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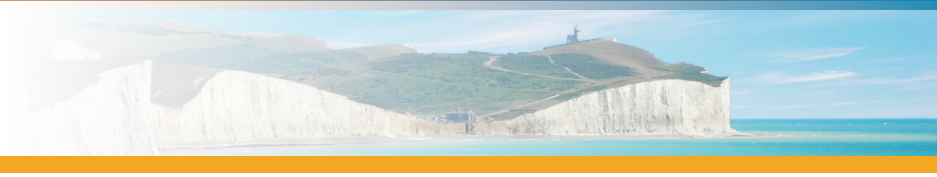
Psychiatry-East

The Eastern Division eNewsletter

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

Editorial



In this issue:

Welcome to the Summer 2023 edition of the Eastern Division Newsletter. I am delighted to take on the role as the new Editor. I thank my predecessor Dr Nita Agarwal for her great contributions as Editor in recent years.

As usual we start with the Chair's Column where Dr Kallur Suresh highlights recent successful events in the region. He also encourages members to apply for upcoming vacancies.

I congratulate Dr James Barclay for his winning article: 'Can We Live and Age as Who We Truly Are? The Future of Equality, Diversity and Inclusion'. This is a fascinating essay about putting communication and relationships at the heart of psychiatry especially by combating stigma & discrimination and increasing inclusivity for older adults.

This is followed by 'Evaluation of Dementia: Practical Strategies for Primary Care and Non-specialist' by Dr Amitkumar Chougule and Balasubramanian Saravanan. They provide a systematic approach including an algorithm for guiding non-specialists in diagnosing dementia. Dr Praseedom writes in 'When a Patient Dies: A Personal Perspective' about her experiences, thoughts and feelings of when she was faced with a patient death. She openly shares the lessons that she has learnt hoping this would help colleagues both junior and senior facing similar issues.

Dr Ekkehart Staufenberg as a neuropsychiatrist, outlines in 'Valproate Prescribing and the Latest Update from The Medicines and Healthcare Products Regulatory Agency - Clinical Caveats to Consider' his concerns if the new directives regarding valproate prescribing come into effect. He suggests that these changes would be costly and damaging to the health of many patients.

We then have two articles by foundation doctors in our region, Dr Collette Russell with 'Psychiatry Exposure in a Regular Foundation Training Programme Post' and Dr Deepak Sharma with 'My Experiences as a Psychiatry Foundation Fellow'. They describe their training experiences in psychiatry and make recommendations for improving things for the future. These are followed by my review of Peter Attia's bestselling book *Outlive* which is about longevity, including how to achieve a longer 'healthspan'.

Finally, Dr Manal El-Maraghy reports on our successful Spring Conference which took place at the Wellcome Genome Campus Conference Centre at Hinxton in May 2023. I hope that reading her report encourages you to think about attending our next conference in the autumn. Before that may I wish you all happy reading and an enjoyable summer.

Dr Sepehr Hafizi, Editor, Psychiatry East

Chair's Column

By Dr Kallur Suresh

It's hard to believe that another six months have gone by since I wrote my column last autumn. So far, 2023 has been a very busy and productive year for the Division. We started the year with a January webinar on ADHD in adult women which received a record number of registrations. The speaker, Laura McConnell, deftly brought together clinical knowledge with lived experience in a thought provoking way.

We ran the Consultant Interview Masterclass again at the end of February and many senior trainees took advantage of the training session. The workshop was highly interactive and feedback from delegates showed that it helped them prepare for their upcoming consultant interviews.

Our Spring Conference 'Psychosis: What is New' was on Thursday 18 May and attracted a record number of registrations. It received very good feedback on its high quality academic content and the delegates enjoyed the experience of being able to meet face-to-face and network with one another. Please look out for publicity regarding the Autumn Conference to be held at the Wellcome Genome Campus this November.

The Eastern Division is again taking part in the MindMasters quiz at the RCPsych International Congress in July. Please attend the Congress in good numbers to cheer on our team. We are also planning a Dean's Grand Round later this year. The College Engagement Network is ongoing and has good representation from our Division. The aim of the network is to ensure mutual learning, consistency and good planning in implementing the Community Mental Health Framework.

I want to draw your attention to a number of vacancies within the Division, some of which we have already filled. However, we do have some other vacancies and I would welcome your interest and contribution in filling them. Please see page 21 for details and how to apply.

I'm sure it's been a busy year for all of you on the clinical and service front. Please let me know if the Division can support you in anyway. The demand on services has never been greater. Thank you all for the work you do for your patients, your organisations and for the wider mental health cause.

It is good to see things returning to normal after more than two years of disruption to the way we work. The rest of 2023 looks set to pose more challenges, including industrial action by some NHS staff. Good planning and preparation should go a long way towards minimising some of the adverse impact of the strikes on patient care.
This is a time of significant change in the health service and service transformation does have an impact on the way we work. It is important that as clinical leaders, we contribute to shape any changes, always keeping our patients at the centre of everything we do. Any change can be anxiety provoking and may seem difficult to adjust to. But it also provides ample opportunities for continuous quality improvement, especially for those who are willing to take positive risk and engage in the change constructively.

The Division's Executive Committee has been working hard to put on some of the events I mentioned earlier. We meet four times a year and these meetings are well attended. There is usually representation from central college staff. If you wish to become part of the Executive Committee, please look out for publicity about upcoming elections for vacant posts.

The rest of this newsletter has many interesting and high quality contributions. We are always looking for members to contribute articles to the newsletter. We publish original research, opinion pieces, audits and QI projects, service evaluations and topic reviews. Please contact our editor Dr Sepehr Hafizi for more information and for submitting articles.

I wish you all a great summer!

