

Psychiatr-East

The Eastern Division e-Newsletter

Winter 2011 Issue 4

EDITORIAL

SEASONS GREETINGS

This year will be witnessing important and fundamental changes to the way that health services in general and mental health services in particular will be delivered and accessed. Psychiatrists will be facing the exciting opportunity for standing up for providing best services to the most vulnerable groups of the population. This winter edition of the Psychiatr-East explores various dimensions of the psychiatrist-patient relationship.

Dr Welsh writes on the Deprivation of Liberty Safeguards, making us reflect on the evolution and interpretation of deprivation of liberty or restriction as it may apply in a good proportion of the cases. Our Assistant Editor, Dr Hamid, writes about the development of a website for early intervention in psychosis, which has the 'Big Society' approach to it, involving a whole raft of organisations, but more importantly, the people who will be benefiting from this project. Prof Peter Jones, talks about research and application of research for developing services for the benefit of our patients. At first glance, it may sound repeating the obvious, but for those who have been involved in the NHS as a provider or as a user,

you may be aware that services are not always evidence-based! Lifecraft is a wonderful organisation led by the users and it is these initiatives where psychiatrists passionately support the efforts of out patients that will help us psychiatrist, not just survive but succeed in establishing a patient-focused and not a pound-obsessed mental health services. Dr Ramachandra gives a moving account of art providing a tribute to altruistic people who have contributed their brain (and wisdom too, in my opinion) to the advancement of science.

It is these situations that make us realise the special role we play and the even more special meaning we as psychiatrists to the neglected and forgotten people in our society. One of our champions has been Dr Lawton and the Division, takes great pride in Dr Lawton being awarded the prestigious, Psychiatrist of the year award. I am eternally indebted to her for making me reflect and encourage me to say 'no'. I shall let you reflect on the articles in the newsletter and I am looking forward to meet you at the Spring Meeting.

**BEST WISHES
RAJA**

Dr V R Badrakalimuthu - Editor



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Chair's Column

HAPPY NEW YEAR TO YOU ALL!

I hope that 2012 has started well and that the year ahead will not be too challenging, as we try to maintain and improve the quality of mental health services for our patients and carers.

Congratulations to Dr Claire Lawton, Consultant in Old Age Psychiatry in Cambridge and recently Associate Medical Director at the East of England SHA who was the winner of the 'Psychiatrist of the Year' Award for 2011.

In recent years the number of doctors in the UK applying for psychiatry training has been low and by August at the end of the second recruitment round only 83% of CT1 vacancies had been filled. The College has appointed an Associate Medical Director for Recruitment, Dr Tom Brown who is leading the national recruitment strategy. It is however at a local level that the most important work needs to be done. We all need to convey our passion and enthusiasm for psychiatry to students and doctors in other specialties. We have established a Recruitment Steering Group within the Division which is chaired by Dr Allen Kharbteng and includes student representatives from our two medical schools, trainees and Consultants. If any of you have good ideas and would like to be involved please contact Allen.

In our membership survey (Psychiatr-East Issue 2) members expressed concern about the cost of CPD activities and there is good news! From January 2012, the full-text of Advances in Psychiatric Treatment will be available to all members free online as part of their annual RCPsych membership. Furthermore, the cost of the print version of the journal drops to £50 per year. From January 2012, members will be able to subscribe to CPD Online for £45 + VAT. Members can access the online version of Evidence-based Mental Health for free through the members' only area. Print copies are just £10 per year for all four issues. The cost of the International Congress which is to be held in Liverpool has been reduced compared to last year and there is an early booking discount until March 30th.

The Autumn Academic Meeting at Dunstan Hall in Norwich had a theme of 'Better Commissioning of Mental Health Services- Values and Value for money' covering many aspects of commissioning mental health care and training both in the public and private sector as well as clinical topics. Our next Academic Meeting will be at Madingley Hall in Cambridge on Tuesday May 1st when the President of the College, Professor Sue Bailey, will be speaking. I hope to see many of you there.



Dr Deborah Girling, Chair, Eastern Division

Have Something to Say?

Contact your Chair,
Dr Deborah Girling
via the Division Manager,
Beverley Francis

Email:

bfrancis@rcpsych.ac.uk

Opinion

The Deprivation of Liberty Safeguards and Psychiatry

The Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act are the result of decades of legal debate and legislative challenge about how to most effectively protect and secure the rights of incapacitated adults (in health, welfare and financial decision-making).

Background

When Mr L, a man with a learning disability, was originally admitted to a psychiatric hospital, the Consultant Psychiatrist responsible for his care considered detention under the Mental Health Act 1983, but decided against it. Although Mr L could not give informed consent to admission, he was “compliant” and not attempting to run away therefore formal “detention” was not pursued. His carers wanted him home but had no means of challenging the decision of the psychiatrist. Legal action was begun on Mr. L’s behalf in 1997 to secure his discharge and was pursued through the High Court and then Court of Appeal until finally it reached the House of Lords in 1998 where it was defeated by a majority of 3 to 2. All five Law Lords’ speeches made reference to the “doctrine of necessity” as the justification for Mr L’s admission and management. **Mr L** took his challenge to the European Court of Human Rights (ECtHR), claiming that his rights had been violated under the European Convention of Human Rights (ECHR). The case of *HL v UK* was decided in favour of HL, upholding HL’s claim. There had been a violation of his rights under articles 5 (1) and 5 (4) of the Human Rights Act. Article 5 (1) of the Human Rights Act states;

“Everyone has the right to liberty and security

of the person. No one shall be deprived of his liberty save in the following *cases* and *in accordance with the procedure prescribed by law...*” including “(e) ...the *lawful detention* of persons for the prevention of the spreading of infectious disease, of persons of *unsound mind*, alcoholics or drug addicts or vagrants” (italics added)

The government was found to be in breach of Mr L’s rights, under article 5 (1), and, moreover, 5 (4); “everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.”

