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Psychiatry-East

The Eastern Division eNewsletter

Editorial

In this issue:

Hello! Welcome to this season's newsletter. Wow! How soon time flies! We are already halfway through the year 2021 and it's been almost 18 months since Covid-19 Pandemic started. The 19th July 2021 was marked as the Freedom Day as per the Government declaration, but rather than getting into the debate about right or wrong I think the most important message for all of us is to continue to take precautions using masks and keeping appropriate physical distances from each other where you think is needed.

With new council members joining RCPsych, congratulations to Dr Subodh Dave as our new Dean, and a huge thank you to Dr Kate Lovett for her unwavering efforts and contributions as out-going Dean.

Now, as before, the edition starts with an update from Dr Abdul Raoof about recent developments in Eastern Division. I would also like to thank him for his hard work throughout these years, as this will be his last report as our chair. And I would like to welcome our new chair Dr Kallur Suresh.

You will find a range of interesting articles covering different aspects of the human mind and behaviours. There is Information on the development of a new service in Cambridgeshire for NHS staff from Dr Muzaffer Kaser and Mr Lee Davies which sounds amazing and is definitely the need of the hour. Then you will come across how and what made Dr Anu Sharma choose the psychiatry of Intellectual Disability. There is also an informative article from Dr Staufenberg on Pandemics - Future and Present, informing us about the recording and monitoring forms for future pandemics in collaboration with WHO and how they can help us to learn more about our clinical patients. Then Prof Keith Rix is calling for expert witnesses. So if you are keen to develop your skill in this area and willing to help the committee please contact Prof Rix. Further on, you will read about patients views of their letters in a Clozapine clinic, advantages and disadvantages of assessments via video link. There is also a very insightful reflection from one of our colleagues, Dr Haseena Hussain, on working in Tier 4 CAMHS. Further down you will find an interesting article 'Back in my Day' which might resonate with many of you. There is a section on Mental Well-being and last but not least we have reports from Dr Suresh on two important events that took place in the division – the new Consultant Interview Masterclass and our Spring Conference 2021 which were a huge success.

I hope you all get something out of this edition. As I have said before, any advice or comments will be appreciated. You have all been stars, working fabulously to keep the services running. Thank you and please make sure you recognise when you need a break, so that you can come back with your mind and body feeling refreshed and recharged to face the world again :)

Dr Nita Agarwal, Editor, Psychiatry East

Chair's Column

By Dr Abdul Raoof

Thank you! It has been an honour and privilege to be your chair; as I come to the end of my term let me take this opportunity to thank you all for your support during the last four years. Despite a third of it being affected by the pandemic we have achieved a lot in that time.

You are in safe hands! As you know Kallur Suresh, who has been doing a wonderful job as our Academic Secretary has taken over as your new Chair and Anna Conway Morris, who has reinvigorated CAMHS training through her innovative approach is the new Vice Chair of the Division. A special thanks to outgoing vice chair Joanna Woodger and other outgoing exec committee colleagues for their contributions to Division activities, as we welcome our new committee members (see next page).

I am particularly pleased to see a great increase in engagement by medical students and foundation year doctors engaging in our events over the years – they are the future. Our poster competitions and essay prizes are becoming ever so popular and our Medical Student event in 2020 was very well received.

Apart from targeted training and professional development opportunities for all grades of trainees and members we strengthened our patient carer involvement during the last few years. Kate King MBE, our patient representative in the exec committee is a great inspiration for all of us and I am really grateful for her contribution towards College's activities regionally and nationally.

Aside from our autumn and winter conferences we have well established events calendar which includes multiple targeted events like the StartWell event for newly appointed consultants. We have opened up our events to doctors from other medical specialties and to our MDT colleagues, in line with our growing recognition that mental health care delivery is a multi agency multi – professional endeavour.

When I took over as the Chair of the division one of my priorities was to improve access to section 12 and AC approval courses within our region. With your support we have now established our own Induction Courses and have supported development of Refresher Courses within the region.

When the pandemic hit about 18 months ago we moved all our activities online; it is amazing how we all adapted to the new normal on online existence. Though we were beginning to establish our online presence in the twitter field prior to that, it was huge learning curve for all of us!

Thanks to Moinul and colleagues at the College for their support. I am proud of our contributions towards national College activities. Colleagues from the region have achieved national recognitions for their contributions in training, research and service delivery. Some of our trainees and SAS colleagues from the region have held leadership positions with PTC (Psychiatric Trainees Committee) and other College committees. Their enthusiasm and contributions have received accolades nationally to our delight.

As you know In 2020-21 during the pandemic our Division was involved heavily in the formation of the Section 12 and AC online courses and worked with CALC (Centre for Advanced Learning & Conferences) and the eLearning Team in helping RCPsych being one of the leading providers of this online course. Thanks to all colleagues for their contributions to this great initiative which helped to maintain uninterrupted supply of approved Mental Health Act practitioners during the pandemic nationally.

As we begin to see the light at the end of the tunnel, let us be optimistic and prepare for the future in which we expect significant change in the way we deliver service for our patients. The College recognises this and it's important that we are at the forefront and able to influence policy decisions and service design. Newly set up CEN (College Engagement Network) provides a platform for this and we are one of the pilot regions.

Thank you all as I always say, you are the College, be involved.

Dr Abdul Raoof, out-going Chair

Eastern Division Exec Members 2021

Dr Kallur Suresh - Chair
Dr Anna Conway Morris - Vice Chair
Dr Abu Abraham - Finance Officer
Dr Manal El-Maraghy - Academic Secretary
Dr Chris O'Loughlin - Head of School
Dr David Middleton - ETC Rep
Dr Abdul Raoof - CALC Lead
Dr Nita Agarwal - Newsletter Editor
Dr Rakesh Magon - Mentoring Lead
Dr Kapil Bakshi - Elected member
Dr Praveen Gandamaneni - Elected member
Dr Sepehr Hafizi - Elected Member
Dr Albert Michael - Co-opted Member
Dr Sadgun Bhandari - Co-opted Member
Dr Ashish Pathak - Co-opted Member
Dr Aastha Sharma - PTC Rep
Dr Kabir Garg - PTC Rep
Mrs Kate King - Service User Rep
Ms Liz Harlaar - Carer Rep

Spring 2021 Poster Prize Awards

Medical Student Category

1st Prize - *Ilias Epanomeritakis*
2nd Prize - *Anna Wood, Tamsin Brown*

Foundation Year Doctor Category

1st Prize - *Eleanor Walder, Rhiannon Newman*
2nd Prize - *Jeremy E Solly, Roxanne W Hook, Joe E Grant, Samuele Cortese, Samuel R Chamberlain*
3rd Prize - *Susan Honeyman, Phoebe Tupper, Rabi Chanda*

General Category

1st Prize - *Muzaffer Kaser, Theodora Karadaki, Zoe Martin, Cathy Walsh*
2nd Prize - *Adebeyo Emmanuel, Parvathy Pillay, Vyasa Immadisetty*
3rd Prize - *Fraser Arends, James Fitzgerald, Anya Ciobanca*

Multi Disciplinary Category

1st Prize - *Tracey Holland*
2nd Prize - *Maisie Frost, Lucy Morter, Basavaraja Papanna, Kapil Kulkarni*
3rd Prize - *Alana Durrant, Andrea Brown, Christine Oxberry, Sathyaranjana Abraham*

Nurse-Led Brief Psychological Interventions at the Staff Mental Health Service

By Mr Lee Davies and Dr Muzaffer Kaser

Mental health of NHS staff has been a major focus during Covid-19 pandemic. Even before the pandemic, a survey of staff conducted by the Health and Safety Executive (HSE 2018) reported that work related anxiety and depression was more common in health and social care: 2,080 cases per 100,000 workers compared with an average of 132 per 100,000 in all jobs. The rate was notably higher in nurses and midwives (276 per 100,000). A survey by British Medical Association concluded that four in ten doctors reported suffering depression, anxiety and emotional distress that was impacting on their work. 90 per cent stated that the working environment contributed to their mental health condition (BMA 2019).

