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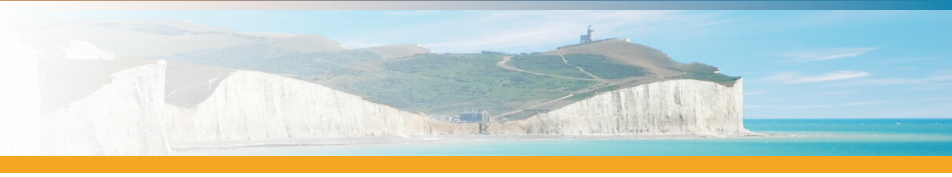
# Psychiatry-East

*The Eastern Division eNewsletter*

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

# Editorial



## In this issue:



Welcome to the Summer 2024 Newsletter. This edition should be a fascinating read as we have been fortunate to receive several high-quality articles with a diverse range of themes. Please do read our chair's column, where Dr Suresh highlights the strength of the division, the range of successful events organised in the past year, and upcoming vacancies.

Dr Fayyaz reflects on her experience at Springbank, highlighting the positive impact of a collaborative and least restrictive approach in treating patients with borderline personality disorder and challenging associated stigma.

Drs Chougule and Bala follow up on their previous article, focusing on the pharmacological management of dementia in primary care and non-specialist settings.

Dr Bergman highlights the need to consider the impact of contraceptives on women's mental health, advocating for personalised contraceptive choices to optimise patient wellbeing.

Dr Kumar describes his experiences as an international medical graduate (IMG) on an attachment, where he learned about patient-centred care and multidisciplinary teamwork. He calls for NHS trusts to create structured attachment programmes to attract more IMGs.

After much deliberation, we decided on a winning article. Congratulations to Dr Lowe on her humorous and educational piece on the impact of sleep disorders on mental and physical health. She emphasises the need for sleep education in medical training and for psychiatrists to prioritise sleep assessments and sleep hygiene over hypnotics.

Dr Lau critiques the representation of mental illness in Western TV and film, arguing that inaccurate portrayals perpetuate harmful stereotypes and stigma, adversely affecting public perception and patient wellbeing.

Dr Warr's film review explores how *All of Us Strangers*, through its depiction of self-discovery, grief, and trauma, resonates with themes of healing and psychotherapy, illustrating the transformative impact of confronting the past and opening to love.

In her book review of *The Fearless Organization*, Dr Matheiken describes how the author explores the role of psychological safety in fostering learning, growth, and innovation across different industries including healthcare and advocates for its integration into leadership practice.

Finally, Dr Manal, our outgoing Academic Secretary, provides a clear flavour of the day at the recent Spring Conference. On behalf of all, I extend my thanks to her for her dedication over the last few years.

Wishing everyone a wonderful summer.

**Dr Sepehr Hafizi, Editor, Psychiatry East**

# Chair's Column

By Dr Kallur Suresh

Hello again and welcome to another great edition of the Division newsletter. We were unable to bring out the winter edition of this newsletter due to unavoidable circumstances but this edition more than makes up for it. I am grateful to the Editors and all the contributors for their hard work in bringing out this double edition.

Looking at the broader political and health context, mental health has unfortunately not been high on the agenda of the parties which have been campaigning for the next general election. I sincerely hope that investment in mental health will continue to increase in line with the growing demand for services and the need for developing new services serving specific patient populations.

As I enter my last year as chair of the Eastern Division, it is both humbling to reflect on the Division's journey over the last three years. There have been several changes to the support structure of the division, the types of events that we have hosted and the way we have attempted to engage with local trusts and service providers. I'm hoping all of this will result in improved access and higher quality services for our patients and enhance the professional working experience of our members.

As Integrated Care Boards (ICBs) have become established and taken on the commissioning role, we as a division have started to engage with our local ICBs and starting conversations about developing new services and exploring opportunities for staffing existing services better. This is an exciting new space for the College to get involved in shaping and influencing service development to meet the needs of the local population.

This edition of the newsletter has attracted a good number of articles ranging from dementia to sleep disorders. Our editor Dr Sep Hafizi is always looking for contributions in the form of articles, reviews, audit reports and opinion pieces. Please submit your contributions in time for the next winter edition.

The Eastern Division has moved from strength to strength in the last year. We have continued to put on popular and high-quality events from the Eastern Division in the form of our spring and autumn conferences as well as events targeted at specific audiences such as our Consultant Interview Masterclass and ADHD webinars. The ADHD webinars hosted by our Division have been extremely popular and attracted a very high number of delegates.

The trainee conference in March was a very successful training conference hosted by the School of Psychiatry. The Consultant Interview Masterclass proved highly popular again and we were able to offer interview practice for many higher trainees looking for their first consultant posts. The spring conference at the Wellcome Genome Campus was praised for its high academic quality and attracted nearly 60 delegates.

We have a number of vacancies in the Division for various roles and please see page 20 for further details on how to apply. I would strongly encourage you to consider applying for these roles. If you need to speak to someone about the role, please contact me or our division manager.

I once again take this opportunity to thank you all for the work you do with our patients and their families and for your contribution to the Eastern division. I wish you all a good summer and look forward to seeing many of you at our autumn conference.

**Dr Kallur Suresh**
Chair, Eastern Division

## Eastern Division Executive Committee Members 2024

Dr Kallur Suresh - Chair
Dr Anna Conway Morris - Vice Chair
Dr Kapil Bakshi - Finance Officer
Dr Andrea Pathak - SAS Representative
Dr Ashish Pathak - ETC Representative
Dr Chris O'Loughlin - Elected Member
Dr Sepehr Hafizi - Newsletter Editor
Dr Abdul Raoof - CALC Lead
Dr Rakesh Magon - Mentoring Lead
Dr Nita Agarwal - Wellbeing Champion
Dr Sadgun Bhandari - Co-opted Member
Dr Albert Michael - Co-opted Member
Dr Fatma Ghoneim - PTC Representative
Dr Anto Eric Varughese - PTC Representative
Dr Tugba Kavasoglu - PTC Representative
Mrs Kate King - Service User Representative
Ms Liz Harlaar - Carer Representative

## Spring Conference 2024 Poster Winners

### Medical Students Category

**1st Prize** - Sangwoo Richard Jung, Dr Catherine Saunders, Professor Rudolf Cardinal, Professor Tamsin Ford
**2nd Prize** - Josiah Cho

### FY Trainees

**1st Prize** - Dr. Arun Rajaram, Dr. Kohul Subramaniam and Dr. Mithilesh Jha
**2nd Prize** - Dr Alice McKaigue, Dr Alexandra Coleman

### General Category

**1st Prize -** Dr Venkata Gudi, Dr Michael Albert, Dr Dev Vrat Singh, Dr Madhu Matthew
**2nd Prize** - Dr S Kumar, Dr D Hooper, Dr Smitha, Dr G Bengalorkar, Vedashree T, Chaitra BA

## Membership Survey 2024

The College has launched a short survey to understand members preferences.

**Membership survey 2024 (rcpsych.ac.uk)**

We'd like to hear about how you'd like to be communicated with, and how you'd like to be involved in College activities.