The Court recognised the “government’s understandable concern...to avoid the full, formal, and inflexible impact of the 1983 (Mental Health) Act” **Novel** legislation, the Deprivation of Liberty safeguards (DoLS) was introduced into the Mental Capacity Act 2005 (MCA) by the vehicle of revision of the Mental Health Act 1983, in 2007, and came into statutory force on 1st April 2009, in England and Wales, to

“... enable the lawful detention of an adult over 18, within a hospital or care home, whether placed under public or private arrangements” in the following circumstances:

the person has a mental disorder, is not subject/liable to be detained under the Mental Health Act 1983, lacks capacity to give informed consent to care arrangements, levels of restrictions/restraint are so high as to fulfil criteria for deprivation of liberty (now or within the next 28 days), and there are no conflicting legal requirements to the deprivation of liberty (advance decision or Lasting Power of Attorney).

Opinion

The Deprivation of Liberty Safeguards and Psychiatry Cont'd...

Legal protection via the Mental Capacity Act (MCA) rather than through mental health legislation was felt to be justified under the principles of “any act done, or decision made, on behalf of a person who lacks capacity must be done, or made, in the person’s best interests”, a principle of the MCA but not of the MHA. The Mental Health Act option was seen as a disproportionate response. The Care Quality Commission (CQC) is responsible for monitoring the manner in which the DoLS are operated by hospitals and care homes, seeking to ensure that the safeguards are working properly. Supervisory bodies must disclose information as part of the inspection process and the CQC reports to the Secretary of State.

What constitutes Deprivation of Liberty?

DoL safeguards provide for compliance with the Human Rights Act by providing legal authority and an appeals process. However, the distinction between restriction of liberty (which is covered by the Mental Capacity Act 2005), and the “vexatious” question of what constitutes deprivation of liberty is “merely one of degree and intensity and not one of nature or substance”. The Court in HL set the threshold at a high level, stating that deprivation of liberty had occurred as staff were exercising “complete and effective control over all of his movements”, a situation that would have led many to consider the Mental Health Act 1983. **Guzzardi v Italy** asserted that “in order to determine whether someone has been deprived of his liberty within the meaning of Article 5, the starting point must be his concrete situation and account must be taken of a whole range of criteria such as the type, duration, effects, and manner of implementation of the measure in question,” a principle enshrined in the Code of Practice accompanying the Deprivation of Liberty safeguard legislation. Examples of acts that may, **when taken together**, amount to a deprivation of liberty, include, from the Code of Practice;

The person is not allowed to leave the hospital or care home. Restrictions that are put in place for the person’s protection would not necessarily amount to a deprivation of liberty

The person has no or very limited choice about their life within the care home or hospital- staff exercise control over assessments, treatment, care and movement within the environment.

The person is not able to maintain contact with the world outside of hospital or care home- staff exercise control over contacts/ access to other people

Restraint is/ was used on admission and the person is not realistically allowed to leave. Carers would not be allowed to discharge.

Guidance to avoid depriving persons of their liberty includes;

- Maximisation of liberty and autonomy
- Person-centred care
- Involvement of family and friends
- Minimising restrictions
- Reviewing the care plan frequently

Recent domestic case law however has introduced continued uncertainty about what in fact is a deprivation of liberty. **DE and JE v Surrey County Council (SCC)** focussed on the issue of “freedom to leave.” DE was married to JE but had been placed in residential care under the doctrine of necessity having been put out of his home by JE in his pyjamas, and after a number of allegations of neglect and abuse of DE by JE. DE had no memory of any difficulties at home and consistently requested to be returned to his home. Although DE could choose to live in any residential care environment and was not subject to any physical or chemical restraint, and nor was he restricted in his contact with JE except when it was felt to be detrimental to his wellbeing (and he could not have unsupervised contact with her), he was found to be illegally deprived

Opinion

The Deprivation of Liberty Safeguards and Psychiatry Cont'd...

of his liberty. Justice Munby found DE to be deprived of his liberty, stating the “Crucial question ...not so much whether ..DE’s freedom or liberty was or is curtailed within the institutional setting ...fundamental issue...whether DE deprived of his liberty to leave the X home ...leaving in the sense of removing himself permanently in order to live where and with whom he chooses , specifically removing himself to live at home with JE.” Less narrow criteria have evolved but created their own challenges.

MIG and MEG concerned 2 sisters. MIG was accommodated in a foster home and MEG in a specialist unit. Both had their own rooms, and crucially neither was free to leave, both would have been restrained if they attempted to leave, MEG was given psychotropic medication i.e. Risperidone, to “calm her”. As both sisters appeared happy in their environments, the courts looked at “happiness” as a determinant of whether or not a person was deprived of their liberty, but this was felt to be relevant insofar as its relationship to “objection” and as a component of a best interest assessment, i.e. that objection can increase conflict and the use of restraint. The “relative normality” of their situation was a key factor. Neither was found to be deprived of their liberty with the conclusion that people in their own homes, care homes or “acute” hospitals while being restrained in their best interests, will typically not be deprived of liberty, with Wilson LJ stating “there is a wide spectrum between the small children’s home or nursing home on the one hand and a hospital setting designed for compulsory detentions like Bournemouth”. **The** thorny issue of the interaction between the MCA and MHA has also given rise to a number of case law studies, with eligibility a key determinant of which legislation is most appropriate for a particular patient group. A person will be ineligible to be DOL

If they are accommodated in a hospital for the purposes of being given medical treatment for a mental disorder (i.e. a mental health patient)

AND *object* to being a mental health patient or to some or all of their mental health treatment (e.g. trying to leave/ not taking medication).

In GJ v The Foundation Trust it was clarified that the Mental Health Act takes primacy and anyone who would have been assessed for detention under the MHA pre-DoLS should still undergo the same procedure. However there are many people in society who *could* fulfil criteria for detention under MHA, but that does not automatically mean they are a “mental health patient” .The “but for” test requires an assessment of whether “but for the treatment related to his physical disorder unrelated to his mental disorder” would the person need to remain in hospital and if the answer is no the person is eligible for DoLS, and if it is yes then the MHA must be considered.

