Welcome to the first issue of Mind the GAP newsletter for the year 2013. There have been a lot of changes in the way we practice medicine. Doctors are required to demonstrate on a regular basis that we are up to date and fit to practise through Revalidation. The aim is to give extra confidence to patients that their doctor is being regularly checked by their employer and the GMC. As GMC says “patients can help their doctors improve their practice by providing them with regular feedback about the care they have received”.

Revalidation for doctors went live on December 03, 2012. GMC has duly sent a reminder for all the registered doctors with a licence to practise about their revalidation dates. For most doctors in training, their first revalidation will depend either on the date of full registration or the expected Certificate of Completion of Training (CCT) date. It is worthwhile to note, irrespective of the revalidation date, your need to start now and get ready with all the evidence that is required. As a doctor in training, Annual Review of Competence Progression (ARCP) plays a major part in revalidation as these doctors work in a highly governed system and their practice is already subject to periodic review.

Of the six types of supporting information that is expected from a doctor at the appraisal in each revalidation cycle, 5 of them will be covered by ARCP. They are continuing professional development, quality improvement activity, significant events, feedback from colleagues and review of complaints and compliments. In addition to these, revalidation process requires you to collect evidence about feedback from patients once in a 5 year cycle. However, there has not been a major emphasis about feedback from patients during ARCP as this is not a formal/mandatory requirement like for e.g. workplace based assessments. Some trusts have recruited external agencies to help their doctors complete the patient feedback questionnaires.

As the postgraduate dean is trainee’s responsible officer, should the deanery put a structured process in place for trainees to collect feedback from patients? Should this be included as a requirement in future ARCP process? The GMC has developed colleague and patient questionnaires. Although they are not mandatory, they provide examples of a questionnaire design. If a doctor is unclear about the process or use of feedback tools they should seek advice from their designated body. GMC further says “where your training programme does not require you to routinely collect items of supporting information, you are not expected to go beyond the requirements of your training programme to collect this”. We always say that the patients’ care and their best interests are at the heart of our practice. Shouldn’t we be seeking feedback from them?

References
http://www.gmc-uk.org/static/documents/content/Supporting_information_for_appraisal_and_revalidation.pdf
http://www.gmc-uk.org/static/documents/content/Developing_implementing_and_administering_questionnaires.pdf
http://www.gmc-uk.org/doctors/revalidation/colleague_patient_feedback.asp
Serotonin Syndrome associated with the addition of Mirtazapine to a mood stabiliser and SSRI

Dr Jaspal Singh Swalli & Dr Martin Curtice

Introduction

Serotonin syndrome is an iatrogenic disorder that results from serotonergic over activity which can be fatal.1 It is usually precipitated by the use of one or more serotonergic drugs. Its clinical presentation consists of alteration in mental state, autonomic dysfunction and neuromuscular disorder.2 Serotonin syndrome was first reported in the 1950s with the use of MAOIs, antidepressants and tryptophan3 however in recent years there has been an increased number of reports of serotonin syndrome with the use of SSRIs.4 There have been various reports in the literature of individuals developing serotonin syndrome with administration of mirtazapine alone5,6 and also with mirtazapine and SSRIs7,8,9 in combination. This case report describes a patient with a severe depressive episode who developed serotonin syndrome from the addition of mirtazapine to a pre-existing combination of lithium and citalopram.

Presentation

The patient was an 84-year-old single, retired, caucasian lady with a known diagnosis of recurrent depressive disorder. She had three previous admissions for depressive episodes, the last admission in 2006 required ECT for a full recovery. Since then she had been successfully managed in the community on a combination of lithium and citalopram. Following a rectal prolapse the patient presented with a four-month history of increasing anxiety symptoms regarding her prolapse and constipation. She was spending increasingly excessive amounts of time in the toilet due to this. Subsequently her mood became low and she described losing interest in the things she usually liked to do. She had surgical intervention for the prolapse which further affected her low mood post operatively at which point she described biological symptoms of depression with poor oral diet and fluid intake requiring hospital admission.

On admission her lithium level was 0.99 (upper therapeutic limit but no side effects evident from this). Electrolytes were all within normal range. In view of the lithium level and reduced oral fluid intake lithium was reduced to 200mg nocte from 400mg and to continue citalopram at a dose of 40mg. The lithium level a few days later was 0.47. In light of worsening depressive symptoms over the first two weeks of her admission, ECT was considered in view of the good response to it previously. However at this juncture the patient was assessed as having the capacity to consent to treatment and to subsequently be able to refuse ECT. She was therefore commenced on mirtazapine 15mg nocte, in addition to the citalopram and lithium, as an augmentative strategy (in preference to stopping and switching classes of antidepressants) which she consented to. Three days after commencing mirtazapine she was treated for a proven UTI.