Completing this survey should take no longer than 5-8 minutes and will help us shape services to suit you, our members.

# My Reflections on Springbank

By Dr Arooj Fayyaz

Personality traits are enduring patterns of perceiving, relating to, and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts. Personality disorders are a group of mental health conditions that significantly impact an individual's thoughts, behaviours and emotions leading to difficulties in various aspects of life. Borderline personality disorder (BPD) is an often-misunderstood mental illness. The common characteristics involve affective instability, impulsivity, anger outbursts, inability to consider consequences, not being able to plan, unclear self-image, fears of abandonment, unstable or intense relationships, feelings of emptiness, and self-harm and suicide (1,2).

Stigma attached to BPD can have a lasting impact on those living with it. They may be labelled as difficult, manipulative or attention seeking. This can lead to discrimination and social exclusion. A lack of awareness and understanding can perpetuate stereotypes contributing to stigma, and hindering empathy and support. Healthcare professionals may hold biases due to the challenging nature of personality disorders thus limiting patient access to appropriate care. Patients may be blamed for their symptoms when perceived as intentional or controlled.

**Springbank Personality Disorder Recovery Unit**

Springbank is an inpatient recovery unit at Fulbourn Hospital in Cambridge, for individuals with BPD struggling to cope despite community input. The multidisciplinary team (MDT) offer a one-year therapeutic programme helping to improve the quality of life of patients by providing evidence-based therapies such as dialectical behaviour therapy (DBT) and skills such as mindfulness. Patients receive a combination of DBT, pharmacotherapy, occupational therapy, physiotherapy, and programmed activities including exercise, cooking, arts, and crafts.

The MDT practise a least restrictive approach in supporting patients and promote positive risk taking. Patients are not forced towards their recovery; they need to make an independent decision and be motivated to engage with the programme. They are not usually detained under the Mental Health Act. Individuals are encouraged to work on their personal growth according to their potential, and to engage in community activities such as volunteer work, driving lessons or anything that interests them, or they would want to pursue towards a career.

**Springbank and I**

Working as a doctor with patients with personality disorders can be challenging and rewarding at the same time. I had only seen these patients in acute settings when admitted in a crisis with increased suicidality or self-harming. With my limited experience I had developed a sense of judgement and prejudice. I believe working at Springbank has changed my perception and approach towards these patients. The team's philosophy is "At Springbank we are a family that supports one another to realise our dreams and reach our potential. We have a collaborative, least restrictive approach, which helps us to choose our recovery path and create a life worth living" (3). The team at Springbank are living up to their philosophy.

The first thing I found as unique was how the community meeting was attended by all patients and staff to discuss goals and activities for the day, and ended up with reading the day's menu and a loud celebratory tapping when dessert of the day was read out. Such an inclusive working environment was the very first positive thing I observed.

Previously, I had worked in settings where positive risk taking was not always put into practice. Although anxiety provoking for staff, believing patients may make impulsive or unwise decisions, positive risk taking can be empowering for patients. It allows them to make their own decisions and learn from the consequences. This leads to personal growth, improved wellbeing, and a positive attitude towards recovery. For the last two years as a speciality doctor on Springbank, I have witnessed many patients progress, taking charge, stepping outside of their comfort zone to pursue opportunities and experiences with the potential for positive outcomes.

Interacting with these patients was initially a challenge for me due to my own biases and their struggles with interpersonal relationships, emotional instability, and self-destructing behaviours. I soon realised how important it was to establish a therapeutic alliance and build trust. I have had the opportunity to have worked with such amazing determined patients who just wanted to be heard, understood, and supported. It can be easy for us to bring up their diagnosis and blame it on their behaviours and personalities, but I strongly believe that if treated and supported effectively we can

# My Reflections on Springbank

By Dr Arooj Fayyaz

make a huge difference in their lives.

Working on Springbank has been a refreshing experience. I have grown into a more patient and empathic human being and a better clinician. My main strategy at times has been simply listening. We all have our good and bad days, so why can't we give our patients that space, hear them out and support them when they need it. A collaborative approach has helped me support patients better, giving them the power to make decisions and gain the confidence they need to live more independently.

At Springbank we have a support system to address our own wellbeing. This includes groups such as reflective practice and mindfulness helping to prevent burnout, as working in mental health may be draining both emotionally and physically.

I have a better understanding of the diagnosis now and believe with patience and empathy we can support patients towards their recovery. It is a privilege to work at Springbank at such an early stage of my career where individuals are managed with respect and are heard and supported in the least restrictive way.

**Measures to Reduce Stigma**

I believe to reduce stigma attached to BPD it is important to educate everyone. More success stories should be shared about how we can make a difference. It is crucial to promote accurate information, have open discussions and foster good understanding. As clinicians I believe challenging stereotypes, and taking a least restrictive approach would be a small but important step towards patient recovery.

With Springbank as an inspiration, I believe working together in a positive and respectful way, we can create an inclusive and supportive environment for all patients with personality disorders.

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# Management of Dementia: Practical Strategies for Primary Care and Non-specialist

By Dr Amitkumar Chougule and Dr Balasubramanian Saravanan

**Introduction**

In recent years, there has been an unprecedented surge in awareness about dementia, with a strong emphasis on early diagnosis and treatment and with much of the focus being directed towards primary care, given the long-term nature of dementia. Patients who either cannot or choose not to visit specialist clinics, should still have access to diagnosis, medication and support. Primary care and non-specialist settings play an essential role in the care of this group of patients. This article provides a pragmatic approach to managing dementia in these settings (1).

**Section 1 – Guidelines for Pharmacological Treatment of Alzheimer's Disease Dementia**

Acetylcholinesterase inhibitors (AChEIs) like donepezil, galantamine, and rivastigmine are advised for those with mild to moderate Alzheimer's disease. Donepezil, as the drug with the lowest acquisition cost, should be the primary choice. In situations where patients with moderate Alzheimer's dementia are intolerant to AChEIs or have contraindications, memantine monotherapy is recommended. For those with severe Alzheimer's dementia, a combination of memantine and an AChEI is suggested.

The AChEI or memantine treatment should be initiated on the advice of specialists such as psychiatrists, geriatricians, neurologists, or other healthcare professionals with specialist skills in Alzheimer's care. Once a decision to start pharmacological treatment is made, the initial prescription may be provided in primary care. For those already on an AChEI, primary care practitioners may commence memantine treatment without additional specialist consultation.

**Section 2 – Guidelines for Pharmacological Management of Non-Alzheimer's Dementia**

In the management of non-Alzheimer's dementia, specific therapeutic recommendations are based on dementia type and severity. For Lewy body dementia (LBD) of mild to moderate severity, donepezil or rivastigmine are the primary recommendations, with galantamine considered only if the initial two are not tolerated. In severe LBD, donepezil or rivastigmine are advised, and memantine becomes an option if AChEIs are contraindicated or not tolerated.

For vascular dementia, the use of AChEIs or memantine is reserved for cases with suspected comorbidities like Alzheimer's disease, Parkinson's disease dementia, or LBD. In contrast, patients with frontotemporal dementia should not be prescribed AChEIs or memantine.

