and narrow in its focus – he believes that a consultant’s medical skills should be taken for granted, but that they are in a unique position for leadership, especially in the age of commissioning, where psychiatrists need to lead and develop relationships with commissioners.

He made reference to the Francis Inquiry and its highlighting of a lack of systems to keep patients safe, a lack of effective leadership and a lack of co-production between clinicians and managers. He raised the issue of the necessity to have a political and commercial awareness, with an ability to match vision to strategy, strategy to tactics, tactics to operational delivery and operational delivery to improved outcomes for patients.

He was very clear that there should be no such thing as a ‘jobbing psychiatrist’ and is often dismayed by the lack of leadership or management ambition shown by new consultants.

The next session was a forum discussion, chaired by Dr Claire Barkley, and comprised of Dr Llewllyn Lewis talking about his role in setting up the Maintaining Adherence Programme in South Essex; (…continued overleaf…)

“Changing Landscapes – New Horizons”

THE WEST MIDLANDS GENERAL ADULT PSYCHIATRY HIGHER SPECIALTY TRAINEES’ ANNUAL CONFERENCE (ENTITLED CHANGING LANDSCAPES – NEW HORIZONS, 21ST CENTURY CHALLENGES IN PSYCHIATRY) TOOK PLACE AT THE UFFCULME CENTRE ON 10TH OCTOBER 2014. DR CHARLOTTE MARRIOTT REVIEWED THIS CONFERENCE FOR MIND THE GAP.

This was a very stimulating and thought-provoking day with a host of inspiring speakers musing on the issues facing Psychiatry today, from clinical challenges to service development, Clinical Commissioning Groups and beyond.

Dr Derrett Watts welcomed the delegates with his inspiring introduction, likening the organisation of the annual conference to the passing on of the Olympic torch. He spoke about the importance of looking to the past in order to learn from history, whilst dealing with the problems of the present and looking to the future, without getting too bogged down in the current difficulties. He welcomed the speakers from a range of backgrounds and geographical areas and provided an entertaining introduction to a very varied and challenging programme.

Prof Fabrizio Schifano came from Hertfordshire to talk about novel psychoactive substances, otherwise known as ‘legal highs’, and the challenges they pose to psychiatry and addiction services. This was a passionate and exciting talk covering biochemistry, pharmacokinetics, psychopathology, the law and the problem of easy availability of these dangerous compounds thanks to the internet. He made clear that ‘legal’ does not mean safe, and the term legal highs should be avoided with patients. The full-profile of side-effects will not be clear for many years and pharmacovigilance is needed. He also spoke about the rise in prescription drug misuse, with a growing market for baclofen, quetiapine, tramadol, olanzapine and pregabalin to name but a few.

Mr Neil Carr (Chief Exec) spoke about Leadership in Psychiatry and his opinion that medical training has been clumsy and narrow in its focus – he believes that a consultant’s medical skills should be taken for granted, but that they are in a unique position for leadership, especially in the age of commissioning, where psychiatrists need to lead and develop relationships with commissioners.

He made reference to the Francis Inquiry and its highlighting of a lack of systems to keep patients safe, a lack of effective leadership and a lack of co-production between clinicians and managers.
Mrs Tracey Wrench talking about using the VALUE model to develop services in Coventry and Warwickshire; Ms Ghazala Ahmad talking about Values-Based Commissioning; and Mr Robert Walker, representative of the RCPsych Service User and Carers Forum, talking about his experiences and involvement in service development.

After lunch and poster presentations were the parallel workshops, covering diverse topics. Professor Chitra Mohan led DoLS: The Acid Test; Dr Kar presented Psychiatric Diagnosis at a Crossroads: DSM-V, ICD-11 or NIMH RDoC?. Drs Martin and Langan led Getting Started in Research; Drs Thangavelu and Chopra talked about The Future Consultant: Surviving the First Year; and Dr Lister spoke about The Shape of Training Review.