After six days of being on this combination of medication nursing staff reported that the patient sustained three falls over a period of 24 hours and that she had had very little sleep for approximately 48 hours. She became very unsteady on her feet, falling back in her chair as she attempted to stand, having previously been independently mobile. She was reviewed by the medical team and appeared less responsive than usual and more confused being disorientated in time and place. She felt warm and clammy to touch with profuse sweating. New coarse tremors of both hands were noted but no focal neurology was found on examination. Her physical observations demonstrated a fluctuating and labile blood pressure (systolic BP 130-180 mmHg) and temperature (36.1-38.5°C). Oxygen saturations on air were normal. BMs were within normal limits. A full blood screen, including creatinine kinase and CRP, was within normal range. The lithium level was 0.42.

In view of the short duration of symptoms, the differential diagnosis included delirium, serotonin syndrome, neuroleptic malignant syndrome or an intra-cerebral event. At this time mirtazapine was stopped and she was initially managed with supportive treatment with close monitoring of physical observations and diet and fluids. After a further 48 hours she required transfer to a general hospital because she stopped passing urine despite satisfactory oral fluid intake. During the initial period of admission to the general hospital she continued to present with fluctuating blood pressure and temperature. She was commenced on intravenous fluids due to an elevated urea but all other blood tests were normal. A chest x-ray and repeat MSU were also normal. A head CT scan did not reveal any acute intra-cerebral event but did demonstrate an incidental finding of a small frontal meningioma but with no associated mass effect.

The dose of citalopram was reduced to 20mg daily and lithium continued at 200mg nocte. Her condition improved such that she returned to the psychiatric hospital. It was concluded that the acute clinical decline was due to serotonin syndrome following the instigation of mirtazapine.

Discussion

Serotonin is a neurotransmitter synthesized from dietary amino acid L-tryptophan. Serotonin is produced peripherally by the enterochromaffin cells and centrally by the raphe nuclei found in the pons and brain stem. Serotonin regulates emotions, personality, sleep, appetite, temperature, pain, sexual and cardiopulmonary functions in the central nervous system.2 Serotonin also regulates smooth muscle tone. Serotonin syndrome is the result of over stimulation of the serotonin (5-HT1A) receptors in the central grey nuclei and the medulla and, perhaps, of over stimulation of serotonin (5-HT2) receptors.2.
This case describes serotonin syndrome induced by the addition of mirtazapine to a pre-existing combination of lithium and citalopram. The patient developed a cluster of symptoms soon after the initiation of mirtazapine namely confusion, insomnia, hyperhydrosis, fluctuating blood pressure and temperature, gait disturbance and tremors all consistent with the triad of mental state changes (confusion, elevated mood, coma, agitation, and insomnia), autonomic changes (hyperhydrosis, fever, tachycardia, tachypnea, low or elevated blood pressure, and diaphoresis) and neurological symptoms (tremor, rigidity, clonus, myoclonus, and hyperreflexia) which characterise serotonin syndrome. There is no specific test for serotonin syndrome but diagnostic criteria have been produced. 10,11

In line with previous reported cases of serotonin syndrome, the symptoms in this case resolved within a few days of discontinuing the presumed causative agent, mirtazapine. Neuroleptic malignant syndrome was considered as part of the differential diagnosis for this acute presentation because it shares many characteristics of serotonin syndrome and, although very rare, antidepressants13,14 and lithium 15 have been associated with NMS-like presentations. The search for adjunctive diagnostic laboratory tests to differentiate between the two conditions remains elusive.16

Previous case reports have shown that both citalopram17 and mirtazapine5,6 administered alone have been associated with serotonin syndrome, but it has not yet been described in combination with each other (serotonin syndrome has been described with mirtazapine in combination with fluoxetine5, sertraline6, fluvoxamine7). Serotonin syndrome has been described when lithium was combined with an SSRI18,19 and SNRI20 This is a new case report describing serotonin syndrome when mirtazapine was added to a pre-existing lithium and citalopram treatment regime.