When addressing Parkinson's disease dementia, rivastigmine is the preferred choice in all severities due to its licensing and supporting evidence. However, in severe stages, memantine may be considered, especially if AChEIs are not suitable or tolerated.

**Section 3 – Precautions and Factors to Consider Before Initiating Pharmacological Treatment in Dementia (2,3):**

**Investigations:**

1. Renal function test
2. Liver function test
3. Pulse
4. ECG – if irregular pulse, bradycardia or cardiac co-morbidities present
5. Caution and enhanced monitoring with patients on beta-blockers and diltiazem.

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**Section 4 – Summary of Dose and Common Adverse Effects of Medications (4):**

| Drug | Dose | Common adverse effects |
|---|---|---|
| Donepezil | Start 5 mg at night. After one month may increase to 10 mg/ day | Diarrhoea, fatigue, headache, insomnia, muscle cramps, nausea, vomit- |
| Rivastigmine | Starting dose 1.5 mg twice per day. If well tolerated after minimum of two weeks, may be increased to 3 mg twice per day. Subsequent increases to 4.5 mg and 6 mg twice per day should be based on tolerability of current dose and considered after minimum of two weeks of | Agitation, anorexia, anxiety, confusion, diarrhoea, dizziness, nausea, nightmares, vomiting |
| Galantamine | Starting dose 8 mg in morning with food, increased to 16 mg/ day after 4 weeks. May increase to 24 mg/day after 4 weeks if | Nausea and vomiting. Serious skin reactions |
| Memantine | 5 mg/day for 1 week, may be increased by 5 mg increments each week to reach a dose of 20 mg/day | Dizziness, constipation, headache, hypertension, somnolence |

**Section 5 – Follow-up and Review (5):**

After starting an AChEI, schedule follow-up at three weeks to check for side-effects and adjust dose if necessary. Subsequent review at three months is crucial to assess therapeutic response. If no marked improvement and no adverse reactions, maintain the current regime and reassess after an additional six months.

**Section 6 – Management of Behavioural and Psychological Symptoms of Dementia (BPSD) (6):**

Over 90% of dementia patients will face challenges related to behavioural and psychological symptoms of dementia (BPSD) such as insomnia, wandering, restlessness, pacing, aggression, and lack of restraint including inappropriate sexual behaviours. These symptoms often indicate unmet needs or signs of distress. The initial step is to recognise and address these needs. It is essential to identify and treat any underlying pain or infection. Caregivers may require guidance and assistance.

**Drugs used for BPSD:**

For depressive symptoms antidepressants are recommended, sertraline is the SSRI of choice. Trazodone, with its useful sedating properties, may be used with a starting dose of 50 mg, once or twice daily. Benzodiazepines are associated with falls, confusion, sedation, and respiratory depression, and so their use is discouraged. However, lorazepam, may be used on an as needed basis to control agitation. The starting dose is 0.5 mg. In case of antipsychotics, risperidone is the only licensed drug for aggression in Alzheimer's disease. Its use should be regularly reviewed and ideally limited to up to six weeks. Please note that, except for small doses of quetiapine, antipsychotics are contraindicated in Parkinson's disease and LBD.

The behavioural management of non-cognitive symptoms in dementia is outlined in Table 1.

| Table 1- Behavioural Management of Non-cognitive Symptoms in Dementia | |
|---|---|
| Aggression | Assessment, psychosocial & behavioural management |
| Wandering | Physical exercise, long walks, identification bracelets, "stop" sign on the front door etc. |
| Sexual problems (decreased libido) | Identify cause, psychoeducation |
| Sexual disinhibition | Male nurses for male patients |
| Sleep disturbance | Assess full bladder, pain/ infections, decrease water drinking during evening, sleep hygiene |
| Incontinence | Identify treatable causes like UTI, drug use. Maintain diary, prompted voiding and reinforcement for appropriate voiding |

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**Summary**

1) Confirm dementia diagnosis and seek specialist advice if uncertain.
2) Evaluate severity, current risks, and check for BPSD. For cases with significant risks and severe BPSD, consider referral to appropriate services.
3) Conduct investigations and rule out contraindications for medications (see Sec 3).
4) Discuss medications, beneficial effects, potential side effects, and monitoring requirements with patient and/or family. Address progressive nature of the illness and set expectations for pharmacological treatment.
5) Initiate medication following guidelines (see Sec 1, 2, 4, and 6).
6) Monitor and review treatment (see Sec 5).

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# Are We Thinking Enough About Contraception in Our Female Patients?

By Dr Marianne Bergman

I used to be a GP Trainee and as a woman, many female patients would be happy to speak to me about their mood, hormones, contraception and hormone replacement therapy (HRT). Perhaps it is because I am physically small and that I have been told I seem approachable – or perhaps it is because they had reached the end of their tether and I was the person they had landed in front of! Either way, I was on the receiving end of many a hormonal horror story and it got me thinking a great deal about our attention as psychiatrists to those little contraceptive tablets – which often are a second thought, and sometimes we do not even list as 'medication'!

Recently, there has been much discussion about the impact of the menopause on women's mental wellbeing. Oestrogen and progesterone are neuromodulators, and we know that different HRT regimens work well for different women. I recently attended the fantastic Menopause and Mental Health RCPsych Course by Dr Louise Newson, GP menopause specialist, and asked the question "should we be thinking about using oestrogen containing preparations whenever we are able, given the positive effects of oestrogen on the brain?" Dr Newson kindly answered – and backed up what I had read before – that preparations such as Zoely (a new combined oral contraceptive pill with the progesterone, nomegestrol and a bioidentical oestrogen, estradiol) and Yasmin (a combined pill with drospirenone and ethinylestradiol) had good evidence in premenstrual syndrome (PMS), premenstrual dysphoric disorder (PMDD) and mood in general compared to other preparations (1,2,6). Yet, I have rarely seen them in our cohort, and research suggests our women are more at risk of mood related and hormonal conditions (3). Of course, there are good reasons for using different methods in populations with certain risks, but what about the risks of not providing the best option for those who are unknowingly affected by prescribed synthetic hormones.

Many groups have considered the impact of contraceptives on individuals. There have been grassroots movements in recent years to empower women about the choices available to them – rather than relying on the cheapest option at the time (cynical, I know). The fantastic 'The Lowdown' (8) is a website developed over the last few years which offers possibly the largest set of reviews of contraceptive pills available (46 combined and counting). And it is fascinating – pills lauded as 'the best thing ever' by some women are slammed by others for turning them into an emotional wreck. Coils that have saved marriages, have caused weight gain and acne in others. And from my GP experience, I have seen this first hand – one size does not fit all, and mood, sleep and weight can all suffer (symptoms vital to our patient assessments). There is a reason why such a range of pill choices continues to exist. Just as we cannot offer aripiprazole to all, we should not continue a blanket prescription for desogestrel 75 micrograms per day (under whatever brand name) without thinking about what might work better. We must consider whether contraceptive choices are affecting our patients' wellbeing and recovery given our knowledge about hormones and mood changes (3,4,5). Research is still ongoing in this area, however, as we listen to our patients when they tell us about side effects of psychiatric drugs, so we should pay heed also to the side effects of these powerful little pills.

