation, where a person is stripped of their individuality and forced into a system of control. Under the guise of 'best interests' the person becomes a patient, who is coerced into conformity. Although we are in the post-asylum era this process is still relevant today. Especially in the inpatient setting, where freedoms are often restricted depending largely on risk. They are then returned to the patient largely depending on how they 'behave'. The first stage of this process is called 'The Betrayal Funnel', Goffman explains that it is when those closest to the patient, whom they trust, conspire against them when they are unwell. They report this to people in positions of power and ultimately trigger the process of institutionalisation.

Perhaps my cultural knowledge and background helped me understand this patient and his experience. Was it this very knowledge that was used against him? What was

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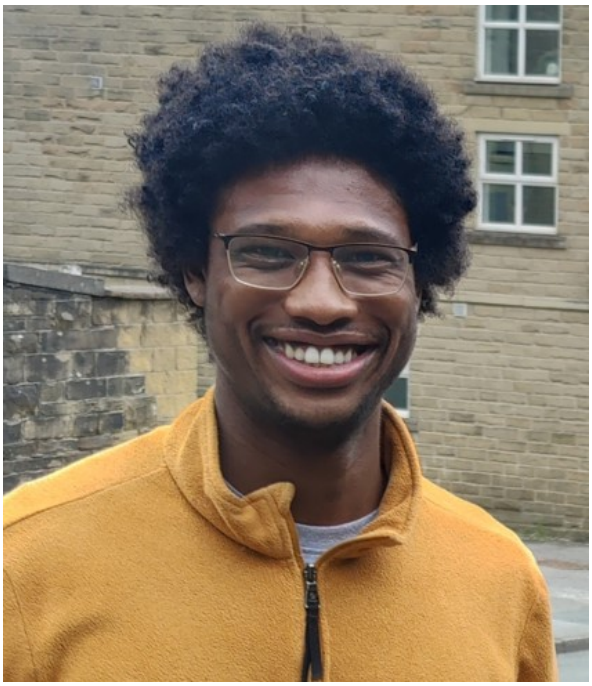
certain was, he felt familiar to me. Like a member of his family, thinking of Goffman's model, did I betray him?

With increasing diversity within the workforce, I hope this reduces some of the biases, racism, stigma and ultimately the inequalities that exist within our mental health system. During my time on that ward, I saw fantastic examples of care that was sensitive, empathetic and holistic. This detention and enforced treatment under the Mental Health Act were truly in this patient's best interest. But this is the point Goffman made; it is with the intent to help that the patient is betrayed. So, in many ways, I do not feel different from those Goffman described over 60 years ago. Does this diverse workforce increase its ability to understand and treat the diverse population that it serves? Or does it provide an 'in' allowing the institutions to function as a restrictive force, as it always has, but cast a wider net? I feel it's the former, I believe psychiatry is improving the lives of many. I am of the opinion that a diverse workforce is best placed to serve a diverse population. But if this is the case, we all may one day be traitors and perhaps my dad was right, it will always be 'your own'.



Dr Jordan Williams
Core Trainee, Leeds and York Partnership NHS Foundation Trust

Mind Ed

MindEd is a free online educational resource covering mental health for young people, adults and older people.

With three quarters of adult mental disorders in evidence by the age of 21, effective early intervention can be essential in preventing the development of ill health and disability.

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Are patients with bipolar disorder being optimally managed with lithium in the Tees, Esk and Wear Valleys NHS trust?

By Kavindu Appuhamy, Anthony Barlow, Tolu Balogun, Muhammad Hannan, Sumeet Gupta

Background and aims

The long-term management of bipolar involves preventing relapses and maintaining stabilisation in mood. In clinical practice, National Institute for Health and Clinical Excellence (NICE) support lithium as the first line treatment for the prophylaxis of bipolar disorder due to its relative efficacy. Its efficacy is dose related but higher doses are associated with side effects and toxicity , which may explain the reluctance of some clinicians to initiate Lithium or to consider aiming for a slightly higher serum lithium level.
We aimed to collate the serum lithium levels of patients with bipolar disorder in various adult mental health teams across the Tees, Esk and Wear Valleys (TEWV) trust. By doing so we hoped to gain a useful insight into the current prescribing practices of lithium in TEWV and whether optimal dosing is being achieved for those most at risk of relapse, as per national and trust guidelines.

