

Psychiatry-East

The Eastern Division e-Newsletter

Winter 2016 Issue 2

Editorial

Welcome to another edition of our Eastern Division Newsletter. We have some very interesting articles in the newsletter and I am sure you will enjoy reading them. Hopefully they will also encourage you to submit your own articles for future editions. This newsletter comes on the back of another very successful Eastern Division conference held recently. A comprehensive report of the conference informs you what you missed out on if you were not there. Future conferences are being lined up for your benefit by the Eastern Division and do make sure you have these dates in your diaries. Just a reminder that the conferences are not the only events that the Eastern Division organises, other things like Startwell programme, session for Foundation doctors and even Approved Clinician training are in the pipeline so do look out for those. Included in the newsletter is a

detailed chair's report informing us of what is going on at the College. We also welcome any ideas on how to improve our events as well as suggestions for our newsletter. We are now planning two editions of the newsletter per year; a spring/summer edition and an autumn/winter edition so do start getting your articles in for our next edition.

Meanwhile I would like to wish you and your family and friends a very happy festive Period!



Dr Vishal Agrawal - Editor, Psychiatry East



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Chair's Column

Since the Spring Meeting there have been many momentous events one of which is a topic in our Academic Programme namely Brexit. For a while the Council was also concerned by the possible impact of the Junior Doctors strike.

The Council has representatives from all the Faculties and Divisions and hence a large number of policies, initiatives and papers have been debated and discussed during the last 6 months. Leading up to the last Academic meeting we had presentations by the Independent Commission on Acute Inpatient Psychiatric Care for Adults with key recommendations focusing on the four hour waiting time pledge and phasing out of out of area treatment by October 2017.

In addition there was a report by the Mental Health Taskforce providing the first national ambition for mental health in the NHS with recommendations designed to deliver the Five Year Forward View. There are a wide variety of recommendations with priorities related to seven day NHS, and integrated approach to physical and mental health care and preventing poor mental health.

The Northern Ireland Division Chair presented the new capacity legislation of Northern Ireland which integrates mental capacity and mental health into a single bill. This also lead to a discussion on the College's view on Capacity Based Legislation in England and Wales which will be brought back to the Council.

There have been long and complex discussions around a review of the College Publications especially as the landscape is changing. The Council decided eventually to outsource the College Journals but retain editorial function in-house and outsource Books to a publishing partner.

The Child and Adolescent Faculty informed the Council of sites which are developing dedicated inpatient services for 16-25 year olds. The Faculty also presented a proposal for a framework for identifying and supporting young carers and young adult carers of parents with mental health problems.

The Intellectual Faculty presented the College's "Championing autism project proposal". During the July meeting a new Special Interest Groups was approved: "Psychiatry of Neurodevelopmental Disorders".

The College's Psychotherapy Faculty presented a report on the "Talking Therapies Workforce" which aims to develop a national infrastructure for psychological therapies for people with complex health needs, to parallel existing services for common mental health problems.

The Registrar reported on the College position statement "Counter-terrorism and psychiatry" emphasising that evidence did not support the perception that radicalisation was a mental health problem and when there are concerns about a patient standard established safeguarding and principles apply.

Chair's Column (cont)

There is a proposal to establish devolved RCPsych Councils for Northern Ireland, Scotland and Wales similar to the model used by GPs recently.

There were many other updates including on the National Collaborating Centre for Mental Health; The Five Year Forward View for Mental Health: RCPsych's strategy to support implementation; Medical Training Initiative (MTI) scheme; The use of Physician Associates in mental health settings amongst others.

The College has appointed a new Director of Strategic Communications, Ms Kim Catcheside. The Chief Executive, Mrs Vanessa Cameron is retiring after thirty-six years at the College. Mr Paul Rees currently Executive Director of Policy and Engagement at the RCGP has been appointed as the next Chief Executive.

With the ongoing changes including the development of Sustainability and Transformation Plans and the "Devo Manc" project of Greater Manchester, the following years will continue to be very busy. The College is actively involved in monitoring inclusion of mental health in the Vanguard sites which are testing new Models of Care as set out in the Five Year Forward View.

I would also like to thank all attendees for your support for the Academic Meeting and the College. We have a number of further events planned including Mental Health Act training and ongoing Startwell events to

support new Consultants. There are always opportunities to get involved in the Division and please feel free to contact any of us on the Executive or our Division Coordinator Moinul Mannan.

With all good wishes for the Festive Season!



Dr Sadgun Bhandari
Chair Eastern Division



Breaking Misconceptions About Psychoanalytical Psychotherapy – My Experience In Practice

By Hannah Pasha Memon

My first experience of psychotherapy was when I was still in school. I helped a friend unravel what was bothering her and, as she thanked me for what appeared to have lifted the weight of the world off her shoulders, I realized that despite the simplicity of her problem, I had really helped her in an unusual yet significant way.