During the pandemic, an array of wellbeing support has been established in an attempt to try and help NHS staff manage the stressful situations they have faced. Most were primary level interventions aimed at majority of NHS staff suffering from mild symptoms. However, for a group of NHS staff experiencing significant and prolonged mental health problems, access to appropriate assessment and treatment is a major challenge. There is little evidence on inclusive and rapid access treatment models to inform decisions of employers.

Staff Mental Health Service (SMHS) in Cambridgeshire and Peterborough NHS Foundation Trust was launched in September 2020. The service is funded by the Cambridgeshire and Peterborough Sustainability and Transformation Partnership (STP) Covid-response monies and is currently accessible to approximately 25,000 staff (from all roles) based in NHS trusts in the region. The Staff Mental Health Service aims to offer a bespoke service with multidisciplinary input of psychiatry, psychology, mental health nursing and occupational health nursing. We offer a diverse range of interventions including longer psychotherapy courses (16-20 sessions). Within the caseload, we identified a group of patients whose needs can be met appropriately with brief psychological interventions (6-8 sessions). In this piece, we would like to share the clinical experiences of specialist nurse-led brief psychological interventions within the SMHS.

Individuals who receive treatment from the SMHS nursing team often present with a range of common mental health conditions, predominantly depression and anxiety. Other presentations included difficulties in the context of personality disorders and adjustment problems. Their mental health problems have been further compounded by the presence of stressors in their professional and personal lives. It is not uncommon for individuals to also experience problems associated with interpersonal difficulties and emotional dysregulation which have been exacerbated by distress, workplace difficulties and lack of access to usual support networks owing to restrictions during the pandemic. One challenge for NHS staff members presenting to the SMHS was that the severity of difficulties would not usually meet the threshold for treatment by locality or specialist services. In some cases, the clinical needs were outside the threshold of referral to the psychological treatments at IAPT services. A group of patients in SMHS reported difficulties due to falling through the gaps of current service provision. Lack of access to support for an individual in distress is clearly problematic. Stigma, concerns about confidentiality, fears of scrutiny from professional regulatory bodies and adverse consequences for career progression can delay or prevent NHS staff from seeking help. Additionally, presenteeism and attending work while unwell is common among NHS staff. Feeling unsupported and emotionally distressed with symptoms of anxiety and depression are precursors of burnout and can lead to poor standards of patient care.

At the SMHS, the brief psychological intervention package provided by the nursing team is drawn from a range of brief psychological interventions from several modalities, including dialectical behavioural therapy (DBT). The package includes eight sessions each of a duration of 45 minutes. We used a skills-based approach bespoke to the individuals' treatment goals which were established in the first session. The package is designed to have a practical feel, each session introducing a new skill, homework to practice and reviewing the previous session. Central to the skills package is the introduction of brief mindfulness, which are practiced by the individual between each session, and where appropriate taught by the individual to people around them. The patients are encouraged to take their own notes in a therapy workbook and provide homework feedback while keeping a log of their experience of skill use.

The skills package focuses on:

i) Brief mindfulness

Ii) Goals & values

Nurse-Led Brief Psychological Interventions at the Staff Mental Health Service

By Mr Lee Davies and Dr Muzaffer Kaser

iii) Distress tolerance

Iv) Interpersonal skills

V) Emotional labelling and regulation.

To date, referrals into the brief psychological interventions package have been representative of the full range of professionals referred into SMHS and have presented an equally diverse range of needs and goals. The interventions have been used as a standalone package with the aim of delivering the right skills to meet the individual's identified goals. it has also been structured as package of skills to provide the opportunity to stabilize an individual who is preparing to commence trauma focused therapy.

The brief psychological interventions package has received good feedback from individuals who have received treatment and had the opportunity to engage with these skills on their identified goals and own wellbeing. Brief psychological interventions skills are open to the concept of "skills fade", so annual "booster" sessions may be indicated. The skills are highly transferable to other aspects of daily living, for instance mindfulness can help with attentiveness toward the other. A key element of those packages is the investment in training staff and providing access to specialist training, particularly the mental health nurses. Mental health nursing has the foundations that can facilitate specialist nurses to develop further in delivering practical psychological interventions. The approach we adopted, particularly mindfulness based and DBT focused work are in line with the biopsychosocial model that mental health nursing training is built upon. We encourage the mental health teams to open up avenues for specialist nurses' training and upskilling in psychological interventions.

References

1) https://www.hse.gov.uk/statistics/causdis/stress.pdf

2) https://www.bma.org.uk/media/1365/bma-caring-for-the-mental-health-survey-oct-2019.pdf

3) Kinman, G., Teoh, K., & Harriss, A. (2020). The mental health and wellbeing of nurses and midwives in the United Kingdom. Society of Occupational Medicine report.

Mr Lee Davies, Clinical Nurse Specialist
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Dr Muzaffer Kaser, Consultant Psychiatrist
Cambridgeshire and Peterborough NHS Foundation Trust

Why I Chose Psychiatry of Intellectual Disability

By Dr Anu Sharma

I had completed 3 years of my core training, and had not yet cleared the exam. I had rotated in all the major specialties and my choices were narrowed down to adult psychiatry or dual. That's where most of the trainees gravitate to and I recall thinking, "that's all the thrill, and it's happening!"

I had worked in the field of Learning Disability a long time ago as a locum doctor, where I first learned about autism and autistic traits. It piqued my interest and found myself applying that knowledge in other specialties as well. Its relevance was particularly noticeable when applied to individuals who lacked full-fledged diagnosis of autism, but still displayed traits in their everyday life and functioning.

I was offered an extension posting, and my priority was the exam. The choice of specialty was of minimal concern to me. I was offered a community job in learning disability, which I indifferently took up.

Then I attended my first clinic with my consultant. And my life forever changed.

In that clinic I came across a varied range of clinical presentations starting with a lady with learning disability and autistic traits with comorbid possible prodromal psychosis, physical health concerns such as DVT and environmental and community psychosocial stressors hugely impacting on her mental health. Following this there were clinical cases of personality disorder with risks of self-harm, Alzheimer's dementia in Down's syndrome with multiple physical illnesses including hypothyroidism and then a young adult with dissociative disorder.

It was like the penny had dropped - all my previous years of training in adult psychiatry, old age and even CAMHS and psychotherapy - were coming together. At that moment, I knew that I wanted to pursue Learning Disability for the rest of my career.

Revelations did not stop at the clinic; it was just the beginning of many more insightful encounters. I consider myself extremely fortunate to be able to work with consultants who opened my eyes to a whole new world to explore.

It was academically stimulating as well. Quite often, just by observing the physical manifestations of facial features, body posturing, and gait, we can decipher at what stage of the intra uterine life an individual might have suffered an insult.

Epilepsy was another epiphany altogether. It is interesting to observe how various neuronal circuits in the brain lead to different types of manifestations in the body. We are all but what our neuro-circuits do to us. *After all, what is the purpose of the body if not to carry our brain around? (Thomas A Edison)*

I started thinking in terms of sensory deprivation and overloading (which had been very abstract concepts before). A lot of the challenging behaviour started making sense - it's a message an individual is trying to convey about something very much distressing happening to them. On the other hand, on rare occasions, the person yearns the sensation of deep touch, which is erroneously reported as self-harming.

I grew as a person, and I became less critical of the people around me. I realise that sometimes I am offended by someone's intransigence or lack of empathy; while in reality the individual suffered from rigidity of thought on account of autistic traits, rather than being intentionally difficult.