**INTERNATIONAL CONGRESS 2012
EASTERN DIVISION - BURSARIES**

**EASTERN DIVISION
RESEARCH PRIZE 2012**

**EASTERN DIVISION
MEDICAL STUDENT ESSAY
PRIZE 2012**

**Further information on the above
Awards can be found on
Pages 20,21 & 22**

Summary & Uncertainty

Despite a wealth of case law guidance the DoLS present a major challenge to psychiatrists in general and old age psychiatrists in particular. The Department of Health has been clear that it must be demonstrated that a patient's *regime* in hospital is "distinct and different" for a non-detained patient as might be seen for a detained patient, which means that a significant proportion of non-objecting patients could be deprived of their liberty. **Inpatients** with dementia who are not free to leave, whose families cannot care for them at home any longer (or maintain regular contact outside of a ward environment) because of the level of their care needs, and who are difficult to place in nursing home environments, and who object at times to elements of their care and treatment (or not) can potentially find themselves "falling between 2 statutes". While most will fulfil criteria for DoLS, a few for detention under the MHA, a

very few will apparently fulfil criteria for neither, based on the separate assessments of the different teams involved, all of which can seem a far cry from circumstances of the original case of HL!

What ultimately constitutes a deprivation of liberty is of course a legal question and only courts can determine the law. Although this avenue is a costly and potentially lengthy one to take it may in some cases be the only one to pursue.

DR SUSAN WELSH

**CLINICAL DIRECTOR & CONSULTANT
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EASTERN DIVISION SPRING ACADEMIC MEETING & AGM TUESDAY 1 MAY 2012



**University of Cambridge, Madingley Hall,
Madingley, Cambridge, CB23 8AQ**

CALL FOR POSTERS

Early Intervention in Psychosis

The story of establishing the first ever web site for
Early Intervention In Psychosis (EI) Services in Norfolk
Dr Yasir Hamid, Assistant Editor - Psychiatr-East

How many people are needed to set up the team's first web site? The answer is six, or at least that it this case. So, who are they and how they did it? Here we meet some of the members who dedicated time and effort from their busy daily schedules to make a dream come true. Setting up a web site for the Early Intervention Services in Norfolk has been discussed for long time in meetings and despite the willingness of team members, it was difficult to take the first step due to many obstacles. However, a group of professionals who come from different teams and different backgrounds finally decided to take the lead in this project and make it run. First we meet David Kennedy, the man behind getting the project starting. "I'm Clinical Coordinator with the West Norfolk EI Team; I'm also a non-medical prescriber. Our team is based at Thurlow House, Kings Lynn. We see people aged 14-35 experiencing first-episode psychosis and have a positive, pro-active and holistic approach to our care. We also run various psychosis/mental health education projects in the area with schools, colleges, community groups and other mental health service providers." David has been working to make a Trust Early Intervention website a reality since early 2010 when he met other like minded people in EI teams from other localities (Sam Harbrow from Norwich and Gary Pitcher from Great Yarmouth). They formed the Norfolk EI Web Site Steering Group and they agreed on the general lines of such project during Summer 2010. Unfortunately their plans were halted due to funding difficulties.

Project Funding

"We were offered us a basic web space, with a limited design" David says. "This was not what we were looking for as we wanted something more innovative and creative." So, instead of giving up, they started to look for external funding. It was then that Paul Johnson came to play his pivotal role in finding funding for this project. Paul is the deputy service manager for Central Norfolk EI. He is the operational manager for the team and he deals with all workforce and qual-

ity issues related to the service. He was therefore the right man for the task. Paul asked around for potential sources of funding. "The idea of getting pharmaceutical sponsorship was not an option since the beginning", We wanted this project to be independent and pharmaceutical sponsorship meant that they will have some control over the content of the web site, something neither we nor patients and their carer would want", says Paul. After some months of email exchanges, phone calls and face to face meetings, the Darren Huckerby Trust (a Trust led by the Canaries legendary ex- footballer Darren Huckerby and providing support for local charities, community projects and individuals in Norfolk) provided funding of £500 towards the cost of setting up the website. Not only this, but Paul was also able to get support from web design company (Graphics Matter) based in Lowestoft who were willing to design the web site for a cost price.

The Content

The first steering group meetings have focused on the issue of the content of the website. The members agreed that the website content should be agreed with service users and their carers as the purpose of this project is to build a bridge between mental health professionals and service users. It is also intended to provide educational material and links to more resources to people who are interested to know more about psychosis and help available to people suffering from this condition. The general content of the website will be a blend of information about psychosis, including information about treatment in a simple language. It will also contain details about Trust EI services and more general content via links to EI Services Facebook pages. Younger EI service users were very interested to participate in this project. Emma Corlett, Children and Young Person Participation Lead in Norwich a member of the EI Steering Group tell us, "I wanted to see service users involved at an early stage as my vision was that the project will be very much service user led. .

Early Interventions in Psychosis Cont'd...



**Members of the Norfolk EI Steering Group.
From left to right:
Sam, Paul, Yasir, David and Gary**

We had an enthusiastic group of young people from our service that were keen to be involved - as in other EI localities.” Emma also brought some ideas from other EI web sites like <http://www.ei-team.org.uk/> to see if we can adopt some of the positive aspects in their site content and design. In addition to putting ideas about the general design and content of the

website, some service users wanted to write about their stories of recovery and share them with others on this web site. “Reading about the stories of recovery of others is a powerful inspiration to other people who are currently struggling with mental health problems” Yasir Hameed, Core Psychiatry Trainee and a member of the Steering Group said. “It sends a clear message that psychosis and indeed other mental health problems are treatable. It also helps to reduce stigma associated with mental illness by encouraging people to talk about the issues related to their mental well being instead of trying to hide away”. The EI website is due to be p and running by Spring 2012. It is another story of innovation in times of austerity. It sends a message of hope that even when teams are struggling with jobs cuts and limited funding, team members can still find ways to be more productive and achieve more through working collaboratively with service users and external agencies to bring more resources to their teams. We hope to write soon about similar projects in clinical teams throughout the East of England region.

Eastern Division - Regional Specialty Representatives

There are currently a number of posts available for Regional Specialty Representatives within the Eastern Division. Vacancies have arisen in the following Specialties due to the current post holder reaching the end of their tenure or the post is currently vacant. Representatives for the following specialties are required:

- Academic
- Child & Adolescence
- Substance Misuse

Anyone interested in taking up one of these posts should forward:

1. A copy of their CV
2. The names and contact details of two referees. The referees must be fellows or members of the College, but should not hold office on the College Education Training and Standards Committee,
3. A statement containing a short profile of the attributes and experience they feel they could bring to the post (electronic copies only please).

