

South Eastern Division NEWSLETTER



Volume 1 issue 3

Letter from the Secretary

Dr Shanaya Rathod

This has been an exciting year for the division. The executive bid a sad farewell and thanked Rosie Baker for leading the division as chair for the past four years and welcomed Phil Davison as the new Chair. Phil has brought new energy and ideas to the division which will

no doubt prepare us for the challenges ahead. We would like all our members to have a say and influence the division's workings. At a time when Psychiatrists as a professional group face a number of uncertainties, our strength remains in our unity and ability to influence the centre.

Letter from the Chair

Dr Phil Davison

I see it as an exciting challenge to chair our division for the next four years. Having been a member of the executive committee for the last four years, I understand some of the political machinations that the College is currently engaged in. Of most relevance to us, is the devolution of College activity and some powers from the centre, to the divisions. We now have an opportunity to influence the centre. Either I or our secretary Shanaya represents our views at the regular Central Executive committee. So contact us, or any member of the executive and talk to us. Come to the excellent divisional meetings that we hold, introduce yourself and join the debates. We can influence the centre. I would like the College (us) to re-discover our role in the setting of standards for the care we offer and provide. We can influence our managers (many of us are managers) to deliver these standards, not only in training our younger colleagues, but in maintaining the standard of care that we are able to offer our patients. I hope that at the end of my four years we will be at the forefront of standard setting and

that locally we feel that we have made a difference. We can do that by meeting regularly, sharing ideas about how we are delivering high quality services and disseminating these ideas to our colleagues and also our managers. Our business is to restore pride in our profession. We will do that by leading changes. We have been given a difficult ride by government in recent times, but perhaps the tide is turning.



Goodbye Rosie

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WINTER 2008

Division Academic Day

'Postcards from the edge' - May 2008

Report by Dr Digby Quedest

The Spring Division Day was held in Brighton Old Ship Hotel. In planning the day an academic focus on the current trends in neuroscience was a guiding light and the two speakers invited to represent the 'cutting edge' did not disappoint. Two major directions in Neuroscience over the last two decades have been neuro-imaging and molecular genetic studies. Prof Hugo Critchley kicked off with a review of his work linking human emotional experience with brain regions. A major point of progress would seem to be the role of the insular cortex, particularly right sided, as a final brain substrate for the coordination and experience of human emotion. One previous criticism of neuro-imaging has been the low numbers of subjects involved. Traditionally, statistical validity has been promoted by the use of multiple cuts in a single scan episode and the setting of low significance levels in e.g. SBM or VBM to control, using a Bonferroni correction. An important aspect of Hugo's work would seem to be his approaching a scientific question from varying angles, or triangulation methods - where a final common outcome is seen by the application of differing experiments.

Prof Paul Harrison's lucid lecture demonstrated that the move from relatively large scale endeavour to molecular can benefit from the same approach. Psychiatric genetics has suffered from similar criticisms to those levelled at the imagers, namely validity. In order to achieve a valid finding in e.g. association studies, two approaches can seem justified: 1) Setting up an a priori model which specifies closely the likely outcomes based on the known aspects of a putative susceptibility gene e.g. NRG1 or 2) an exceedingly large number of samples to be collected in order to overcome multiple testing issues. The genome wide screen (GWS) is one such large scale endeavour but the finding of an increase in micro-deletions and copy number variants (CNV's) reported in Nature in September '08, of which I am a co-author, would not seem to resolve any of the issues, as they rest on a 'dirty' hypothesis, specifically that random faulty structure of genes can generate disordered brain material which could presumably then show up in Hugo Critchley's studies! But this is not what happens - his work suggests replicability is possible in different groups suggesting an elegance condition and not the ravages of intra-uterine viral destruction, a previous

hypothesis. We are then all left with both macro and micro scientific efforts chasing the same tale: 'How do we find out what the brain is doing, and where, in a manner which lends itself to prevention, diagnosis or treatment?' Or at least that is what academic psychiatrists are interested in!

John Lyon Memorial Prize 2008

At the South East Division Academic meeting, Dr David Briess, Specialist Registrar in General Adult Psychiatry, The Warneford hospital, Oxfordshire presented his work on 'The Use of Text-Messaging for Monitoring of Mood in Patients with Bipolar Disorder' and was declared the winner of the John Lyon Prize by the panel of judges on the 15th May 2008.

'NEWS FLASH'

DATE FOR YOUR DIARY

South Eastern Division
Spring Academic Meeting
6 May 2009

Theme: Controversies and Challenges
in Psychiatry

Speakers

Prof Guy Goodwin, Prof John Geddes

Prof Swaran Singh and

Dr Steve Pearce

Trainees Prize: Presentations

Venue: University Dept of Psychiatry,
The Warneford Hospital, Oxford OX3 7JX.