Going forwards (as Dr Newson recommended) we should be asking the question 'Are your symptoms related to your hormones?' Indeed, when I ask female patients about hormones, PMS, contraception, nearly always, they have something to say. They tell me that no one has asked them before. They have stories of trying 100 different pills until they found 'the one' or they have felt rotten since starting a method but not mentioned it to anyone. Additionally, we know contraceptives can cause physical symptoms, such as nausea and headaches, and the jury is out on changes in weight. Could these be affecting our patients' mental state too? We know our patients can struggle to arrange to see a GP and advocate for themselves, to make links between pills they have been on for years and changes in their mood and emotions. Are our patients aware of the risks and benefits of the methods they are on, and, if not, how do we know? Do they know that the Depo-Provera contraceptive injection (which our cohort are far more likely to be on than those without mental illness) can reduce bone mineral density and cause weight gain, like some antipsychotics? It is easy to stay with a contraceptive method, but that does not mean it is always right (7). Perhaps we don't see contraceptives as something we need to consider, but they may have an impact on mental health, and may exacerbate the risks associated with the psychotropic medications we commonly prescribe. Please see Table 1 for common side effects and how to manage them (8).

Ultimately, more evidence comes out every day about the impact of hormones on mental health. I believe this evidence will only continue to grow. To offer the most person-centred decision making, it would be fantastic if we could ensure that our patients are on the best option for them and signpost them to appropriate resources: I

# Are We Thinking Enough About Contraception in our Female Patients?

By Dr Marianne Bergman

have listed some below. There are fantastic resources available online to help choose a pill based on side effects, and to offer a range of methods including long-acting contraceptives (7,8,9). Also, we need to ensure that we have asked the best questions about cyclical symptoms, and we are not missing a PMDD diagnosis or perimenopause. This certainly does come under our remit and should continue to be promoted along with menopause awareness. It may be that our patients are content with their hormones, but unless we ask these questions, we cannot truly know. And if we aim to be holistic then it is something we need to know.

**Table 1: Managing Common Adverse Effects Associated With the Combined Oral Contraceptive Pill** (8)

| Problem | Management strategies based on practice |
|---|---|
| Nausea | Reduce oestrogen dose<br>Exclude pregnancy<br>Take pills at night<br>Change to progestogen-only method |
| Breast tenderness | Reduce oestrogen and/or progestogen dose<br>Change progestogen<br>Consider using a pill containing drospirenone |
| Bloating and fluid retention | Reduce oestrogen dose<br>Change to progestogen with mild diuretic effect (i.e. drospirenone) |
| Headache | Reduce oestrogen dose and/or change progestogen<br>If headache occurs in hormone-free week, consider:<br>• extended use or<br>• giving oestradiol 50 microgram transdermal patch in this week or<br>• try oestradiol valerate/dienogest pill[18] |
| Dysmenorrhoea | Extended pill regimen to reduce the frequency of bleeding |
| Decreased libido | No evidence supports a benefit of one type of oral contraceptive pill over another |
| Breakthrough bleeding | If taking an ethinyloestradiol 20 microgram pill, increase oestrogen dose to a maximum of 35 microgram<br>Change progestogen if already taking an ethinyloestradiol 30–35 microgram pill<br>Try another form of contraception. Consider the vaginal ring. |

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# The Crucial Role of Clinical Attachments in Shaping Futures of International Medical Graduates

By Dr Shivakumar Ajay Kumar

Embarking on my journey as an International Medical Graduate (IMG) from India into the NHS has been a remarkable experience marked by adaptation, learning, and invaluable support from mentors and colleagues alike. For IMGs aiming to practice in the UK as junior doctors, obtaining a General Medical Council (GMC) licence entails facing the Professional and Linguistic Assessments Board (PLAB) exams, with the second part of the exam typically taken in the UK. This step requires leaving the familiarity of home and involves significant investment on multiple fronts: emotionally, financially, and in terms of time. However, the allure of being part of the NHS and engaging with its robust psychiatric landscape served as a beacon of inspiration for me.

According to the 2023 Workforce Report by the GMC, more than half the doctors who joined the NHS workforce in 2022 were IMGs (1). Despite the availability of opportunities such as the Medical Training Initiative (MTI) for IMGs with experience in their home countries, many young IMGs after PLAB exams, encounter significant challenges in securing relevant opportunities within their field of interest. It is widely acknowledged that IMGs hailing from diverse healthcare systems require a tailored approach to their integration into the NHS. For many young doctors, pursuing clinical attachments is vital in gaining a deeper understanding of the NHS, thus better positioning us to secure roles to serve in the NHS. These formative experiences during our nascent days in the NHS have the potential to shape the trajectory of our careers in profound ways.

This underscores the importance of implementing a structured clinical attachment programme at the trust level, particularly tailored to the needs of junior IMGs. Acclimatising to the NHS as an attachment student necessitates comprehensive induction and adept mentorship to maximise the learning experience. I was fortunate enough to secure an attachment in psychiatry under the guidance of Dr Ahmed Shoka and his team at the Peter Bruff Assessment Unit, Essex Partnership University NHS Foundation Trust (EPUT) and under the mentorship of Dr Dilshana Bapakunhi, Senior Registrar at EPUT, whose guidance has been instrumental since my days as a medical student in India.

During my clinical attachment, I actively engaged in multidisciplinary team meetings (MDTs), a new experience that broadened my perspective on patient-centred care. I had the privilege of observing procedures at the Electroconvulsive Therapy (ECT) clinic and attending the trust's weekly teaching programmes. Additionally, I had the opportunity to observe the memory clinic MDT discussions and also familiarise myself with electronic medical record systems used across the trust. Collaborating with the registrars, I embarked on a clinical audit and a case report project, a rewarding endeavour that further helped me understand that development across multiple domains is the way forward in the NHS.

Each moment spent during the attachment proved invaluable, particularly the enlightening discussions with the trust's pharmacists. These exchanges provided a platform to explore tailored management strategies for patients with unique needs. This collaborative approach epitomised the spirit of patient-centred care and represented a paradigm shift in the kind of clinical practice I was used to back in my home country.

I quickly learned that seeking guidance from colleagues is not a sign of weakness but a testament to their commitment to delivering the best possible care. I observed that with patient care, there is little room for ego or error. Within the NHS, teamwork is not just a catchphrase—it is the cornerstone of patient care. Rather than relying solely on individual expertise, healthcare professionals are encouraged to learn from one another. This collaborative environment is very new for young IMGs, and I slowly understood that it not only enhances outcomes for patients but also provides invaluable learning opportunities for doctors at all levels of experience.

As the number of IMGs seeking opportunities within the NHS continues to rise, securing suitable clinical attachments has become increasingly challenging. Many face obstacles such as misinformation and become victims of unscrupulous practices, sometimes leading to financial exploitation. These challenges not only hinder IMGs from gaining valuable experience within the NHS but also undermine the integrity of the system. Finding equitable solutions to these issues and possibly introducing official clinical attachment programmes at the trust level across the NHS is essential to ensure that young IMGs have fair and transparent access to opportunities within the UK. This will ensure that their experiences early on with the NHS are valuable.