Regional Specialty Representative Job Description

The CV and statement should be sent via email to:
Beverley Francis, Eastern & South Eastern Divisions Manager
bfrancis@rcpsych.ac.uk

Mind Over Matter: Memory, Forgetting, Brain Donation & The Search for Cures For Dementia

Shoreditch Town Hall, London 12—23 October 2011

A Review of the Exhibition

The question of what happens after death is one that has fascinated and preoccupied mankind for many centuries. Religions, philosophers and rationalists have all proposed their own answers, varying from the extremely spiritual to bluntly matter-of-fact. These theories, religious beliefs, and even superstitions have deeply influenced the attitude of society towards the use of the human body after death by scientists. Despite many years of awareness about the various ways in which one can help other human beings and contribute to the onward march of science, most people balk at the thought of gifting one's mortal remains to science. Even scientists and medical professionals, who are more aware than most, haven't exactly been queuing up to gift their bodies or organs. This is perhaps due in part to the strong emotions evoked by having to make such a decision, but the unfortunate negative publicity brought on by events such as the Alder Hey revelations hasn't helped any. **Who**, then, are the people who decide to make that brave and selfless decision to donate their body parts to science? What motivates them? These are the questions that drove artist Ania Dabrowska and researcher Dr Bronwyn Parry to explore the issue further in science - art collaboration supported by the Wellcome Trust. In particular, they looked at volunteers who donated their brains as part of one of two naturalistic studies of ageing and dementia. They also took a behind-the-scenes look at the actual 'brain bank' in an effort to demystify the process. It took 3 years to complete, and involved, quite understandably, much hard work in reassuring various bodies including research ethics committees on how the work would proceed. It was perhaps inevitable that they sought the help of Prof Carol Brayne and Dr Jane Fleming at the Institute of Public Health, University of Cambridge, who designed and still manage the MRC Cognitive Function and Ageing study (CFAS) and the Cambridge City over 75 cohort (CC75C)

study. These are both longitudinal follow-up studies of older people looking at health and cognitive function, and have brain donation arms.

Volunteers from these studies who agreed to be de-anonymised were interviewed by the two, with Ania Dabrowska capturing their portraits. The rich yield from their efforts over the 3 years was condensed and curated into an exhibition titled 'Mind Over Matter', a quote borrowed from one of the participants. The Wellcome trust supported the venture, which was shown at Shoreditch Town Hall in London from 12 - 23 October 2011. The inaugural was attended by surviving volunteers and their families, who were said to be very positive about the exhibition. It was showcased in the BBC's "The Culture Show", and much to the pleasant surprise of the project team, attracted about 100 visitors a day, each day – much beyond their wildest expectations. A limited edition book bearing the same title was released for sale at the same time. **T**he exhibition is perhaps better described as an art installation. It was arranged in the basement of Shoreditch town hall - at first glance a rather grim-looking place reminiscent of a decrepit industrial setting, all exposed pipes, unpainted walls with broken plaster and brickwork laid bare. **A**ny doubts one might have entertained about the appropriateness of the setting soon receded as one progressed through the display. The portraits of the 12 chosen participants were beautifully lit, while the background faded into insignificance. Each portrait carried a brief quote from the person about why they had chosen to donate their brains, and a concise biography was shown next to the portrait. Perhaps not surprisingly, the reason was usually altruism - to help the progress of science, to help fight Alzheimer's disease and so on. **W**hat was interesting though, was how people incorporated their motivations into their value systems - the atheist with rational reasons and the religious with the principle of doing good unto others.

Mind Over Matter: Memory, Forgetting, Brain Donation & The Search for Cures For Dementia Cont'd....

Then there was a series of smaller pictures the artist had taken of the brain bank. The photographs of gleaming stainless steel pathology lab tables, cold sharp instruments and clinically dissected brains; they evoked little emotion and were printed in faded colour that was nearly monochrome. This was in stark contrast to the larger-than-life, full colour photos of the volunteers in ornate frames. There were also displays such as slide shows of some volunteers' lives as seen through their photographs over a lifetime, a series of blown-up pictures of microscopic brain sections, white clinical lab coats and finally a striking display of lace doilies - referring to a scientist's description of a brain riddled with Alzheimer's disease. In all the rooms an audio track of the volunteer interviews interspersed with original background music composed by Gaetano Serra for the project played in a loop. I am not sure what I expected when I set out for the exhibition, but what I came away with was a great deal of admiration for the project team. And somewhat unexpectedly, I found myself quite

moved by the volunteers, their stories, and the unfussy virtue behind their decisions. These people were from the Cambridgeshire area (mostly Ely and the fens); their stories were very familiar to me, as I have been working for the last two years with older people from this area. Often, after a visit to an older person's residence and an hour spent learning about their life, I am left with a feeling of sadness and loss - these are ordinary people who did extraordinary and heroic things during the War, now living somewhat isolated lives, forgotten by society, fading quietly away in their twilight years; yet they are unfailingly gracious, polite and grateful for what little society does for them. Through "Mind Over Matter" some of these heroes have been given due recognition, and their stories preserved for eternity.

<http://www.mindovermatterproject.co.uk>

Dr Pranathi Ramachandra
Consultant Psychiatrist, Cambridgeshire &
Peterborough Foundation Trust, Cambridge

Report from Annual East of England Senior Trainees Conference 2011, Colchester Dr Elayaperumal Ramanathan, ST6 Registrar, Colchester

The conference was chaired by Prof Peter Jones, University of Cambridge. The Mental Health Czar, Dr Hugh Griffiths, provided the key note address



on a Cross- Government Mental Health Strategy and the current reforms in NHS including QUIPP, Medically Unexplained Symptoms at this conference held for the first time in Colchester. He talked about specific models such as RAID (Rapid Assessment Interface and Discharge) currently implemented in Birmingham City hospital and integrated care pathways. Andrew Geldard, Chief Executive of North Essex Partnership NHS Foundation Trust, talked about the positioning of strategy in NHS management processes and particularly looked at the implementation of 'No Health Without Mental Health' in an era of NHS organisational changes and the over-riding requirements of the NHS QUIPP programme.