Dr Kallur Suresh
Chair, Eastern Division

Eastern Division Exec Members 2023 (before Congress)

Dr Kallur Suresh - Chair
Dr Anna Conway Morris - Vice Chair
Dr Kapil Bakshi - Finance Officer
Dr Manal El-Maraghy - Academic Secretary
Dr David Middleton - ETC Rep
Dr Ashish Pathak - Co-opted Member
Dr Abdul Raoof - CALC Lead
Dr Nita Agarwal - Elected Member
Dr Rakesh Magon - Mentoring Lead
Dr Andrea Pathak - SAS Representative
Dr Sepehr Hafizi - Newsletter Editor
Dr Albert Michael - Co-opted Member
Dr Sadgun Bhandari - Co-opted Member
Dr Natalie Ashburner - PTC Rep
Dr Anto Eric Varughese - PTC Rep
Mrs Kate King - Service User Rep
Ms Liz Harlaar - Carer Rep

Spring Conference 2023 Poster Winners

Medical Students Category

1st Prize *- Lorna Bo (Med Student), Dr James Fitzgerald (ST5), Dr Fraser Arends (ST6)*
2nd Prize *- Jessica Harding (Med Student), Prof Paul Fletcher, Prof Bernard Wolfe*

FY Trainees

Joint 1st prize *- Dr Sarah Perrott (FY1), Dr Angus Macleod (Consultant)*

Joint 1st prize *- Dr Anmol Arora (FY1)*

3rd prize *- Farakish (FY2), Dr Girdlestone (FY2), Dr Jenkins (FY2), Dr Sonagara (SHO), Dr Sri (consultant supervisor)*

General Category

1st prize *- Dr Sabrina Das (CT2), Dr Catherine Weeks (ST6), Dr Trevor Broughton (consultant)*

2nd prize *- Dr Chandranathan Magesh (CT2) , Dr Humaira Hasin (CT1), Dr Sima Shende (Consultant)*

3rd prize *- Dr Deepash Hosadurg (GPST), Dr Vandana B Menon (Consultant)*

Multidisciplinary Category

1st prize *- Dr Osagbai Joshua Eriki (CT2), Dr Ngozi Agunwamba (ST6), Dr Alice Hill (CT2), Dr Lorna Almond (CT3), Ms Maniya Duffy (Occupational Therapist), Ms Devashini Naidoo (occupational Therapist), Dr David Ho (Consultant Psychiatrist), Dr Raman Deo (Consultant Psychiatrist)*

2nd prize *- Dr Alana Durrant (ST4), Dr Pedro Ramos Barbosa (CT1), Dr Ruth Chipperfield (Cons Psychiatrist), Dr Stephanie Casey (Clinical Psychologist), Molly McWilliam (Trainee Cognitive Behavioural Therapist), Rhiannon Reed (Assistant Practitioner), Angela Alderdice (Nursing Associate)*

3rd prize *- Dr Ngozi L. Obiejemba (Specialty Doctor), Yetunde C. Adeniyi (Consultant), Olayinka O. Omigbodun (Consultant)*

Can We Live and Age as Who We Truly Are? The Future of Equality, Diversity and Inclusion

By Dr James Barclay

In November 2022, headlines were made when Ngozi Fulani, a black British charity boss, was repeatedly asked where she was "really" from by Lady Susan Hussey, the late Queen's lady-in-waiting. As various commentators explained, this question – ostensibly neutral – when directed at British people of minority ethnic backgrounds, can mask a more sinister underlying message: "you cannot possibly be British" (1). Lady Hussey apologised and has since resigned (2). The relevance of this episode for our purposes is as follows: old age psychiatry is also in the business of finding out "where our patients are from", not by insensitive questioning that leaves the patient feeling disempowered, but through empathic enquiry into their formative experiences and relationships, family history, beliefs, values and sociocultural context. Only through this understanding can we find effective interventions for our patients. This article will make the case that if old age psychiatry is to embrace equality, diversity and inclusion (EDI), it must return to basics: namely respectful therapeutic alliances, with patients being treated as individuals and placed at the heart of their care.

The consultant psychiatrist Dr Russell Razzaque has argued that "the relational pillar has atrophied" within mental health settings (3). Against a background of reductions in funding and staffing crises, the current care climate prioritises rapid throughput and shorter episodes of care, arguably relegating the therapeutic relationship to an afterthought. This effect may be exaggerated in older adult services. Patronising communication towards the elderly in clinical settings (or 'elderspeak') can hinder good clinician-patient relationships (4). Doctors can be guilty of excluding older patients from medical decision-making, turning to relatives instead (5). In a study that presented doctors with two identical case histories of depression – one in a young patient and another in an older patient – the older patient was more likely to be diagnosed with dementia or a physical illness whilst the younger was correctly diagnosed (6). The same study found that older adults were less likely to be referred for specialist treatment. The combination of poor communication with ageism within psychiatry is demonstrably incompatible with fairness, inclusion and good quality care.

Of course, ageist stereotypes are not restricted to healthcare. Despite there being more people than ever before in older age groups in the UK, ageism remains rife in our society (7). The ubiquity of "anti-ageing" products within the beauty industry illustrates this well. To return to the episode referenced above, various commentators attempted to defend Lady Hussey by pointing to her advanced years (she is 84), insinuating that problematic behaviour around race was somehow to be expected from the elderly (8). One consequence of negative societal stereotypes about ageing is that the patients we see in our clinics will inevitably hold biases, conscious or otherwise, regarding their own advanced years, a phenomenon known as self-stereotyping. There is research to indicate that participants with negative beliefs about ageing die on average 7.5 years earlier than those with more positive beliefs (9) and are more likely to develop dementia (10). Psychiatrists have a responsibility to understand the sociocultural influences acting upon their patients, while never losing sight of the uniqueness of the individual sitting in front of them.

Capturing our patients' sociocultural contexts within case formulations, including instances of carer strain, will also help us to find meaningful interventions. We live in an increasingly socially disconnected age and for many of our patients, loneliness will be a factor in their presentation. The elderly are at particular risk due to the life stressors potentially encountered alongside ageing including retirement, bereavement and loss of hearing and vision (11). Spouses or partners of elderly patients may experience a higher degree of carer burden compared with working age adults due to their increased vulnerability to frailty and ill health themselves. The RCPsych EDI policy highlights a form of discrimination called "direct discrimination by association" whereby an individual is treated unfairly due to their association with someone with a characteristic protected under the Equality Act 2010 (12), and indeed a recent study looking at stigma in dementia caregiving found that over two thirds of family carers reported a degree of social ostracism due to the health needs of their loved one (13). At the level of major mental illness, there has been growing interest in approaches such as "Open Dialogue" which emphasise consistently involving the patient's core social network in treatment (14). Such approaches do not appear to have been widely trialled in the elderly population so this may be a promising avenue for the future. An eye to context in psychiatric assessments can help to identify and address areas of difficulty in the system around a patient, as well as harnessing the system's strengths.

We are of course working in an imperfect system, and many of the system's shortcomings are a consequence of unprecedented strain within both health and social care settings. Any innovation will require creativity at an organisational level. In my own practice I have seen inspiring examples of collaboration between NHS and

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By Dr James Barclay

third sector organisations such as Mind's "Stepping Stones" scheme in Hertfordshire, which allowed volunteers to support inpatients through the discharge process by assisting with social care queries and signposting to sources of community support (15). This feels particularly relevant for older populations who can feel excluded by modern systems requiring access to smartphones or computers. Old age psychiatrists should also be outspoken in championing primary care social prescribing programmes that link patients with community resources, not as a substitute for existing treatments but rather as a complementary approach (16).