This case highlights the importance of being cautious when combining multiple medications which individually may induce serotonin syndrome especially in the elderly,21 and to be vigilant for the emergence of symptoms suggestive of serotonin syndrome. Furthermore it highlights the importance of close monitoring and thorough investigation of such cases as whilst a potentially fatal condition, it has a good prognosis with quick cessation of the causative agent and appropriate supportive management.

References


Authors: Dr. Jaspal Singh Swalli is a CT2 trainee in Old Age Psychiatry & Dr. Martin Curtice is a Consultant in Old Age Psychiatry; both work at Juniper Centre, Moseley Hall Hospital, Alcester Road, Moseley, Birmingham, B13 8AQ
A Survey of the knowledge, attitudes and behaviour towards FP-10 prescribing amongst doctors working in the Birmingham and Solihull Mental Health Foundation Trust

Dr Salman Hashmi, Dr Jayne Greening, Dr Daniel Jackson

Abstract

A survey into the knowledge, attitudes and behaviour of FP-10 prescribing amongst 76 doctors working in the Birmingham and Solihull Mental Health Foundation Trust (BSMHFT) showed that use of FP-10 prescription pads was common, often prompted by change in medication or for convenience, with the knowledge of their cost implication and security risk.

Background

This survey was performed in response to an alert by the Trust’s central Pharmacy about the over-spending on FP10 prescriptions across the trust. During 2009/10, BSMHFT spent £2,445,079 on FP-10 prescriptions\(^1\) and a published index of monies spent on FP-10s showed a great discrepancy amongst various teams. The trust central Pharmacy intends to produce a policy in the future but in the meantime has directed us to the Medicines code\(^2\).

Several Trusts across the UK have policies on FP10 prescribing with Berkshire Healthcare NHS Foundation Trust’s\(^3\) being the most detailed and comprehensive. These seem to have been written in response to both cost and security issues, following incidents of FP10 prescription pads having been stolen. A national policy was not identified.

It was felt a survey was needed to examine the current attitudes and practices of FP10 prescribing across BSMHFT to direct any future policy making by the central pharmacy in this area.

Aims & Objectives

This survey aims to examine the knowledge, attitudes and behaviour of FP10 prescribing across BSMHFT to direct any future policy making by the central pharmacy.

Method

Primarily, this was a survey study, using primary data, to be collected through a carefully designed questionnaire. Variables that were considered whilst designing the questionnaire were based on a KAB study (Knowledge, Attitude and Behaviour). The time dimension of the actual data collection should be 07 to 10 days, implying the cross-sectional nature of this undertaking. The maximum number of Doctors working within BSMHFT was targeted in March 2011 using both a central email list and personal email lists. A reminder email was sent two weeks later.

Graph 1

<table>
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<tr>
<th>Situation for FP-10 use</th>
<th>Doctor’s convenience</th>
<th>Aids rapport</th>
<th>Prescribing control</th>
<th>Accepted practice</th>
<th>Unreliable GP prescribing</th>
<th>Potential misuse of prescription</th>
<th>Only for psychotropics</th>
<th>Recording of capacity and consent occurs</th>
<th>Secure handling of FP10 is important</th>
<th>Serial numbers of FP10s are recorded</th>
<th>Awareness of local guidelines</th>
<th>Knowledge of cost implications</th>
<th>I should minimise FP10 prescriptions</th>
<th>Encouragement of patient dependence</th>
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<tbody>
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<td>Prompt initiation</td>
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<td>30%</td>
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Results

76 (61.8%) Doctors responded to the survey from a total of 123 identified email addresses. The majority of responders were consultants (57%) and middle grade doctors (34%) with varying degrees of FP-10 prescribing habits. The situations that the prescribers use FP-10s are shown in Graph 1.

As additional comments, responders stated they would also use FP-10s when GP refuses to prescribe, in emergency situations and when there has been difficulty accessing the central pharmacy. The above table (Table 1) shows the number of responders whose practice aligned with certain statements.

Conclusions

It is interesting to note the varied reasons doctors have for issuing FP10’s. When asked in what circumstances they would use a FP10 prescription all of the choices were checked, but those surrounding changes in treatment were checked significantly more. Additional comments by the recipients suggested that other reasons were the GP being unable/refusing to prescribe certain medications (e.g. cholinesterase inhibitors) and in times of emergency. One interesting comment was “weekly prescriptions for people with thoughts and intent of overdose” suggesting a need for this type of prescription in acute monitoring situations.