# The Crucial Role of Clinical Attachments in Shaping Futures of International Medical Graduates

By Dr Shivakumar Ajay Kumar

As I now embark upon my journey within the NHS, I am humbled by the support and guidance I have received from my senior colleagues. By encouraging junior IMGs, we not only pave the path for a brighter future in healthcare but also foster a culture of excellence and innovation. Together, we can shape a healthcare landscape where every patient in the UK reaps the benefits of our collective commitment to nurturing the healthcare professionals of tomorrow.

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# Wakey, Wakey! Sleep Disorders – A Lost Territory of Psychiatry....?

By Dr Joanne Lowe

Do you know your sleep spindles from your theta waves, or your narcolepsy from your cataplexy? If the honest answer is no, this would not be a great surprise. Astonishingly, although sleep is something we all do and need, and the health implications of not getting enough of it are vast, the subject is largely absent from the Medical School curriculum, and only gets a cursory bit-part at the Psychiatry Training stage. All this, despite 1 in 4 of us claiming to have a sleep disorder and nearly half of us admitting to not getting enough sleep (1), 'not getting enough' equating to anything less than a minimum of seven hours per night (2). And, furthermore, all this despite the consequences of sleep deficit comprising, to name but a few, an increased risk of cardiovascular disease, some cancers, diabetes, obesity, a weakened immune system, reduced cognitive function and dementia, road traffic accidents and accidents at work. So disordered sleep or sleep deficit is a veritable car-crash, both literally and metaphorically.

As psychiatrists we are only too aware that sleep deprivation can precipitate mental illness, that mental illness can precipitate sleep disorder, our treatments can precipitate sleep disorder, and that our patients frequently come to us for help to ensure a good night's rest. Not only our patients, but all of us are prone to engaging in lifestyle habits which contribute to the Western-world's sleep deficit pandemic, such as alcohol consumption, smoking and use of stimulants, most notably that highly prized commodity, caffeine. That's not to mention the global addiction to blue-light liquid-crystal displays and light emitting diodes which obliterate our natural melatonin spike when we take them to bed for a quick scroll through the day's goings-on. In the spirit of 'parity of esteem' for all psychiatric disorders, the aim of the rest of this article is to focus your attention, albeit transiently, on the fascinating phenomenon that is sleep, and obviously to keep you awake and alert for the next five minutes, without you grabbing any cheeky micro-sleeps before the end.

Where to start? We have so much to learn about this neglected and yet so fundamental a topic: what constitutes normal sleep? How should we conduct a sleep disorder assessment? Which of the over 100 sleep disorders do we need to know about? What is the relationship between sleep disorder and mental disorder? What do we need to know about sleep and medication?

Let's for now turn attention to some basics and engage in a little myth-busting relating to melatonin, the 'Vampire Hormone' (it comes out at night). There are two factors (relating to sleep, not relating to this writing) which will determine how likely you are to want, either to stay awake, or fall asleep, right now. One is your suprachiasmatic nucleus, the 24 hour- (+ 15-minute) clock, lying deep in the middle of the brain, ideally placed over the crossing of the optic nerves, the optic chiasm. This suprachiasmatic bunch of 10,000 neurons instructs your pineal gland to send out melatonin to bombard you with the message 'it's dark, it's dark, and it's time to sleep'. However, contrary to the belief of many, including those who prescribe it, melatonin does not play much of a role in generating sleep. It is the time-keeper, but not the generator. Melatonin's role is to create a day-night rhythm, that makes you feel alert or tired at regular times of the day or night. Incidentally, melatonin the hormone was discovered by a mind-bending experiment where the melatonin of a cow was noted to change the colour of a frog, but that is for another day (3).

The second factor determining whether you are desperate to doze off or not is the under-appreciated chemical, adenosine. Adenosine increases in concentration the longer you spend awake, paying close attention to the amount of time that has elapsed since you woke up. Increased adenosine brings increased 'sleep pressure' or 'sleep drive' and increased sleep pressure will make you want to crawl under the duvet asap. Adenosine is a cool compound: it both suppresses the wake-promoting brain regions and stimulates the sleep promoting brain regions. That is unless you turn the kettle on right now and get yourself a mug of adenosine-receptor antagonist….. If you have indeed now made a beeline for the coffee jar, spare a quick thought for your brain. You have chosen to imbibe a psychoactive drug, which even if absorbed a whole six hours before your bedtime stands a high chance of reducing your sleep time by up to one hour (4). And you can extrapolate from that the result of having your coffee two hours before bedtime. And if you fell asleep in the last minute or two, please reread the first paragraph which will remind you why this is ill-advised! Additionally, in the shorter term, you are electing to disturb your non-REM (NREM) sleep, and by association your mind's ability to consolidate memory, particularly declarative memory. So, if you are approaching the MRCPsych exam diet, or any other exam diet, consider your nutritional diet and try your best not to

# Wakey, Wakey! Sleep Disorders – A Lost Territory of Psychiatry....?

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fall prey to the temptation of having an extra coffee, tea, Coca-Cola or ten bars of dark chocolate, to cram those last essential facts at the end of the day. In the long run you will be far more productive by prioritising the ZZZs. It's a no-brainer (pardon the pun).

Just one last reminder for all of us seeing sleep-challenged patients…. Max out on the sleep hygiene assessment and information-giving before maxing out on the Z-drugs, benzos and/or antihistamines!

Thank you to Professor Matthew Walker, Department of Psychology, University of California, Berkeley, for his inspiration!

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# The Stories We Are Told: Representation of Mental Illness in Western TV and Film

By Dr Gloria Lau

Psychiatry has always been affected by shifting political landscapes and cultural attitudes towards mental health, and there are few better ways of understanding this than the way mental illness is portrayed on our screens. The stories we are told shape the way we perceive the world, and mounting evidence shows that the brain can process media similarly to the direct experiences we have in our everyday interpersonal interactions (1,2). This makes TV and film, which are more widely accessible than ever, incredibly powerful tools to change public perception (3). Historically, Western film and TV have perpetuated the harmful stereotypes within the public consciousness that underlie stigma towards those with mental illness (4). Among other deleterious consequences, stigma can lead to low self-esteem, avoidance of help-seeking behaviours for fear of rejection, and prejudice and discrimination against these groups. All of these worsen outcomes for our patients (5,6). This makes stigma and its representation a topic of concern that all psychiatrists should be engaging with.

I argue that Western TV and film often inaccurately represent mental illness for the purpose of making a story more interesting or palatable. This is often brought about through dramatisation, leading to the portrayal of characters suffering from mental illness as frightening and 'other'. However, while less frequently discussed, this can also be through romanticisation and trivialisation. Both are borne of lack of nuanced understanding of mental illness, and both can play into its damaging stereotyping and stigmatisation.