Current standards

NICE guidelines currently stipulate that for Lithium-naïve patients, clinicians should aim to maintain a Lithium serum level between 0.60-0.80 mmol/L, however for patients who have relapsed whilst taking Lithium a higher range of 0.80-1.0 mmol/L should be considered. This guidance is also mirrored by the TEWV trust policy. From our daily practice, we did not feel that many patients were within the higher serum lithium range and so we aimed to identify if this clinical standard was being met across the trust.

Methodology

A team of four resident doctors collated data on a sample size of 150 adults with bipolar disorder across 18 adult mental health teams covering all the regions in the trust. Using the lithium register we were able to find the most recent serum lithium level of each patient and then based on the patient's clinical history we determined which serum lithium range would be most clinically appropriate. As "relapse" was considered quite a vague term, we used admissions (both informal and formal) or documented signs and symptoms consistent with relapse as a proxy for this. Evidence of relapse on lithium was only searched in a period over the past 12 months as it was not considered feasible to look through each patient's whole history. We also reviewed the discharge summaries from patients who had inpatient admissions in the past 12 months to determine if their lithium dose had been increased.

Results

We found that the most common serum lithium level was between 0.63-0.72, with nearly 50 patients having a serum lithium level within this range. Only one patient had a serum lithium level over 1.0 mmol/L. We also found that patients in the >65 age group had the greatest proportion of patients in the therapeutic range, contrary to our hypothesis as we felt that the complexity of increased comorbidities would have made it more difficult to manage this condition.

Out of 150 patients, 118 had not experienced a relapse in the past 12 months, and 32 did. From the patients with no relapse, 79% had their serum lithium level within the target range of 0.60-0.80 mmol/L. However, only 16% of patients who had experienced relapse had a serum lithium level in the range of 0.80-1.0 mmol/L. From our further analysis we also identified that only 45% of patients who had an inpatient admission due to relapse of their bipolar disorder had their lithium dose increased during their inpatient stay.

Discussion

Our results show that we seem to be more comfortable with maintaining patients in lower lithium target ranges than higher ranges. We believe this is partly due to the well documented narrow therapeutic index of lithium and the potential for lithium toxicity. However, we would argue that utilising lithium to its maximum potential is important as it is widely regarded as the most effective long-term treatment for bipolar disorder and has the potential to reduce relapse rates and the distress it can cause to patients, families, and carers in the community.

During our patient record searches we also identified that documentation of lithium dose changes and most recent lithium levels in discharge summaries was generally poor. This lack of clear communication may put patients at risk upon discharge as community teams would be unaware of any important changes that may have been made.

One important factor to consider is that some patients are non-compliant with their medication which can often lead

Are patients with bipolar disorder being optimally managed with lithium in the Tees, Esk and Wear Valleys NHS trust?

By Kavindu Appuhamy, Anthony Barlow, Tolu Balogun, Muhammad Hannan, Sumeet Gupta

to relapse, in these cases higher dose titration of lithium would not be considered appropriate as their relapse would not have occurred due to lithium resistance.

Future actions

We have disseminated our findings with the trust's drug and therapeutics committee, and as a result, we have updated the medication safety series document for all resident doctors to improve documentation of lithium dose changes in discharge summaries and also reminds clinical teams to consider the question of whether a higher dose of lithium would be clinically appropriate. In conjunction with the chief pharmacist, we have also updated the regional shared care guidelines across the trust, reminding all clinicians of the higher target ranges that should be considered for all patients who have relapsed. We also plan to carry out another audit cycle in spring 2024, to determine if the changes we have implemented has led to an improvement in adherence to the clinical standards.

Conclusion

We appreciate there is a fine balance to strike with maintaining a therapeutic dose of lithium and ensuring the safety of the patient, but we hope this audit will showcase that more awareness around the recommended higher target ranges for the most at-risk patients is required.

Dr Kavindu Appuhamy
Core Trainee, Tees, Esk and Wear Valleys NHS Foundation Trust

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An Interprofessional Case Based Teaching Programme for the Multidisciplinary Team of an Acute Adult Psychiatric Ward

By Dr Oriana Bezzina and Dr Venkatraghavan Ramaswamy

Background

Working on an inpatient psychiatric ward can be both rewarding and challenging. The most unwell and complex patients are admitted, requiring multidisciplinary (MDT) care and support. Patients have often been through significant adverse life events, have suicidal, self-harm and challenging behaviours. Staff working on psychiatric wards therefore face unique challenges in terms of acuity, complexity, exposure to violence, suicide and self-harm and a demand for quick turnovers. Staff experience high levels of stress and burnout, which can impact compassion [1].