Unfortunately, Dr Pran Bijral was unable to attend the final session of the conference as planned to talk about the Third Sector Organisation Perspective of the Future of Addiction Services, but Dr Derrett Watts closed the conference just as he had opened it, giving his NHS Perspective on the topic. This tied in with Professor Schiffano’s earlier talk, describing society’s attitude to alcohol and drug use as ambivalent, and criticising successive governments for their half-hearted solutions to the problem, with the implementation of screening and brief interventions, but without an increase in taxes, the introduction of a ban on advertising, a weekend closing day or random breath tests, as recommended by the WHO. He feels that politics and policies overshadow substance misuse psychiatry, and we are in the sticky situation where there are 1.6 million dependent drinkers, but only 6% of whom are receiving treatment.

Echoing earlier talks about commissioning and leadership, he spoke about his recent experience of tendering to provide services and adopting a partnership approach with third sector organisations.

He sees the future as being recovery-focused, with more access to services and an integrated recovery focus, and the need for collaboration with service users to further develop services.

I would like to thank the organisers for their hard work in putting together a very challenging, cohesive and inspiring programme, and, of course, thank all of the wonderful and impassioned speakers.

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**Driving after psychosis – An audit on patient & mental health professionals’ awareness in Birmingham & Solihull**

**Dr Dawn Parris, Birmingham & Solihull Mental Health Foundation Trust**

**Background**

During an acute episode of psychosis, a patient must stop driving, and inform the DVLA of the change to the health. It is the license holder's responsibility to inform the DVLA. In order for a patient to be considered for relicensing, certain criteria must be met. It is the psychiatric team's responsibility to inform all patients with acute psychosis of the above points.

**Aims**

An audit was undertaken between February and April 2013 which looked at whether patients who had undergone an acute episode of psychosis within the previous three years who were treated under BSMHFT were aware of the laws around driving and psychosis, if they informed the DVLA, and subsequently stopped driving. The audit also looked at members of the psychiatric team whether they were aware that such guidelines existed, of their responsibility to inform the patients of them, if they told their patients and clearly documented this in the patients' notes.

**Methods**

17 patients were asked questions from a pre-set questionnaire by an interviewer. 38 mental health professionals (MPHs) from BSMHFT answered questionnaires themselves.

**Results**

Patients - none of the patients were aware of the driving restrictions surrounding acute psychosis. Some patients continued to drive during their psychotic episode.

MPHs - most were aware of driving restrictions but the majority could not state the full and correct guidelines. 63% did not always clearly document having informed the patients of the DVLA restrictions in the patients' notes – which has the potential for legal ramifications

Both - As the majority of MPHs inform their patients of the driving restrictions, but most of the patients are not aware of them, there is a miscommunication between the two groups.

**Conclusion**

Information regarding DVLA restrictions and psychosis should be made more widely available to both patients and MPHs - whether this be through posters, emails or written information.
A completed audit & re-audit to reduce psychiatric outpatients’ non-attendance rates

Dr B Nabavi¹, Dr K Nithiananthan², Dr A Khan³
¹Specialist Registrar in General Adult Psychiatry, Small Heath Health Centre (BSMHFT)
²Associate Specialist in General Adult Psychiatry, Small Heath Health Centre (BSMHFT)
³Consultant in General Adult Psychiatry, Small Heath Health Centre (BSMHFT)

Aims
In order to improve the rate of outpatient clinic non-attendees, we piloted a practice of making a phone call to the patients within one working day prior to their appointments. The main aim of this study was to establish whether such practice would make any significant differences in the proportion of non-attendance. We measured the clinical and demographic details of non-attendees in order to ascertain the existence of any significant correlations between these factors and the rate of non-attendance.

Methods
This was a retrospective audit and re-audit. We recruited 100 consecutive samples of outpatient clinic follow-up appointments before making the changes. Another 100 consecutive outpatient clinic follow-up attendees were recruited after introducing the phone call reminder.

In order to minimise selection bias, we only included those patients who had a routine follow-up appointment; and excluded initial and urgent assessments.

Results
In total, 200 outpatient clinic attendees were reviewed. There was 6% (from 19% to 13%) reduction in the rate of DNA between the audit and re-audit groups. We managed to make a phone call to 50% of the attendees, as did to 50% of non-attendees.