Eastern and South-Eastern Divisions, Second Joint Academic Meeting

November 2008

Report by Dr Rob Jackson

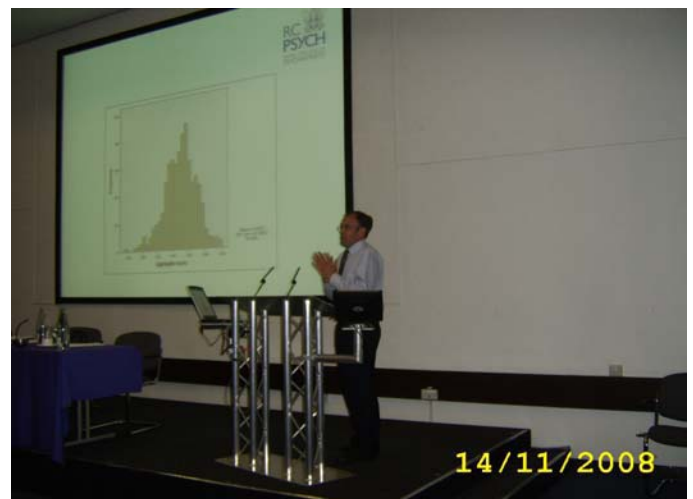
Persuading colleagues to raise their noses from the grindstone and attend meetings at which they learn new things (and gain CPD points into the bargain) is potentially a most rewarding task, but frustrating if the attendance is disappointing despite high quality speakers and genuine new ideas. The joint academic meeting of Eastern and South-Eastern Divisions held in the autumn of 2008 was successful in both ways. There were both excellent presentations by important and distinguished speakers on crucial topics, and a good turn-out with plenty of audience participation.

Though people have to travel further on average for a joint meeting, the reward of meeting a broader range of colleagues seems to outweigh the drawbacks of time in cars or on trains. In particular, a fair number of colleagues from south of the Thames were willing to programme their satnavs to deal with the frustrations of the M25 orbital car park.

The meeting was held in a steel-and-glass site in the new University of Hertfordshire campus on the outskirts of Hatfield; the venue was comfortable despite one of the rooms having a ceiling that looked as if it was adapted from a small aircraft hangar, and the catering was very welcoming. The meeting had an overall theme of the future professional role of psychiatrists, but with two clinical topics - on the interface between the Mental Health and Capacity Acts, and the management of personality disorder. The first speaker was Robert Robinson, President of the Mental Health Review Tribunal and a solicitor. His expertise meant his talk on the two recent changes to mental health law will be essential knowledge if you are likely to be applying the amended MHA or assessing the capacity of a patient in the near future. His handout on the Mental Capacity Act/MHA interface will be referred to regularly by those of us who have a copy; it was also refreshing not to have an identikit PowerPoint presentation. There were many audience questions about points of law, and a lot of concern about the best interests of patients. In particular, it is not yet clear whether care for people with dementia is tantamount to deprivation of liberty, despite the existence of duty of care. Mr Robinson expects the need for care to win out, but case law precedents have yet to be set by suitably senior courts.

Next, Laurence Mynors-Wallis, Associate Dean of the College, gave a very clear Cook's tour of the new landscape of GMC revalidation, relicensing and recertifica-

facilitating improved practice. There will be a staged roll-out to trusts during 2010. All doctors will be granted their first licence without the need for supporting evidence of CPD or satisfactory appraisal, but the renewed licence around 5 years later will require supporting evidence. The role of the Responsible Officer - the Medical Directors of Trusts, or the equivalent in PCTs - will be crucial, but not easy. They will have to approve doctors as fit to continue practice, but marginal cases will be open to tricky legal challenge both ways. He presented a survey reporting that psychiatrists experience huge variations in the robustness of the appraisal process nationwide.



After the break, Prof. Dinesh Bhugra, President of the College, spoke eloquently about the role of the psychiatrist in the future. In particular he wants us to reclaim the healer role, clearly linking disease and illness, though retaining and promoting further the holistic nature of good psychiatric assessment and management, and the central role of the doctor-patient relationship. Career development and the recognition of highly specialised competencies acquired as a Consultant (he used the word "credentialling", and reported our Royal College is more sceptical than the physicians or surgeons) will need to be approved and recognised somehow, but the Academy of Royal Medical Colleges have not yet agreed a final approach. Many lay people have no idea what psychiatry is about. He cited a Tory MP who thinks it would be just as helpful to have a good friend who can tell us to pull our socks up. The friend you chat with in the pub is unlikely to have learnt the contents of the MRCPsych syllabus, though. Finally and most importantly, as psychiatry



models and enthuse UK medical undergraduates about psychiatry as a rewarding, holistic and enjoyable discipline as well as a challenging one.