Colleague support, improving the understanding of patients, and accessing a reflective space can help support the restoration of compassion, improve job satisfaction, positive attitudes, and staff wellbeing [2,3]; factors which are all linked to better patient outcomes and care.

An interprofessional educational intervention utilising a case-based teaching style was introduced to the multidisciplinary team of two acute adult inpatient wards with the aim to improve patient understanding and team dynamics by providing protected time for reflection, learning and social collaboration between MDT professionals.

The Educational Intervention

The intervention involved a monthly 90-minute teaching session for a period of 7 months. All members of the MDT were invited. Sessions were generally led by 2-3 members of the MDT from different professional backgrounds e.g. resident doctor, psychologist, and pharmacist. The two main components of the sessions were:

1. A Case Presentation on an inpatient admitted to the male or female ward, alternating each month. 20-30 minutes followed by 15 minutes of discussion/ reflection.
2. A Topic Presentation on an important aspect linked to the case. 20-30 minutes followed by 15 minutes of discussion/reflection.

Figure 1 summarises the timetable including the different topics and professionals who led the case and topic presentations for each session. Attendees could attend face-to-face in a meeting room or online via MS Teams.

Programme Timetable

Date	Case Presentation	Linked Topic Presentation	Topic
31st Jan 24	ST5 Doctor	Psychology Team	Over and under control personality
20th Mar 24	F2 Doctor	F1 Doctor & Advanced Physical Nurse Practitioner	Diabetes & MCA
10th Apr 24	Consultant Psychiatrist	Consultant Psychiatrist	Eating Disorders
24th Apr 24	F1 Doctor	SALT	Autism
26th June 24	CT1 – Audit presentation	Pharmacist & Psychologist	Hypnotic Medication & Sleep Hygiene
3rd Jul 24	Humankind	Humankind	Alcohol & Substance Misuse
31st Jul 24	ST5 doctor	Occupational Therapy	OT Assessment
August Break			
NB: the original times of two sessions (Feb & May) had to be rescheduled due to resident doctors strikes and/or clinical acuity/low staffing which is why there were 2 sessions in Apil and July			

Figure 1 Programme timetable

Feedback & Analysis

Feedback was collected anonymously on paper forms for each session except the session led by the eating disorders consultant. Forms were sent by email to those who attended online. This included Likert and free-text questions on the teaching content, style, quality, relevance, and value of sessions. A feedback form regarding the whole teaching programme was given out following the final session in July. Presenters were sent a separate feedback form at the end of the 7 months to gain understanding of their experiences presenting and leading sessions with different colleagues. Likert items were analysed using Microsoft Excel and a basic thematic analysis was undertaken for open text questions.

Attendee Feedback

The average number of face-to-face attendees was 13 (range 7–16) and on MS Teams was 3.4 (range 0–7). Attendees included resident doctors, consultant psychiatrists, nursing staff, physical health nurse practitioners, psychologists, pharmacists, occupational therapists, support workers, activity coordinators and SALT.

Results from the Likert questions are summarised in tables 1 and 2.

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Table 1 Summary of results from the Likert measures on the feedback forms for individual sessions. Likert scale – 10 "extremely useful" and 0, "not at all useful".

Criteria	Over & Under Controlled	Diabetes & MCA	Autism	Hypnotic medication & sleep hygiene	Alcohol & Substance Misuse	OT Assessment
Usefulness	9.8	9.8	9.7	9.6	9.7	9.8
Content & relevance	9.7	9.9	9.8	9.6	9.7	9.8
Teaching skill	9.9	9.8	9.8	9.5	9.7	9.8
Overall	9.8	9.8	9.8	9.5	9.7	9.8
Do you feel more confident?	100% yes	75% Yes 7% unsure 17% did not answer	100% Yes	100% Yes	100% Yes	100% Yes

Table 2 Overall Teaching Programme feedback (10 – extremely valuable/easy, 0 – not at all valuable/easy)

Survey question	
How valuable have you found the teaching programme?	9.9
How easy have you found it to attend the monthly teaching?	7.5
Should the teaching programme continue?	100% Yes

Five main themes were identified from the open text questions:

Accessibility

Attendees found it beneficial to have access to CPD during the working day which was integrated within ward practice.