After spending a major part of my training and non-training days as a junior doctor in adult psychiatry, I have had my share of experiences when I doubted my choice of career, and sometimes even felt bulldozed after experiencing the transference and countertransference with certain group of patients. Of course, I carried those emotions with me to my home and dealt with them by unintentionally displacing them onto my family.

Learning disability was different to a great extent. I was awestruck by the smile that emerged on the face of most of the patients attending the clinic. They were delighted to meet with the doctor, which is the highlight of their day or perhaps even week. During home visits, I recall some patients (and the families too) waving goodbye until my car drives out of sight. It is a heart-touching sight - what have I offered them to be rewarded with such positivity and gratitude?

The charm does not stop here. The faculty has so much more to offer. I have a myriad of opportunities to pursue ADHD, autism, sensory assessments, forensic risk assessments, sexual risk assessments and so on. The team is richly supported by psychologists, disability nurses, epilepsy nurses, occupational therapists, speech and

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language therapist and many more. I am not pressured in my clinic to prescribe a tablet for a certain "problem". In the field of mental health, we all strive to practice the bio-psycho-social model of medicine; here in the psychiatry of learning disability, we actually make it come to life, holistically.

I can say for most of my colleagues in the field of psychiatry of learning disability that the work is worshipped. There are days when I moan about, but given a second choice, or a third or a fourth - I would still choose the path of learning disability.

I may not have gone where I wanted to go, but I ended up where I needed to be. (Douglas Adams)

So, with warm regards, I welcome you all to the world of psychiatry of intellectual disability, where we rationalize with our brain, but serve with our heart.

Dr Anu Sharma, Consultant Psychiatrist
Norfolk and Suffolk NHS Foundation Trust

MindEd

MindEd provides accessible, engaging online training in emotional and behavioural 'first aid' and essential therapeutic skills for those involved in mental wellbeing and care of children and young people in the UK.

MindEd offers free, completely open access, online education with over 350 sessions. Our e-learning is applicable to a wide range of learners across the health, social care, education, criminal justice and community settings.

MindEd web tools for those working with young people | Royal College of Psychiatrists (rcpsych.ac.uk)

Pandemics - Future and Present

By Dr Ekkehart Staufenberg

The monitoring and synchronisation of the often bewildering array of symptoms and signs in a pandemic can be confusing to any clinician.

Ideally, we all would need a detailed knowledge across all our individual specialties and sub-specialties regarding the seamless interface of psychopathological phenomenology with neuro-structural and neuro-functional aetiopathogenetic processes.

In encephalitis, and less well-defined encephalopathies associated with past, present, and most importantly any future viral / bacterial / zoonotic and other pandemic threats, we require a synchronised methodology to ascertain, record, and then gather systematic data on such presentations' symptoms and signs. This will permit us to learn more for our clinical patients, and to formulate further clinical research questions and programmes.

To date, possibly the most highly regarded environment for such coordinated work internationally has been lead for over 10 years by Professor Tom Solomon, Liverpool University, and Director of the NIHR Centre based in central Liverpool in a dedicated medical research center. Most of the collaborative research sites in the UK and across a network based within each of the world's continent have led to early and ongoing data on the current SARS-CoV-2 pandemic, including the first study of >16k patient data in May 2021 under the ISARIC-CCP acronym (to google). There are regular excellent interdisciplinary training events online, and also bi-annually at the NIHR co-funded environment in Liverpool.

In April 2021, Professor Tom Solomon was asked by the WHO Brain Health Unit to coordinate an international group of clinical academics to prepare a recording and monitoring form for future pandemics , based on the ISARIC-CCP format.

I am now writing to share that this work has been completed and is very much of interest (if not a duty!) for our consideration in our specialties as potential instrument to use for 'Long COVID' presentation.

Professor Tom Solomon collated a group of senior neurologists, neuropathologists, epidemiologists (and one Neuropsychiatrist) all of whom were 'invited' to become members of the WHO COVID-19 Surveillance Work Group. Individual heads of their respective national clinical research centres for infectious diseases headed up what became four teams (each about 6-8 'core members' as they were called), with some 10+ additional colleagues.

The work resulted in the publication by the WHO (after the WHO AGM had approved all) of detailed new clinical Characterisation Record Form(s) for four scenarios of patient population for any future infection based pandemic (or endemic) events:-

- The generic WHO CRF format (for acute presentations)
- The WHO CRF (adding women / pregnancy specific items) format
- The WHO CRF - Child & Young People (with developmental specific considerations added) format, and the
- The WHO CRF – 'chronic disease' format – this is the one relevant to our neuropsychiatry, behavioural neurology, mental health specialties and subspecialties.

All formats were published on 31 January 2021 on the WHO.int/dashboard.

A simple registration of our respective organisations will permit access and synchronised recording (all anonymised, and CG compatible, of course) by all of us.

There is a link to Tom's and the WHO Brain Health Unit, and support is available for queries.

As a longstanding clinical research collaborative centre for all the ISARIC-CCP studies, our Neuroscience Division in the NNUH FT has nearly completed the 'roll out' of the WHO CRF formats.

I encourage us all to perhaps think about this for our specialties, also.

Please also note the enormous amount of educational material that you can access via the WHO.int/dashboard links, most, if you look carefully, are UK based (nearly all lead or set up by Tom Solomon!) as charitable educational activities. Also look out for his amazingly motivational, and wonderful training events when we all meet again.

Brain infections and accompanying inflammatory

Pandemics - Future and Present

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conditions, many mediated by auto-immune processes will never be a mystery to us if we support the structured, systematic and synchronized recording using this format.

There will be clinical research opportunities for all age groups in the clinicians trying to provide care and support for our individual communities.

Dr Ekkehart Staufenberg, Consultant Psychiatrist Norfolk & Norwich University Hospital

RCPSYCH PODCASTS

The Psychiatric Trainees Committee (PTC) are proud to present this podcast series that celebrates the lived experience of colleagues and explores topics affecting physician wellbeing.

In the first episode, PTC rep Dr Daniel Wilkes speaks to Finding True North author and psychiatrist, Professor Linda Gask and medical student Usama Ali.

You are not alone - Episode 1: Doctors with Mental Illness (rcpsych.ac.uk)

Calling expert psychiatric witnesses

By Prof Keith Rix

Psychiatrists who provide expert evidence in the family courts may have been aware in November 2020 of 'The President of the Family Division Working Group on Medical Experts in the Family Courts Final Report' (https://www.judiciary.uk/wp-content/uploads/2020/11/Working-Group-on-Medical-Experts-Final-Report-v.7.pdf).

This report by Mr Justice Williams is the report of a working group that was set up to address a problem of a "paucity of medical expert witnesses in family cases involving children". One of the shortage groups identified was "child and family psychiatrists". Given that the focus of the family court system is the protection of the vulnerable child, it will be appreciated that this problem is a serious one.

The working group engaged in a consultation process and surveyed both clinicians and lawyers. It identified a number of problems relating to the provision of medical expert evidence to the family courts and it has made a number of recommendations that are intended to address these problems.

The main barriers or disincentives identified to the provision of expert assistance to the family courts were, in order of importance: financial, court processes, lack of training and support, and perceived criticism by lawyers, judiciary and the press. Judicial criticism and hostile cross-examination were identified by 35% of respondents as a reason for the shortage of expert witnesses. Sixty-two per cent of respondents did not feel supported by their medical royal college or professional association to complete expert witness work although how many of these were psychiatrists is not stated.

The lawyers surveyed had noted a decline in the quality of expert reports which may be the result of more experienced and conscientious experts giving up expert witness work and leaving the work for those less able to provide reports of a sufficient quality.

In relation to training, the working group identified a large appetite for more training including from respondents who had never previously provided expert witness work wanting to receive training.

