

**South Eastern Division  
Spring Academic Meeting  
Blenheim Palace, Oxford  
19<sup>th</sup> May 2011**

**Dr Catherine Quarini**

The day began with a **welcome and introduction to the meeting which incorporated the AGM** from **Dr Phil Davison**, Chairman of the South Eastern Division.

Dr Davison gave an overview of the structure of the Royal College of Psychiatrists (accompanied by some interesting and amusing photos!) and explained how the South East Division works within the College structure. The Chairmen of the different Divisions attend the Council Meeting (formally called the Central Executive Committee) every two months at which they represent their members. The South Eastern division is one of the largest divisions, covering the greatest population of any UK health region, and members of the executive committee meet quarterly to discuss any issues affecting members, with additional committee meetings to focus on clinical excellence awards.

The most recent council meeting was held in March 2011 and the discussions focused on

- Training and recruitment into Psychiatry;
- Quality of care and commissioning services;
- College finances;
- Ways to involve members in the division, including introducing a system of electronic voting.

**Dr Catherine Kinane**, Financial Officer for the South Eastern Division, presented the **financial report**. She took up office in July 2010 and expects to hold this position for the next 4 years. The main success in the past few months has been that a formal 'Financial Recovery Plan' for the Division has been accepted by the College, and Division debts have been written off. This puts the Division in a much stronger financial position and therefore more able to focus on other aspects of the business plan such as improving clinical services. She thanked the speakers for attending today's meeting and asked members to extend the invitation to the next academic meeting to other members of their multidisciplinary teams.

This concluded the AGM, and the academic meeting focusing on 'Clinical Updates' began.

The first talk '**Pharmacological treatment of depression. If at first you don't succeed...**' was given by **Prof Philip Cowen**, from the Oxford University Department of Psychiatry. He outlined the efficacy of SSRIs, which are

commonly used as a first line treatment for depression, and went on to discuss the options for people who do not respond to these and are still symptomatic after several weeks. There is evidence that outcomes are better if a patient switches to another class of drug, rather than a different SSRI, but these results come from very large trials and the effect sizes are small so in practice there may not be much difference between choosing a different class of drug as the second line treatment, or using a different SSRI. He then discussed the options for ongoing management, including CBT, augmentation with another drug, such as mirtazapine, lithium, or an atypical antipsychotic. A case study of a patient who responded to augmentation with an atypical antipsychotic was presented. He reviewed and summarized the evidence base for different augmentation strategies.

The next two sessions focussed on epidemiological aspects of Psychiatry. Firstly, **Dr Julia Sinclair** from the Southampton University Department of Psychiatry spoke about '**Management of AUDs (alcohol use disorders) in patients with mental health problems**'. She gave the audience some statistics on the extent of the alcohol problems in the UK. 24% of the UK population currently use harmful levels of alcohol, and there are 1.6 million alcohol dependent people in the UK, of which only 2% have received treatment for their condition. A much greater prevalence of harmful alcohol use is seen in psychiatric patients than in the general population. Some of the barriers to implementing treatment services are the lack of funding, as most of the budgets for addiction problems are given to drug rehabilitation programmes rather than alcohol addiction services, and problems with diagnostic definitions whereby people with another diagnosis in addition to AUDS are often excluded from alcohol addiction services. Barriers to effective care once people have been diagnosed were discussed. These include organisational issues such as the separation of mental health services from acute trusts, separation of alcohol misuse services from general adult psychiatric services, under resourcing, and negative staff attitudes towards these patients. Solutions proposed included using better screening tools for AUDs, ensuring that AUDS were treated concurrently and specifically as part of mental illness treatment, and ensuring that all staff members have training in the detection and management of AUDs.

Following on from this, **Prof John Geddes**, from the Oxford University Department of Psychiatry, presented a talk on '**Recent advances in the management of bipolar disorder**'. This began with an overview of bipolar disorder, addressing some of the common myths surrounding this condition, and highlighting to the audience the associations between bipolar disorder and increased mortality and morbidity from a range of other conditions, including infectious, respiratory, and cardiac causes. Recent research has focussed on the use of lithium in bipolar disorder and the efficacy of lithium in the prevention of suicide and reducing the risk of relapse was discussed, as well as some of the limitations of lithium use for safety reasons. It was also interesting to hear about the OXTEXT initiative and the 'True Colours' mood monitoring system which is currently being used in Oxford, and involves patients using SMS or email to

record their daily moods. The mood ratings are captured in a database which produces a prospective visual chart of their mood changes over time. This has proved easy to use and forms an important part of self-management for patients, as well as being more reliable as the information is entered daily and as the person is experiencing the mood, rather than retrospectively at later clinic visits. Finally, a meta-analysis comparing the efficacy and acceptability of different antimanic agents was presented, and the surprising finding that treatments vary greatly in these respects was discussed.

The coffee break that followed was a good opportunity for everyone to catch up with colleagues and read the excellent poster presentations which were displayed outside the meeting rooms.

**Prof Guy Goodwin**, from the Oxford University Department of Psychiatry, then spoke on the topic of '**Bipolar disorder and the bipolar phenotype**'. This session focussed on some of the features of bipolar disorder and the overlap with other psychiatric conditions, the bipolar phenotype, and the challenges and difficulties surrounding diagnosis. As bipolar disorder shares features with unipolar depression and with schizophrenia, these may be misdiagnosed. The diagnosis of bipolar-2 disorder depends on the definitions of hypomania. Increasingly, the problem of diagnosis inflation is being seen in clinical practice, whereby children are diagnosed with bipolar, treatment options from bipolar-1 disorder are inappropriately extrapolated to milder forms of the condition, and bipolar disorder is confused with borderline personality disorder. It was interesting to hear about the bipolar phenotype and research comparing students with and without bipolar disorder and finding differences on structural brain imaging, and circadian rhythm parameters, including awakening salivary cortisol. Significant challenges exist in managing bipolar disorder, and many of these stem from the overlap of bipolar disorder with conditions such as borderline personality disorder, as different services are provided for different conditions, a problem similar to that described earlier by Dr Sinclair.