The sessions were open to the whole MDT which attendees reflected positively on. There were difficulties for some staff members to attend sessions. There was consistently a limited number of consultants and nursing colleagues who could attend. Overall, attendees felt that the frequency and length of sessions was adequate.

Shared perspectives

The sessions gave attendees an opportunity to "hear different professional viewpoints" and "share experiences with colleagues" in a safe and reflective environment.

Understanding roles of the MDT

Attendees commented that the sessions improved their "understanding of colleagues' roles".

Case focussed and reflection

Attendees found the cases useful to "improve empathy" and "understanding of complex patients".

Team building

"Getting to know the team better" in an informal educational setting improved professional relationships for some attendees.

Presenter feedback (n = 7)

Presenters found it *easy* or *very easy* and *very* or *extremely valuable* being paired with MDT colleagues. They highlighted benefits associated with improved MDT relationships and teamwork in addition to helping improve understanding of different viewpoints to cases and roles. All presenters found the experience *very or extremely valuable* overall and they all would recommend presenting to other colleagues. Presenters highlighted the importance of having protected time to prepare and deliver the teaching.

Method Limitations

The feedback was only completed by those who attended the sessions and there will be a level of responder bias. Feedback was not obtained from those who did not attend; this is an aspect which can be explored further. Formal quantitative measures such as specific rating scales were not used.

Conclusions

Effective interprofessional collaboration can be a key mechanism for tackling poor-quality service delivery, improving patient safety, help shape professional behaviour and develop effective teams. It focuses on social theories of learning through experience or reflection [4]. Case-based learning has also been shown to improve teamwork and patient outcomes whilst enhancing clinical knowledge, skills, and practice behaviour. Using a case as the basis of learning helps provide relevance as well as an opportunity to reflect on the complexities of patient care [5].

Attendees of our programme were able to discuss and reflect on cases with colleagues, sharing experiences and learning from one another. Attendees found it beneficial discussing challenging and complex cases, improving their understanding of patients' issues, and enhancing

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empathy. The sessions were also led by the MDT allowing attendees to better understand people's roles and an appreciation for different professional viewpoints. Some attendees identified a benefit in team building and professional relationships.

From experience and review of the literature, although local teaching/training exists within professional silos, there is a lack of regular interprofessional training integrated within the psychiatric inpatient routine/culture. This interprofessional case-based teaching programme was successfully integrated within the acute psychiatric inpatient setting. Further adaptations need to be considered to improve attendance of the wider MDT, particularly for nursing. It would be useful for objective measures to be integrated within future research design to objectively measure changes in compassion, empathy, burn-out and teamwork.

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Transcultural Workshop

By Dr Mahira Syed

I was honoured to be part of the organizing committee for the Transcultural Psychiatry Workshop that was held on 4th September 2024 at the Tapton Hall. It was part of the Sheffield Health and Social Care Trust's monthly Grand Teaching Rounds. This face-to-face event was an evolution of the successful Applied Transcultural Session, which was conducted online during the COVID-19 pandemic at the Leeds and York Partnership NHS Foundation Trust. While the online session laid the groundwork for conversations around transcultural psychiatry, this in-person workshop allowed for more interactive and immersive engagement, fostering deeper understanding and collaboration between professionals and organisations.

The Growing Importance of Transcultural Psychiatry in the changing world

Transcultural psychiatry explores the impact of cultural, ethnic, and societal factors on mental health and illness, acknowledging that culture profoundly influences how individuals experience, express, and cope with psychological challenges. By integrating cultural awareness into clinical practice, transcultural psychiatry seeks to address healthcare disparities and improve outcomes, especially for ethnically diverse communities. The workshop aimed to build a culturally competent workforce that understands and addresses the nuanced mental health needs of marginalised populations in the United Kingdom.