The working group's recommendations include encouragement to the royal colleges to engage with commissioners and / or trusts to promote a more supportive environment to medical professionals who wish to undertake expert witness work and for the royal colleges and the Family Justice Council (FJC) to engage with NHS England and clinical commissioning groups to seek changes to contracting arrangements to enable healthcare professionals to undertake expert witness work within the parameters of their employment contracts. It has recommended the creation of greater training opportunities for medical professionals, including mini pupillages with judges, cross-disciplinary training courses with medical and legal professionals, and mentoring, peer review and feedback opportunities.

One recommendation was that each of the medical royal colleges and faculties should appoint an expert witness lead to support the work of members undertaking expert witness work. The Forensic Faculty of the Royal College of Psychiatrists has been asked to consider this recommendation. I have been appointed the Expert Witness Lead for the Faculty of Forensic and Legal Medicine and I will fulfil the same role for the Royal College of Physicians of which the FFLM is a faculty. I hope that we will soon hear who is to fulfil this role for the RCPsych.

Another recommendation was that the FJC should create a subcommittee to support and maintain the implementation of the recommendations. That subcommittee has been established and I am a member of it. On 25th March it hosted an on-line seminar for experts, lawyers and judges to publicise the report's findings and set out the plans to implement its recommendations. One of the recommendations was for the establishment of regional committees to implement locally recommendations such as:

- Setting up and delivering training to experts and lawyers
- Setting up and delivering a medical mini-pupillage scheme (providing the opportunity for medical experts to sit with judges)
- Promoting inter-disciplinary respect and cooperation through promoting feedback from judges and lawyers to experts and vice versa through mentoring and peer discussion of cases in an anonymous environment

The regional committees correspond to the NHS regions and for each there will be legal and expert co-chairs. His

Calling expert psychiatric witnesses

By Prof Keith Rix

Honour Judge Jaron Lewis, who is based in Chelmsford, is the legal co-chair and I am the expert co-chair for the Eastern England committee. We are anxious to make contact with psychiatrists, and other medical specialists, in Eastern England who already provide, or would consider providing, expert evidence to the family courts. We welcome expressions of interest in joining the Eastern England Regional Committee. It would be helpful to find out to what extent the problems identified nationally are also local problems. But it may be that there are areas where things work well and psychiatrists in these areas may assist in helping to improve the provision of expert evidence throughout the region. We would like to ascertain what training, refresher and update courses need to be provided locally but, if there are such courses already being provided locally, the committee may be able to publicise them or facilitate their more widespread delivery. The working group identified not only disincentives for consultants taking on expert work but also for 'senior registrars' [*sic*] so we would like to hear from specialty registrars who have been able to obtain expert witness training and from those who would like to obtain it. We may be able to facilitate secondments or attachments so that specialty registrars can gain experience working with consultants who undertake expert witness work.

Although this initiative comes from the family court system, my hope is that some of its recommendations will spill over into the other legal jurisdictions and improve the provision of expert psychiatric evidence to the whole of the justice system.

Prof Keith Rix, Honorary Consultant Forensic Psychiatrist Norfolk and Suffolk NHS Foundation Trust. Visiting Professor of Medical Jurisprudence University of Chester.

Patients' views of their letters in a Clozapine Clinic

By Dr David Dodwell

Introduction

From 2000, it has been UK government policy for doctors to share their letters with patients [1]; it is now recommended that doctors write directly to patients rather than copying GP letters to patients [2 3 4]. Studies in adult psychiatry report that patients generally value the letters (71-91%), find them helpful (51-96%), accurate (74-94%), and understandable (86-100%) [5-14]. Some studies excluded patients with psychosis or noted difficulties in engaging people with schizophrenia. No psychiatric studies considered training issues or how to write in a way patients are more likely to understand.

Aims

My aims were (a) to review the uptake of receiving letters; and (b) to get feedback from my patients about my clinic letters.

Materials and Methods

The patients were my caseload at the Peterborough clozapine clinic (who were all sufficiently fluent in English not to require an interpreter).

For my letters I use a template with standard headings which reflect standard medical headings, but with wording modified for a lay audience in some cases.

I compiled a two page feedback questionnaire. The first page asked general questions about the letters and the second page asked about the usefulness of individual headings. With each patient who had previously agreed to have a copy of their clinic letter, I offered the feedback questionnaire at the end of the normal consultation. I asked the patient to complete the questionnaire before leaving the clinic and hand it in at reception on the way out, without writing their name on the questionnaire.

Results

My personal caseload at this time was 52 patients.

Uptake of letters

Forty-two patients (81%) wanted to receive a letter. The features of patients accepting and declining letters were not statistically different in terms of gender, ethnicity, not working, severity, and diagnosis. Older patients were more likely to want a letter (medians 45 and 37 years, $p<0.002$).

Questionnaires

Eligibility and returns

Of the 42 patients who wanted to receive letters, two were not eligible and two failed to submit returns, so the total number of returns was 38 (95% of those eligible).

Feedback

Letters were considered accurate by 95%, understandable by 87%, helpful by 84%, polite and considerate by 95%. 68% preferred a letter addressed to the patient, 18% didn't know, and 13% did not prefer this. Letters were considered helpful in understanding the patient's mental health problems in 71%, feeling understood and supported in 82%, understanding the treatment plan in 74%, and in knowing how to access help in 76%. 74% said they always read their letters; only 11% never showed them to other people.

In terms of the usefulness of specific headings, those considered most useful were about diagnosis, medication, mental state, and key clinician (78-68%). Assessment, plan, discussion and psychosocial headings scored 65-48%.

Learning points

Current guidance is that out-patient letters should normally be sent to patients. They should be written to the patient (as 'you') in an understandable way (with a copy to the GP) [4]. Writing to the patient is linked to better readability [15] and helps get the right mindset for language and tone. Although the original guidance noted training issues [16], this is not mentioned in the psychiatric research or detailed in recent guidance.

As professionals we spend a long time learning not just our specific vocabulary, but also ways of speaking and writing which come to form part of our professional identity [17]. Guidance now asks us to abandon these as much as possible, which can be experienced as de-skilling or a threat to identity. I prefer to regard it as a new challenge to develop expertise as a translator. One trap is the 'false friend': a word that, unknown to its users, has different meanings to different users. For doctors, acute and chronic refer to timescales; for many lay people, they both mean severe. Psychiatrists know that schizophrenia is often used by lay people to mean 'split personality'. Translation is not just about vocabulary but also often has to convey cultural differences [18]: tea can be a drink, a light afternoon snack, or a main evening meal. English

Patients' views of their letters in a Clozapine Clinic

By Dr David Dodwell

language use can vary considerably between people from different world cultural backgrounds [19] . Translation also involves understanding pragmatics (the actual use of language, including inferred, implied, and context-specific communications).

Writing a letter which is clear, simple, and unambiguous becomes a new skill. There is some guidance [20] which I have summarised in the box with the acronym APT CUBES. Technical information should be explained. Letters should not introduce new upsetting information and should be non-judgemental and inclusive. Skills can be developed through patient feedback studies (such as this) and peer review [21].

Conclusions

This study shows that, in an out-patient clinic for patients on clozapine (nearly all with a diagnosis of psychosis), the majority want copies of their clinic letters, and prefer them addressed directly to themselves. The letters are viewed favourably by most patients. The letters help them feel understood. The patients value information about their diagnosis and medication particularly. There are a number of issues which deserve further study, including why patients decline letters, what would make letters better, and how to train staff in best practice.

How to write to patients: APT CUBES

Active: I prescribed risperidone *(not risperidone was prescribed)*
People: people with schizophrenia *(not schizophrenics)*
'Thou': I saw you *(not he was seen)*

Chunk: use short words, short sentences, headings, bullet points
Unambiguous: long lasting *(not chronic)*
Basic: poo *(not stools)*
English: twice a day *(not b.d.)*
Specific: two pints of 5% lager *(not a couple of drinks)*

Your personal knowledge of the patient may mean modifying specific points.