Report from Annual East of England Senior Trainees Conference 2011, Colchester Cont'd...

Dr John Hague (GP and Commissioner in Suffolk) spoke with enthusiasm about the challenge of Medically Unexplained Symptoms and the benefits of Early Intervention in Psychosis based on the DH's "*Mental health promotion and Mental Illness Prevention; the Economic Case*". **Dr** Raouf, Consultant Psychiatrist and Member of the Operational Board, East of England Deanery discussed the implications of the strategy on training. He argued the strategy and NHS reforms would have a significant impact on training. The changes will not be limited to the organisational structure or to funding streams. They would challenge the profession, trainers, trainees and educationalists to adapt the curriculum, methods of delivery and assessments to reflect the new landscape. He emphasised that the Service provider organisations will need to be sensitive to the changes by developing

effective educational strategies to be efficient and competitive as Local Education Providers. This conference for the first time had five service users speaking about experiences in psychiatry and they were given a standing ovation. Dr Christopher Jones spoke about the implications of the strategy on research. This conference also invited high quality research and service project presentations and the abstracts of the winning submissions are presented elsewhere in this newsletter. The success of the conference was also that it invited delegates from across the country. It was also the most cost effective trainee conference. The delegates gave a 100% excellent or good rating for the theme of the conference, general achievement of aim/satisfaction, choice of speakers, administration prior to and on the day of the event.



Prize Wining Abstracts

From the East of England Senior Trainees Conference

A Systematic Review of the Treatment of Eating Disorders among Ethnic Minorities in Western Settings Dr Sarmila Sinha, MRCPsych

Aims: This systematic review aims at looking at the utilisation of treatment, access to treatment and referral of ethnic minorities for treatment of eating disorders in western settings. It also aims to explore the barriers in accessing and utilisation of treatment including the role of acculturation.

Methods: The review included both qualitative and quantitative studies. The literature search was conducted on all relevant multiple electronic databases, namely PubMed, PsychINFO, MEDLINE, CINAHL and EMBASE. **The** search identified a total of 2786 articles. Out of the 2786 articles, 12 articles (1 qualitative and 11 quantitative) were selected for the purpose of the research.

Results: The review showed that ethnic minority communities in UK and USA were far less likely to seek and receive treatment for their eating disorders (Cachelin et al, 2005; Cachelin et al, 2000;

Cachelin et al, 2006; Marques et al, 2010; Nicdao et al, 2007; Pike et al 2001) and also less likely to be diagnosed and referred to eating disorder services or clinics for treatment of their eating disorders (Waller G., et al, 2009; Abbas et al 2010; Becker et al, 2003). **Referral** bias of ethnic minority participants to specialist eating disorder services were found in the three quantitative studies (Waller et al 2009; Becker et al, 2003; Abbas et al, 2010). **Five** studies (Cachelin et al, 2000; Cachelin et al, 2005; Cachelin et al, 2001; Nicdao et al, 2007 and Cachelin et al, 2006) pointed to the fact that more accultured ethnic minority participants were more likely to seek treatment for their eating disorders. **Conclusion:** The above study has shown that ethnic minorities are less likely to have access to treatment for Eating Disorders.

Audit of Implementation of End-of-Life Care Pathway Dr Neeti Sud (Core Trainee in Psychiatry), Dr Mani Krishnan (Consultant Old Age Psychiatrist)

Aim - This Audit was set out to determine compliance to the recently implemented end-of-life care pathway for patients who were residents of two of our long stay dementia inpatient units. We also aimed to examine the needs of staff as they adopted the new pathway. **Method -** Local care pathway for end-of-life care was formally evaluated using a questionnaire that was handed out to all qualified nursing staff. **Results -** The audit revealed difficulties around the diagnosing of dying, communication with patients and the provision of emotional or spiritual support. However, there was general consensus that the revised end-of-life pathway was used appropriately. Almost half the staff felt that they have not received adequate training. About 30% of the staff felt that they do not have enough confidence in identifying end-of-life (9 out of the 17 responses). In contrast, only 12% staff felt that they lacked confidence in delivering the

pathway (5 out of 17 responses received). 82% felt confident in discussing end-of-life with carers. 70% of the staff had received positive feedback from carers. Out of the 17 staff members who responded to our questionnaire only 2 had received negative feedback.

Conclusions - Further work is needed to ensure that the end care pathway continues to provide and promote best practice in order to improve care of the dying. We conclude that there is need for education, training and continuing professional development related to communication skills, assessment and care planning, symptom control and provision of psychological, social and spiritual care in the last days of life. We recommend that there should be a survey of bereaved relatives and also have made suggestions to create a booklet for relatives. We are already in the early stages of starting a reaudit.

Prize Wining Abstracts

From the East of England Senior Trainees Conference

**Jorge Zimbrón, MBBS,a,b; Sonia Ruiz de Azúa, Psy, PhD,c,d;
Golam M Khandaker, MBBS, MPhil,b; Kumar P Gandamaneni, MBBS,a
Carolyn M Crane, MSc,a,b Ana González-Pinto, MD, PhD,c,d
Peter B Jones, MD, PhDa,b and Jesús Pérez, MD, PhDa,b**

Aims: There have not been any direct comparisons of socio-clinical characteristics between people at high-risk for psychosis (HR) and those with first-episode psychosis (FEP). Assuming continuity between HR and FEP, it would be reasonable to suggest that clinical antecedents and socio-demographic variables associated with individuals with FEP might also be present in people at HR, but to a lesser degree. **Methods:** We selected 30 individuals referred to our early intervention service (Cameo) that met criteria for HR according to the Comprehensive Assessment of At Risk Mental States (CAARMS). They were matched by age and gender with an equal number of randomly selected patients who fulfilled DSM IV diagnostic criteria for a first episode of non-affective or affective psychotic disorder. Comparisons were done using Fisher Exact tests and Mann-Whitney U tests. **Results:** Both groups showed similar sociodemographic and clinical characteristics, including immigration status, employment history, marital status, family history of

psychotic illness, self-harm, and alcohol and drug use. The HR group had a significantly lower level of education (26% vs 44% completing A-Levels), higher burden of trauma (97% vs 70%), earlier onset of psychiatric symptoms (mean age 14.9 vs 17.6), and longer delay to access specialised services following the onset of symptoms (131 vs 53 weeks). Functioning was greatly impaired in both groups. After a two-year follow-up only 3 (10%) of the HR group made a transition into FEP. **Conclusions:** The similarities observed between individuals at HR and those with FEP suggest that some of the known factors associated with psychosis may in fact be associated with developing a *predisposition for* rather than a *transition into* psychosis. The more severe presentation in people with FEP, despite a lower burden of trauma and a later onset of symptoms, suggests a population with a lower resilience against psychosis. Future studies of mediators of psychobiological resilience against psychosis might prove useful in identifying important mechanisms in the develop-