The organizing team included Dr Nazish Hashmi (Consultant Perinatal Psychiatrist, Leeds and York Partnership NHS Foundation Trust), Dr Christiana Elish Aboh (Consultant Psychiatrist Tees, Esk and Wear Valleys NHS Foundation Trust), and Wendy Tangen (Inclusion Lead at Leeds and York Partnership NHS Foundation Trust), alongside me and Dr Khadeeja Ansar as General Adult Psychiatry Higher trainees in West Yorkshire. Dr Seonaid Beaumont, a Dual Higher trainee in General Adult and Old Age Psychiatry at Sheffield Health and Social Care Trust, played an integral role in the planning and coordination of all presentations, contributing significantly to the success of the workshop.

Crafting the Workshop Theme

To ensure the workshop met the needs of its audience, an online survey was circulated among prospective participants weeks in advance. The survey aimed to gauge the audience's understanding of the importance of cultural competence in healthcare, identify knowledge gaps and areas of interest to tailor the workshop content. Findings from the survey informed the selection of specialist panel members and speakers, ensuring their expertise aligned with the audience's needs. The resulting theme emphasized the necessity of developing a culturally competent workforce while addressing systemic gaps in understanding and resources.

Highlights of the Workshop

The 120-minute workshop was attended by over 100 medical professionals mainly from South Yorkshire. The agenda was thoughtfully designed to combine theoretical insights, practical examples, and interactive discussions.

The workshop began with a compelling presentation by Dr Christiana Elish Aboh, who highlighted how ethnic minorities often face marginalisation in healthcare access. She provided a data-driven overview of the disparities and underscored the importance of adopting a culturally competent approach in mental health services.

A panel of distinguished professionals shared their experiences and perspectives:

- A Consultant Psychiatrist based at the Psychiatric intensive care unit
- A Chaplain, offering insights into the intersection of spirituality and mental health.
- A GP and community leader, representing a local ethnic community.
- An Expert by experience who is also a mental health nurse, sharing personal encounters with the healthcare system.

Each panellist discussed how cultural factors influenced mental health care delivery and outcomes, shedding light on both challenges and opportunities.

Several presentations showcased local resources and initiatives designed to address cultural disparities in mental health care. Dr Abdul Rob, GP and CEO of the Pakistani Muslim Centre, spoke about the 'Being There

Transcultural Workshop

By Dr Mahira Syed

Project'. This is a collaboration between the Pakistan Muslim Community and the Sheffield Health and Social Care NHS Foundation Trust. This project provides culturally sensitive mental health support and exemplifies how partnership and compassion can transform lives within diverse communities. Melissa Simmonds, Community Network Leader at Sheffield Health and Social Care Foundation Trust, presented on the Patient and Carer Race Equality Framework (PCREF), an anti-racism initiative by NHS England. PCREF mandates NHS mental health trusts to co-produce and implement actions aimed at reducing racial inequalities in care.

Participants then engaged in small group-based discussions centred on the case scenarios. These discussions encouraged the practical application of transcultural principles, enabling participants to brainstorm real-world challenges and develop culturally informed approaches.

Pre- and Post-Workshop Surveys

To evaluate the workshop's impact, participants completed surveys before and after the event. These surveys provided valuable insights into the workshop's effectiveness and informed recommendations for future sessions.

Impact and Feedback

The workshop was met with overwhelmingly positive feedback. Participants appreciated the diverse panel composition, which included perspectives from a Psychiatrist, Primary care professional, Chaplaincy, and Experts by experience. This multidisciplinary approach enriched the discussion and underscored the workshop's relevance.

- Awareness of transcultural issues rated as 'above average' rose from 15% pre-workshop to 60% post-workshop.
- Knowledge of internal and external resources improved significantly, with 'above average' ratings increasing from 4% to 52%.

Participants expressed further interest in exploring 'culture bound syndromes, cultural considerations in old age psychiatry and understanding of various cultural terminologies' in the future workshops.

Dissemination and Future Plans

The success of the workshop has set the stage for broader dissemination of its findings. Future steps will include sharing insights and data with other NHS Trusts to inspire similar initiatives, submitting presentations to regional and national conferences to raise awareness and drive policy changes, and organising follow-up sessions based on participant feedback to address emerging needs in transcultural psychiatry.

To extend the impact of this workshop, we presented a poster summarising its outcomes at the International Medical Graduates Conference 2024, held on 9th October 2024. This conference, jointly organized by NHSE and Bradford District Care NHS Foundation Trust, provided a platform to showcase our work to a wider audience.

