

Royal College of Psychiatrists

# Psychiatry-East

## The Eastern Division e-Newsletter

*Merry Christmas*



## Editorial

"Winter is coming", this to all of us heralds a time of festivity, cheer and time with friends and family. Apart from the Game of Throne fans of course, where it sets a very ominous tone!

In this edition there is something for everyone. We have Dr Niaz giving some top tips to the junior trainees on how to get what might seem the very elusive, letters of MRCPSych, after one's name.

Dr Malipatil, has shared his journey of the innovative development practice adopted for SAS doctors in his Trust, which we hope will inspire some fellow colleagues.

Dr Shardlow gives her perspective of what works and what works not as a part time employee.

Verity Chester and Dr Alexander share their pearls of wisdom on the ever vexing issue of outcomes for patients with intellectual disability in secure settings.

Dr Pushpanathan gives us a report on the successful Eastern Division conference held recently.

As always, as a perennial theme, the Chair of the Division, Dr Raoof gives us an update on the last six months. A

big thank you to all of our contributors. I hope you all enjoy reading this edition. If you are interested to submit to the news letter we would love to hear from you. Research, audits, innovative practice, reflective learning, challenges, a moan... we are all ears and eyes.

The list is by no means exhaustive and if there is something you are unsure of feel free to drop a line and we can discuss this further. Your feedback and suggestions are valued, so please do get in touch with your ideas and proposals on how to improve the newsletter.

I end on the note, literally "wish you a Merry Christmas and a Happy New Year.... good tidings for Christmas and a Happy New Year...!" Sing along!



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**Dr Indermeet Sawhney, Editor, Psychiatry East**



# Chair's Column

By Dr Abdul Raoof

Hi Colleagues,

I am sure all of you will agree that 2017 was an eventful year on all fronts!

The NHS was in the news throughout the year and none of us would have failed to notice how mental health has attracted public attention and shot up on the list of political priorities. Our College has done well to attract and sustain media attention.

The challenge for us in the New Year is to contribute positively to translate this into tangible improvements in the care our patients receive.

As the services in our region are trying to come to terms with the changing NHS landscape and new structures like STPs, it is incumbent up on us to inform and influence the process through active clinical engagement and leadership. We need to be armed with relevant information and data to be effective. The College is committed to work with patients, carers and all mental health professionals to achieve this goal. In the Eastern Division, this year we have strengthened patient/carer representation in our [Executive Committee](#). We also had three trainee representatives joining the committee in 2017. As we welcome these new members I am sure they will bring in a lot of expertise, new ideas, enthusiasm and energy!

The Division Executive committee is keen to hear from members and affiliates of all grades in the region about what is happening in the front line and how best the College can support and disseminate relevant information and advice to our colleagues. Please email me your suggestions: [a.raoof@nhs.net](mailto:a.raoof@nhs.net)

I was particularly pleased to see the high number of Foundation Year doctors who attended our spring and autumn conferences. It would have been nice to see a higher number of psychiatry trainees. Our Academic Secretary Dr Kallur Suresh would be delighted to hear your ideas on how we can make our conferences more relevant to trainees and other colleagues.

The recent [census by the College](#), the [HEE data](#) and the [Mental Health Workforce Plan](#) highlight recruitment challenges we face. Please click on the links to see the details and figures for East of England. We really need to do our best to make East of England the preferred destination for our trainees by improving trainee experience and quality of their training and supervision. The College has launched a new [web page to help and support IMGs \(International Medical Graduates\)](#) and their supervisors.

The College has multiple initiatives to promote psychiatry as a career. [CLICK HERE](#) to read about them and how you can contribute

Let me take this opportunity to thank each one of you personally for your contribution towards College activities throughout the year despite busy clinical commitments. I know that many of you have given up your personal and family time for various College led recruitment, assessment and quality improvement activities.

On behalf of the Executive Committee I wish you a joyous and relaxing festive period, Have a lovely Christmas and a Happy New Year!