A high proportion of Doctors considered the convenience of their patients when using a FP10 prescription, perhaps suggesting difficulty in obtaining a GP prescription in a timely manner. Doctors showed awareness that ‘Securing and safe handling of FP10 prescription forms is good practice’ and that there is potential for the prescriptions to be abused, however only 24% checked ‘Serial numbers of FP10 prescriptions are recorded in the notes or an FP10 register at my workplace’. Most also recognise that FP10 prescriptions have a cost implication to the Trust and that they should minimise this, supported by additional comments responders made. Interestingly half of the responders stated that they were aware of the local guidelines or protocol; perhaps being aware of the lack of guidelines presently.

There are several limitations to this survey. It would be difficult to replicate in an exact manner due to personal email lists having been used, however the majority were on a central email list which are readily available. We became aware that some of the doctors had recently left the trust and were working elsewhere, but their reflections were included due to recent contact with BSMHFT. 38.2% of doctors failed to respond, which could have significantly affected the results of the survey. This survey did not examine the difference between the varieties of sub specialisations within the trust. It is also possible that FP-10 prescription behaviour could be affected externally by different GP practices having different stances with regards to psychiatric medicines. This was a cross-sectional survey with a year delay in write up, possibly meaning a change in knowledge, attitudes and behaviour to FP-10 prescribing. The questionnaire has not previously been piloted, but it was felt that it thoroughly addressed the KAB variables.

Overall this survey has provided the needed data on the knowledge, attitudes and behaviour towards FP-10 prescribing of Doctors across the trust. This will aid construction of a comprehensible protocol or set of guidelines to be drafted by our central pharmacy. This data will also help the Trust reduce costs from FP-10 prescribing by examining alternative solutions to reasons given for their use.

Recommendations and Action Plans

Recent attempts have been made to reduce the prevalence of FP-10 prescribing and it would be useful to examine the effect of these efforts on knowledge, attitudes and behaviour of the trust Doctors by completion of the audit cycle.

It is possible with the recent raising of awareness of the cost to the trust of FP-10 prescriptions that the total spend on this has reduced already and further information from pharmacy and regular updates to medical staff can confirm this.

Recommendations to the central pharmacy for production of comprehensive guidelines on this issue have already been made, but this survey should be made available to the Director of Pharmacy & Medicines Management to reinforce this.

It is hoped that the results of this survey will be presented at a local level with publication in a local newsletter. The original participants and other Doctors across the trust will be notified of the survey results by trust email.

References


Authors: Dr. Salman Hashmi is a Consultant Psychiatrist in Sandwell CRHTT (was a ST6 trainee at the time of survey in BSMHFT0; Dr. Jayne Greening is a Consultant Psychiatrist in Birmingham & Dr. Daniel Jackson is a CT2 psychiatry trainee in Birmingham.
Audit: On call experiences for higher trainees and trainers across the West Midlands. A learning opportunity or service provision?

Dr. Derrett Watts, Dr. Roji Thomas, Dr. Mohammed Abbas Ramji

Aims

An audit survey was undertaken in order to evaluate on call experiences of higher trainees and trainers across all psychiatry sub-specialties through the West Midlands and to develop criteria for a further audit.

Background Review

There is extensive anecdotal discussion about the varied levels of exposure and intensity of work undertaken by higher trainees and trainers out of hours across the West Midlands. Other than the need to undertake on call work in order to enhance the experience of higher trainees for its educational value, there is little guidance for the type and frequency of on call work expected from the Royal College of Psychiatrists for doctors in training. The only guidelines currently in place appear to be the European working time directive that stipulates a 48-hour average working week for junior doctors from August 2009.

Method

An online survey was set up that explored various aspects of on call work and sent to all higher trainees and trainers across all sub-specialties of psychiatry by email. This includes the psychiatric specialty that participants work in, the frequency and type of on calls, and the grades of doctors participating on the on call rota. The survey asked about the different settings in which patients are seen and the sub-specialties these patients fall under, the number of mental health act (MHA) assessments undertaken and how many of these lead to admission. The survey explored hand-over arrangements, workplace based assessments undertaken and respondents were asked for additional comments.

Results

21 higher trainees and 45 trainers responded to the survey. Some of the results are shown in the following graphs.
There was a wide range of responses regarding the number of MHA assessments completed by higher trainees within 3 months, ranging from none to 25. The number of MHA assessments completed by trainers within the 3 months prior to the survey ranged from none to 12, with 14 trainers (31%) not undertaking any mental health act assessments at all.