This workshop exemplifies how collaboration, cultural awareness, and dedicated planning can drive meaningful change in healthcare. By fostering a deeper understanding of transcultural psychiatry, we ensure we take a significant step toward building a more inclusive and equitable mental health system.

Dr Mahira Syed
Higher Trainee, General Adult Psychiatry, Bradford District Care NHS Foundation Trust

An Amateur's Guide to Reimagination: Reflections on the year's Summer School

By Dr Ben Dempster and Dr Grace Bretnall

Following our report in the summer newsletter, where we described the evolution of this year's summer school, we thought it interesting to write up our reflections after the event, now we've had time to process it.

While there was no question in our minds initially of our need to evolve, we were acutely aware of the lack of experience and resourcing of our team, which at the time, consisted of just the two of us. Looming over us was the shadow of three highly successful years and the easy temptation in front of us to say "*don't fix what isn't broken*". The temptation was made greater still when one considered the scale of the challenge in front of us. Nevertheless, we backed our instinct and felt we needed to change. We were keenly aware of the world's, and our, fatigue with online-only events and formats since Covid. Indeed, our feedback from previous years had reflected this precise principle. A necessity at the time, it had become apparent the world was itching to move away from this. Accordingly, we took the daunting but crucial decision to evolve in response- we simply had to create face-to-face content for our delegates.

So then, what do we change? We were anxious at redesigning a well-defined format, and were conscious to make it a year of evolution, not demolition. We were wary of offending by implication the founding members. Optimistic, and now weighed down with the enormity of this, we began with an inspiration – a conference we had been to at the Royal College in London. We were keen to emulate its format, networking, energy and most importantly, that it was in person. A good starting point.

We felt the next most rational thing to do was make a wish list, and we tried to not let our ambition be limited by practicalities – that would come later. Our starting point was a full in-person three day event, which was quickly identified as unfeasible. Too hard, too expensive, too ambitious.

Next, we considered a hybrid event, let people choose to attend in person or online. A rational and sobering discussion with previous presidents marked this out as unrealistic – would anyone really come? I suppose therein was born our greatest fear – nobody showing up. We had run into practical and technological challenges on this score too. The world was not set up for hybrid working.

So, if not that, then how about another type of hybrid? We settled on two days online, with an optional third in-person day. This was all very well, but the next problem was what to do with this day. Are we evolving for evolution's sake? A central idea that had stuck with us had been an experiential day describing life as a trainee. After all, we were trying to promote that very ambition, weren't we? This turned out to be crucial and defining for us, though we didn't know it at the time. We learnt then that evolution is only so important as it is in service of the final goal – this experiential day would be our mission. But what experience?

In turns out life as a psychiatric trainee is difficult to summarise. The experiences are so varied. While there were obvious areas to focus on – simulations, applications – we were aware of the need to give a *realistic* insight, and that meant dealing with difficult topics too. So, as we have learnt, if in doubt, simplify, and emulate what you have seen elsewhere. How do we as trainees process difficult situations? Of course! Balint group. Why not have them experience that? After some discussions, we managed to book the real local Balint leaders for the day, and had a trainee present a "real" case to the delegates. The feedback for this has been exceptional.

While our experiential day shaped up well: Balint group, talks and tours, Stephen Fry, simulation sessions, it did leave us with a problem. We had three days' worth of speakers from last year, and only two days to accommodate them. Applying the copycat principle we had started off with, we now felt we had the confidence to rip up the format for the talks too. Feedback had suggested they were too long, and people struggled to

An Amateur's Guide to Reimagination: Reflections on the year's Summer School

By Dr Ben Dempster and Dr Grace Bretnall

maintain attention. Data from attendance suggested a slump in the afternoon. The aforementioned inspiring conference experience utilised a plenary system, with talks no more than 35 minutes. An author with even the most limited attention span managed to sit through that. Using that, we were able to rework the sessions, grouping them thematically and shortening their presentations. This allowed us to introduce a Q&A at the end. All of this went down very well, and we were pleased to receive the heart-warming feedback we craved. Our attendance data even improved too. Better yet, we had avoided the agonising conversation of not inviting a speaker back for this year. At the start of this journey, we would never have had the confidence to do that, and yet here we were.