Prof. Bhugra urgently invites feedback via the special section of the College website about the recent MHA amendments, and how they are working in practice. A draft of the third edition of *Good Psychiatric Practice* is also on the College website for comment.

The next item took the theme of our professional role further, with a debate on whether "The Psychiatrist is an Extinct Species." By chance this was an Oxbridge battle, with Prof. Tony Holland from Cambridge opposing the statement, and Dr. Digby Quested from Oxford proposing it. Prof. Holland spoke of the return to acceptance of a psychiatric perspective as an essential part of multi-axial thinking in his specialty of learning disability. Normalisation and de-institutionalisation had brought a backlash against the medical model, but after that antithesis a synthesis was now happening. He emphasised there was a core of medical expertise to ensure that treatment for specific disorders is effective and humane. We need to avert the risk that our specific skills will be devalued.



Digby Quested addressed the same concerns, but stressing the risk of being lost in multidisciplinary teams. The development of functional teams has badly affected continuity of care, and lines of accountability risk being very confused. The recent MHA amendments may dilute statutory roles, and prescribing responsibility may change with the advent of non-medical prescribers. He quoted an on-call psychiatric trainee who was involved in a joint assessment with a crisis response team member, but wrote nothing in the notes for future reference. When asked why he hadn't, the trainee replied: "I didn't realise that was important."

PMETB has diminished the Royal Colleges' role in setting standards of medical training. In our desperation to be liked we are abandoning our original standards. Dr Quested put these changes in the context of our adaptation and fitness as a species, with a Darwinian risk of extinction if we are not fit for the future. However it is not clear if this will be a catastrophic sudden change or a gradual waning - but maybe, rather than becoming as extinct as the dinosaurs, we need to evolve and take wing, as the birds.

The final presenter was Dr. Chess Denman, a psychotherapist from Cambridge, who gave an enthusiastic, positive yet bounded presentation on the management of personality disorders - in particular, suicide risk reduction. She kept the theme of self-preservation going by describing how her own unit had evolved from a small in-patient unit which inflexibly only offered one type of therapy and was thus at risk of extinction, to one which offered a broad, eclectic service valued by commissioners. The theme of respect, accurate assessment and management of risk, informed consent, and consistent and coherent management ran right through her talk. Personality disordered patients are a high-risk group, whose risk is heightened further if they are rejected (say when the key-worker who knows them is on leave) or if units play patient ping-pong with them. This reinforces the appalling self-esteem most PD patients feel. They usually can be found to have a disorder of the disgust system, having a horror of themselves. A preoccupation with horror books and videos is part of the picture: "it's as if you've sat down next to a spider, only you *are* the spider." Proper diagnosis, clear communication of that to the patient, and a consistent plan both to manage crises and avoid the all too common cocktail of psychotropics, as Dr Denman called "brainofix", are all crucial. She finished with the theme of creative imagination and problem-solving which were suitably positive ways to end the day.

If you didn't get to Hatfield, you missed a good meeting, and I suggest you give the next one a try.

New Member Profile

Dr Rob Bale: I trained as a psychiatrist in South West London working as a research fellow and then Lecturer in Community psychiatry before becoming a Consultant in Wandsworth where I worked for 5 years. In need of a change I moved to Oxford, and the South Easter division, in 2003. I now work with a CMHT in East Oxford providing a community based service. I have a particular interest in working with individuals experiencing long term psychotic illnesses. Throughout my consultant career I have been involved in service development and for the last 4 years have been Clinical Director of Adult Services in Oxfordshire. I firmly believe that the involvement of clinicians in management is crucial for the delivery of a high quality service. Psychiatrists are core to the delivery of mental health care and we need to maintain the leadership role in clinical services and nationally in leading policy and service development.

Article- Should we use Risperidone in behaviour problems in children with Autistic Spectrum Disorder (ASD)?

By Dr. Marla Minn-Din, Acting Consultant Child & Adolescent Psychiatrist, Northampton & Dr. Imran Mushtaq, Associate Specialist Child & Adolescent Psychiatrist, Milton Keynes

Autistic Spectrum Disorders (ASD) comprise a group of developmental disorders that manifest in the first 3 years of life and are characterized by impairments in reciprocal social interaction and communication and by the presence of restricted behaviours, interests, and activities (DSM-IV, 1994). Psychotropic medications are often prescribed as adjunctive therapy to address symptoms such as aggression, self-injurious behaviours, stereotypes, and hyperactivity, which are commonly seen in children with ASD (Hollander et al, 2003; Volkmar et al, 2004). The US FDA has approved Risperidone for the symptomatic treatment of irritability in autistic children and adolescents in October, 2006.