Based on NHS Digital content style guide

Dr Davd Dodwell, Locum Consultant Psychiatrist Cambridgeshire and Peterborough NHS Foundation Trust

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Patients' views of their letters in a Clozapine Clinic

By Dr David Dodwell

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Assessments via Video Link – Advantages and Disadvantages

By Dr Dilum Lankathilaka

As individuals and as health professionals, we have been facing unprecedented challenges with the COVID-19 outbreak. None of us, including health services, were prepared for this magnitude of disruption to services, stretching of resources and challenges one after another. Lockdown and social distancing led to limits to footfall on health service sites and to travel, and health services have had to find a way to see patients. We turned to technology and started to use video calling for patient reviews.

I would like to share my own experience of virtual clinics via video and have also incorporated the views of service users and colleagues in this article.

Advantages

One of the advantages of video calling was that we could do it from anywhere. We did not need to come to an office to review patients. This gave us the flexibility of working from home or an office or even a vehicle; in effect from anywhere convenient and appropriate. It saved time and cost of travel for health care professionals as well as service users and their carers.

Video calling allowed for better time management; for example, if a meeting ran late, I could easily spend that time on other work while waiting. We did not have to leave early to attend meetings. Time was well used and managed.

Late appointments or last-minute cancellations became easier to manage for me. I could call another patient or attend to other work instead of having empty time slots.

For some patients, seeing mental health care professionals via video calls was easier and more acceptable than seeing them face to face.

One of the biggest professional advantages of online meetings was how easy it was to attend professional meetings and training programs. It was simpler to organise peer group meetings and the number of attendees improved. Even out-of-area doctors were able to join and attend group meetings. Training sessions became more accessible and cheaper as we did not have to think about travel or finding accommodation.

Disadvantages

On the other hand, some service users lost the only (or one of the few) contact they had with the outside world, making them more isolated. This had a negative impact on their mental wellbeing.

Some service users found video calling more difficult and frightening, especially if they were already paranoid about devices or of being monitored. It had a negative effect on their mental health.

The scope of assessment was limited to what we saw on the screen or heard on the phone. The possibility of a holistic assessment which we usually undertake when we do home visits, for example, looking at personal care, state of the home, evidence of substance abuse and state of activities of daily living, was lost with video assessments.

It is also important to note that assessments under the Mental Health Act are not valid if they are conducted via video link. (https://www.bmj.com/content/372/bmj.n228)

Online training sessions came at a cost - face to face contact, personal touch and connections were lost and networking became impractical.

Challenges

One of the biggest frustrations were technical issues. It was not unusual to experience technical difficulties such as frozen screens, non-working microphones, broken connections, computers crashing in the middle of an assessment making us frustrated and service users feeling disappointed and rejected.

The loss of connection with the service user and the human touch of care was a big price that we must pay with the increasing use of remote-access technologies. As mental health professionals, we all value and appreciate face-to-face contact with patients. Getting to know them via video calls does not give the same professional satisfaction to most of us.

Assessments via Video Link – Advantages and Disadvantages

By Dr Dilum Lankathilaka

Lessons

In summary, conducting assessments and reviews via video calls was the solution which was adopted during this extraordinarily difficult time. I believe that online meetings will continue to play an important and significant role in the future, especially with training and career development. But I hope that we will be able to find the right balance between face-to-face reviews and online assessments for consumers.

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http://www.bailii.org/ew/cases/EWHC/Admin/2021/101.html

Dr Dilum Lankathilaka, Specialty Doctor
Cambridgeshire and Peterborough NHS Foundation Trust

Reflections from a Child and Adolescent Psychiatrist

By Dr Haseena Hussain

I am fortunate to work in an innovative Tier 4 Child and Adolescent Mental Health Service (CAMHS). We have an inpatient General Adolescent Unit (GAU), Home treatment team (HTT) and Dialectical behavioural Therapy (DBT) community team. We created the 72-hour crisis admission, and 4-week admission and assessment pathway. Since these innovations we have seen the need to use out of area GAU beds dramatically reduce and no longer be needed. Working in an inpatient service and essential service, has meant the continuation of face-to-face care for our service. Managing the high acuity on the unit, ever changing restrictions and lockdown rules due to COVID19 has been exhausting. We have had to change leave and discharge plans according to government guidelines and have needed to adapt our unit to have an isolation ward. We are still trying to maintain the flow of admissions and discharges with staff sickness, stress, and overwork. I am grateful for the team I work with and the dedication of staff in this emotional and physical battle against COVID19.

We have all felt the increased demand, strain, and pressure from working during these times. It has brought up all sorts of questions for us. We might ourselves have experienced illness, the sad loss of loved ones or needed to take care of our children, significant other, relatives or friends. Maybe we have realised that we need a break, a career change or diversion on a different life course. Here I reflect on some of the things that have kept me going and motivated at work, during this unprecedented time.

I looked after one young person who struggled to engage with professionals and who was furious at being admitted to hospital for self-harm and suicidality. During inpatient and hospital at home treatment, they went from refusing to attend the DBT sessions to creating a folder on DBT skills and what they had learnt, to completely stopping self -harming through the intervention. On discharge, they gave me a card and it simply and so powerfully said "Thank you for believing in me". I cared for a young person who had extreme anxiety and was confined to their room for months during lockdown. They made a remarkable recovery through a 4-week inpatient admission and 4-week HTT intervention. I was touched by the feedback I received at the end of treatment, about how my personalised recommendations on health and wellbeing, had made a difference to the young person and their family. Through the intervention of HTT, we managed a young person with psychosis and poor self-care. At the end of our three-month intervention, they were thankful for their recovery, return to education, normal function, and socialisation. There was a young person who told a colleague following a Care Programme Approach meeting (CPA) that what I had said in the meeting, was the first time anyone had ever stood up for them.

There was a young person who following an inpatient admission and transition to home, with great pride showed me their room, photos of their family, technology, and the music they liked. At the end of the tour, they asked me if I now understood why, they did not like being in hospital. My answer was that yes, of course I did. There was a gracious moment at the end of a challenging week when a young person thanked me and said that at least I try. There was a young person who personally asked me to sit down with them, to write a letter to our Chief Executive about the unit's poor internet connection. We were both pleased when they got a reply, with an individualised dongle and a letter saying that the matter would be investigated further. There are moments of relaxation when I take part with the young people in an activity group. There was a fun moment, when a young person announced to the team, that it is not every day that their consultant goes out with them for a walk. There are young people who delight in my custom sewn space scrubs. There is still the sadness for the young people who have not yet recovered, who have not found treatment beneficial or who are not at a better place in their journey.

There is a reality to the challenges we face, with increasing demands, workload, and reduced resources. There are societal and social determinants which affect disease development and inequalities across these domains. Systemic influences and familial patterns affect a young person's developmental trajectory and can either lead to psychopathology or resilience. Societal models which widen the gap between socioeconomic status only perpetuate the problem. Changing our perspective alone will not fix this mental health crisis. Healthcare models and systems can create innovative change. We can move away from models that are stuck trying to patch up old ways of working. This requires individual and collective change to influence these narratives. Each one of us working in healthcare has this responsibility, and our personal influence in our workplace should not be underestimated. Reassess why you came into this profession and reconnect with your population and the model you believe in.

Reflections from a Child and Adolescent Psychiatrist

By Dr Haseena Hussain

We often focus on what we have not achieved and find it easier to observe our faults. It is hard to cultivate an attitude of kindness towards ourselves. Sometimes we can get overwhelmed by all that is going wrong that we fail to see all that we have done right. As I look back at this past year there are so many more of these meaningful moments and as a acknowledge this, I realize that it is these moments, that have made the difference and kept me motivated in the work that I do. Even with increasing demands, exhaustion and overwhelm we all have these moments. There are these glimmers of hope in the challenges we face. They may not be obvious at first, but as we search deeper, we can see the small shoots of life peering through.