In 1960, *Psycho* (7) began the trend of unstable 'psychopathic' killers which has become a popular staple trope of the thriller genre. Since, the idea that mental illness and violence are intrinsically linked has been perpetuated by many other shows and films (8), for instance in the more recent *You* (9) and *Joker* (10). After all, as psychiatrist Peter Byrne says, "*follow the money* is the first rule of movie psychiatry" (11): Hollywood is not above using mental illness as a plot device or to create sensationalist moments of shock and controversy. Indeed, over the last 30 years, popular TV shows and movies have disproportionately connected mental illness with violence, risky health behaviours and aggression (4,12). These narratives feed into the stereotype of mentally ill people as 'other' and to be feared, further widening the chasm of 'us' and 'them' which can leave stigmatised people feeling isolated and unable to reach out for help (13).

On the other hand, there is the romanticisation and trivialisation of mental illness; the idea that the struggle is to be admired or that it can be overcome with sheer will alone. *13 Reasons Why* (14), a show about a teenage girl who takes her life and leaves behind a series of videos which blame the actions of others for her decision, opens the conversation for important topics such as the consequences of sexual assault and bullying on mental health. However, it also romanticises suicide, which is depicted as a form of revenge used by the character to torment her tormentors, and which garners her all the attention and sympathy she had craved in life. She is painted as a victim, and a vigilante. One study found a significant increase in suicide rates among US adolescents in the months following the show's release, while taking predicted trends into account (15). It could be argued that televised romanticisation of mental illness should be considered irresponsible, and those who suffer the consequences are the impressionable young people watching at home (16).

Another example of a 'positive portrayal' turning sour is *The Big Bang Theory*'s (17) character Sheldon Cooper, a brilliant physicist with evident traits of autism spectrum disorder (ASD) who is 'specially gifted'. This is a mental illness stereotype seen in other movies and films (18,19), such as *Rain Man* (20) and *A Beautiful Mind* (21). His behaviours are largely depicted as endearing and quirky. The wider cast tease him for his obsessive rituals and difficulty understanding social subtext. He is forgiven for saying things that are inadvertently offensive but ultimately harmless, with canned laughter designating his behaviours as amusing. What the show fails to capture are the real lives of people with ASD. These stories are myriad, and few are represented here. Alongside periods of joy and calm can be pain, trauma, screaming, self-harm and strained relationships. Sometimes their stories involve frustration at a world that they cannot comprehend and that fails to comprehend them. Caricaturising mental illness, offering a 'watered-down' version in the form of one-dimensional characters, creates unrealistic expectations of how people with ASD should act, and makes light of their struggles (18,22).

Fiction is powerful: it piques the imagination and emulates experiences and relationships in the mind. Fiction can perpetuate or diminish stigma in a way facts and figures simply cannot. It has been theorised that media providing positive representation of a stigmatised group can reduce prejudice (2,23). And indeed, there exist many examples of films and TV not discussed here which attempt to accurately portray mental illness and do a good enough job that they can even be used to educate patients and psychiatrists (11). However, even well-meaning and thoroughly researched media can

# The Stories We Are Told: Representation of Mental Illness in Western TV and Film

By Dr Gloria Lau

struggle to accurately portray what it is really like to live with these disorders (11,19). To draw closer to accurate and sympathetic representation requires improved understanding of mental illness, and also for this to be informed by lived experience – not just of a few patients, but of a sample which is truly representative.

As psychiatrists, our understanding of mental illness is cultivated by the countless stories we hear from our patients over our careers. As such, we have a responsibility to join the discourse and to educate the public in a way that is clear and free from medical jargon. We can encourage patients to share their stories, and act as advocates when they are unable to articulate their own experiences. If you are a psychiatrist reading this article, you already have a wealth of experience to share, which could dispel misinformation and feed into a kinder societal narrative for those experiencing mental illness.

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# Film Review: All Of Us Strangers
## (Directed by Andrew Haigh. UK: Searchlight Pictures; 2023)

By Dr Lianne Warr


In *All of Us Strangers*, Adam, a screenwriter (masterfully portrayed by Andrew Scott) ignores the things that cause him pain, occasionally indulging in weed, Chinese takeaway and 80s *Top of the Pops* re-runs to feel a little better (1). It's time though for him to take on the task of (finally) writing about his parents, who died in a car crash when he was 12. Adam and his real-life creator (writer & director Andrew Haigh) are painfully aware what a cliché this could be, but deftly avoid melodrama throughout. Instead, with a cast full of ghosts and Scott's heartbreaking subtlety, Haigh pulls off a gut-wrenching exploration and explosion of grief, trauma and "The Power of Love".

Something starts to open up in Adam; a spark with Harry (Paul Mescal) ignites around the same time he starts visiting his childhood home. Things take a surreal turn as Adam finds the ghosts of his parents waiting for him there, bringing him in from the cold, toasting him with whisky and marvelling at the man he has become. Mum (Claire Foy) bakes him flapjacks and pours him tea – he finally comes out to her. Or the ghost of her. The idea of her.

In an interview with *The Guardian*, Haigh described "a generation of queer people *grieving* for the *childhood* they never had" (2) which made my heart hurt, not least because it reminded me so strongly of things patients had said to me during my psychotherapy placement last year. And not just things said, either; things I felt and *ached* from in the transference. As part of the creative process, Haigh returned to his own childhood home: "I started getting eczema again, and I'd not had eczema since I was a kid. It was coming up in the exact same places. I thought, 'What the f*** is happening to me?' I feel there is a sense that your body remembers trauma. Somehow things get almost embedded in your DNA, and they find ways to leak out" (2). Yes Andrew Haigh, I thought. That is *exactly* how it is, inevitably reminded of van der Kolk's *The Body Keeps the Score* (3).

The whole film reminded me, palpably, painfully, of therapy and the things I felt that during that year-long placement with my patients. Adam returns to his parents' home at intervals throughout, entering a thoughtful, liminal, almost hallucinatory place. I thought of the challenges faced by patients in their journeys to meet me in the therapeutic space: 'one foot in the past; one in the present'. When Adam reaches the door, the ghost of either mum or dad is there to greet him. On occasion they are both there. They decorate the Christmas tree together whilst The Pet Shop Boys version of "Always on my Mind" plays in the background. Mum sings to him (1):

*Maybe I didn't treat you*
*Quite as good as I should have*
*Maybe I didn't love you*
*Quite as often as I could have*
*Little things I should have said and done*
*I just never took the time*

# Film Review: All Of Us Strangers
## (Directed by Andrew Haigh. UK: Searchlight Pictures; 2023)

By Dr Lianne Warr

*You were always on my mind,*
*You were always on my mind.*

I'm not ashamed to tell you I cried in the cinema.
In another scene, Adam's father (Jamie Bell) essentially tells him 'it's alright if you're gay; don't mind mum'. Adam opens up and tells him how much he struggled growing up, how he was bullied and called a girl; how he came home at night to cry alone in his room. Dad tells Adam he knew all along. There is a heartbreaking pause (and one of those Scott micro-expressions that slay me) – I'm paraphrasing here:

Adam: "You heard me crying? So why didn't you come in?"