We found no statistically significant differences regarding age, marital status, ethnicity, care level, diagnosis, duration of illness, attending depot clinic, the morning or afternoon appointments and education. However, we found a higher proportion of male non-attendees in both audit and re-audit samples, (50% vs. 63%) and (41% vs. 53%), respectively.

Conclusions
Although, our results indicated some improvement in the proportion of attendees, it was a time consuming practice. We made some recommendations including: identifying specific group of patients with previous poor history of attendance and male patients, as well as those patients who are employed, easily accessible and have no language barrier; considering automatic text, as it is less time and resource consuming.

Evaluation of the quality of assessment of alcohol and substance misuse during initial psychiatric assessment carried out on in patients admitted to two psychiatric hospitals in the same mental health trust.

Dr Claire Breidenbach Roe¹, Dr Rosie Field¹, Dr Chandan Aladakatti²
1. Sandwell West Birmingham NHS Trust, Sandwell General Hospital, West Bromwich
2. North Staffordshire Combined Health Care NHS Trust

Aims
Recording of alcohol and substance misuse history in patients notes is often inadequate. This audit aimed to evaluate the quality of alcohol and substance misuse assessment during initial psychiatric assessment carried out on inpatients admitted to two psychiatric hospitals. This was a re-audit to see if recommendations that had been carried out had had an impact.

Methods
A retrospective audit evaluating assessment of substance misuse documented in inpatient records. Documentation of current and previous usage, dependence and treatment for alcohol, illicit drugs & smoking; demographic data were recorded. The source of data collection was the initial assessment proforma. All inpatients on one day during the week commencing 11th June 2014 at hospitals one (H1) and two (H2) were identified; no patients were excluded; giving a total of patients at H1 and 25 patients at H2 a total of 106 patients.

Results
The initial assessment forms varied with H2 having more subheadings than H1. Enquired history was documented greater at H1 compared to H2; alcohol (82.7%(H1) vs. 76%(H2)), smoking (56.8%(H1) vs. 48%(H2)), Illicit drugs was documented better at H2 than H1. (80%(H2) vs. 78%(H1)). The level of detail and dependence also varied significantly between patients at both hospitals. Recording of substance misuse was generally less well documented on elderly care versus adult wards.

Conclusions
Overall quality of recording of substance misuse history was better at H1 than H2. There was variation in terminology used at both hospitals, leaving recordings subject to interpretation. On some occasions there was data recorded but it lacked depth and clarity. Some patients with a clear background of substance misuse had a lack of detail recorded about their current misuse. This re-audit showed despite provisions put in place to help improve initial clerking of patients, the recording of substance misuse continued to be poor.
Research:

TRAINEE’S PERCEIVED KNOWLEDGE LEVEL FOR CLINICAL SKILLS & COMPETENCIES: SCOPE FOR DESIGNING FOCUSED TRAINING

Dr Rahul Chandavarkar, CT3
rchandavarkar@nhs.net
Dr Nilamadhab Kar, Consultant Psychiatrist
nilamadhab.kar@bcpft.nhs.uk
Black Country Partnership NHS Foundation Trust

Background

The MRCPsych examination was introduced in 1972 and since 2008 has consisted of four components. Paper 1, Paper 2, Paper 3 and the Clinical Assessment of Skills and Competencies (CASC). The CASC takes place after successful completion of the three written papers and determines whether candidates are suitable to progress to higher specialist training.

The cumulative results report (compiled by Professor Anthony Bateman in 2011) found that of 3171 CASC candidates, 1247 passed (39.3%). Just under half of those who passed did so on their first attempt (n = 858, 49.0%) but there was a great disparity between the pass rates of candidates graduating from UK and foreign medical schools. For candidates graduating from UK and Irish medical schools it was 84.7% and 64.1% respectively compared with 26.8% for graduates from Indian Borders (Afghanistan, Pakistan and Nepal), 27.8% from the Indian Subcontinent (India and Sri Lanka) and 30.1% for others. This was a statistically significant difference.