Dr Abdul Raoof. Chair, Eastern Division

# Top Tips to Clear CASC

By Dr Faiza Niaz

Nearly there and just one last small hurdle...the four letter word "CASC" between you and your MRCPsych degree! The exam CASC might seem insurmountable at the moment but believe me, it is not mission impossible. Here are some top tips to sail through!

Currently CASC has two circuits – the morning circuit has four pairs of linked stations and the afternoon consists of eight individual stations. Royal College of Psychiatrists has recently advised candidates that from January 2018 the morning circuit of 8 'link stations' will cease to exist. A new circuit of 8 single stations will be introduced. This circuit will have 4 minutes to read the instructions and 7 minutes to complete the task. The second circuit of 8 single stations which normally takes place in the afternoon with 90 seconds to read the instructions and 7 minutes to undertake the task remains unchanged. However, this should not have an impact on your preparation and performance, as the CASC blueprint remains unchanged.

## Approach to CASC

Approach to this exam has to be systematic and with a positive frame of mind. Timing is of essence; you should know when it is the right time for you to take the exams and only you can make that call. Once you have decided to take the plunge, it should be topmost on your list of priorities. Appearing in the exam when you are not quite prepared or for the sake of experience, can lead to undermining of one's confidence. Additionally, your finances also bear the brunt.

Ideally, start early; soon after taking your paper B when the theory is fresh in your mind and on your fingertips before it all evaporates. Get involved with the groups preparing for the exams and don't leave it too late. This helps building your mindset towards practical approach and moving away from the theoretical slant.

When preparing for CASC no trick or tip can substitute for the core knowledge and the ability to communicate that knowledge by developing your interviewing skills. In the period preceding CASC, prepare with the other group of trainees and attend courses. This is crucial as it will help you identify your areas of weakness. The aim is to develop your communication and interviewing skills during this period. Trainees who have cleared the CASC are a valuable asset as they have seen the real situation and tap on their valuable experience. Try and book in practise sessions with supervisors who are Royal College examiners as they have a better insight into the marking system.

For some candidates staying late to practice is not an option, try finding a study partner who can practice with you on video link. The idea is to have repeated rehearsals to reach the stage where you have developed the ability to deal with most common situations and any variations.

You will benefit from having a structured approach with a checklist for most common scenarios. Always be well prepared for the physical examination stations. These are the easiest to pass if you have practiced well. If you find them difficult there are excellent YouTube videos which is a good resource to tap into to hone your skills in this context.

There are many courses available for preparation of CASC which don't come cheap and some are heavily oversubscribed. I would advise you not to waste too much money on attending too many courses. Attend one good course and borrow and share reading material from your colleagues who have attended other preparatory courses. These courses are conducted by quite experienced people and any feedback given should be used as an opportunity to identify the areas that need work. Mock exams are a good idea and help you in developing your confidence as they mimic the exam situations.

# Top Tips to Clear CASC

By Dr Faiza Niaz

## The D-Day

On the day of exam, give yourself enough time so that you can reach the exam centre well before time. It will be a challenge to keep calm but believe in your ability and hard work that you have put in. Dress smartly, as the first impression makes a difference. Keep yourself well hydrated. There is a long break between the two circuits, avoid discussing stations with others as it may create self-doubt.

During the reading time, always make sure that you have made a note of patient's name as getting "anomia" during the task is not uncommon. Make sure you have read the task written on the bottom of the page slowly and deliberately lest you misconstrue the task required.

When you enter a station, smile and introduce yourself to the examiner. You should appear confident and professional when introducing yourself to the patient. Be polite and courteous. Keep yourself focused on the task requested and try to have the same structured approach that you have practiced for many months. Take cues from the patient and be empathetic and responsive to what the patient is saying, you should not come across as rehearsed. When the one minute warning bell rings, wrap up the station. Always say thank you before leaving the station.

If you have a feeling that one station did not go well, do not dwell on it as it would affect your performance in the next station. Remember that each station is marked separately even if it is a linked station.

Evoking the blessings of the heavens above can only come in handy and strengthen your case for passing!

Most importantly, Keep Calm and pass the CASC.