The last lesson this edition has taught us, as they say in these parts, was that *shy bairns get nowt*. The much-remarked interview with Stephen Fry exemplifies this, and we are often asked how we achieved it. The answer is very simple – don't be shy, ask. Write a letter. Send an email. Knock on a door. You would be surprised at the answers you might get.

So, overall, what did we learn? Not to be afraid to put our stamp on something, you got to that position for a reason. Evolution for its own sake is pointless, but with direction it can be incredibly rewarding. Taking a risk can make it all the better. And lastly, huge tasks are made little by breaking it down, keeping it simple, and drawing parallels with your experience. You can achieve more than you think.

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International Medical Graduates

The Royal College of Psychiatrists is keen to support International Medical Graduates (IMGs) who choose to follow a career in psychiatry in the UK.

RCPsych have produced a guide for International Medical Graduates pursuing a career in psychiatry in the UK. The guide provides a comprehensive overview of working, training and living in the UK as a psychiatrist.

A Guide to Living and Working in the UK for International Medical Graduates

Northern & Yorkshire Division Autumn Conference 2024

By Dr Sumeet Gupta

This year, our autumn conference occurred on 27th September 2024 at the Holiday Inn, Scotch Corner, Darlington. Our focus was on local development and expertise. The morning session addressed recent challenges and developments in local mental health trusts. We heard from Dr Christian Hosker and his colleagues, Professor Graeme Martin and Richard Wylde, from the Leeds and York Partnership NHS Foundation Trust, who discussed the medical engagement work within their trust. Professor Subha Thiagesh from Southwest Yorkshire Partnership NHS Foundation Trust shared the difficulties faced by their trust and how their leadership team managed these challenges. Dr Kedar Kale from Tees, Esk and Wear Valleys NHS Foundation Trust provided a brilliant outline of the trust and highlighted their fantastic work. Unfortunately, the other three mental health trusts in our area could not send representatives, but we hope to hear from them soon.

The divisional executive committee is eager to foster more collaboration among psychiatrists working in different trusts, including the private sector. The morning session made it clear that many of the challenges faced by various mental health trusts are similar, and we hope that effective collaboration will benefit everyone.

The afternoon focused on clinical topics. Dr Ankush Vidyarthi, Consultant Liaison Psychiatrist and Clinical Lead for the Leeds Liaison Psychiatry Service, gave a fantastic overview of chronic fatigue syndrome, including the controversies surrounding its diagnosis and management. As most mental health trusts are no longer providing addiction services in most areas, we have lost knowledge and skills in managing alcohol and substance abuse disorders. Dr Soraya Mayet, Consultant Addictions Psychiatrist at Humber Teaching NHS Foundation Trust, updated us on managing these disorders and recent developments. Lastly, Dr Suresh Komati, Consultant Neuropsychiatrist at Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust, provided an excellent overview of neuropsychiatric services, especially dissociative and functional neurological disorders. He was able to explain complex neuronal circuits straightforwardly.

Ninety people attended the conference, which also featured over twenty outstanding posters. Overall, the conference offered an exceptional and rare networking opportunity. We invite members to suggest topics for future webinars and conferences.

Dr Sumeet Gupta
Vice Chair, Northern & Yorkshire Division

Upcoming Northern & Yorkshire Events 2025

Wednesday 29 January 2025
Premenstrual Dysphoric Disorder (PMDD) - The Psychiatrist's Perspective and Lived Experience
(Online)

Friday 28 March 2025
Spring Conference
(Online)

Friday 4 April 2025
Perinatal Psychiatry Update
(Online)

TBC September 2025
Autumn Conference
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The Northern & Yorkshire Division is made up of members from areas including Leeds, York, Bradford, Cumbria, Tyne & Wear and Gateshead.

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

Northern & Yorkshire Division Vacancies

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

Regional Representatives

- Academic: Division-wide
- Child and Adolescent: North East region
- Eating Disorders: Division-wide
- General Adult (shared role): North East region
- Intellectual Disability: North East region
- Old age (shared role): Division-wide

Regional/Deputy Regional Advisor

- Deputy Regional Advisor (North East and Yorkshire regions)

Executive Committee

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

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Deadline for next edition
Submit your articles for Summer edition by 30 May 2025 to northernandyorkshire@rcpsych.ac.uk

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