Many years later, I found myself training in Psychiatry. As part of the training, I attended our Balint Groups and heard a Psychoanalytical Psychotherapist speak of 'unconscious conflicts', 'relationships' and 'transference'. In our group discussions, he asked us to read 'Individual Psychotherapy and the Science of Psychodynamics' by David Malan. As I turned each page of that book, I was consumed by the stories of people who were never saying *just* what one heard, that there was always more to it than the words uttered. With a partly-cynical-partly-curious mind-set, I set off to apply psychoanalytical concepts in my clinic.

46 year old Sarah* attended my out-patient clinic who had been suffering from symptoms of anxiety and depression. The main trigger for her current problems was the breakdown of her complex relationship with her manager, by whom Sarah felt criticised, particularly due to her mental health problems. When the manager informed Sarah that she will be moved to a new location for 6 weeks, Sarah stopped going to work. Sarah explained that she was already having a hard time driving to her current work-location (which was a distance of 44 miles from her home) and on two occasions had fallen asleep whilst driving causing her to drive into the side of the road and bursting two tires. Naturally, she found the idea of having to drive to an even further location too dangerous.

Coinciding with this was the split up with her boyfriend with whom she had had a 5 year intermittent relationship. He was very good to her when their relationship began but as they became closer, Sarah suffered his binge drinking and in a drunken state, verbally abusing her and throwing things. He was self-employed yet she was funding his habits and eventually used up all her savings and declared bankruptcy. They split up around the same time that she gave up work.

Sarah then left their rented home and moved to a new place. She had been on sick leave and had found it hard to adjust to her new home. She had not unpacked her bags or boxes and was finding it impossible every day to do so. Her sister had been very supportive and Sarah often spent days and nights in darkness in a room in her sister's home, attempting to 'sleep her life away'.

Sarah had had a very loving and caring mother and a difficult father. Initially when her parents' had started dating, they were happy together but over time, Sarah's father became verbally and physically aggressive to her mother. As a child, Sarah sought his love and physical contact by pretending to be asleep so he would have to carry her to her bedroom.

*The name of the patient has been altered for confidentiality.

Breaking Misconceptions About Psychoanalytical Psychotherapy – My Experience In Practice (cont)

By Hannah Pasha Memon

When she was about 20 years old, her parents separated and with time, the family dynamics improved. Her mother later developed dementia and completely lost her personality, leading to complete dependency on Sarah for many months. Sarah admitted to feelings of resentment and anger towards her mother for needing constant care but simultaneously felt guilty for these feelings and was upset that she lost a person whom she cared for so much. Her mother died 6 years ago and a few months later, her father died too.

Prior to these life events, Sarah described herself as a strong person who considered crying and being emotional a 'weakness'. As an adolescent she had decided she would not make the mistakes her mother did with her marriage.

The similarity between Sarah's choice of partner and her father was evident to both of us, though Sarah seemed consciously unaware. She stated that she felt like she had become her mother, that she was forgetting things (memory problems) and was worried that she would come to the same end.

As I guided Sarah to recognize her feelings, she cried more and more. As time went on, she got stuck with one question, "Why can't I move on? Why won't I unbox my things and officially move into my new home? Why am I not getting better?" I finally suggested that she was probably not allowing herself to get better as a means to punish the people around her for whom she had made sacrifices, doing things their way, which had got her nothing. She therefore was resisting any motivation to get better as a means to punish these people for what they had done to her.

Sarah's reaction was immediate. She abruptly stopped crying and remarked, "I had not thought of it like that". There was a palpable change in the air around her and it was a perceptible turning point during the review. When I spoke to her a month later, she happily reported that her bags were unpacked and she had finally moved on.

No doubt, this is not proof of an effective treatment. That is that unfortunate reality of psychoanalytical psychotherapy, that it cannot be weighed using statistics or outcome measures. But I wish for the reader to ask themselves whether they brush off every psychoanalytical concept because one such as the oedipal one is 'illogical' and unacceptable 'due to the lack of scientific proof', not to mention abhorrent in meaning. I believe many of us are guilty of this.

We have all, in our practice, questioned our patients' search for that 'magic pill' that will sort everything. We have all realised that many require long-term treatments which last months to years. If we had more psychoanalytical psychotherapists amongst us, I wonder if psychoanalytical psychotherapy could play a bigger role in managing our revolving door patients. With the dearth of in-patient beds' across the country, that would certainly be a treatment option worth looking into.

Observing Yalom Therapeutic Factors in Alcohol Support Group

By A Bhowmick and B Sharma

It is known in the UK 9 million adults drinking alcohol are doing so at the risk of their health, of which about a million have some level of dependence, quarter of whom may benefit from intensive treatment. Talking therapies being the main form of treatment received, usually in a group setting for over 2-3 months. There are various theories of group therapy; Dr I Yalom defined 11 therapeutic factors as “actual mechanism of effecting change in the patient”. Whilst working for Essex STaRS (Specialist Treatment and Recovery Service in Harlow), we wanted to observe the frequency of use of these therapeutic factors at ADAS (Alcohol and Drug Advisory Service). In previous studies this usually involves Yalom’s 60 item Q-sort of curative factors (done by participants); there has been one study using the Therapeutic Group Interaction Factors Scale (TGIF, tool developed for systematically and observing the presence/absence of therapeutic factors); other than this there have not been studies directly observing the use of the therapeutic factors.