In summary, we must once again place relationships and communication at the heart of our values base as a profession, while raising awareness of the impact of ageist stereotypes in healthcare. Alongside this we must ensure our interventions make use of the resources found within our patients' family systems and communities. In this way we can create a future for old age psychiatry that is experienced by patients as being truly fair, inclusive, empowering and embracing of diversity.

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Dr James Barclay
ST6 Psychiatry, Hertfordshire Partnership University NHS Foundation Trust

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

By Dr Amitkumar Chougule and Dr Balasubramanian Saravanan

Dementia is the seventh leading cause of death and one of the major causes of disability among older people globally (1). According to the Alzheimer's Society, if current trends continue, the number of people with dementia in UK is forecast to increase to 1 million by 2025 and 1.59 million by 2040 (2). Patients who do not wish to attend a memory clinic or undergo investigations, and frail patients especially in care homes, often fail to receive a timely diagnosis. This is an important step for receiving tailored support and treatment enabling people to lead full lives and engage with their families and communities for as long as possible. In view of current strains on specialist services, clinicians in non-specialist settings are essential for providing an early diagnosis. Here we describe a practical approach for the diagnosis of dementia in non-specialist settings.

Dementia is an umbrella term to describe chronic widespread cognitive impairment, associated with significant changes in functioning. These impairments may have a number of causes and are progressive and largely irreversible. Diagnosis is essentially a two-stage process. Stage I: diagnosis – should be differentiated from delirium, depression, drug treatment, concomitant physical illness, and normal memory loss that accompanies aging. Stage II: determining cause – commonest cause is Alzheimer's disease, followed by vascular dementia, Lewy-body dementia, and frontal lobe dementia.

There are three primary expressions (3):

1. **Neuropsychological** – amnesia; aphasia (receptive or expressive); apraxia; agnosia
2. **Neuropsychiatric** – with associated symptoms such as psychiatric and behavioural disturbances
3. **Deficits in activities of daily living (ADL)** – problems in dressing, eating, and going to toilet.

This triad is common to all dementias, differentiation being based on clinical presentation, presence of other features and other aspects of history and examination.

It is important to recognise that diagnosis should be "timely". This means that diagnostic assessment should be considered when the patient wants it and, in some cases, when the carers need it. This should not stop clinicians from raising awareness on the need for early diagnosis and the availability of resources. Ruling out other diagnoses is important as a dementia diagnosis has substantial emotional, legal and social implications (4). The clinical presentation can provide a major clue about the diagnosis and can help with ruling out other diagnoses.

Step 1: Ruling out diagnoses that may mimic dementia

Scenario A: subjective complaint of cognitive decline. In patients with subjective cognitive decline, it is important to rule out clinical depression, anxiety disorders, age appropriate cognitive decline, sleep disorders, medication-related cognitive decline, other medical conditions like severe constipation, thyroid disorders, iron and vitamin deficiencies (thiamine, niacin, vitamin B12, vitamin D), problems with eyesight and hearing, recent concussion, amnestic disorder and mild cognitive impairment as these conditions can present with a dementia-like picture especially when the patient has more than one condition.

Scenario B: carer observation of significant cognitive decline, patient with limited insight. Here establishing good rapport, reassurance and a rapid assessment of insight and capacity can go a long way. Irrespective of cognitive decline and capacity, an attempt should be made to seek consent from the patient before obtaining carer history. One must rule out delirium, acute neurological conditions, and substance intoxication before proceeding with the dementia workup. NICE guidelines recommend the use of the following tools to differentiate dementia from delirium along with history and examination (5): Long confusion assessment method (CAM) and Observational Scale of Level of Arousal (OSLA).

If it is not possible to differentiate between delirium, dementia, and delirium superimposed on dementia, treat for delirium first. In case of acute neurological condition or substance intoxication, appropriate referrals should be made. When above conditions are ruled out and patient is presenting with severe cognitive and functional decline along with significant behavioural challenges then the person may have progressed to advanced dementia with associated behavioural and psychological symptoms of dementia (BPSD). In such cases, cognitive examination is not usually feasible and a referral to the memory clinic should be considered.

Approach to evaluation (6). Good history and examination along with relevant investigations for suspected diagnoses help. Where there is doubt do a cognitive assessment. Abbreviated Mental Test Score (AMTS) and GPCOG take few minutes and are appropriate for screening.

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If above tests suggest significant cognitive decline, further cognitive assessments must be arranged, with a longer appointment time or home-visit and tools like Montreal Cognition Assessment (MOCA) and Addenbrooke's Cognitive Examination (ACE-III). A normal score almost always rules out the diagnosis. However, NICE guidelines recommend "do not rule out dementia solely because the person has a normal score on a cognitive instrument" (5). Where diagnosis is unclear or objective cognitive decline is noticed on tests, then further steps should be followed.

Step 2: Arriving at dementia diagnosis – following ICD-10 criteria must be fulfilled (7):

1.	**ICD-10 Criteria**	**Tools for assessment**
	√ Decline in memory characterised by impairment of registration, storage, and retrieval of new information √ Impairment of thinking and of reasoning capacity, and a reduction in the flow of ideas √ Difficulty in attending to more than one stimulus at a time and to shift focus of attention	1. Detailed history from patient and/or reliable carer/family member 2. MOCA 3. ACE-III
2.	Evidence of clear consciousness	1. History 2. Mental status examination (MSE)
3.	Impairment in personal ADL secondary to cognitive decline	1. History 2. Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE) or the Functional Activities Questionnaire (FAQ) (NICE, 2018)
4.	Duration of cognitive decline and impairment of ADL for >6 months	History

Step 3: Dementia subtypes

NICE do not recommend diagnosis of dementia subtypes in non-specialist settings and encourages referral to specialist services (5).