*Dr Faiza Niaz, ST6  
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## References:

1. Change to the MRCPsych CASC Examination, Effective January 2018, Royal College of Psychiatrists.



# Forgotten tribe...Not: “Creating Opportunities for SAS Doctors at Hertfordshire Partnership University NHS Foundation Trust”

By Dr Venkatesh Malipatil

The SAS doctors workforce is responsible for providing a significant proportion of the service delivered by medical staff and is therefore a key part of the medical workforce. We need to maximise the potential of this important cohort of doctors.

Doctors in SAS grades have predominantly felt undervalued and lacking in recognition and status. There is a feeling they have been overlooked, particularly in terms of professional development. There has been a lack of consistency in how these doctors have been developed and supported in their roles. This has an impact on the delivery of quality patient care and, for the employer, results in a workforce that feels undervalued and does not reach its full potential.

Quality improvement is at the heart of medical practice. Revalidation requires all doctors to take part in quality improvement for the benefit of their patients in order to sustain their licence to practice. SAS doctors are particularly well placed to deliver quality improvement given their extensive exposure to clinical work and proximity to patients.

Hertfordshire Partnership University NHS Foundation Trust (HPFT) aspired to create more educational opportunities for Specialty Doctors and Associate Specialists (SAS Doctors). The Trust created dedicated Professional Development Days for SAS doctors. This was followed by creating Quality Improvement (QI) fellowships specifically for SAS doctors utilising SAS development funding from Health Education East of England. This was the first time that such innovative schemes were established at HPFT to create opportunities for this group of doctors. The objective of creation of dedicated

professional development days was to enable all SAS doctors within the organisation to have the opportunity to take ownership of their professional development and to be a valued and fairly recognised part of the NHS. There have been in total, 11 development days held so far with each one of them having an important clinical and management theme which is very relevant to medical practice of SAS doctors.

The professional development days had high quality external speakers invited to deliver the presentations and the feedback from the SAS doctors showed that they valued attending development days to enhance their professional development. Creation of dedicated professional development days ensured SAS doctors were supported in developing as clinicians, managers, leaders, trainers and researchers. This educational innovation was an example of the organisation identifying the appropriate professional development that is needed to support the development and maintenance of skills, of this cohort of doctors in a planned way.

The Quality Improvement fellowship was designed to develop SAS doctors' skills and competencies in QI. The successful applicant undertook 12 months experience that provided support in developing this expertise. They worked on a QI project over the period of their fellowship. The appointed QI fellows were mentored by a senior Consultant in the Trust throughout their one year fellowship period. Funding for field work – such as attending courses/ conferences/ site visits related to the QI project was provided. A study visit to Qulturum- a world leader and innovator in QI, based in Jönköping, Sweden was arranged as part of the fellowship. The Fellows attended a two day 'Analysing data' short course at the University of Hertfordshire. The fellows were given one session

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SAS funded time for the work. This was a great opportunity for Quality Improvement Fellows to have an insight and learn about the culture and priorities of quality improvement within the NHS.

I was appointed as the first Quality Improvement Fellow in 2015 and completed my fellowship in May 2016. I undertook a project on timely completion of discharge summaries. Through implementation of Quality improvement methods, we were able to demonstrate consistent improvement in the standards over a one year period. I was fortunate to have had great opportunities to meet with enthusiastic and inspiring quality improvement leaders at organisational, national and international levels as well as learning key QI concepts.

My study visit to Qulturum, Jönköping in Sweden in March this year was one of the proudest moments in my career. With regards to the future, I am continuing my involvement in the Trust's move towards e-discharge summaries and continue to work towards enhancing quality and safety for patients.

The professional development days and fellowships were highly successful in achieving the objective of developing SAS doctor's skills and competencies across several domains of clinical practise. In our Trust, we hope that the fellows will be a key part of our future organisational QI journey.

I would recommend creation of similar opportunities in other Trusts as well so that the talent of this group of doctors does not go untapped, lest they become a forgotten tribe!



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## References:

1. GMC Good Medical Practice published in 2013
2. SAS Charter for England published in 2014
3. SAS Development Guide-Academy of Medical Royal Colleges Published in February 2017

# Flexible Working. Is it working?

By Dr Sophie Shardlow

As a flexible working Consultant psychiatrist I thought it may be interesting to stop and think about my hours of work and whether they are working for me, for my employers and most importantly for my patients. More and more of us are turning to part-time working hours, and there has probably never been a better era for this option, but does it really work and who does it work for?