This study was done in P4C (preparation for change) group, a highly structured six week group that supports dependent level drinker to safely reduce their alcohol intake, comprising of 5-10 members. I sat in during week 3 and week 5 (May – June 2016) of the group, and made tally mark as to statements made by the therapists and participants into the 11 therapeutic factors. Most frequently repeated statements in the two weeks were regarding “interpersonal learning” and “guidance”. In 2 weeks there was a marked increase of statements regarding “self-understanding/developing social skills”. The group was small, on week 3 having 5 participant and 2 at week 5; and only one observer. Thus this can be put forward for a larger study (larger group, continual observation, multiple observers, and observers trained in using the TGIF), to see if the results can be duplicated. If so then the emphasis can be made on concentrating more on “self-understanding” therapeutic factor.

Taking EMDR and trauma training to the Syrian refugees in Gaziantep on the Syrian border of Turkey

By Walid Abdul-Hamid, President of the British Arab Psychiatric Association (BAPA), Consultant Psychiatrist at North Essex Partnership NHS Trust, EMDR Europe Consultant and a Trustee of HAP

EMDR is an evidence-based psychotherapy for post-traumatic stress disorder (PTSD), with more than 38 controlled studies (15 randomized clinical trials) demonstrating its effectiveness in reducing and curing PTSD symptoms. It has been shown to provide outcomes similar to those achieved by cognitive behavioural approaches. Rolf Carrier, (of the UN) hailed at Liverpool Conference of the EMDR Association for UK and Ireland, EMDR as one of the great health discoveries of our time— in its consequentiality on par with the discovery of: penicillin, polio vaccine and oral rehydration—to tackle the massive problem of trauma the world is facing. The current global estimate of PTSD is 500 million persons.

As the President of the RCPsych Diaspora Group member; the British Arab Psychiatric Association (BAPA), I have been working tirelessly since 2013 to transfer the trauma therapy EMDR to the most affected areas of the Arab world. This was through volunteers going to refugee camps to treat PTSD refugee sufferers but since 2013 I worked with the Humanitarian Assistance Programme (HAP) UK & Ireland (www.hapuk.org) and started a project in the Middle East providing training to the Arab mental health professionals in EMDR in Istanbul. Syrian mental health professionals were the biggest group trained (53% of the participants). These professionals have, through the training and the Skype supervision that followed, given HAP first-hand experience of the trauma Syrian people have suffered.

The Syrian refugees continue to be displaced and exposed to severe and difficult environments both physically and psychologically (1).

Sian Morgan, President of HAP UK & Ireland, from now on to be renamed “Trauma Aid UK” organized the first EMDR training for Middle East mental health professionals in Istanbul in November 2013. The training was delivered in Arabic by Mona Zaghrout, EMDR Institute Accredited Trainer from Palestine. The Syrian mental health professionals were the biggest group trained (53% of the participants). Up to the end of 2015, the Middle East training in Istanbul trained around 60 mental health professionals. In addition, in 2016, Trauma Aid UK has provided training to members of BAPA, an organization of Arabic speaking psychiatrists in the UK, at low cost in order to enable the Arabic speaking psychiatrists to help the 20000 Syrian refugees coming to UK over the next few years.

The situation in the Middle East since the Russian intervention has become very dangerous for mental health professionals to move inside Syria and be able to attend the training in Istanbul. Also, the increased terrorist threat from terrorist organizations like ISIS and PKK, in addition to the European crisis with the refugees have forced the Turkish government to restrict the movement of Syrians in Turkey. All these changes have made it difficult for Syrian mental health professionals who work with refugees to come to Istanbul for training (2).

Taking EMDR and trauma training to the Syrian refugees in Gaziantep on the Syrian border of Turkey (cont)

By Walid Abdul-Hamid, President of the British Arab Psychiatric Association (BAPA), Consultant Psychiatrist at North Essex Partnership NHS Trust, EMDR Europe Consultant and a Trustee of HAP

For all these reasons, it was decided to conduct the EMDR training in Gaziantep, Turkey on the Syrian border for the first time since the beginning of the Middle East Programme that started in 2013. This training was conducted, between the 19th and the 22nd of April 2016, by Sian Morgan (EMDR Europe Accredited Trainer) with the help of the EMDR facilitators and psychiatrists Dr Walid Abdul Hamid and Dr Khalid Sultan. 36 mental health professionals working with the Syrian refugees in Turkey were trained on Part 1 of the 3 part EMDR training. The training sessions were hosted by Sham Humanitarian Organization (several of whom were trained previously through HAP in Istanbul) within the activities of the fourth conference of the Syrian Association for Mental Health (SAMH).

This course will be followed up with supervision by Skype for each participant to supervise their use and application of EMDR. This will be followed by parts 2&3 of the training conducted in September 2016.