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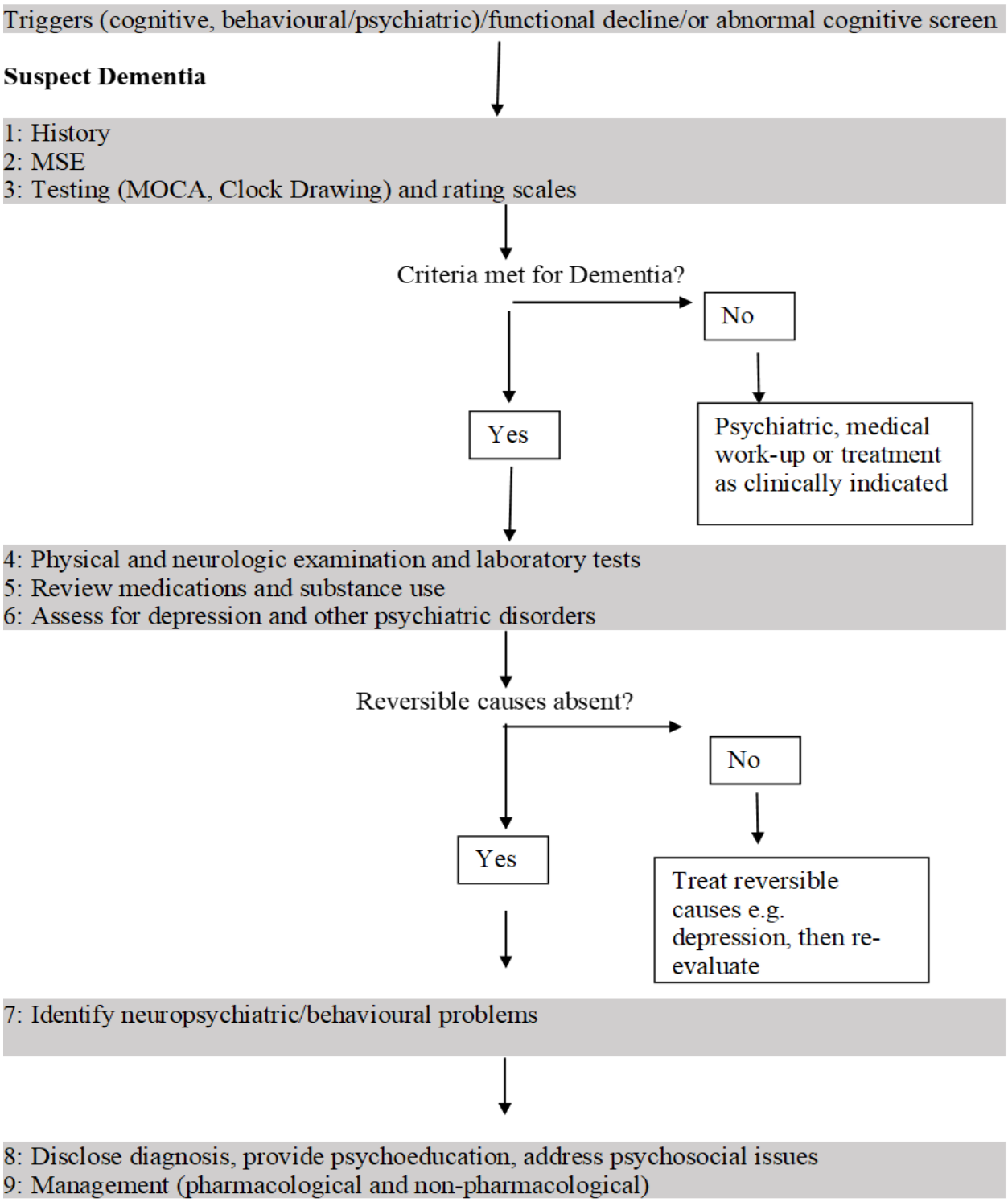
Algorithm for Assessment of Dementia in Primary Care (8,9):



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Conclusion

Dementias are a heterogeneous group of clinical syndromes unified by symptoms of deteriorating cognitive and behavioural function. Patients require a thorough history, targeted evaluation, and ongoing psychopharmacological and psychosocial management. Evaluation is challenging and requires a systematic approach. Primary care physicians are ideally situated to diagnose dementia, provide treatment and attend to the needs of caregivers.

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Dr Amitkumar Chougule
ST5 in General Adult and Old age Psychiatry, CPFT

Balasubramanian Saravanan
Consultant Psychiatrist; Cambridge Crisis Team, CPFT

When a Patient Dies: A Personal Perspective

By Dr Asha Praseedom

We knew when we were medical students that once we were fully-fledged doctors, we would deal with matters of life *and* death. Why then does it hit us so hard when a patient dies? We are human, and loss of life affects us, no matter how experienced we might be. However, I wonder if it might also have something to do with the fact that we have not been taught to *expect* deaths in mental health settings.

Even the most severe of conditions that we manage are not considered terminal, and this means that any death when it occurs, is an unexpected death. In addition, a death by suicide automatically triggers various internal and external processes ranging from an internal investigation to a coroner's inquest and beyond.

Being a psychiatrist of a certain vintage, I have had my fair share of negative outcomes. Two in particular have however been seared in my memory.

The first was that of a man with an established diagnosis of severe mental illness and a history of sporadic engagement. He had had several years of stability in the community, but yet another relapse sadly resulted in his death. The second incident was that of a young woman with a personality disorder, who had been under the care of services for several years. She sadly passed away after taking an overdose. This inquest was particularly difficult because of the lasting effects it had on some nursing colleagues.

These were two very different individuals, both of whom had however become so distressed by the symptoms of their respective conditions that they decided to end their life, despite everyone's best efforts. Both deaths also triggered a tsunami of consequences for the clinicians that had tried their best.

What lessons if any, might one take from these experiences? My own experience has taught me the following:

- It is indisputable that we do what we do because we want our patients to get better
- A patient failing to do so can feel like failure, and the death of a patient by suicide might feel like the ultimate failure
- This belief can often be reinforced by difficult investigation processes, confrontational families, hostile coroners, and unsympathetic systems
- Good support systems are essential to managing one's well-being
- We need to be kind to ourself, no matter how difficult this might seem at the time
- Support groups for psychiatrists exist; consider joining one
- Ongoing liaison with coroners' services and related agencies is essential to improving the experience of psychiatrists dealing with patient deaths
- The Royal College of Psychiatrists has a Patient Safety Group as well as a Working Group on the Effect of Suicide and Homicide on Psychiatrists. Beyond these groups the college has many Special Interest Groups – please do consider joining, there is strength in numbers.

You may find the following resources helpful:

Support services:

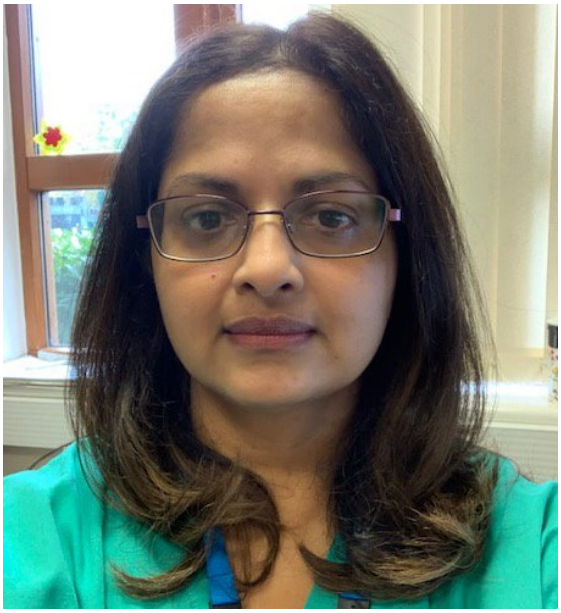
RCPsych Psychiatrists' Support Service (Helpline: 020 8618 4020; Email: pss@rcpsych.ac.uk)

The section of the RCPsych website relating to your wellbeing if a patient dies by suicide:

https://www.rcpsych.ac.uk/members/workforce-wellbeing-hub/if-a-patient-dies-by-suicide

For trainees and trainers:

Oates A, Gibbons R. After a patient dies by suicide: an illustrative case for trainee psychiatrists and trainers. BJPsych Bull 2022;46(5):293-7.