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SPOTLIGHT: Interview with Prof Peter Jones

Professor Peter Jones is the Director NIHR CLAHRC Cambridgeshire and Peterborough. In 2008 CPFT was selected for a prestigious Collaboration for Leadership in Applied Health Research and Care (CLAHRC), a collaboration between Cambridgeshire & Peterborough Foundation Trust (CPFT), the University of Cambridge including the Judge Institute, University Department of Engineering and NHS Cambridgeshire and NHS Peterborough.

Q: As director of the CLAHRC, why do you think your work is important to families in Cambridgeshire and Peterborough? Let's start at the bottom, not why it's important to clinicians but why it's actually important to families.

PJ: I think there are several reasons why it's important to patients and their families. First, it allows the services that help them to be evidence based and one of the main aims of the CLAHRC is to speed up the process of getting cutting edge research evidence into services and the services designed to be as effective as they can be. Historically, it's taken a very long time for research findings to make a difference to clinical care. Secondly, I think it changes the culture we're trying to build capacity in health services and social services where staff can become more sophisticated consumers of research evidence to understand why research can be useful to them and also to take part in the research and to shape the research questions. And then finally, we know that patients do better, they have better outcomes, in services that are involved in research its not quite clear why that is but it's a very consistent finding around the world.

Q : And you are very much, if you like, looking at the services the patient receives in different areas of healthcare, such as end of life care, service user advisory group, people with learning disabilities, looked after children and the adolescent strand of the child and adolescent theme and improving access to psychological therapies, gosh, that is an ambitious list if you are, if you like, going to examine each service, see what clinicians are doing, see what researchers are doing and seeing the impact it has on patients.

PJ: It is a broad list but there are some principles that run through those domains, what we're interested in is very vulnerable people having to navigate pinch points in, so for instance, the transition from child and adolescent services into adult services. These historically have been two completely different worlds.

Q : Some people, calling it a pinch point, say that people fall through gaps in services and we've had on the news as well as adolescents going through the child and adult services but weekend services for patients undertaking surgery or end of life care.

PJ : I think of a vignette of what we are trying to do. A young adult, a 17 or 18 year old, with learning disability in casualty on a Friday afternoon with belly ache is in an impossible position, there will be social services involved, there will be mental health services involved, there will be A&E there will be surgery and that individual is the least well placed navigator of the most complex system and that's what we are trying to help people with.

SPOTLIGHT: Interview with Prof Peter Jones Cont'd...

Q: And would it in the end lead to better value for money for the NHS and improve services for the patients because if we take, like in the adolescent strand of the CLAHRC presumably if you get people going from the adolescent services into the adult services they don't fall through those pinch points or gaps then it stops them getting into trouble later in life and that saves money to the public purse.

PJ: It is about saving money on one level but I think it's about increasing the value of services and what they can do for patients and their families. Now often services that add more value will ultimately result in cost savings but the money isn't our primary point. I think for the National Institute of Health Research, who has funded the CLAHRC, there is an important growth agenda that want the economy to grow through investments in health research but we are keeping our eye on value in services.

Q: Now you are taking that creativity from working with the Engineering Design Centre and the Judge Business School, into communicating through your website for toolkits about various strands of the CLAHRC so that, if you like, you can inform health care professionals about what you are doing nationally and all over the world and patients and their carers too. Is that, if you like, a commitment that you feel you're passionate about, to communicate your work so that people can see that change that research is making?

PJ: Very much so, I think the communication is partly about communicating results but its also about communicating a different way of undertaking applied health research so called, as the managers would say, co-production where the consumers of research which might be health services, social services or patients and their families they are involved very early on in forming the question and working with the researchers so they are absolutely primed and ready to put the results of the research into practice. And that's a culture change and communications key to that.

Q: And we haven't spoken yet of that other word which is often banded about in relation to health care research but is true in your case, innovation, there's been real innovation, if you like, in applying these management principles to the four service .

PJ: Yes, innovation is something I have come to understand a little more over the past two years. There's a contrast between an invention and an innovation or a piece of new knowledge. A piece of new knowledge only becomes an innovation when you do something with it, when you apply it. There is a lovely quote from Sir Clive Sinclair who was of course a great inventor and when he was talking about Thomas Edison he said, Thomas Edison didn't just invent the light bulb he lit up New York and I think that shows the difference between an invention and innovation. It's when you do something exciting with a discovery that it becomes innovative and of course that's exactly what we're trying to do in the CLAHRC.

SPOTLIGHT: Interview with Prof Peter Jones Cont'd...

Q: And finally, you told a lovely story earlier but have some of the findings of this CLAHRC research surprised you personally?

PJ: Yes, several have in different ways really, some of the findings surprise one because results are blindingly obvious and we should have known this before so for instance, the complexities in care pathways for adolescents for instance, or people with learning disabilities going across boundaries, when you map that as the systems engineers do, you map the care pathway, it's complexity is bewildering and we should really have known that before. Another surprising finding I think comes from the improving access to psychological therapy work where we've been analysing data from over 100,000 consultations in East Anglia and been comparing the outcomes of people getting their psychological treatments over the phone or face to face and unexpectedly we find that those who get their psychological therapies over the phone are actually doing better in terms of their outcomes. That's a slightly counter intuitive finding but it has major implications for the way services may be delivered and of course partly about cost you need to review buildings as you can do more treatment sessions over the phone than you can face to face but in terms of, as I said before, value for those people using the services it's a huge improvement in that they can stay at home, they can have their therapy at their own convenience, it alters the relationship they have with the therapist, it is a much more equal relationship so I think that's a good example of a surprising finding that may have real impact.