I thought it might be nice to start with a quote, so I used our famous friend google in order to start things off; this was the first quote I found:

*"There is no such thing as work-life balance. Everything worth fighting for unbalances your life"*  
*Alain de Botton.*

Well this was not exactly what I had in mind but certainly got me thinking! As a part time worker, what is it I am hoping to achieve and balance. We all talk about the ultimate goal of the best 'work-life' balance, but what is that and how do we get there?

There are a number of different reasons people work part-time such as looking after elderly relatives, personal ill health, wanting to reduce stress or burn out, wanting to pursue other options, portfolio working, those approaching retirement or just trying to achieve this better quality of life. However, the most common reason continues to be down to childcare – which may be a choice or down to need, especially with the ever increasing costs of childcare. Although most doctors who work flexibly are women, it is important that we remember childcare is not only done by women and not the only legitimate reason for wanting to work flexibly.

Formal flexible training first became available in 1969 with the offering of part time training; it was specifically aimed at women with domestic commitments. The importance of providing flexible working patterns was emphasised by the Department of Health, in 1998, in 'Working together – securing a quality workforce for the NHS'. This has continued to be emphasised and

flexible working is now much more part of the NHS working culture, with less resentment and stigma attached to it then perhaps it previously had. Every trust must now have a flexible working policy and procedure. Given the current climate with national shortages of psychiatrists and trainees, as well as the recent Brexit concerns, and the fact that an ever higher proportion of doctors are women, it is crucial to offer flexibility in the work place to recruit and retain staff – one of the main reasons for doctors leaving medicine early in their careers is the long hours of work.

So now that Flexible working is more of a given and more psychiatrists are doing it, is it actually working for anyone? Does it work for the Doctor? Well, in theory, of course it may help to achieve that work life balance we are all craving, and many full time workers may look on with envy. However, in reality is this really the case, or does it actually make that balance more difficult?

Working part time hours can in some cases mean trying to squeeze a full time job in to fewer hours, ultimately meaning the work must be done outside of actual working hours, which may be very difficult if you have commitments at home. The demands on you may be unrealistic in the time you have or you may put unrealistic demands on yourself as a Doctor, especially if you have previously worked full time. Some of these issues may be resolved if you job share and can hand work over, but this I suspect comes with its own problems, especially depending how compatible you are, as a clinician, with your job sharer. There are also the non-clinical issues to consider, such as achieving enough CPD points, attending conferences and courses on days when you wouldn't normally work, progressing your career in the way that you would like to within the time that you have, and then there's fitting in SPA time as well, appraisals and revalidation. It can be a real juggling act to try and achieve what you would expect from yourself and what other colleagues expect you to be doing. It may feel that you are missing a lot when you are not at work, and constantly feel you are catching up. The ultimate question also has to be is it working for you and

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your circumstances, or does it seem to be that you are busy and stressed at work and then busy and stressed when you are not at work, maybe because you are not at work enough! Or perhaps being at work is the calmer bit compared to the chaos at home!

What about our employers, does it work for them or would they rather not have any flexible workers at all. There are advantages in recruitment and retainment, but there are other advantages such as access to different skills particularly with job sharing, less absenteeism for domestic reasons, increased employee satisfaction and commitment, and a more balanced workforce. There are few disadvantages, except perhaps increased administration and possibly some additional costs. On a more national level, there have been recent articles in newspapers and comments from politicians that flexible workers are the '*downfall of the NHS*'. The argument being part time working is not cost effective and perhaps taxpayers are not getting the best return for their investment. Others have questioned the part time workers dedication to activities beyond their clinical responsibilities, and politicians have controversially said that doctors who received expensive medical training and then work part time are a huge burden on the NHS and a drain on resources.