Dr Asha Praseedom
Consultant Psychiatrist, Cambridgeshire and Peterborough NHS Foundation Trust

Valproate Prescribing and the Latest Update from The Medicines and Healthcare Products Regulatory Agency - Clinical Caveats to Consider

By Dr Ekkehart Staufenberg

The Medicines and Healthcare products Regulatory Agency (MHRA) have recently published an update on the safer prescribing of valproate containing medicines (including sodium valproate, semi-sodium valproate, valproic acid) for patients (1). As a direct result, and in the presence of limited current evidence, consultant led prescribing of valproate is becoming an increasingly 'policy' driven initiative with highly restrictive consequences on clinical practice.

To date the different formulations of valproate are used in wide-ranging applications across numerous and difficult to treat neuropsychiatric conditions; some of these conditions may carry a significant risk of mortality through diverse number of mechanisms. The therapeutic indications for valproate, some with associated ICD-11 codes (2), include the following:

- Bipolar disorders (6A60 – 6A6Z)
- Seizure and epilepsy syndromes (ranging from 8A60.0Y – 9D52) – more than 64 separate illnesses with often very limited therapeutic/pharmacological options for treatment, particularly if associated with autism spectrum disorders (ASD – see below)
- Brain injury-related neuropsychiatric presentations
- Neurodevelopmental disorders (6A00 – 6A0Z) including ASD and attention deficit hyperactivity disorder
- 'Augmentation' of antipsychotics in non-affective psychotic disorders
- Migraine-related conditions including those with associated seizures (ranging from 8A80.0 – 9D52)
- Multiple other conditions where valproate may act as a 2nd or 3rd line therapeutic agent

Following Sir Norman Lamb's seminal initiative about 6 years ago to address the relatively high prevalence of foetal malformations and bring this to the attention of the House of Commons (personal communication, 2017) a structured prescription monitoring mechanism known as 'The Annual Risk Acknowledge Form' was established. The specialist prescriber is to formally meet with their patient and for relevant valproate-related risk statements on the form to be discussed and countersigned with confirmation that other therapies had not been found to be effective. This includes balancing the risks posed to women and their unborn children in terms of treatment with valproate versus the risks associated with inadequately or sub-optimally treating the index illness.

The recently proposed directive by the MHRA, however, appears to bear little relationship to the dramatic reduction in the incidence of valproate related congenital malformations. Nor does the directive address the enormous health benefits for tens of thousands of patients who are continuing to lead a life with conditions which might otherwise have led to graver impairments in their quality of life.

The new policy, potentially for implementation at some point in 2023, suggests two additional changes:

- Valproate-based formulations only to be prescribed after two '*specialists*' have signed a specific electronic form agreeing to the need for the treatment, and
- Also, all men under 55 years of age who are prescribed valproate to be included within the recommended monitoring programme.

MHRA data for England in the period from October 2021 to March 2022 suggest that only 17 women were prescribed valproate during pregnancy. This represents some 0.00001 percentage of all prescriptions that contain some sort of valproate formulation (3).

The Association of British Neurologists (ABN), in particular in the person of Dr Tejal Mitchell (Consultant Neurologist, Cambridge & Peterborough), have been advising the MHRA as to our grave reservations with regards to the unintended consequences on the health and safety of men and women with epilepsy currently requiring treatment with this family of medications when presenting with recurrent seizures. The risk associated with a potential complete ban on valproate prescribing might also substantially increase the risk of 'Sudden Unexplained Death in Epilepsy' (SUDEP) in patients with epilepsy, and significantly compromise the mental healthcare of patients with neuropsychiatric conditions, including those with ASD.

The Royal College of Psychiatrist (RCPsych) also express their concerns about this issue and advocate a nuanced approach to the role that valproate plays in the management of chronic mental health conditions many of which carry a high degree of morbidity and economic cost (4,5).

It seems that national headlines in various media groups and outlets have had disproportionately greater impact

Valproate Prescribing and the Latest Update from The Medicines and Healthcare Products Regulatory Agency - Clinical Caveats to Consider

By Dr Ekkehart Staufenberg

in determining policy directives for clinicians than any data obtained from published research. My professional view is that our duty of care towards our *individual* patient requires us to reiterate the potential unintended consequences of any upcoming restrictive directives. In addition, I am confident that I can draw on patient and carer support in this matter from my supra-regional clinic. Furthermore, at a national level, we need to gather all the evidence relating to unintended consequences to our patients with the introduction of this new MHRA directive, and provide peer support for individual consultants who may need to continue to prescribe valproate for their patients (with their consent) as on balance it may be the least harmful option, or who may feel forced to reduce down the dose of valproate in their patients potentially leading to increased rates of status epilepticus, hospital admissions and mortality.

Most probably, we will also need to consider the commissioning of *de novo* dedicated clinics for the review of patients already on valproate, and for any new patients going onto valproate, with the need to include the time dedicated to this by two specialists, thus lengthening any existing NHS waiting lists for seeing a consultant in all our specialties. The directive's stipulation that 'two specialists' are to countersign prescribing forms of any valproate medicine attests to the simplistic thinking that this is only a matter of providing or denying a signature. Indeed, as diligent senior clinicians, i.e. consultants that adhere to best clinical standards, we would have to review all case notes for evidence for the efficacy and safety of any previously prescribed anti-seizure or psychotropic medications before any decisions are made to provide a second signature for the prescription of valproate. Nationally, this would require NHS providers to fund hundreds of additional consultant outpatient clinics in order to fulfil the demands of this directive. Has anybody considered this!

I believe that organisations such as the ABN and RCPsych should provide the Government and the media with the evidence that this directive may in practice effectively lead to a ban on the use of valproate with consequent risks to the physical and mental health of many of our patients.