The downloadable "CLAHRC communication toolkits" are designed to be accessible to health care professionals and people who want to learn more about the latest innovations in health care research and the impact they are having on improving care standards for people. They are available from www.clahrc-cp.nihr.ac.uk

The National Institute for Health Research (NIHR) CLAHRCs are partnerships between a lead NHS organisation and an academic institution. CLAHRCs have been established to undertake high-quality applied health research focussed on the needs of patients, to support the translation of research evidence into practice in the NHS and to increase the capacity of NHS organisations to engage with and apply research.

This is an extract from the interview which can be found on the CLAHRC website www.clahrc-cp.nihr.ac.uk/about-us/podcast-2. This is part of a new series of four "CLAHRC Communication Toolkits" that can be downloaded and used by health care professionals and patients wanting to learn more about the latest innovations in health research and care.



Prof Peter Jones



Registered Charity: 1048144

A user-led organisation supporting the wellbeing and recovery of adults who have experienced mental distress

Groups and activities

We have a number of groups and activities running from Monday to Friday, between 12 noon and 4pm. These include our creative group, music group, singing group, women's group, creative writing group, meditation group, art group and social enterprise group.

Information Service

Our Information Centre is open Monday to Friday, 1pm to 4pm. It offers information about mental health as well as signposting to other services. We publish the Mental Health Handbook for Cambridge and Ely.

Social Club

Our Social Club is open every Monday, Tuesday, Thursday and Friday, 4pm to 7pm. It offers a relaxing social environment, internet access, friendship and good company.

Counselling Service

Lifecraft members can access free, long or short term, one-to-one counselling. The overall ethos of the service is client centred and, as an organisational member of The British Association for Counselling and Psychotherapy (BACP), it works in accordance with the BACP ethical framework.

“My counselling has been extremely helpful in my recovery. Medication, whilst being helpful, is not the long term solution to my problems. The service is an important part of my care plan and support network.”

Member Employment Scheme

Our Member Employment Scheme encourages paid member employment opportunities at all levels. We have members working in reception, the kitchen and Social Club, as well on short-term project work. “I've used my job role as part of my CV to support my job applications.” Lifecraft Keyholder “Being a Key-holder gives me a place to realise my capabilities safely and gradually, rather than plunging into the deep end.” Lifecraft Keyholder

Peer Support Groups

Peer support is at the heart of our organisation. We recognise that often those best placed to give the right kind of information, support and practical guidance regarding an issue are those who have experienced it themselves. Our peer support groups offer a safe place for peers to support each other to manage or overcome specific issues, including postnatal depression, anxiety and living with a physical disability.



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Benefits of Peer Support Groups:

Build a network of people who have a common understanding.

Gain inspiration and support from others' experience.

Learn new practical ways of managing problems and developing new skills.

Feel empowered and increase confidence and self-esteem.

Pooling information and joint problem solving creates a wealth of information which individuals can draw upon in times of need.

Foster a sense of personal responsibility and self-awareness which can lead to a greater sense of control and mastery of their particular condition or situation.

Support To Achieve Realistic Targets (START) Group

Our START group is an 8 week course supporting our members to achieve day-to-day targets.

Campaign and awareness raising work

We work hard to present mental health in a positive light and help to tackle stigma and discrimination through our campaigns and projects.

Shame No More

Is our anti self-stigma project, is working to help individuals overcome the shame and discredit they feel because of their mental health diagnosis.

Making Mental Notes

Is our multi-media project, includes a celebrated bi-monthly radio programme on Cambridge 105FM.

South Cambs Users Forum (SCUF)

SCUF is for people who have accessed help for mental health problems and who want to help shape and influence services as well as keep up to date with the local and national agenda.

Contact:

Lifecraft, The Bath House, Gwydir Street, Cambridge, CB1 2LW

Tel: 01223 566957

Email: info@lifecraft.org.uk

Website: www.lifecraft.org.uk

**Eastern Division
Spring Academic Meeting
1 May 2012
Maddingley Hall, Cambridge**



CALL FOR POSTERS

The Executive Committee of the Eastern Division invites submissions for poster presentations at their Spring meeting in May 2012.

The posters can be on new research, audit, literature reviews or other matters of clinical significance.

Submissions should be in the form of an abstract of no more than 400 words and submitted by email before **2 April 2012**.

Applicants will be informed whether they have been accepted or not by **9 April 2012**.

INSTRUCTIONS ON THE PREPARATION OF ABSTRACTS:

1. Abstracts should be typed single spaced, font size **10** in Word format using standard text, or text-only format. Apple Mac documents cannot be accepted. Hand-written abstracts will not be accepted.
2. The title should be in **bold**, followed by the full name(s) of the author and all co-authors, including titles (e.g. Dr) and their affiliations.
3. The title must contain no abbreviations.
4. The abstract must be no more than 400 words.
5. Where relevant, submissions should clearly state the aims, methods and results of the study.
6. Bibliographic references, tables and appendices are not included in the abstract.
7. Please make sure you check all spellings carefully.

HOW TO SEND ABSTRACTS:

Email your abstract to: Beverley Francis bfrancis@rcpsych.ac.uk with the subject reference 'YOUR NAME-EASTERN DIVISION ABSTRACT 2012'.

Attach your abstract as a Word document.

Include the following information in your email message:

- Title of the presentation
- Name of main presenting author
- Membership number (if applicable)
- E mail address
- Postal address
- Daytime telephone number
- Name of author's work organisation

For any further queries, contact Beverley Francis, Tel: 020 7977 6651, Fax: 020 7481 4842
bfrancis@rcpsych.ac.uk or Dr Regi Alexander, Academic Secretary, Eastern Division R.Alexander@uea.ac.uk

CLOSING DATE FOR SUBMISSIONS: 2 April 2012

EASTERN DIVISION BURSARIES 2012



INTERNATIONAL CONGRESS 2012

EASTERN DIVISION - BURSARIES

The Eastern Division awards bursaries annually to enable SpRs (ST4-6), SHOs (ST1-3), inceptors, affiliates and staff grades working in the Division to attend the Congress. Following the conference, recipients will be required to write a report about the meeting & what they gained from attendance. This report will be considered for inclusion in the Division's Psychiatr-East eNewsletter.