Most importantly, what about our patients, do they still get the service they need from us? I suppose the biggest argument against part time work would be continuity of care, but in practice does this really differ from our full time colleagues. Realistically, it may be more difficult for crisis care, to follow up on your management plan, but this happens at weekends and due to annual leave for full time colleagues as well. It may be that continuity is more of an issue for colleagues in other specialities, especially general practice for example. In many cases our patients may be unaware we work part time but it could be frustrating for them, families, service providers or colleagues, if they wish to speak with us urgently and we are not in until the next week.

From a more personal perspective, I can say I enjoy working flexibly and it does give me a little more balance in life. It can be difficult financially and hard to balance wages against childcare costs. I also find it tricky to attend many external events which are vital to keep knowledge up to date, relevant and interesting. Some days everything seems like an 'unbalanced fight' it can feel overwhelming with the amount to catch up on and then on other days it feels like a blessing to be at work!

In our world of political correctness flexible working is definitely here to stay, as it should be, and with our ever changing, fast paced, high demand and high expectation NHS, perhaps more and more of us will be looking to the option of flexible working. With burn out and stress levels on the rise, perhaps, rather than the '*downfall of the NHS*', part time working will become its saviour ...

*Dr Sophie Shardlow*

*Consultant Psychiatrist in Learning Disabilities, HPFT*

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1. Working together: securing a quality workforce for the NHS: The department of Health, 1 September 1998.
2. Part-Time training and working for male and female psychiatrists: *Advances in Psychiatric Treatment*, vol.7 2001, p 453-460. Anne Cremona and Alicia Etchegoyen.
3. Why having so many women doctors is hurting the NHS: A provocative but powerful argument from a leading surgeon: Article *The Daily Mail*, 2 Jan 2014, Professor J Meirion Thomas.



## How do we measure the treatment outcomes of patients treated within forensic/secure intellectual disability services

By Verity Chester and Dr Regi T Alexander

Forensic intellectual and developmental disability (FIDD) services operate at the interface of the health, and criminal justice systems, caring for a highly heterogeneous patient population. Patients typically have multiple diagnoses, high levels of serious mental illness, personality disorder, developmental disorders, substance misuse histories, extreme levels of psychosocial disadvantage, and histories of abuse from others. While offending behaviour or criminal conviction is a common prerequisite for admission, some patients take an “upwards referral” pathway, where they are moved from general mental health or intellectual disability services to forensic units, despite never being convicted.

This group utilise high health expenditure, at approximately £180,000 per patient per year, with a median length of stay of 2.8 years (Alexander et al., 2011), and some patients remain in services for indefinite periods (Vollm et al., 2017). While some studies describe the outcomes of psychological treatment programmes, such as fire setting or sexual offending, few studies describe care models followed at the service level (i.e. the entire programme of treatment followed, including psychiatric, psychological, social and occupational programmes), or the short (during admission/point of discharge), or long term (post-discharge) treatment outcomes.

One of the difficulties in this area is methodological, as individual patient care pathways differ based on the discussed heterogeneity. Treatment offered to a male patient admitted for seriously assaulting his sibling during a psychotic episode will differ to that offered a female patient with a history of personal trauma, and public order offences. One individual may respond quickly and positively to treatment, and one may experience motivational issues before engaging. Healthcare commissioners value simple, quantitative measures of outcome to assess value of a service, however this is clearly a challenge for forensic ID services, which treat highly complex patients according to their individual needs.

This was the topic of a recent evidence synthesis project, led by members of the Clinical Research Group for Forensic Intellectual and Developmental Disability (CRG:FIDD - <http://www.forensiclearningdisability.com>). The project examined how outcomes of the FIDD population should be measured, through three strands of research; 1) a systematic review assessing outcome measures used within published studies, 2) consultations with patients, their families or carers, and 3) a Delphi consensus exercise which established the outcome domains of most value to all stakeholders.