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Dr Ekkehart Staufenberg
Consultant Psychiatrist, Norfolk & Suffolk NHS Foundation Trust

Psychiatry Exposure in a Regular Foundation Training Programme Post

By Dr Colette Russell

A full-time UK foundation training programme lasts two years. It starts with FY1, previously named 'House Officer' and FY2, previously (and often still referred to) as 'Senior House Officer'. The foundation years compromise of six rotations of 4 months, generally with one in a surgical specialty and one in community (1). The term 'community' can be used quite broadly, often referring to GP rotations, but can also include psychiatry and paediatrics, both inpatient and community based.

The Foundation Programme Application System (FPAS) is complex and many FY1s are allocated posts that they might not be completely happy with. However, even if a doctor is interested in psychiatry but they do not have a psychiatry rotation, there is still good exposure to the speciality.
With the average age of hospital inpatients continuing to rise, patients are becoming increasingly complex, with comorbid mental health conditions becoming increasingly common (2). In the Emergency Department and in acute medicine, presentations and admissions related to alcohol and substance misuse are a daily occurrence. This highlights the importance of all clinicians needing to be competent and confident in managing common mental health problems.

At the start of my training, I became a Royal College of Psychiatrists (RCPsych) Foundation Doctor Associate, which I was amazed to find out it is completely free, offering access to fantastic online resources. Alongside this, the RCPsych organises various seminars, events and conferences with free or subsidised tickets for foundation associates. These are great opportunities to increase exposure to the specialty and start building professional relationships. Moreover, this can remove one of the biggest challenges facing foundation doctors who do not have a psychiatry rotation: getting to know psychiatrists! Whilst attempting to organise a taster week in psychiatry, I realised just by being based in a separate building or a different site creates a barrier, despite psychiatrists being some of the most enthusiastic doctors when it comes to recruiting and supporting juniors to join their speciality.

Therefore, here are my recommendations to help foundation doctors interested in psychiatry:

- Introduce yourself! If you are interested in outreach or teaching, contact the medics educational department and introduce yourself at induction. Maybe you can become an official point of contact for foundation doctors looking to organise a taster week in psychiatry
- Teach! Topics related to mental health and mental illness are included in the core foundation learning outcomes (3), but often little teaching is provided at a local level

Finally, the psychiatry foundation fellowship is of huge benefit to foundation doctors interested in or who have chosen psychiatry and it should continue to be promoted to all medicals students who are considering pursuing psychiatry. However, simple things may go a long way when it comes to increasing accessibility of psychiatry to foundation doctors not on the fellowship.

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Dr Collette Russell
FY1 Doctor, Princess Alexandra Hospital

My Experiences as a Psychiatry Foundation Fellow

By Dr Deepika Sharma

I think I have always known I wanted to do psychiatry. I kept an open mind at medical school, but psychiatry was the specialty I was most interested in. It was the one in which I could thrive, building on my strengths having previously worked as a mental health nurse. When I became aware of the Psychiatry Foundation Fellowship (PFF), I was eager to apply and was thrilled when I was accepted in the East of England.

The PFF was introduced in 2018 as part of the #ChoosePsychiatry campaign (1). It aims to inspire and enhance the enthusiasm of newly qualified doctors interested in psychiatry (2). The scheme spans over both foundation years and comes with many benefits: attendance at Balint groups, a mentor, free attendance at RCPsych International Congress plus a £1,500 CPD fund (3). Data from 2020 show that 252 applicants applied for 40 available PFF places across UK (4). Applicants are asked 'white space' style questions, e.g.: 'What aspect of psychiatry do you find most challenging?', and to provide examples of times when they have demonstrated RCPsych values (3).

The best part has been my incredible mentor – Dr Pathak. We meet regularly to discuss opportunities for me to reach my goals (including writing this article!) and accessing study leave. I have had a great rotation at the Derwent Centre with access to 1-1 consultant supervision, weekly psychiatry teaching and have managed to join one Balint group session. I recently attended the Eastern Division Spring Conference and I hope to attend Congress in July, which I would not have been able to afford otherwise.
Despite this, things have not been completely smooth-sailing and PFFs need support to ensure future applicants can access the amazing benefits offered. Here I list my recommendations:

- Balint groups could be opened up to PFFs and other foundation doctors. This might encourage them to consider CT1 training in the region
- Local PFFs could be invited to take part in psychiatry projects/audits/teaching sessions
- Unfortunately, FY1 doctors do not get additional study leave outside of mandatory teaching leave. I have not yet received an answer from the regional leads about accessing study leave to attend Congress. More support is required from higher management
- Psychiatry-related opportunities are limited and not well advertised. A trainee could help co-create a list of available opportunities including a page on our Intranet

I write this with the hope that it raises awareness of how our region can advocate for and support foundation doctors interested in psychiatry. PFFs are already enthusiasts for psychiatry – let us work together to enhance this, so we can attract the best and brightest to our core training programmes.

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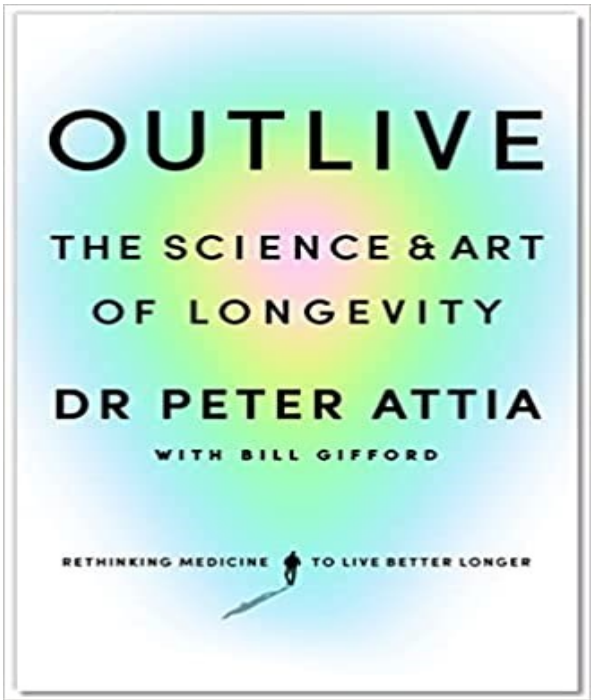
Dr Deepika Sharma
FY1 Psychiatry Foundation Fellow, The Princess Alexandra Hospital NHS Trust

Book Review: Outlive, The Science & Art of Longevity

By Dr Sepehr Hafizi



In his recently published and best-selling popular medicine book *Outlive: The Science and Art of Longevity*, Peter Attia, a Canadian-American doctor and researcher, with the help of journalist co-author Bill Gifford, presents his ideas for living a longer and healthier life (1). He proposes that the current approach of trying to treat slow diseases in their late stages, which he describes as Medicine 2.0, should be replaced by the new approach of Medicine 3.0 which entails prevention, health promotion and lifestyle changes. He argues that this approach would support our bodies towards not just a longer lifespan but also a longer 'healthspan' i.e. extended years of life with good health.