Dad: "I thought maybe that if I'd been your age, I might have been one of those bullies too."

Adam: "Yeah. I think I knew that."

But here, Adam gets to rewrite some of his history, sobbing as his father hold him close and strokes his hair (I also cried…again). In the mirror, we see Adam reflected as a little boy. In the therapy room too, parental ghosts were tangible. I hope I was able, in some small part, to enable my patients to look at their ghosts directly and salvage some compassion for themselves as children; maybe for their ghosts (living or dead) as well.

At the end, Adam makes a choice, to open himself up to love (or the possibility of it, at least). He has told Harry already how his grief and self-loathing tangled themselves together in a knot in his chest, which he would do anything to avoid feeling. I was a total wreck myself by the end (as you may have predicted). I thought about the special role we can play in helping our patients confront reality and start the healing process in untangling those knots. Adam's parents have the chance to tell him they're proud of him. Again, I'm paraphrasing here:

Adam: "Why would you be proud? I haven't achieved anything for you to be proud of."

Mum: "You have been through all this, and *you're still here*. That's why we're proud."

I'm proud of my patients, I thought. And I thought about "The Power of Love".

P.S. The soundtrack was banging.

P.P.S Don't worry about me I'm always crying at films.

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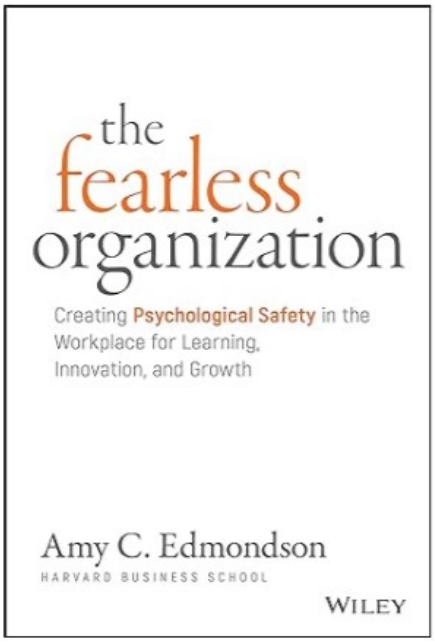
# Book Review:
# Amy C Edmondson's The Fearless Organization

By Dr Shevonne Matheiken




In this book, Edmondson brings together over two decades of research on psychological safety and its importance in learning, innovation and growth across different industries (1). There is a particular focus on why the healthcare industry (which is included under VUCA* organisations) has much to learn from these findings.

Psychological safety is defined by the author as **the belief that the work environment is safe for interpersonal risk taking**. She describes how every day at work entails a series of micro-decisions which involve interpersonal risk, and that our weighing up of the pros and cons of these decisions determines what we say or do. Within a large organisation, there can be pockets of high and low psychological safety. Edmondson quotes Professor Edgar Schein (who wrote about this in the 1960s), and notes that psychological safety is vital for helping people overcome the defensiveness and 'learning anxiety' they face at work, especially when something does not go as expected.

In explaining the title of her book further, Edmondson refers to evidence from different industries to demonstrate that fear truly inhibits learning and cooperation. She points out regretfully that many managers (consciously and otherwise) still believe in the 'power of fear to motivate'. She makes an important clarification that working in a psychologically safe environment does not mean people 'always agree with each other for the sake of being nice'. The candour expected is far from staying in one's comfort zone, it is the willingness to engage in productive conflict so as to learn from different points of view.

Edmondson goes on to make it clear that in VUCA organisations psychological safety is 'not a perk', but a core requirement. She opines that being able to create psychologically safe environments should be a vital leadership skill for managers. This is because it can make or break an employee's ability to contribute, grow and learn, and collaborate. She writes about the dangers of silence where the culture of an organisation does not encourage (or tends to punish) those who voice their concerns out aloud. Several useful terms are explained with context in this book such as 'situational humility' and 'proactive inquiry'. In relation to the benefits of diverse teams, Edmondson highlights that diverse teams cannot be linked to innovation and efficiency by default, unless there is also psychological safety. She shares important findings that support psychological safety as even more vital for employees who are minorities in relation to various characteristics.

This is not the first book to make references to the aviation industry as a guide for the healthcare industry to do better, particularly in relation to attitudes to risk management and errors. One of the most gripping bits for me was the narration of the bird strike event (leading to dual engine failure), which took place 90 seconds after Flight 1549 took off from New York City's LaGuardia Airport on 15 Jan 2009 (2). This was a rare event, one that was not in the instruction manual and classed as a 'non-normal situation' in aviation jargon. Essentially, it meant that the pilots were on their own, with the advice being limited to 'use common sense and good judgement'. It made me think of what healthcare leaders, scientists and politicians faced at the start of the COVID-19 pandemic: an unexpected crisis that did not come with a guidebook, one that needed quick decisions to be made, and one that would cost (or save) lives depending on the consequences of these risky decisions. I will not break the suspense of that story here, but hopefully you will read it for yourselves.

Another interesting industry example highlighted in the book is that of Pixar (3). The book describes the undefeated success of Pixar's 19 consecutive films, after their debut with *Toy Story* in 1995. A crucial component

# Book Review: Amy C Edmondson's The Fearless Organization

By Dr Shevonne Matheiken

of their production process is Pixar's 'Braintrust' which operates with 3 rules:

1. Feedback must be constructive, about the project, not the person. Also, the filmmaker should not be defensive or take it personally and be willing to hear the truth.
2. Comments are suggestions, not prescriptions.
3. Candid feedback must not come from a 'gotcha' attitude but from a place of empathy.

By using the Braintrust process of early peer feedback to embrace failure, they succeeded in avoiding later high-stakes failures. Regarding the complexities of running such a peer feedback group, Edmondson talks about the 'fragile and temporal nature' of psychological safety and the need to exercise caution in scenarios where candid feedback can be 'destructive'. This can happen in the absence of constant monitoring of peer group dynamics by those leading it, which may result in outcomes far from those intended.

Another important part is the author's description of the practical steps on how psychological safety can be created in the workplace and the barriers in doing so. She talks about the need to destigmatise failure as being crucial to the success of this process and includes a self-assessment tool for leaders.

Edmondson ends the book by answering some questions that may arise in the reader's mind:

- Won't having psychologically safe workplaces take too much time?
- I'm all for psychological safety at work, but I'm not the boss. What can I do?
- Is psychological safety about whistleblowing?
- Help! My colleague is bringing his true self to work and it is driving me crazy!

In summary, I found this book enlightening and comprehensive on the topic of psychological safety in the workplace. The author presents compelling research data in a simple and engaging manner. It is well-referenced and mentions other books which may be of interest to the reader on related topics. I would recommend this book whether you hold a formal leadership position or not, considering that we all have a duty to contribute towards creating inclusive and fair workplaces. The new GMC good medical practice guidelines (2024) also highlight this duty (4).

*VUCA – volatile, uncertain, complex, ambiguous environments, first described in the context of the US Army.