The outcome measures highlighted by the systematic review were organised into three broad domains; a) effectiveness, (b) patient safety and (c) patient and carer experience. Focusing first on effectiveness, research often utilised measures such as length of stay, discharge outcome, clinical symptoms, treatment responsiveness, reoffending behaviours and risk assessment. When effectiveness was discussed within the consultations, patients and families highlighted a number of areas not considered within the literature, or alternative perspectives. For example, difficulties in using length of stay (LOS) as a measure of service quality or treatment outcome were noted. Patients’ generally preferred a short LOS, while families discussed the “right” LOS, so that their relative could benefit from treatment. Clinicians also critiqued this measure due to its lack of independence from factors not directly linked to patient progress, such as legal restrictions, or the availability of suitable discharge placements. Families also suggested that their perceptions of clinical improvement could be incorporated into outcomes assessment, utilising their specialist knowledge of their relative through the lifetime.

The systematic review highlighted a number of studies which focused on patient safety, such as restrictive interventions (e.g. physical restraint, seclusion and as required medication), and so called ‘never events’, e.g. suicide and death within services. The consultation with parents and carers focused on victimisation within services, reducing

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psychotropic medication where possible, and on physical health. Within the patient and carer experience domain, studies focused on quality of life, therapeutic milieu, patient involvement and patient satisfaction. No published studies identified measures of seeking carer experience or satisfaction. Within the consultations, carers stated that it was important for their satisfaction to be taken into account and that this was often linked to their relative's outcome.



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All of the outcome domains highlighted by the review and consultations were entered into the Delphi consensus process, from which an outcome framework was developed. The framework has a number of clinical and policy implications and can be used by hospitals to index patient change on an individual and whole service level, as well as service quality. The research concluded that future service evaluations should measure treatment outcomes using this framework, and a future prospective, national outcomes study is planned.



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## Eastern Division Autumn Conference 2017 'Navigating Complexity' Conference Report. By Dr Malathi Pushpanathan



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*"The event brought together approximately 77 delegates, which included Psychiatrists, Foundation Year trainees and medical students"*

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Year after year, the RCPsych Eastern Division conference has continued to remain one of the interesting and mind captivating events for the psychiatrists. The most recent autumn RCPsych conference on 9th November 2017, at the Wellcome Genome Campus, once again confirmed this and was even more fascinating with the topic "NAVIGATING COMPLEXITY".

The event brought together approximately 77 delegates, which included Psychiatrists, Foundation Year trainees and medical students.

The conference began with a warm welcome from the Chair, Dr Raoof, who transferred his optimistic views on the future of Psychiatry to the audience.

Dr Gareth Cuttle gave an engaging update on the Gatsby Wellcome Neuroscience Project, which was an update from the last autumn conference. Key topics included the need to modernise psychiatry curriculum with neuroscience, to support teaching and learning, and a 'Brain Camp' for trainers.

Dr Sue Mizen, chair of the Psychotherapy faculty made an excellent contribution to the next session, where she delivered the "RELATIONAL AFFECTIVE MODEL", as a treatment option for complex personality disorders. It was fascinating to know that

psychodynamic intervention could have neuroscience basis and how dysregulation of BECS (Basic emotional command stage) could explain the difficulties in patients with Personality Disorder, Eating Disorder, somatisation and substance misuse.

In contrast to this, Professor Thomas Barnes explored the evidence base available for pharmacological relapse prevention in schizophrenia. Amongst various factors in relation to relapse, the hypothesis of supersensitivity psychosis was quite interesting to note.



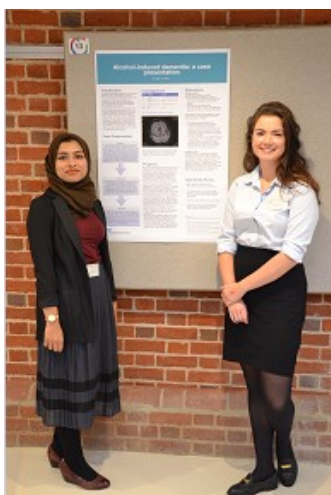
*Dr Gareth Cuttle, Project Manager, Neuroscience Project*



## Eastern Division Autumn Conference 2017 'Navigating Complexity' Conference Report. By Dr Malathi Pushpanathan

He concluded that there was strong evidence in first episode psychosis, for continuing antipsychotic medication to prevent the risk of relapse. He also emphasized that pharmacological approaches need to be combined with addressing the other relapse factors like medication adherence, substance misuse and critical environment.