Attia begins by listing the main chronic diseases of ageing which he refers to as 'the four horsemen'. These are heart disease, cancer, neurodegenerative disease, and type 2 diabetes & related metabolic dysfunction. He explains that we can make changes in our lives to help reduce the risk of developing these diseases. He describes these 'tactical domains' as exercise, nutrition, sleep, emotional health, and exogenous molecules. The first four domains are discussed in more detail later in the book in their own sections. Exogenous molecules such as drugs and supplements are only mentioned within the sections relating to the first four domains.

Attia tackles each of the four domains in turn, but it is clear that his main focus is on exercise which he describes as the most powerful longevity drug. He states that even small increases in weekly exercise can have significant beneficial effects. Attia's 'Training 101' emphasises working on improving the following three factors: cardiorespiratory function, muscle strength, and stability. Cardiorespiratory fitness as the first factor Attia explains can be improved through a combination of exercises. One type of exercise is through incorporating long steady endurance activities of moderate intensity into one's routine. This 'zone 2' level type of effort allows recruitment of type II muscle fibres and increased mitochondrial biogenesis. The other type of exercise is meant to increase one's maximum aerobic effort and enhance VO2max (the maximum amount of oxygen the body can use during exercise). Important to note that VO2max has been shown to be a significant predictor for longevity (2). The second factor relates to increasing muscle strength. This is to help reduce the effects of sarcopenia (gradual loss of muscle mass, strength and function that occurs with ageing and immobility). Interestingly, he notes that reduced grip strength has been associated with increased mortality. The third factor is stability which often tends to be neglected. There are a range of exercises that Attia recommends which can enhance stability and reduce the risk of injuries.

The next domain that he tackles relates to nutrition. Attia explains that some of the evidence here does not quite meet the Bradford Hill criteria. He discusses three types of nutritional interventions as calorie restriction, dietary restriction, and time restriction. He notes calorie restriction as the best, but only when there is also good diet present. He states that no amount of alcohol is beneficial and that a Mediterranean diet which includes nuts and olive oil may be as powerful as statins in some people for primary prevention. There is an appropriate emphasis on adequate protein intake, especially in the elderly. He states that protein is best absorbed via animal sources and that at least 180 g of protein per day throughout the day are required. Time restricted feeding also known as intermittent fasting (IF) has become much more popular in recent years and can help with fat loss. Its main mechanism may actually be via reducing calorie intake rather than reduced insulin resistance. Again, in IF it is important that there is adequate protein intake in order to mitigate against loss of lean mass. A reduced carbohydrate intake would help reduce insulin resistance as part of IF, but it need not be as restrictive as in a keto diet. He suggests that individual monitoring via a continuous glucose monitor (CGM) would give the best personalised data for making changes to one's diet. This kind of device can be expensive, but interestingly, I was recently informed by a colleague about the Zoe Health

Book Review: Outlive, The Science & Art of Longevity

By Dr Sepehr Hafizi

Study where CGMs are attached to volunteers for research purposes to check on the body's responses to specific types of food to help with weight loss or improve long-term health (3).

Attia goes on to discuss the importance of good sleep and the deleterious effects of insomnia on a range of health parameters including the consistent association with insulin resistance. He also mentions an association between chronic poor sleep and Alzheimer's disease. He advocates for sleep monitoring, better sleep hygiene and cognitive behavioural therapy for insomnia.

Attia ends his book with the final domain which relates to emotional health. He discloses how he had suffered trauma as a child and that therapy in adulthood has made a major difference to his life. He describes how he uses mindfulness and tools based on dialectical behavioural therapy to help him with his emotional health. Indeed, at the end of the book he recognises that longevity only really matters if you have good relationships and good emotional health.

Attia's book *Outlive* is full of useful and evidence-based information, written in a style that is clear and engaging. He often uses metaphors and anecdotes throughout to make complex concepts more comprehensible for the lay public. One maxim that I simply cannot forget is that good oral health is associated with good overall health. This is presumably because those who care enough to attend to their dental health, are also more likely to attend to their health in general. Other than his book Attia also provides useful information and resources including podcasts on his website (4).

In conclusion I would highly recommend *Outlive* to anyone who is interested in the idea of longevity and who wants to make practical changes in their life to help them live a longer and healthier life.

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Dr Sepehr Hafizi
Consultant Psychiatrist, Cambridgeshire and Peterborough NHS Foundation Trust

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For more information please click on following link:
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Eastern Division Spring Conference 2023 Report

By Dr Manal El-Maraghy

The Eastern Division Spring Conference was set to invite a record number of attendees since before Covid. The fact that it was face to face in the beautiful setting of Hinxton Hall Conference Centre on the Wellcome Genome Campus was an important factor. People are missing the human connection and personal networking not fully recovered since Covid began. That said, the fact that the speakers were all knowledgeable, well respected, well known was definitely a major attraction.

The night before, the executive committee gathered for the quarterly meeting, just the second in person one after so many virtual ones. It was followed by another lovely dinner joined by some of the speakers. It was another enjoyable relaxing evening to get us all ready for the conference the next day.

The conference began with an introduction from Dr Raoof (immediate past Chair of the Division), who kindly stepped up in the absence of Dr Kallur Suresh (Chair of the Division), who had been hit with a nasty flu infection the day before.

The packed day was to explore our understanding of the "Psychosis Phenomenon" from various angles, with a fresh eye and taking into consideration contemporary issues and approaches.

First talk was delivered by Professor Chakraborty, a consultant psychiatrist in Early Intervention in Psychosis working in Leicester with an honorary position at the University of Leicester. She has a particular interest in psychopathology, currently part of the international SCAN panel, leading on the revision of the chapter dealing with psychotic symptoms. Added to that, she has an interest in global mental health and volunteering on mental health awareness. She is also the national lead for recruitment for Health Education England alongside a lot of other national responsibilities towards psychiatry and education, particularly for the CESR application process. In her talk titled "The thoughts society refuses to believe in: Delusions and beyond", Professor Chakraborty spoke about the importance of embedding psychopathology and phenomenology in clinical practice and training in psychiatry. She threw light on a number of rare delusions. She particularly spent time identifying differences between delusions, obsessions and over-valued ideas. In her conclusion, she advised the audience to listen to the patient's story and experience, focusing

Eastern Division Spring Conference 2023 Report

By Dr Manal El-Maraghy

on psychopathology and formulation rather than nosology. At the end of the day, in her view, compassionate patient-centred care is the key to helping patients.