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4. Good medical practice 2024: https://www.gmc-uk.org/professional-standards/good-medical-practice-2024



**Dr Shevonne Matheiken**
ST6 in Old Age Psychiatry, Cambridgeshire and Peterborough Foundation NHS Trust

# Eastern Division Spring Conference 2024 Report

By Dr Manal El-Maraghy


Our latest conference held on the 26th April 2024 in the beautiful settings of Genome Wellcome Campus in Kingston Hall in Cambridgeshire proved another successful enjoyable educational event covering a variety of topics delivered by esteemed speakers.

Dr Kallur Suresh, the Division Chair, unfortunately, could not join us. With the support of the dedicated members of the Exec, Mr Moinul Mannan (Divisions Committee Manager), Mr Michael Jamieson (Divisions Event Manager) and Mr Gareth Griffiths (Divisions Administrator), the day went smoothly.

After a short introduction, during which attendees were invited to have an active role within the division and have their voice heard in the college, I introduced and chaired the first session.

We started the day by bringing in the topic of "Global Mental Health", an important topic, high on the Agenda of the Royal College of Psychiatrist. Professor Mohammed Al-Uzri gave an excellent talk addressing the challenges in International Psychiatry. Prof Al-Uzri is the Presidential Lead for Global Mental Health with a great portfolio establishing and been the College Advisor for Medical Training Initiative (MTI). He was awarded – beside many others awards and medals – the Royal College of Psychiatrist Highest Honours: The Honorary Fellowship of the College for his services to Psychiatry in UK and Overseas in 2023. He summarised the College international strategy and addressed some of the challenges. The College is keen to deliver training but to ensure positive impact and sustainability taking into account culture and logistics. His inspiring speech was followed and complemented by the practical experience of Dr Peter Hughes who continues to work with the WHO. Dr Hughes is the founder of the Volunteering Special Interest Group at the College. The title of his talk was "Global Mental Health- Why it is important". Sharing his experiences, his talk took us on a virtual visit to many countries and exposed the audience to a number of cultural differences and reference to stress and resilience where there is war and trauma. Dr Hughes was a consultant psychiatrist in London and Chaired the London Division of the RCPsych but now he is interested in integrated mental health in primary care. He laid out the principles of Global Mental Health on a hierarchy, with basic services and security at the base, then going up to community and family support, then focused non-

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specific support; at the top of the pyramid specialised service can be met.

Before a short break we had a presentation from the poster winner among the medical students.

We returned to our lovely bright lecture room to listen to a talk by Professor John O'Brien about disease modifying therapy for dementia. Prof O'Brien is a professor of Old Age Psychiatry in the University of Cambridge; he is a National Institute for Research Emeritus Senior Investigator and a Fellow of the UK Academy of Medical science. He spoke to us about the new advances in and understanding of this debilitating illness, giving hope that there are new approaches. Recent positive results from anti-amyloid treatments for Alzheimer's disease were highlighted with a possible major impact on current treatment pathways. Are we looking at Alzeheimer disease without dementia?!!. The amazing talk was followed by a presentation from the poster winners in the category of FY trainees.

The audience went on for a lovely social delicious lunch break with time to visit the poster exhibition and have some fresh air in the beautiful surroundings of the Genome Wellcome Campus.

The theme for the first part of the afternoon session was about functional neurological disorder (FND). Dr Anna Conway-Morris, Consultant Psychiatrist for Eating Disorder in Cambridge and Head of School chaired the afternoon session. She invited the poster winners from the general category to present before she introduced Dr Matt Butler. Dr Butler's talk focused on clinical presentation, pathophysiological mechanisms and treatment principles. Dr Butler is a specialist registrar in Psychiatry in SLaM and a Welcome Doctoral Clinical Research Fellow. He kindly shared wealth of research works he was involved in and threw a light on the most recent advances in using psychedelic treatment for FND referring to a systematic review where 69% of patients had made some recovery while 23% had made a full recovery. His highly clinical illustration was followed by an interesting and intriguing talk from Dr Mohamed Gheis about the Global impact of FND. Dr Gheis is a Clinical Assistant Professor of Psychiatry and he flew all the way from British Colombia Canada where he practices now, however his training was in Wales and UK. He took us back as far as the pharaohs' understanding of the physical aspect of mental health then fast forwarded to here and now looking at the burden of FND on global economy, illustrating the absence of equity and concluding that solutions could be found with global legislative trends, in strategies, in research and in digital technology.


*Poster presenters at the conference*

After this heavy session we went off for a short break for some coffee and a last opportunity for connection with colleagues. On return, winners for first prize were announced in all categories and they had the opportunity to take a photo with Dr Anna Conway-Morris. The audience stayed until the last session not worried about the traffic and still as interested to listen to Prof Sagnik Bhattacharyya, Professor of Translational Neuroscience and Psychiatry at King's College in London. His presentation focused on the association between cannabis use and outcomes in psychotic disorders such as schizophrenia and how this difficult dual presentation can be managed. He illustrated his points by referring to the results of several research studies many of which he has led on. His enthusiasm and interest in the topic kept all attendees engaged till the very end.

The day had to come to an end and all left in good spirits. The preliminary verbal feedback is overall very positive.

**Dr Manal El-Maraghy**
Academic Secretary, Eastern Division

# Upcoming Eastern Division Events 2024

## New Frontiers in Dementia: Are we ready for disease modifying treatments? (Webinar)
## 8th October 2024

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

## Eastern Division Autumn Conference 2024
## Friday 25th October 2024

**Fielder Conference Centre, Hatfield Business Park, Hatfield Ave, Hatfield AL10 9TP**
**Speakers to be confirmed**
**More information will be available soon. Please click:**
**Eastern Division events (rcpsych.ac.uk)**

**Follow us on Twitter:**
**@rcpsychEastern**

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# Eastern Division Vacancies

We are currently looking to recruit enthusiastic and experienced members in the Eastern Division

## Current Appointed Vacancies

**Forensic Regional Representative**
**Liaison Regional Representative**
**General Adult Regional Representative**
**Neuropsychiatry Regional Representative**
**Medical Psychotherapy Regional Representative**
**Eating Disorders Regional Reprentative**
**Deputy Regional Advisor**
**Academic Secretary**

**Eastern Division vacancies (rcpsych.ac.uk)**

**If you are interested in taking up any of the above posts please email moinul.mannan@rcpsych.ac.uk, including a copy of your CV.**

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**: £200
**Eligibility**: All medical students training in Medical Schools located within the Eastern Division.
**Where Presented**: Eastern Division Autumn Conference 25th October 2024

**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: 4th October 2024**
Submissions should be made to:
Moinul Mannan
Divisions Committee Manager
moinul.mannan@rcpsych.ac.uk

**Deadline for next edition: Friday 25th October 2024**
**Submit your articles to: psychiatry.east@rcpsych.ac.uk**

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

**Editor:** Dr Sepehr Hafizi, Cambridgeshire and Peterborough NHS Foundation Trust
**Chair:** Dr Kallur Suresh, Essex Partnership University NHS Foundation Trust
**Review Board:** Eastern Division Executive Committee, Royal College of Psychiatrists
**Production:** Moinul Mannan, Divisions Committee Manager, Royal College of Psychiatrists