Post lunch session was a lively and compelling speech by Dr Dasha Nicholls, chair of the Eating Disorders faculty on "The interface between Eating Disorders and Obesity". It was interesting to see the fine comparison she made between anorexia nervosa and obesity with regards to emotions and behaviour. She concluded on focussing on the importance of early intervention - both in diagnosis and treatment.



*Delegates with poster displays in the breakout area*

A refreshing talk from Dr Subodh Dave on trainees, supervisors, support available for trainees and the practical hurdles that both the trainer and trainees face in the current climate, was clearly comforting and reassuring for the trainees.

Dr Kallur Suresh conveyed his gratitude to all participants, session moderators and presenters, in his capacity as Academic Secretary.

The conference was not just lectures and discussion but was an excellent opportunity for the delegates to display their research work in the form of posters. Dr Albert Michael and Dr Abu Abraham took a lead role



*Dr Albert Michael handing out poster prizes*

in shortlisting the best three posters in various categories including one for Medical Students, Foundation Year Trainees and Psychiatrists. The selected trainees had a chance to present their posters to the delegates.

The conference gave a platform for the trainees to network with their peer group from other areas, Training Programme Directors and Head of the School of Psychiatry.

Overall it was an incredible, thought provoking, refreshing day with exceptional speakers and presentations which was supported by the perfect ambience of the venue and scrumptious lunch and tea breaks. The whole event was beyond any doubt a huge success.



*Breakout area for delegates, Wellcome Genome Campus Conference Centre*



Royal College of Psychiatrists

**Thursday 17th May 2018**  
**Eastern Division Spring Conference**  
**'New Services, New Treatments'**  
**Wellcome Genome Campus, Cambridge**



**FREE Entry for Foundation Year and Medical Students through 'Enhancing Foundation Experience in Psychiatry' initiative of HEEoE School of Psychiatry**



**Lectures on various topics including a keynote presentation, poster exhibitions, prizes and networking sessions**

**6 CPD points**  
**(subject to peer group approval)**

**For further information and to register please visit: <http://bit.ly/2c4B0Ue>  
or contact: [moinul.mannan@rcpsych.ac.uk](mailto:moinul.mannan@rcpsych.ac.uk) Tel: 0203 701 2590**

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The Royal College of Psychiatrists is the professional body responsible for education and training, and setting and raising standards in psychiatry.

The Eastern Division is made up of members from Essex, Hertfordshire, Cambridgeshire, Bedfordshire, Norfolk and Suffolk.

We'd like to thank all members for their contributions towards Eastern Division activities throughout the year.

## Eastern Division Medical Student Essay Prize

The Eastern Division has established this prize in order to raise the profile of the Division and to encourage medical students to pursue further study and professional training in Psychiatry.

**Prize:** £200

**Eligibility:** All medical students training in Medical Schools located within the Eastern Division.

**Where Presented:** Eastern Division Spring Conference, 17th May 2018 at the Wellcome Genome Campus, Cambridge

### Regulations:

1. Eligible students are invited to submit an original essay of up to 5000 words on any aspect of psychiatry. The essay should be illustrated by a clinical example from medical or psychiatric practice relevant to mental health and should discuss how the student's training and awareness has been influenced as a result. The essay should demonstrate an understanding of the Mental Health issues pertinent to the clinical problem and should include a discussion of the effects and consequences of the condition for the individual, their family and the wider healthcare system.
2. The essay should be supported by a review of relevant literature and should be the candidate's own work.
3. The Eastern Division Executive Committee will appoint three examiners to judge the entries. Criteria for judging merit will include: clarity of expression, understanding of the literature and evidence, cogency of argument and the overall ability to convey enthusiasm and originality. The Division reserves the right not to award the prize if no entry reaching the agreed minimum standard is received.

**Closing date: Friday 27th April 2018**

Submissions should be made to:

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### Deadline for next edition

Submit your articles for summer 2018 edition by 11th May 2018 at [psychiatry.east@rcpsych.ac.uk](mailto:psychiatry.east@rcpsych.ac.uk)

### Royal College of Psychiatrists - Eastern Division E-Newsletter

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