Conclusions

An on call frequency of between 1 in 7 and 1 in 12 for higher trainees should perhaps be the recommended range in order to balance the educational benefits of seeing cases in an on call setting. The appropriateness of home visits ‘out of hours’ may need to be reviewed in light of safety concerns and lone working policies. There is a widespread opinion amongst trainees that the educational component of the on call commitment is diluted by the need for service provision. Handover arrangements need to be clarified and a gold standard of at least a telephone conversation could be expected even if to report nothing to hand over. More trainees could be encouraged to complete WPBAs and discuss cases in supervision to enhance the educational value of on call. The findings will be circulated to local trainees at the West Midlands Higher Trainees conference 2012 and presented to the West Midlands school board. We hope this report will stimulate discussion as to the training needs and experiences of trainees and trainers and the role of the psychiatrist in completing emergency work ‘out of hours’. We plan to develop audit criteria and complete an audit on on-calls following discussion and implementation of findings discussed above.

Authors:

Dr Derrett Watts is a Consultant Psychiatrist and Training Programme Director for Higher Specialist Training, General Adult Psychiatry, West Midlands Deanery; Dr Roji Thomas is a ST5- General Adult Psychiatry trainee in BSMHFT; Dr Mohammed Abbas Ramji is a ST6- General Adult Psychiatry trainee in BSMHFT, Birmingham.
West Midlands Psychiatry Specialty Trainees Conference 2012

We would like to take this opportunity to thank all the speakers at our annual conference held on 16th November 2012. We the trainees are all really energized by the response we got. We would also like to thank the organising committee members for their outstanding work to make this event a great success.

The session for poster presentations by trainees and medical students received a huge attention. The posters were judged by Dr. Jayne Greening and a prize was awarded for the best poster. The winner was Dr. Ankur Kumar, a CT2 trainee working at Penn Hospital, Wolverhampton.

The abstracts of the winning poster and the highly commended poster are presented below.

THE EDITORIAL TEAM

Observation Levels and Leave from a Psychiatric Hospital - Re-audit of clinical practice in Penn Hospital, Wolverhampton

Dr Ankur Kumar, CT2, Penn Hospital, Black Country Partnership NHS Trust

Dr Nilamadhab Kar, Consultant Psychiatrist, Penn Hospital, Black Country Partnership NHS Trust

BACKGROUND: At the point of admission to Penn hospital patients are placed on varying levels of observation levels depending on their clinical status, risk to themselves or others. It is expected that patients on higher levels of observations for the associated risk should not be granted leave. Following an initial audit, feedback was given to medical teams regarding the status.

AIM: To assess whether any discrepancy between the levels of observation and leave of absence from the ward exists and to compare these findings from the original audit conducted on 15/02/12.

STANDARDS: There should be documentation on the legal status, level of observation, risk to self and others, and leave granted for all in-patients. No patient with higher observation levels for clinical reasons or for risk to self and others should be granted leave.

METHODS: The medical and nursing notes of 35 patients that were in-patients on 26/07/2012 were assessed for the documentation on the legal status, level of observation, risk to self and others, and leave granted.

RESULTS: Findings of the re-audit compared to the initial audit were as follows: evidence of documentation of patient’s legal status 82.9% v 73.7%; level of observations 71.4% v 52.6%; risk to self 71.4% v 50%; or risk to others 57.1% v 34.2%. In the re-audit there was no discrepancy between level of observation and grant of leave compared to 2.6% on first audit.

CONCLUSIONS: There has been overall improvement in documentation following dissemination or results of the initial audit. In addition no patients with higher level of observation was granted leave in the re-audit.

RECOMMENDATIONS: There is a need for further improvement in the documentation figures regarding legal status and risk; this needs to be reviewed periodically. Communication of audit findings and re-audit are recommended.
Audit into the Implementation of NICE guidelines for the assessment, diagnosis and initial management of autism spectrum disorder

Dr Rebecca Stubbs

Aim
The diagnostic pathway for autism spectrum disorders (ASD) within child and adolescent mental health service (CAMHS) in Birmingham is under review. Evaluating whether the current referral pathway, diagnoses and initial management are meeting national standards (NICE guidelines for autism in children and young people, Sep 2011) will guide changes to current practice.

Background
Once thought uncommon, prevalence rates of ASD are now estimated at 1% in children. Mental health services play a key role in diagnosis; close collaboration with other health agencies and the education sector is essential. Recent evidence has shown that 70% of people with ASD meet the criteria for other psychiatric disorders, often undiagnosed. NICE guidelines were reviewed in 2011 to standardise diagnosis and improve coordination between agencies.