Dr Haseena Hussain, Consultant Psychiatrist
Hertfordshire Partnership university Foundation Trust

RCPSYCH PSYCHIATRISTS SUPPORT SERVICE

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

Our service is totally confidential and delivered by trained Doctor Advisor College members.

For information about the Coronavirus, please visit our **information hub**, you can also find specific **guidance for clinicians here.**

Get in touch with the support service

Call our dedicated telephone helpline on 020 8618 4020
Email us in confidence at **pss@rcpsych.ac.uk**

The service is available during office hours Monday to Friday

Back in my day

By Dr James Fitzgerald

Every now and again I hear from certain seniors who sing the great epic poetry of **back in my day**. These bards sing about the great golden age in which they practiced and the decline and fall of standards due to the current generation of doctors who are lazy, decadent, entitled and generally thick.

If they lived in the mid 20th century:

Back in my day, we didn't have the fancy treatments such as evidence-based medicine, working time directives, secondary services and patient advocacy. We worked in the golden age of mid 20th century psychiatry. All we had were supratherapeutic doses of neuroleptics, Lithium, 5 times a week ECT, and long stay wards to help regulate the neurotransmitters. We lived in a doctor's apartment across the road, not like juniors today who live in their own homes. Overnight, all 80 inpatients would be sedated and locked in their bedrooms, ready for their daily ward round and basket weaving before the morning handover. If we didn't do all that, our seniors would be angry and they would be right. We worked hard then, not like today…..

If they lived in the late 19th and early 20th century:

Back in my day, we didn't have the fancy treatments such as supratherapeutic doses of neuroleptics, Lithium, 5 times a week ECT, and long stay wards. We worked in the golden age of late 19th and early 20th century psychiatry. All we had were insulin shock therapy, straight jackets and surgery to remove teeth and gonads to help remove the cause of insanity. We lived in a single doctor's apartment in the hospital, not like juniors today who live in a doctor's apartment across the road. Overnight, all 180 inpatients would be sedated and strapped to their beds in the open single sex wards, ready for their daily treatments before the morning handover. If we didn't do all that, our seniors would be angry and they would be right. We worked hard then, not like today…..

If they lived in the age of the lunatic asylums:

Back in my day, we didn't have the fancy treatments such as insulin shock therapy, straight jackets and surgery to remove teeth and gonads. We worked in the golden age of the lunatic Asylums. All we had were ice water baths, leeches for blood-letting, regular beatings, indentured servitude and manual labour to balance the four humours and purify the corrupted soul. We lived in a communal dormitory in the asylum, not like juniors today who live in a single doctor's apartment in the hospital. Overnight, we made sure that all 900 inmates were regularly hosed with cold water in the twilight before the dawn, fresh hay in their cells, deloused with powder, and all the shackles well maintained in case they escaped in the night before the morning handover. If we didn't do all that, our seniors would be angry and they would be right. We worked hard then, not like today…..

If they lived in prehistoric times:

Back in my day, we didn't have the fancy treatments such as temples for the gods, alchemical potions or astrological formulations. We worked in the golden age of shamanic medicine. All we had were repetitive dance and drumming techniques, poultices made from animal fat, amulets made from the bones of dead ancestors and a sharpened bull femur to burrow into the possessed persons skull to let the demons out. We lived in a hut made of animal hides and sticks from the forest, not like juniors today who live in stone dormitories. Overnight, we made sure we harmonised our spiritual energy with all the gods of our land to maintain a bountiful harvest, fertility for the clan and to ward off evil curses and hexes before the morning handover. If we didn't do all that, our seniors would be angry and they would be right. We worked hard then, not like today…..

And I can guarantee that into the next millennium and beyond, the bards will still be singing:

Back in my day, we didn't have the fancy treatments such as up linking revised cybernetic neurocognitive functional processing units into the prefrontal cortex or administering extra-terrestrial synthetic psychopharmacology into the cerebro-spinal fluid via the foramen magnum. We worked in the golden age of 25th century psychiatry. All we had was ketamine based synthetic entheogens and neuroempathically designed cognitive transgenic reformulations. We lived on the cusp of an event horizon, not like juniors today who get to go to another dimension beyond time and space beyond which reality manifests itself. Overnight, we would be assessing and reconfiguring transhumanist dysfunctions

Back in my day

By Dr James Fitzgerald

on Alpha Centuri for 700 interdimensional lifetime units before the morning handover. If we didn't do all that our seniors would be angry and they would be right. We worked hard then, not like today…..

Dr James Fitzgerald, Specialty Registrar
Cambridgeshire and Peterborough Foundation NHS Trust

RCPSYCH Library Services

Our Library aims to support members in their practice by providing easy access to the best resources. The vast majority of these are available online but there is also a library space at 21 Prescot Street that is staffed Monday to Friday, 9.30am - 4.30pm.

Library services include: access to databases and journals, book borrowing, free literature searches and document supply.

For more information please click on following link:
Library | Royal College of Psychiatrists (rcpsych.ac.uk)

Tips for Mental Well-being for yourself, your children and what you can use to help others as well

By Dr Nita Agarwal

Things remain tough for many of us. I just hope the below tips which you might already be aware of can help in reminding ourselves to use them. There are things in which we don't have any control of, so instead of thinking and getting stressed about them, think of things you have control in, and days might become easier. Make sure you look after yourself.

Regular exercise. Walking in a local park or even with the use of a home-fitness DVD.

Eat a well-balanced, healthy diet and avoid excessive alcohol as this can worsen conditions such as depression and anxiety.

Even if you don't feel like making an effort, do some activities like drawing, listening to music, reading, writing, anything that will give a break to your mind and when not at work.

Good sleep is very important. Try to unwind before going to bed.

If you are worried about feeling low or your mental- health please speak to someone. Don't suffer on your own.

Avoid spending time on your own especially if feeling stressed. Talk to someone who will help in allaying your stress and anxiety rather than increasing it.

But if for you spending time on your own for a few minutes is comforting and helpful, then don't be afraid of that as well.

As a family- you can make a calendar, each person in your family can think of something which has gone well today and add it on calendar and put it on display so that every day all of you can read it.

Limiting the amount of time per day individuals spend reading about COVID-19, world news, browsing social media, internet can increase stress.

If you find you frequently ask others for reassurance regarding your health, or a condition you have concerns around; consider limiting the amount of time you discuss this topic with others. Instead use the time spent talking to friends/family to discuss a variety of topics.

Think of others…Sometime shifting concerns from our own and instead thinking of others and whether you can help them in any way is likely to have beneficial effects on our own mental health.

At points in the day when anxiety about your own health becomes high, try to distract yourself with other enjoyable activities.

Self-help books, many of which follows the principles of cognitive behavioural therapy- many people find them helpful.

Try different mindfulness techniques. Regularly practising relaxation techniques (not just at times of crisis) can help. There are self-help books to assist you with this.

Think of any new hobbies or jobs that you may wish to try. (I learned about a new hobby #Trainspotting from one of my patients).