Walid demonstrating EMDR Eye Movements



Sian lecturing and Khaled translating

I stayed further to attend the SAMH Conference and they both presented papers on EMDR also had the opportunity to treat some Syrian refugees with PTSD using EMDR. In one of these refugees treated by myself is a young woman from Aleppo who lived in a district that was attacked by the regime forces and during the attack; her fiancée was killed and she was raped. The patient was reluctant to talk about the rape to a male therapist although she mentioned that a film of the rape runs every night in her mind and stops her from sleeping.

Taking EMDR and trauma training to the Syrian refugees in Gaziantep on the Syrian border of Turkey (cont)

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I used the Blind to therapist protocol after asking her to choose the worst still picture that represent the event. After an hour's EMDR session the client was smiling and according to Walid this was the fastest result he had ever had with EMDR. The session was attended by a female trainee who will continue the therapy under my Skype supervision.

Few days after all the HAP team left Gaziantep and on Sunday 29/04/2016, a car bomb exploded outside the police headquarters in the Centre of Gaziantep.

This terrorist attack claimed the life of 3 policemen and injured 22 (3). This incidence highlights the dangers involved in humanitarian work and the HAP team in spite of being aware of the increased terrorist threat in Turkey, decided to risk this to build hope particularly after the ceasefire plans that unfortunately has not yet been established fully.

References

1. HAP Middle East Programme:

<http://www.hapuk.org/projects-2/middle-east/>

2. Restriction on Syrians movement in the Middle East:

<http://www.bbc.co.uk/news/world-europe-34957830>

<http://www.foxnews.com/world/2015/09/23/as-migrants-mobilize-turkish-government-invokes-restrictions-on-syrian-movement.html>.

3. Gaziantep terrorist attack:

<http://www.dailysabah.com/nation/2016/05/06/death-toll-in-gaziantep-car-bomb-attack-on-police-headquarters-rises-to-three>

Falls in Dementia

By Dr KK Shankar, Consultant Old Age Psychiatrist
Hertfordshire Partnership University NHS Foundation Trust

Falls in older adults are a major public health concern. Approximately 30% over the age of 65 and 50% over the age of 80 fall at least once each year. It is estimated to cost NHS more than £2.3 billion per year. (1). Most falls are not caused by single risk factor but occur due to interaction of several determinants (2). Patients with dementia are at higher risk of falls. The estimated prevalence varies between 40- 60%. This is two to three times compared to age matched controls (3,4). In addition to motor impairments (impaired gait, reduced muscular strength and impaired balance) , executive functional impairment (5) is also associated with an increased risk of falls. Falls are more likely found in subjects with dementia with Lewy bodies and vascular dementia and the risk becomes higher with the severity of dementia (6,7) Studies of postural instability have found particular impairments in patients with Alzheimer's disease when central processing of conflicting information is required (8). Neuropathological studies show degeneration in parts of the brain controlling cardiovascular (autonomic) reflexes(9) A high prevalence of autonomic dysfunction, manifest as orthostatic hypotension and cardioinhibitory carotid sinus hypersensitivity has been shown in older people with dementia.(10)) People with dementia also recover less well after a fall than those without dementia. (11). Patients with AD are at higher risk for fractures and have a lower bone mineral density than healthy controls. (12) Depression (13) Behavioural disturbances (14), Disinhibited behaviour (15), Wandering behav-

iour(16) day time sleepiness(17) presence of urinary incontinence (18) have independently associated with falls in Older adults with dementia.

Psychotropic drugs have been reported in several studies to be associated with increased risk of falls (19,20,21). A study of fractures in patients over the age of 50 (22) found the highest risk in those treated with SSRIs while relationship with others were not significant. Sterke et al(23) looked into the dose- response relationship between psychotropic drug and falls. The Hazards ratio for the drug were, Antidepressants (2.84; Confidence Interval 1.93-4.16), Antipsychotics (2.78; 1.49-5.17), Hypnotics (2.58; 1.42-4.68) and Anxiolytics (1.60; 1.20-2.14). Use of high level of anticholinergic medications was associated with greater risk of fracture (24) and approximately 50% of dementia patients are exposed to at least one anticholinergic medication and 20% at least one psychotropics in primary care (25). Cholinesterase inhibitors may increase the risk of syncope with no clear evidence on effect on falls, fracture or accidental injury in dementia patients but may improve the balance (26). Memantine on the other hand may have a favourable effect on fracture, with no effect on other events (27). Further, drug associated falls risk is significantly elevated following any change in medication (28).

Although NICE 2013 recommends multifactorial interventions in reducing falls, the evidence for such interventions to work

Falls in Dementia (cont)

By Dr KK Shankar, Consultant Old Age Psychiatrist
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effectively in patients with dementia or who are institutionalised is limited (29). The few attempts that have been undertaken to prevent falls in people with cognitive impairment or dementia living in nursing homes or attending accident and emergency departments have used multifactorial fall-prevention programs. These have produced divergent and inconclusive results. For example, multifactorial intervention was not effective in preventing falls in people with cognitive impairment (30), while it was effective in people with cognitive impairment (31, 32) and in people with a Mini-mental State Examination score higher than 18 (33).