Up to **2** bursaries may be awarded to a value of **£150 each**, up to an annual total of **£300**.

The bursaries will be advertised in announcements about Eastern Division meetings, meeting registration forms and in the Psychiatr-East eNewsletter. Applications will be dealt with on a "first come, first served basis".

Applications should submit a covering letter (giving details of what they hope to gain from attending the Congress, why financial support is required and which other sources of funding that have been explored) to the Academic Secretary.

All expense claims, together with receipts, must be submitted to the Eastern Division Finance Officer at the Division address within four weeks of the International Congress. Applications for reimbursement received after this time will not be accepted.

Closing date: **31 May 2012**

Dr Regi Alexander – Academic Secretary
C/O Beverley Francis
Eastern & South Eastern Divisions Manager
Email: bfrancis@rcpsych.ac.uk
Tel: 020 7977 6651

EASTERN DIVISION RESEARCH PRIZE 2012



The Eastern Division has established an annual prize for the best research project conducted by any doctor of non-Consultant grade working within the Eastern Division. The value of this annual prize will be £200. The aim of the prize is to stimulate good quality research amongst trainees and non-Consultant career grade doctors who will then be afforded the opportunity to present this research at one of the Divisional Academic Meetings.

Regulations:

- I. Eligible entrants will be working in the Eastern Division in a non-Consultant post, at the time of completion of the research project and when making the prize submission.

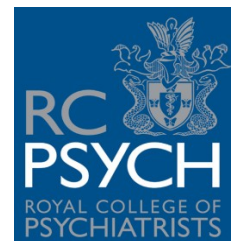
- II. The Eastern Division Executive Committee will appoint three examiners to judge the entries.

Closing date: Friday 31st August 2012

Submissions should be made to:

**Dr Regi Alexander – Academic Secretary
C/O Beverley Francis,
Eastern & South Eastern Divisions Manager
Email: bfrancis@rcpsych.ac.uk Tel: 020 7977 6651**

EASTERN DIVISION MEDICAL STUDENT ESSAY PRIZE 2012



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

Prize: £100

Frequency: Annually

Eligible: All medical students training in Medical Schools located within the Eastern Region

Where Presented: Autumn Academic Meeting of Eastern Division

Regulations:

- I. 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.
- II. The essay should be supported by a review of relevant literature and should be the candidate's own work..
- III. Submissions should be sent in triplicate. The essays will be judged by a panel of three Eastern Division Executive Members. 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.
- IV. The prize will be circulated annually to the Deans and Mental Health Leads" of local Medical Schools.
- V. The Eastern Division will provide a subsidised place for the prizewinner at the Autumn Academic Meeting. The prizewinner will be required to provide an edited version of their essay for possible publication in the *RCPsychiatr-East*.

Closing date: 31 August 2012

Submissions via email to:

Dr Regi Alexander – Academic Secretary
C/O Beverley Francis, Eastern & South Eastern Divisions Manager,
Email: bfrancis@easterndiv.rcpsych.ac.uk Tel: 020 7977 6651

Do people with Dementia die at their preferred location of death? A systematic literature review and narrative synthesis

Dr Vellingiri Badrakalimuthu, ST5 Registrar in Old Age Psychiatry,
Cambridgeshire & Peterborough Foundation Trust, Cambridge
Dr Stephen Barclay, Macmillan Post-Doctoral Research Fellow, General Practice and Primary Care Research Unit,
Department of Public Health and Primary Care, University of Cambridge

Aim & Method: Place of death is an important component of the quality of a person's death. It is thus important to explore patient's preferred place of death as part of their advance planning for end-of-life care, the more so in dementia, as actual end-of-life care in practice is often inconsistent with patients' advance directives. This aim of this study is to undertake a systematic review and narrative synthesis of the literature concerning place of death of people with dementia and the preferences for location of death of people with dementia as well as family carers and healthcare providers preferred location of death for patients with dementia. **Results:** Studies relying on death certificate data show that patients with dementia die more commonly in care homes

than other locations contrasting with prospective studies which show that death is more common in own residence and hospital. Age (older), gender (male), availability of hospital and nursing home beds and enrolment in hospice, influence place of death. There is very limited evidence of patients, family carers and healthcare providers' views on preferred location of death for patients with dementia and where available, family carers views are more agreed to rather than patients own views regarding place of death. **Conclusion:** This study on place of death raises major concerns on end of life care for patients with dementia which has implications on health and social care policies related to dementia.

Selected for presentation at Dementia Research: Knowledge in to Care, 2011
Event organised by NIHR CLAHRC & DeNDRoN.
Presented as a poster at the Annual Meeting of Faculty of Old Age Psychiatrists 2011.
Submitted for publication
Winner of the Eastern Division Research Prize 2011

Royal College of Psychiatrists - Eastern Division E-Newsletter

Editor: Dr V R Badrakalimuthu, Cambridgeshire & Peterborough NHS Foundation Trust

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Editorial Team/Production: Beverley Francis - Eastern & South Eastern Divisions Manager

The opinions expressed in this newsletter are those of individual authors and do not necessarily represent the views of the Royal College of Psychiatrists .

Division e- Newsletter and welcome exciting suggestions for a unique name for the publication. Please complete the following form with your ideas and return it to the registration desk. **We** would like to see articles on a wide range of topics of general interest to clinicians in the Eastern Region. This might include clinical issues, developments in psychiatry, service provision, training, original research and audits, interface between psychiatry and other medical specialities, psychiatry and ethics, regional news, personal experiences, book reviews etc. Contributions are welcomed from career psychiatrists, trainees, medical students, general practitioners and other health professionals working in psychiatry and other related medical specialities. We would be pleased to receive original articles, opinions, debate, commentary, case reports, and letters. Creative contributions involving poems and photos will also be considered. Please limit contributions to a maximum of 1,000 words unless agreed with the Editor. The Editorial Committee reserves the right to edit contributions as deemed necessary. Shorter typed contributions are acceptable. Contributions should be submitted in a recognisable Windows format by email. Letters should not exceed 200 words. **Authors** are encouraged to include a (returnable) colour photo of themselves.