Methods
A sample of children, at The Blakesley Centre community CAMHS team, Yardley, diagnosed with ASD between September 2011 and August 2012, were randomly selected. Medical notes were searched for evidence that NICE guideline criteria were met in diagnosis and initial management. Of these 42 children (5-15 years), 35 had been referred for autism assessment; medical notes were searched for evidence that recommended referral information was provided.

Results
Assessment: details of developmental history, communication and social skills were provided in 100% of cases; assessment for common co morbidities and documentation of injury/neglect were found in only 30%. Initial management: less than 8% of families received information on risk of autism in siblings, and information on local support was not provided to 60% of families. Follow-up within six weeks was achieved in all cases. Referral information: details of antenatal, perinatal and developmental history provided in all cases; information on risk factors for autism in 11% and details of previous assessments included in 50%.

Conclusions
Main weaknesses identified were poor consideration of co morbidities and documentation of abuse in assessment, and referrers failing to provide information on autism risk factors. Developing a proforma incorporating a checklist of items for the assessor and referrer should increase compliance with NICE recommendations.

Re-audit: March 2013.

Author: Dr. Rebecca Stubbs is a CT3 Psychiatry trainee working at The Barberry, Birmingham and Solihull Mental Health Foundation Trust, Birmingham.
Upcoming Events

The Royal College of Psychiatrists’ International Congress 2013

Date: 2 – 5 July 2013

Venue: Edinburgh International Conference Centre, 150 Morrison Street, Edinburgh, EH3 8EE

For details contact: tel: 020 7235 2351, fax: 020 7245 1231, email: info@rcpsych.ac.uk

RCPsych Faculty & Section Annual Meetings

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Venue</th>
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<tr>
<td>6-8 February</td>
<td>Faculty of Forensic Psychiatry Annual Meeting</td>
<td>Scandia Copenhagen Hotel, Copenhagen, Denmark</td>
<td>Tel: 020 7977 6657, Email: <a href="mailto:calc@rcpsych.ac.uk">calc@rcpsych.ac.uk</a></td>
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<tr>
<td>8 February</td>
<td>Symptom Based Management</td>
<td>Cavendish Conference Centre, London</td>
<td>Tel: 020 7235 2351 ext 6129, Email: <a href="mailto:conference@rcpsych.ac.uk">conference@rcpsych.ac.uk</a></td>
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<tr>
<td>27 February - 1 March</td>
<td>Faculty of Liaison Psychiatry Annual Meeting</td>
<td>The Rougemont Hotel, Exeter</td>
<td>Tel: 020 7977 6659, Email: <a href="mailto:events@rcpsych.ac.uk">events@rcpsych.ac.uk</a></td>
</tr>
<tr>
<td>1 March</td>
<td>Spirituality and Clinical Psychiatry: Training and Practical Issues for Mental Health Practitioners</td>
<td>Etc Venues, Victoria, London</td>
<td>Tel: 020 7977 6657, Email: <a href="mailto:calc@rcpsych.ac.uk">calc@rcpsych.ac.uk</a></td>
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<tr>
<td>13 - 15 March</td>
<td>Faculty of Old Age Psychiatry Annual Conference</td>
<td>Midland Hotel, Manchester, UK</td>
<td>Tel: 020 7235 2351 ext 6129, Email: <a href="mailto:conference@rcpsych.ac.uk">conference@rcpsych.ac.uk</a></td>
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<tr>
<td>18-19 April</td>
<td>Faculty of Medical Psychotherapy Annual Meeting</td>
<td>Ettington Chase, Stratford upon Avon</td>
<td>Tel: 020 7977 6659, Email: <a href="mailto:events@rcpsych.ac.uk">events@rcpsych.ac.uk</a></td>
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Forthcoming GAP peer group meetings 2013

◊ 13th March 2013
◊ 15th May 2013
◊ 18th July 2013

The views expressed in the articles are the views of the authors and do not necessarily reflect those of the editors of the newsletter. This newsletter is intended to inform and promote the positive work of the West Midlands General Adult Psychiatry higher trainees. It is also hoped that it provides a platform for junior trainees, trainees in other specialties, SAS doctors and Consultants. We aim to publish this newsletter twice a year. Portfolio certificates are provided.

Contributions should be sent to the editorial board:

rajkumaranjali@yahoo.com; docdoniparthi@yahoo.co.uk; dr.juhisharma@gmail.com; saugata@doctors.org.uk; sujit.sharma@nhs.net