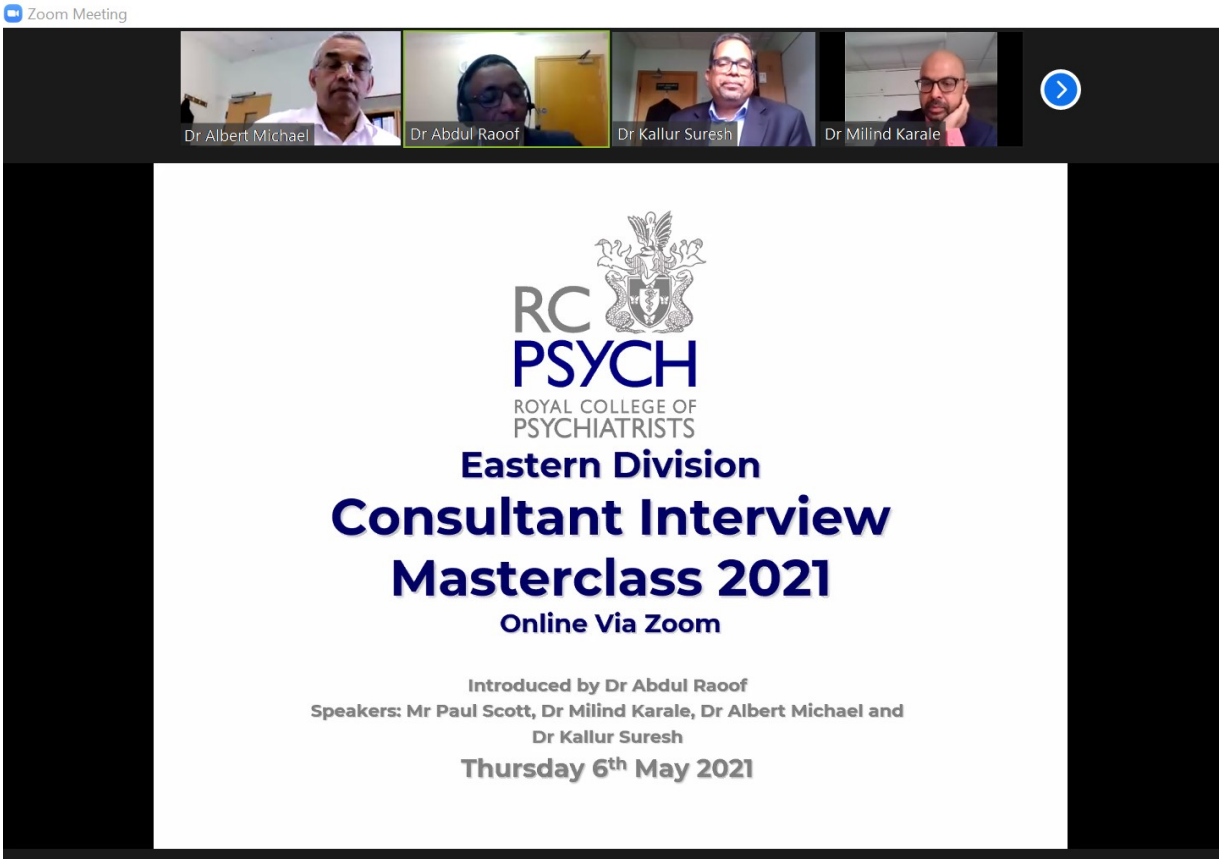
You can download free anxiety management tools. Living Life to the Full is a free online life skills course.

Build a jar of hope - as a family talk about what you have missed and what you hope for in the future, each member writes one down on a piece of paper everyday and put it in the jar. You can read these ideas when feeling low or having a bad day.

Dr Nita Agarwal
Editor

Eastern Division Consultant Interview Masterclass

By Dr Kallur Suresh



The Eastern Division hosted a new event on 6th May 2021 in order to support higher trainees preparing for upcoming consultant interviews. As part of this, the Division put together an interactive half-day programme on Zoom which comprised of four sessions.

It started with an introduction by the chair Dr Abdul Raoof followed by a talk from Mr Paul Scott, Chief Executive of Essex Partnership University NHS foundation Trust, who gave a CEO's perspective of what is important in consultant interviews. This was followed by a Medical Director's perspective on consultant interviews where Dr Milind Karale spoke about what a medical director would look for in a prospective consultant and answered questions from delegates about how to cope with interview questions.

Dr Albert Michael, an experienced college assessor then spoke about the role of the College representative on the Advisory Appointments Committee (AAC) panel and how the college helps ensure a fair process and adequacy of training in order to be appointed as a consultant psychiatrist in the NHS. The job descriptions approval process which is a part of this was also highlighted.

The programme concluded with the new Chair of the Division, Dr Kallur Suresh, giving some practical tips on excelling in consultant interviews. Delegates had lots of questions in this session and found it very insightful.

The masterclass received extremely positive feedback from all the delegates, who found it really helpful, informative and interactive. The delegates were unanimous in their opinion that a similar event should be repeated at least on a yearly basis and possibly expanded to include a mock interview.

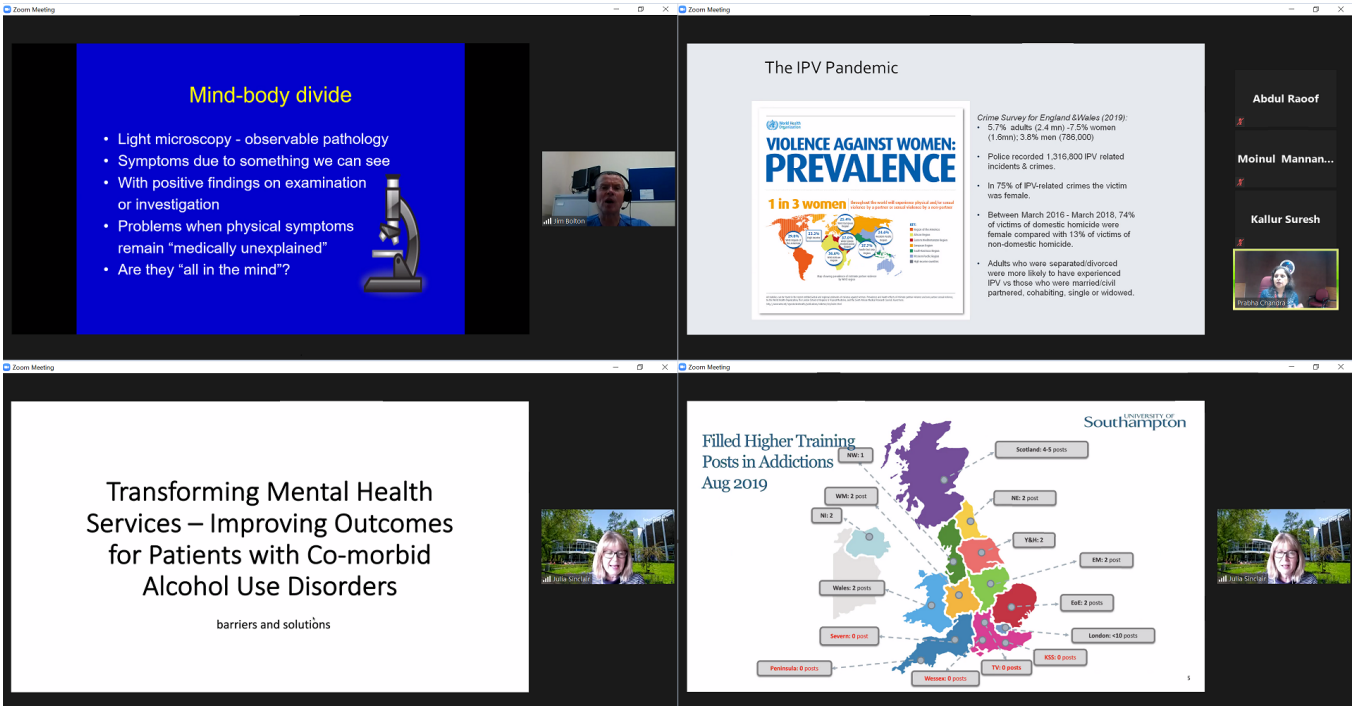
We had a total of 46 senior trainees and new consultants who registered for the event and the Eastern Division is very likely to host a similar event next spring.

Watch this space!