After lunch and a chance to walk in the beautiful Palace grounds, we divided into two groups to attend the workshops.

The first workshop on '**Evolutionary and Developmental Perspectives: Why do they matter for Psychiatry?**' was lead by **Dr David Geaney**, Consultant Psychiatrist and Honorary Senior Clinical Lecturer from the Oxford University Department of Psychiatry, and **Mr Alan Percy**, Deputy Director of Oxford University Student Counselling Service. Dr Geaney began by comparing evolutionary theories of the heart and brain, demonstrating that just as sinus tachycardia is a disorder if there is no contextual cause for it, but is a normal and useful response to stress, so depression is a disorder if there is no cause for it, but is a normal response to certain life events, and has an evolutionary explanation. He explained that for over two thousand years physicians had routinely differentiated depressive disorders from similar symptoms as a normal response of sadness to difficult life events. A change to this understanding came

in 1980, with DSM-3 criteria which abandoned this distinction, with the exception of responses to bereavement. The aim of this was to improve reliability, but it may in fact have been the beginning of a change in attitudes amongst both the public and professional medical bodies worldwide, which started to regard normal adaptive emotional responses as disordered. Depression is a normal response to loss, not just the loss of bereavement, but also the loss of employment, relationships, financial losses etc. and the understanding of this, and acknowledgement that therefore depressive symptoms must be common within the community, has only faded in the last few decades. Depressive symptoms reflect innate evolutionary mechanisms and are seen not only across human cultures, but in other primates, and there are several theories of how these responses were beneficial in the environment of evolutionary adaptation, although they may not be beneficial in today's environment. Elevated mood can likewise be seen to have evolved to give advantages in particular situations. The problem now of failing to distinguish normal sadness from depressive disorder has consequences both for the patient receiving unnecessary treatment, and society as a whole as funding is diverted away from more serious cases, psychiatric credibility is undermined, and epidemiology and research on these conditions could be flawed.

Mr Percy then continued the workshop by describing the changing presentations of students to the University Counselling Service, and how some of these shifts can be attributed to the failure to distinguish normal sadness from a depressive disorder, and the tendency for patients and clinicians to label normal adaptive responses as a disorder. Five years ago most students presented with issues related to academic work, transition to university, or personal relationships, whereas now there is a much greater emphasis on symptoms, with self-diagnoses of depression, anxiety disorders, or ADHD, with people wanting to be given certain diagnoses. Mr Percy suggested that many of the reasons behind this relate to cultural and social factors, particularly changing family structures and parenting styles; changes in the education system with fewer exams and more continuous assessment at school perhaps making it harder to adapt to exams at university; and changes in the portrayal of mental illness on TV. As Dr Geaney had already discussed, loss is a predictor of low mood, and Mr Percy explained that many students may be experiencing loss of the academic status and identity they had at school, loss of supportive relationships at home, and a loss of certainty about their goals and aspirations. This workshop prompted many questions from the audience, and lead into an interesting discussion with the speakers about how to deal with these changing presentations in practice.

The second workshop was on '**The Therapeutic Alliance and Antipsychotic Medication**' and was lead by **Dr Rob Chaplin**, Consultant Psychiatrist. This workshop focussed on interviews with 21 general adult psychiatrists about their practice when prescribing antipsychotic medication, particularly in relation to how much their prescribing practices involved shared decision making with the patients. Most felt they did this, and involved the patients and took their views into account. There was some debate over the discussions that doctors should

initiate about side-effects of medications, from giving the patient as much information as possible from the beginning, to responding to their particular questions and concerns about adverse effects. Dr Chaplin then talked through some transcripts of recorded consultations between patients and Psychiatrists discussing antipsychotic medication in out-patient departments. This gave a very interesting insight into the wide variety of consultation styles, and although all the consultations involved shared decision making at some level, some focused more on the doctor's concerns, with a lack of engagement on the issues the patient wanted to discuss, and some decisions were considerably more 'pressured' than others. This workshop provided the audience with lots of points to reflect on in relation to their own practice and how they relate to their patients, and prompted a lively discussion about the doctor-patient relationship in different circumstances.

After a coffee break the day concluded with a talk from **Prof. Sue Bailey**, President Elect of the Royal College of Psychiatrists, on '**College Direction**'. After an introduction and summary of how the Division fits into the College as a whole, Prof. Bailey discussed some of the challenges facing Psychiatry, and some possible solutions to these. These included increased competition in healthcare provision, clinical commissioning, and the changing role of public health medicine and the impact this will have on other clinical specialties. Education and Training concerns were discussed, including the uncertain future of the current Deanery system, and this prompted several questions from the audience about training and the recruitment of trainees. This talk provided a useful opportunity for members to ask the President about issues affecting them at a local level, as well as issues affecting the College in general.

The Academic Meeting went well, with a relaxed atmosphere and good participation from members throughout the day. We were able to meet with colleagues from other parts of the Division to learn and share experiences. It provided a great opportunity to hear about some of the research and developments that members of the Division have been working on, as well as to participate in and reflect on some interesting discussions about evolutionary psychiatry, the changing perceptions and presentations of mental illness, and our own practice and interactions with patients.