Evidence for individual falls prevention interventions for adults with cognitive impairment is varied and inconclusive. (34) When compared with the literature on falls interventions in healthy older adult populations, both primary and synthesis studies in older adults with cognitive impairment are lacking in number; quality and homogeneity of sample population and interventions. Most intervention studies to reduce the falls rate either exclude people with cognitive impairment or do not report them separately (35). Exercise program may potentially assist in preventing falls of older adults with dementia in the community (36) have positive effects on balance, gait and independence in the activities of daily living (37). Tapering and discontinuation of psychotropic medication over a fourteen week

period was associated with 39% reduction in rate of falls. (38). Assessment of home hazards by an Occupational therapist along with specific recommendation was associated with 20% reduction in risk of falling (39). Management of symptomatic orthostatic hypotension, depression and encouragement of physical activity may provide a fruitful strategy to reduce falls in people with dementia (13).

There is need for increased awareness of the potential consequences of drug side-effects and of the changes in health status in people with dementia. Fall prevention program in in-patient units needs to be tailored for individual patient. Psychiatric and behavioural symptoms also need to be focused on (40). Meaningful individual activities and a balance between activity, rest and sleep can create conditions under which patients retain a normal diurnal rhythm. Individualized supervision could be another important measure for preventing accidental falls. In addition, a properly designed environment can support intact functions and contribute to a sense of security and well-being.(41) As older people with dementia are at particularly high risk of falls and their associated morbidity, it is important that prevention of falls remains a research priority in this patient group. Further work is required in patients with dementia to determine optimal delivery of interventions and to identify the most important modifiable risk factors.

Falls in Dementia (cont)

By Dr KK Shankar, Consultant Old Age Psychiatrist
Hertfordshire Partnership University NHS Foundation Trust

References

1. NICE Guidance: Falls in older people: assessing risk and prevention; Clinical guideline [CG161] Published date: June 2013
2. World Health Organization (WHO) (2007). World Health Organization Global Report on Falls Prevention in Older Age[Online]. Available at: http://www.who.int/ageing/publications/Falls_prevention7March.pdf
3. Asada T, Kariya T, Kinoshita T, Asake A: Predictors of fall-related injuries amongst community-dwelling elderly people with dementia. *Age Ageing* 1996;25:22-28.
4. Thapa PB, Gideon P, Fought RL, Ray WA: Psychotropic drugs and risk of recurrent falls in ambulatory nursing home residents. *Am J Epidemiol* 1995;142:202-211..
5. Kearney, Fiona C; Harwood, Rowan H; Gladman, John R F; Lincoln, Nadina; Masud, Tahir. The Relationship between Executive Function and Falls and Gait Abnormalities in Older Adults: A Systematic Review. *Dementia and Geriatric Cognitive Disorders* 36.1-2 (Aug 2013): 20-35
6. Buchner DM, Larson EB. Falls and fractures in patients with Alzheimer-type dementia. *JAMA*.1987;257:1492–5. [PubMed]
7. Morris JC, Rubin EH, Morris EJ, Mandel SA. Senile dementia of the Alzheimer's type: an important risk factor for serious falls. *J Gerontol*. 1987;42:412–7. [PubMed]
8. Chong RKY, Horak FB, Frank J, Kaye J. Sensory organization for balance: specific deficits in Alzheimer's but not in Parkinson's disease. *J Gerontol* 1999; 54A:M122-8.
9. Burke WJ, Coronado PG, Schmitt CA, Gillespie KM, Chung HD. Blood pressure regulation in Alzheimer's disease. *J Auton Nerv Syst* 1994;48: 65-71.
10. Ballard C, Shaw F, McKeith I, Kenny R. High prevalence of neurovascular instability in neurodegenerative dementias. *Neurology* 1998;51:1760-2.
11. Shaw FE, Bond J, Richardson DA et al. Multifactorial intervention after a fall in older people with cognitive impairment and dementia presenting to the accident and emergency department: Randomised controlled trial. *BMJ* 2003;326:73.
12. Hanyu, Haruo Cognitive Function and Calcium. Vitamin D and calcium for the prevention of falls and fractures in patients with dementia].false; National Library of Medicine. *Clinical calcium* 25.2 (February 2015): 275-282.
13. Allan LM, Ballard CG, Rowan EN, Kenny RA. Incidence and prediction of falls in dementia: a prospective study in older people. *PLoS ONE [Electronic Resource]*, 2009, vol./is. 4/5(e5521), 1932-6203;1932-6203 (2009)
14. Sylliaas H, Selbaek G, Bergland A (2012). Do behavioral disturbances predict falls among nursing home residents? *Aging-Clinical & Experimental Research*, 06 2012, vol./is. 24/3(251-6), 1594-0667;1720-8319 (2012 June)
15. Kosse N.M., De Groot M.H., Vuillerme N., Hortobagyi T., Lamothe C.J.C. Factors related to the high fall rate in long-term care residents with dementia. *International Psychogeriatrics*. 27 (5) (pp 803-814), 2015.
16. Katz IR, Rupnow M, Kozma C, Schneider L. Risperidone and falls in ambulatory nursing home residents with dementia and psychosis or agitation: secondary analysis of a double-blind, placebo-controlled trial. *American Journal of Geriatric Psychiatry*. 2004;12:499–508.
17. Chen P.-Y., Chiu H.-T., Chiu H.-Y. Daytime sleepiness is independently associated with falls in older adults with dementia. *Geriatrics and Gerontology International*. (no pagination), 2015.
18. Lee CY, Chen LK, Lo YK, Liang CK, Chou MY, Lo CC, Huang CT, Lin YT Urinary incontinence: an under-recognized risk factor for falls among elderly dementia patients. : *Neurology & Urodynamics*, 09 2011, vol./is. 30/7(1286-90), 0733-2467;1520-6777 (2011 Sep)
19. Park H., Satoh H., Miki A., Urushihara H., Sawada Y. Medications associated with falls in older people: Systematic review of publications from a recent 5-year period. *European Journal of Clinical Pharmacology*. 71 (12) (pp 1429-1440), 2015.
20. Woolcott, John C; Richardson, Kathryn J; Wiens, Matthew O; Patel, Bhavini; Marin, Judith; et al. Meta-analysis of the impact of 9 medication classes on falls in elderly persons. *Archives of internal medicine* 169.21 (November 23, 2009): 1952-1960.
21. S. Hartikainen, E. Loennekers and K. Louhivuori (2007). Medication as a risk factor for falls: critical systematic review. *Journals of Gerontology Series A-Biological Sciences and Medical Sciences*, 62, 1172-1181.10.1093/gerona/62.10.1172