What is the evidence?

There are Double-blind Placebo-controlled trials (DBPCT) (Table 1) which compare Risperidone and Placebo. The treatment duration varies from 8 weeks to six months. We have not found the trials which use Risperidone for more than six months. These trials have shown improvement in behaviour in children with ASD. However there is a possibility of relapse six months after discontinuation of Risperidone (Research Units, 2005). The children seem to tolerate the drug but experience side effects. The most common side effects include somnolence and weight gain. One trial has shown transient tardive dyskinesia when the drug was used for six months (Nagaraj R et al, 2006).

Controversial issue?

Use of medication in Child and Adolescent psychiatric disorders has always been controversial and ASD is not an exception. Some suggest that off-label use of Risperidone is justified when other approaches fail or are unfeasible, and when underlying causes of aggression have been considered (Morgan et al, 2007). But this view is questioned because of the concerns about the limited knowledge of long term safety and it has been argued that antipsychotics should not be given to children with behavioural problems whether they have a diagnosis of autism or not (Timimi, 2007). The licence holder (Janssen-Cilag) withdrew their application to the UK licensing authority to include irritability in autism as a licensed indication (Morgan et al, 2007).

The Core Working Group for National Autistic Plan for Children (2003) acknowledges that Risperidone appears encouraging and there is a place for the use of medication in co-morbid behavioural problems. Under the current climate of lack of evidence of long term use (more than six months), more research is required to determine how long the drug can be used safely for children with ASD who may have chronic behavioural problems.

Table 1: Randomised controlled trials of Risperidone in children/adolescents with ASD

Author	n	Interventions	Outcome	Comments
Nagaraj R et al (2006)	39	6-month DBPCT	Improvement in CARS* 63% (Risperidone) vs 0% (Placebo)	Most common side effects: weight gain and somnolence. 3 - transient TD
Pandina GJ et al (2007)	55	8-week DBPCT	Reduction in ABC-I** scale from baseline	Most common side effect: somnolence
Shea S et al (2005)	79	8-week DBPCT	Reduction in ABC-I** scale from baseline in 64% (Risperidone group) vs. 31% (Placebo group)	Most significant side effects include somnolence, weight gain, increase in pulse rate and BP
Research units on Paediatric Psychopharmacology Autism Network(2005)	63(part I) 32(part II)	Part I (4 month open label treatment with Risperidone) Part II (8 week DBPCT)	Risperidone showed persistent efficacy and good tolerability for intermediate-length treatment	Rapid return of disruptive and aggressive behaviour in most patients on discontinuation after six months
Aman et al (2005)	101	8 week DBPCT	Measures of safety and tolerability	Adverse events: mild to moderate (most common side effects include somnolence and weight gain)
McCracken JT et al (2002)	101	8-week DBPCT	Reduction of irritability score in 56.9% (Risperidone group) vs 14.1% (Placebo group) Increased side effects in Risperidone group	Side effects: weight gain, increased appetite, fatigue, drowsiness, dizziness, and drooling

*Childhood Autism Rating Scale (CARS), **Aberrant Behavior Checklist-Irritability (ABC-I)

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SOUTH EASTERN DIVISION The John S Lyon Memorial Prize



The South Eastern Division has established The John S Lyon Memorial Prize, an annual prize for the best project conducted by any doctor of non-Consultant grade working within the South Eastern Division. The aim of the prize is to stimulate innovation amongst trainees and non-Consultant career grade doctors.

Regulations:

- I. Eligible entrants will be working in the South Eastern Division in a non-consultant post, at the time of completion of the project and when making the prize submission (or shall have held such a post on 1 February 2010). Only **one** submission per person will be accepted.
- II. A Sub-Committee made up of members of the South Eastern Division Executive Committee will examine entries and shortlist three submissions, which will be presented at the Divisional Academic Meeting. The Sub-Committee will then decide who will be awarded the prize. There will be clear guidelines to aid the decision-making process.

Closing date: 1st February 2010

Instructions for submission:

The project can be essay, report on innovation and service delivery, a literature review or a narrative account of a case. These criteria will alternate with audit or research in 2011. The project should be predominantly the individual's own work. **Abstracts only to be submitted (not full projects)**. Abstract should be typed in single spacing, font size (10) Ariel in Word format using standard text, or text only format. Apple Mac documents cannot be accepted. The title should be in bold, followed by the full name (s) of the author(s) and all co-authors, including titles and affiliations. Hand-written abstracts will not be accepted. The abstract should be no longer than 500 words. Bibliographic references, tables and appendices must not be included in the abstract.

Abstracts, with the subject reference of your surname - John S Lyon Memorial Prize 2010, should be sent via email to:

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