Dr Kallur Suresh, out-going Academic Secretary
Eastern Division

Eastern Division Spring Conference 2021

By Dr Kallur Suresh



The Eastern Division held its spring conference on Thursday, 10 June 2021, online via zoom. 74 delegates had registered for the conference and in line with current college policy, the event was virtual and this enabled us to invite international speakers to give talks at the conference.

The day kicked off with a welcome address by the outgoing chair Dr Abdul Raoof who reflected on the progress the Division has made in the last four years under his leadership. It is worth noting that the division has taken the lead in helping the Colleges CALC and eLearning team in developing and delivering national level section 12 and AC Approval and Refresher Courses.

Dr Jim Bolton, Chair of the Faculty of Liaison Psychiatry at the College delivered a lecture on assessing and managing medically unexplained symptoms. It was a good refresher of the basic principles of liaison psychiatry and how general hospital psychiatry has expanded in recent years with more funding available for such services, thereby enabling quicker discharges from the general hospital.

The first keynote address was delivered by Professor Prabha Chandra, a professor of psychiatry at the National Institute of Mental Health and Neurosciences, Bangalore, India, who spoke about the stark realities of gender-based violence and what psychiatrists need to know about this.

Dr Ahmed Huda, a consultant psychiatrist in early intervention team, spoke about the medical model in mental health and how psychiatric conditions are very similar to chronic medical disorders in their natural history and course, despite psychiatry following syndrome-based diagnostic model.

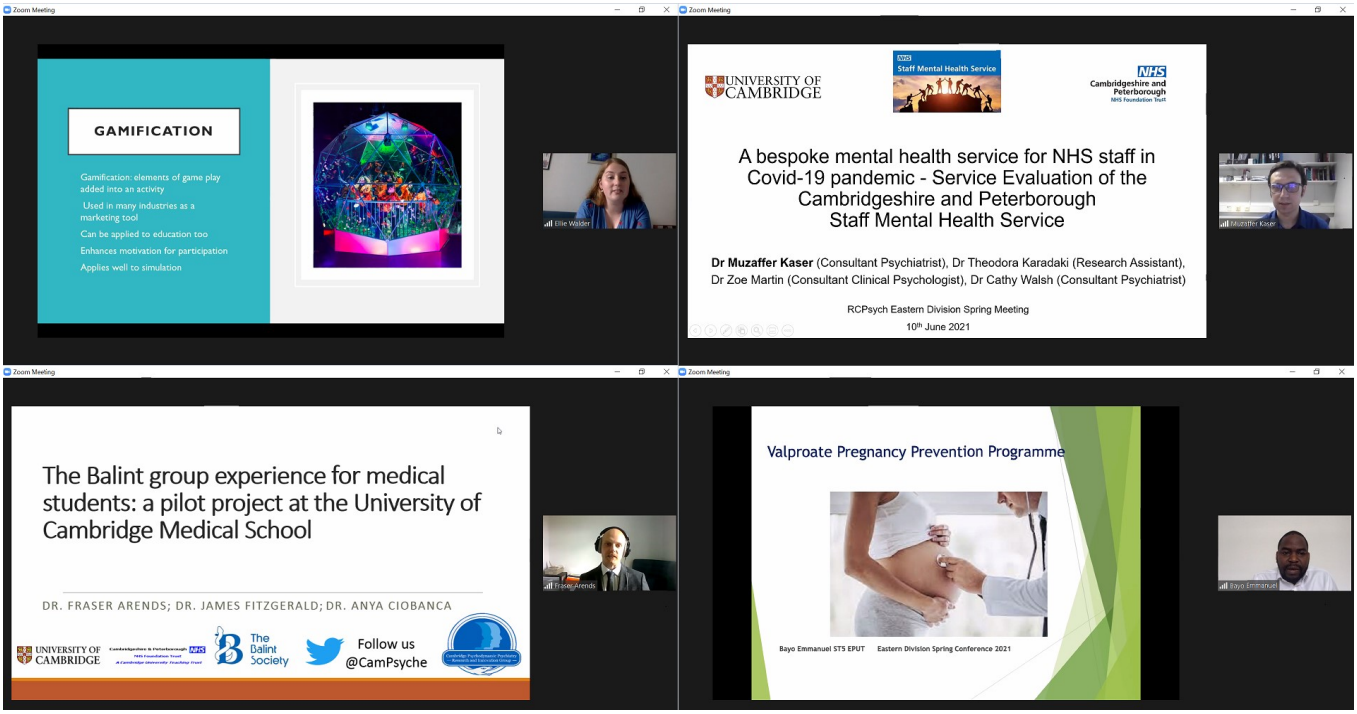
There were plenty of high quality posters to view during breaks and selected posters were presented by the relevant authors in the afternoon session in order to compete for prizes. The poster presentations were coordinated by Dr Albert Michael and Dr Kapil Bakshi.

Dr Kate Lovett, outgoing Dean of the College reflected on her time as Dean and the significant progress made in training and educating future generation of psychiatrists as well as how the College has adapted and minimised the effect of the pandemic on delivery of MRCPsych CASC exams.

Fiona Watson from the college library services briefly spoke about how members and Fellows of the college can utilise the library resource for research and literature

Eastern Division Spring Conference 2021

By Dr Kallur Suresh



Shortlisted delegates giving their poster presentations

search. The second keynote address was delivered by Professor Julia Sinclair on improving outcomes for patients with comorbid alcohol use disorders. She lamented the sharp decrease in the number of addictions consultants following the changes to the commissioning of addictions services some years ago.

The last item on the agenda was the prize presentations of poster competition and the Division congratulates all the prize winners for the outstanding quality of their research and presentation.

The Conference then came to a conclusion and delegates were invited to complete the feedback form for the event. We are happy to confirm that the conference received extremely positive feedback form delegates.

This year's autumn conference is scheduled for 4th November 2021 and it will be an online event.

Please visit the Division website for details of the programme and make sure you save the date in your diaries. We look forward to many more of you joining the autumn conference. Hopefully we can meet and network next year with the potential return to 'in person' events.

You can follow the activities of the Division on Twitter @rcpsychEastern or look out for email updates from the Division.

Dr Kallur Suresh, out-going Academic Secretary Eastern Division

Upcoming Eastern Division Events 2021

Eastern Division StartWell Event
Tuesday 5th October 2021

StartWell is a Consultant led initiative for Psychiatrists in their first five years as a Consultant or Locum Consultant. The event is also open to Higher Level Trainees.

StartWell focusses on 6 elements to support Psychiatrists in their first Consultant role with the intention to establish good habits for their careers.

Speakers: Dr Subodh Dave, Dr Mihaela Bucur and Dr Asif Zia.

For more information please click:
Eastern Division StartWell Event 2021 (rcpsych.ac.uk)

Eastern Division Autumn Conference
Thursday 4th November 2021

Our annual Autumn Conference suitable for Psychiatrists of all grades. The event will run online again via Zoom with excellent speakers, Poster Awards and Medical Student Essay Prize competition.

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

Speakers: Prof Naomi Fineberg, Prof Allan Young, Prof Peter Jones, Dr Adrian James and Prof Kam Bhui.

For more information please click:
Eastern Division events (rcpsych.ac.uk).

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Royal College of Psychiatrists, Eastern Division

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

Eastern Division Medical Student Essay Prize Autumn

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: £100
Eligibility: All medical students training in Medical Schools located within the Eastern Division.
Where Presented: Eastern Division Autumn Conference (online event) 4th November 2021

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: 29th October 2021
Submissions should be made to:
Moinul Mannan
Eastern Division Manager
moinul.mannan@rcpsych.ac.uk

Deadline for next edition
Submit your articles for Winter 2020 edition by 29 October 2021 at psychiatry.east@rcpsych.ac.uk

Royal College of Psychiatrists - Eastern Division E-Newsletter

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