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22. Bolton JM, Metge C, Lix L, Prior H, Sareen J, Leslie WD: Fracture risk from psychotropic medications: a population-based analysis. *J Clin Psychopharmacol* 2008; 28:384-391
23. Sterke CS, Zierv G, van Beeck EF, Looman CW, van der Cammen TJ. Dose-response relationship between selective serotonin re-uptake inhibitors and injurious falls: a study in nursing home residents with dementia. *British Journal of Clinical Pharmacology*, 05 2012, vol./is. 73/5(812-20), 0306-5251;1365-2125 (2012 May)
24. Chatterjee S., Bali V., Carnahan R.M., Chen H., Johnson M.L., Aparasu R.R. Anticholinergic Medication Use and Risk of Fracture in Elderly Adults with Depression. *Journal of the American Geriatrics Society*. 64 (7) (pp 1492-1497), 2016.
25. Schubert, Cathy C; Boustani, Malaz; Callahan, Christopher M; Perkins, Anthony J; Carney, Caroline P; et al. Comorbidity profile of dementia patients in primary care: are they sicker? *Journal of the American Geriatrics Society* 54.1 (January 2006): 104-109.
26. Montero-Odasso M., Muir-Hunter S.W., Oteng-Amoako A., Gopaul K., Islam A., Borrie M., Wells J., Speechley M. Donepezil improves gait performance in older adults with mild Alzheimer's disease: A phase II clinical trial. *Journal of Alzheimer's Disease*. 43 (1) (pp 193-199), 2014.
27. Kim DH, Brown RT, Ding EL, Kiel DP, Berry SD : Dementia medications and risk of falls, syncope, and related adverse events: meta-analysis of randomized controlled trials. *Journal of the American Geriatrics Society*, 06 2011, vol./is. 59/6(1019-31), 0002-8614;1532-5415.
28. Sorock GS, Quigley PA, Rutledge MK, Taylor J, Luo X, Foulis P, Wang MC, Varadhan R, Bellantoni M, Baker SP. Central nervous system medication changes and falls in nursing home residents. *Geriatric Nursing*, 09-10 2009, vol./is. 30/5(334-40), 0197-4572;1528-3984 (2009 Sep-Oct)
29. Coussement J, De PL, Schwendimann R et al. Interventions for preventing falls in acute- and chronic-care hospitals: A systematic review and meta-analysis. *J Am Geriatr Soc* 2008;56:29-36.
30. Shaw FE, Bond J, Richardson DA et al. Multifactorial intervention after a fall in older people with cognitive impairment and dementia presenting to the accident and emergency department: Randomised controlled trial. *BMJ* 2003;326:73.
31. Neyens, Jacques C L; Dijcks, Béatrice P J; Twisk, Jos; Schols, Jos M G A; van Haastregt, Jolanda C M; et al. A multifactorial intervention for the prevention of falls in psychogeriatric nursing home patients, a randomised controlled trial (RCT). *Age and ageing* 38.2 (March 2009): 194-199.
32. Rapp, Kilian; Lamb, Sarah E; Büchele, Gisela; Lall, Ranjit; Lindemann, Ulrich; et al. Prevention of falls in nursing homes: subgroup analyses of a randomized fall prevention trial. *Journal of the American Geriatrics Society* 56.6 (June 2008): 1092-1097.
33. Jensen, Jane; Nyberg, Lars; Gustafson, Yngve; Lundin-Olsson, Lillemor Fall and injury prevention in residential care--effects in residents with higher and lower levels of cognition. *Journal of the American Geriatrics Society* 51.5 (May 2003): 627-635.
34. Booth V, Logan P, Harwood R, Hood V Falls prevention interventions in older adults with cognitive impairment: A systematic review of reviews. *International Journal of Therapy and Rehabilitation* 2015 Jun;22(6):289-96.
35. Oliver, D. et al. (2007). Strategies to prevent falls and fractures in hospitals and care homes and effect of cognitive impairment: systematic review and meta-analyses. *BMJ*, 334, 82.
36. Burton E., Cavalheri V., Adams R., Browne C.O., Boverly-Spencer P., Fenton A.M., Campbell B.W., Hill K.D. . Effectiveness of exercise programs to reduce falls in older people with dementia living in the community: A systematic review and meta-analysis. *Clinical Interventions in Aging*. 10 (pp 421-434), 2015. Date of Publication: 09 Feb 2015.
37. Littbrand, H., Rosendahl, E., Lindelof, N., Lundin-Olsson, L., Gustafson, Y. and Nyberg, L.. A high-intensity functional weight-bearing exercise program for older people dependent in activities of daily living and living in residential care facilities: evaluation of the applicability with focus on cognitive function. *Physical Therapy*, 2006; 86, 489-498.
38. Campbell AJ, Robertson MC, Gardner MM, Norton RN, Buchner DM. Psychotropic medication withdrawal and a home based exercise program to prevent falls: a randomized, controlled trial. *J Am Geriatr Soc* 1999;47:850-3
39. Cumming RG, Thomas M, Szonyi G, et al. Home visits by an occupational therapist for assessment and modification of environmental hazards: a randomized trial of falls prevention. *J Am Geriatr Soc* 1999;47:1397-402.
40. Pelffolk, T., Gustafsson, T., Gustafson, Y. and Karlsson, S. (2009). Risk factors for falls among residents with dementia living in group dwellings. *International Psychogeriatrics*, 21, 187-194.
41. S. Tangman, S. Eriksson, Y. Gustafson and L. Lundin-Olsson. Precipitating factors for falls among patients with dementia on a psychogeriatric