Her inspiring and informative talk was followed by a talk on the personal experience of Mr Jason Grant-Rowles. A brave expert by experience, he spoke about his first episode of psychosis in 2015 while he was travelling to Brazil and the difficult time he went through, having to face some scary paranoid delusions, and auditory & visual hallucinations. He had to come back to the UK and later received treatment under the Mental Health Act. He had to accept that he was suffering with a mental illness that is nevertheless treatable; once he accepted treatment and followed a management plan including medication, recovery and psychological approach and acknowledging the support of his wife and family, his condition improved. His message was one of hope. A few years later he got married and started to work in a number of roles that he has cherished and appreciated, mostly supporting people with similar difficulties. His advice was to hold on to hope but to take responsibility, and on recovery to look for further education and self-advocacy. He was supporting others and in return he was getting support from others.

The session was rather overwhelming for some but was followed by a needed break and coffee, with an opportunity for audience members to go through the 20 posters, all of high quality.

The morning sessions were concluded with an extremely interesting talk by Dr O'Reilly, the Chair of the RCPsych Medical Psychotherapy Faculty. Dr O'Reilly is a consultant psychiatrist in medical psychotherapy and a member of the British Psychoanalytic Association. She has a great interest in the application of psychoanalysis into psychiatric care, towards enriching clinical understanding and supporting staff. She spoke about meaning and the unconscious processes of a psychodynamic approach to psychosis. She brought up an interesting case to illustrate how psychoanalytic ideas can contribute to the understanding of psychotic processes and symptoms. Her message was in line with Glen Gabbard's view, that a psychodynamic approach to psychiatry provides an overarching coherent conceptual framework for which all other treatments can be provided. She used the case not to refer to psychotherapy as a treatment for psychosis, but to use it as a platform for understanding patients' dilemmas better whilst caring for them. While the conference was titled 'What's New in Psychosis', Dr O'Reilly brought into the present, a previously established approach towards psychosis which may have been forgotten. She revisited the theory about the unconscious controlling the conscious, and how sometimes hallucinatory experiences may be fulfilling a purpose. She concluded that working in a psychodynamic way may seem to be time and resource consuming but ensures we have time to think and care. We need to consider what a therapeutic milieu is for our patients and ensure there is time for reflective practice for staff.

With such a packed morning, it was time for a lunch break where networking was much welcome on a nice sunny day, where participants sat around tables to catch up and to enjoy the sun and delicious food.

The afternoon academic session started with feedback from Dr Albert Michael on the posters. He invited a number of medical students, FY1 and trainees to give a short presentation and to engage all participant in helping to identify the winning submission. What an amazing number of presentations just like the morning's talks: we head from medical students about psychodynamic psychiatry education, phenomenologically informed extension of the predictive processing model of delusions, an interesting talk about artificial intelligence and another on effects of antiepileptics on immunoglobulins. There were also presentations related to dementia – ahead of the afternoon talk – including assessment and treatment, and a memory clinic audit on documentation of sensory impairment. In the absence of her juniors, Dr Menon as consultant, stepped up (rather than down) to present their hard work.

Eastern Division Spring Conference 2023 Report

By Dr Manal El-Maraghy

Poster presenters at the conference

Next was Dr Raj Mohan, FRCPsych, consultant psychiatrist at South London & Maudsley, presidential lead for race and equality and immediate past Chair of the Faculty of Rehabilitation and Social Psychiatry. He is particularly interested in equality, diversity and inclusion, implementing co-production and a patient-centred and biopsychosocial approach. His talk about addressing inequality in care for people with psychosis was stimulating. Dr Mohan shared data evidencing that issues relating to inequality are much worse for people suffering with psychosis with an ethnic minority background, adding to further social disadvantages. He made references to adverse childhood experiences and social environment, concluding that social adversity i.e. deprivation, disadvantage, discrimination, racial trauma are strong factors acting on top of any developmental and genetic predispositions. His talk stimulated many questions particularly from carers in the audience.

This was followed by a short break with the final session being delivered by Dr Latha Velayudhan, Clinical Reader in ageing and dementia studies at the Institute of Psychiatry, Psychology and Neuroscience, King's College London. She is a clinical academic with a research interest in neurodegenerative disorders, in particular neuropsychiatric symptoms and biomarkers. Dr Velayudhan shared her work in the use of cannabinoids for neuropsychiatric symptoms in Alzheimer's and Parkinson's dementias. She played a number of interesting videos to help the audience gain a better understanding of the patient experience and suffering.

With announcing the prize winners and a conclusion from Dr El-Maraghy, Academic Secretary, this fantastic informative and stimulating day came to an end with what felt like highly positive feedback from the audience. Hard work behind the scenes was a reason for the day's success. Amongst other colleagues, Moinul Manna (Division manager) and Michael Jamieson (Events manager) played a crucial role in making sure the conference was delivered at its best.

Executive Committee dinner the evening before the conference

Dr Manal El-Maraghy
Academic Secretary, Eastern Division

Upcoming Eastern Division Events 2023

Development Opportunities Midway Through Consultant Career TBC 2023

For upcoming information please keep an eye on our webpage:
Eastern Division events (rcpsych.ac.uk)

Eastern Division Autumn Conference 2023
Friday 17th November 2023

Wellcome Genome Campus Conference Centre, Hinxton, Cambridge
Speakers to be confirmed
More information will be available soon. Please click:
Eastern Division events (rcpsych.ac.uk)

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Eastern Division Vacancies

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

Current Appointed Vacancies

Liaison Regional Representative
General Adult Regional Representative
Neuropsychiatry Regional Representative
Rehab and Social Regional Representative
Medical Psychotherapy Regional Representative
Deputy Regional Advisor

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.

Mindmasters July 2023

Meet your Eastern Division team for Mindmasters at International Congress 2023! Representing the Division and challenging for the win at Mindmasters 2023 are..

Support our team at RCPsych International Congress 2023: http://bit.ly/3lUbN6G

Royal College of Psychiatrists, Eastern Division

Royal College of Psychiatrists
21 Prescot Street
London
E1 8BB

Phone: 0208 618 4000
Email: moinul.mannan@rcpsych.ac.co.uk

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 17th November 2023

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: 10th November 2023
Submissions should be made to:
Moinul Mannan
Divisions Committee Manager
moinul.mannan@rcpsych.ac.uk

Deadline for next edition: Friday 10th November 2023
Submit your articles to: psychiatry.east@rcpsych.ac.uk

Royal College of Psychiatrists - Eastern Division e-Newsletter

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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