Conference Report - Autumn Conference 'Psychiatry Post-Brexit'

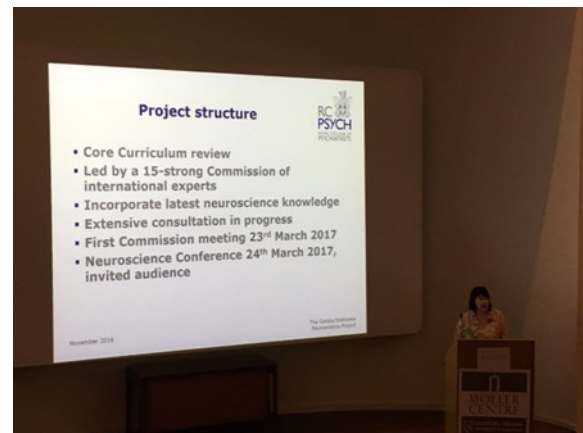
By Dr Kallur Suresh, Academic Secretary, Eastern Division

A highly successful autumn conference on 10th November at the Møller Centre in Cambridge was attended by over 70 registered delegates from all over the region and outside. For the first time, the conference and poster presentation opportunity were opened up to non-medical colleagues from around the Eastern Region. The conference featured a variety of clinical and academic talks for all interests. Feedback from delegates was highly positive.



The conference kicked off with an overview of the Wellcome/Gatsby Neuroscience Project of the Royal College, with talks by Dr Gareth Cuttle, Project Manager and Dr Wendy Burn, Co-Chair and immediate past Dean. The two-year project aims to revise the psychiatric

curriculum and make neuroscience a more integral part of the training.



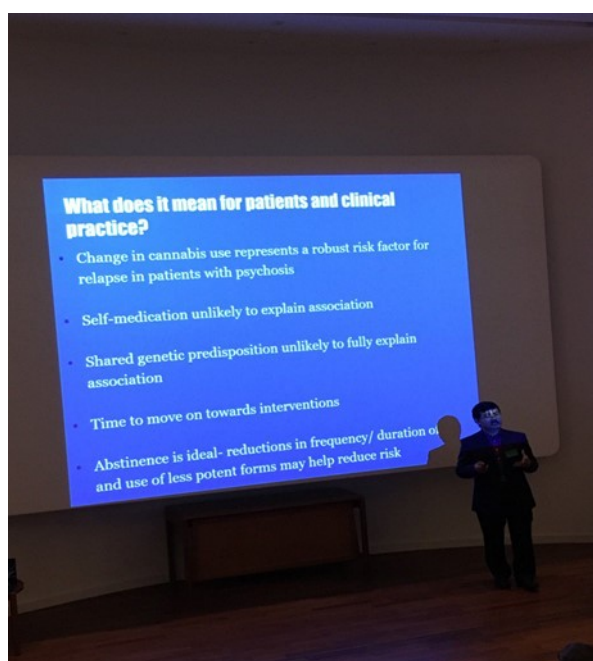
The audience actively participated in the discussion and the speakers collected written feedback and comments from the audience that will inform their work.

Dr Sagnik Bhattacharyya, Reader in Translational Neuroscience and Psychiatry at the Institute of Psychiatry, King's College, London spoke about relationship of cannabis use to

Conference Report - Autumn Conference 'Psychiatry Post-Brexit' (cont)

By Dr Kallur Suresh, Academic Secretary, Eastern Division

relapse and hospitalisation in patients with schizophrenia. His message was stark: It is time to draw a line under the debate of whether cannabis has an adverse effect on outcome measures in schizophrenia (the evidence is clear that it does) and move on to



interventions. For a practising clinician, the message was to encourage patients to stop using the drug if feasible or at least shift from higher potency 'skunk' cannabis to lower potency 'hash' and reduce the frequency of use.

The keynote address on Brexit and its implications for Psychiatry and Psychiatric Research was delivered by Professor Rob Poole, Professor of Social Psychiatry at Bangor University. His entertaining talk concluded that there would be a significant adverse effect on staff recruitment, cross-border academic

collaboration and more generally on UK Science, besides uncertainty about the long term implications of the UK leaving the European Union.



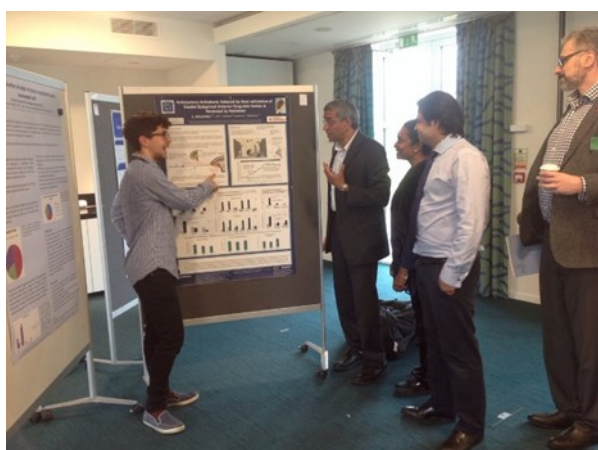
Snippets of academic content of the talks were made available to those who were unable to attend through Twitter using the hashtag **#EastDivConf**. You can catch up on all the [twitter feed and photos](#).

The afternoon session featured an update on psychiatric aspects of epilepsy by Dr Ekkehart Staufenberg, Consultant Neuropsychiatrist. He spoke about the new criteria for diagnosis and the NICE guidance on treatment. The final talk of the day was looking at the implications of adulthood trauma in female patients with schizophrenia, with data from a Turkish mental hospital, presented by Dr Muzaffer Kaser, from the Behavioural and Clinical Neuroscience Institute, Cambridge.

Conference Report - Autumn Conference 'Psychiatry Post-Brexit' (cont)

By Dr Kallur Suresh, Academic Secretary, Eastern Division

Delegates used break times to look at the more than 30 posters presented by trainees and multi-disciplinary colleagues. Many medical students and Foundation Year trainees attended the conference along with Core and Specialist Psychiatry Trainees. Three of the best posters in each category were given the opportunity for oral presentation and were given prizes. The judges remarked that the posters were of a very high quality. Well done to all trainees and congratulations to the prize winners!



The Executive Committee of the Eastern Division would like to thank all the delegates for their support to the conference and would welcome any feedback about topics for future conferences. We aim to make the academic content relevant to practising clinicians and hope to welcome many more members to the next one.

SAVE THE DATE in your diary
Thursday 8th June 2017
Eastern Division Spring Conference to be held at the
fantastic venue of
Wellcome Genome Campus, Cambridge
Look out for publicity in the New Year

EASTERN DIVISION MEDICAL STUDENT ESSAY PRIZE 2017



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

Prize: £200

Eligibility: All medical students training in Medical Schools located within the Eastern Division.

Where Presented: Eastern Division Spring Conference, 8 June 2017

Regulations:

1. Eligible students are invited to submit an original essay of up to 5000 words on any aspect of psychiatry. The essay should be illustrated by a clinical example from medical or psychiatric practice relevant to mental health and should discuss how the student's training and awareness has been influenced as a result. The essay should demonstrate an understanding of the Mental Health issues pertinent to the clinical problem and should include a discussion of the effects and consequences of the condition for the individual, their family and the wider healthcare system.
2. The essay should be supported by a review of relevant literature and should be the candidate's own work.
3. The Eastern Division Executive Committee will appoint three examiners to judge the entries. Criteria for judging merit will include: clarity of expression, understanding of the literature and evidence, cogency of argument and the overall ability to convey enthusiasm and originality. The Division reserves the right not to award the prize if no entry reaching the agreed minimum standard is received.

Closing date: Friday 31st March 2017

Submissions should be made to:
Moinul Mannan
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Deadline for next edition - Submit your articles for summer 2017 edition by 1st May 2017 at
psychiatry.east@rcpsych.ac.uk

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