Although various factors have been suggested as contributing to CASC pass rates, one core issue is trainees’ knowledge base. George E. Miller suggested four stages of development “knows, knows how, shows how, and does” as the cognitive and behavioural steps an individual progresses through (acquiring knowledge to performing a task in practice).

The CASC scenarios listed on the website for the Royal College of Psychiatrists and MRCPsych CASC courses.

Trainees were requested to evaluate how comfortable they felt with each CASC scenario in the survey using a 4-point response scale (where 1=not comfortable at all and 4=very comfortable). This was considered a way of helping trainees to identify their own level of knowledge for each scenario.

Results

Twenty eight trainees (n=28) completed the survey. These trainees consisted of both British and foreign Medical School graduates. The results showed considerable variation in trainees’ perception about their skills and knowledge base (see Table 1).

Discussion

Trainees need background knowledge relevant to their stage of training. The ‘knowledge level’ helps the trainee to understand how to implement their skills, but also why they are implementing them. The variations in perceived knowledge level were wide across the different CASC scenarios in this survey, despite all trainees responding at the same level of training and attending the same course.

Trainees can identify their knowledge and skill level in different CASC or real life clinical scenarios, which may help them to focus on deficit areas. This information may also help trainers to design specific training modules to develop knowledge and skills in those areas. Repeat evaluations of this kind may reflect progress of the trainee and can improve their confidence during the CASC examination. Surveys such as these may also identify trainees who require specific and additional support in order to improve their performance for CASC examination.

Limitations

This is a survey of perceived knowledge and may not be an accurate reflection of the trainees’ actual potential. It is also acknowledged that for a concept like this to be effective and developed further, this type of survey would need to be replicated on a larger scale.

Conclusion

The survey results suggest that, even at the same training level, trainees vary significantly in the perceptions of their knowledge in various clinical scenarios. Level of knowledge may influence performance in a test situation and deficit in knowledge base can be addressed relatively easily through focused training. This may be the initial step for improving outcomes in clinical skills test scenarios.

Take Home Messages

• Trainees’ knowledge base is a contributing factor of CASC pass rates.
• Trainees vary significantly in the perceptions of their knowledge of CASC scenarios.
• Level of knowledge influences performance and can be used by trainers to improve clinical exam outcomes for their trainees.

MCQs

1. When was the MRCPsych examination introduced?
   A) 1952  B) 1962  C) 1972  D) 1982  E) 1992

2. How many stages did George E. Miller propose for a trainee to be able to demonstrate competence in performing a task in practice?
   A) 1  B) 2  C) 3  D) 4  E) 5

References

1. Bateman A. MRCPsych Examinations Cumulative Results http://www.rcpsych.ac.uk/pdf/MRCpsych%20Cumulative%20Results%20 REPORT%20%20-%20August%202011.pdf

2. Hussain A, Husni M. Preparing for the MRCPsych CASC - an insight based on experience. BJRIM 2010; 3, 314


MCQ Answers: 1) C  2) D

NEWS:

Howard White Memorial Prize

Congratulations to Dr Yasmin Naar and Dr Soha Gouda. Dr C Paci & Dr A Hashmi won the 2014 Howard White Memorial Prize competition. Dr Naar won the prize for best audit presentation for her audit entitled ‘Audit on mental health review tribunal reports’. Dr Gouda, Paci and Hashmi won the best poster prize for their poster on Monitoring cardiovascular variables in dementia patients before and after prescribing AChEIs.

Dr Howard White was a Consultant Psychiatrist in Birmingham and a former Clinical Lecturer at Birmingham University. He was also President of the Section of psychiatry at the Birmingham Medical Institute. He died prematurely in 1980, at the age of 53, at the peak of his career. He had already established himself as an examiner, teacher, and administrator, and the Howard White Memorial Prize was set up in his memory by his friends and colleagues.
Clinical Audit

DEMONSTRATING PRACTICE DEVELOPMENT IN SMOKING CESSATION

Dr Kath McMillan ST5 (GAP) 
RAID Heartlands Hospital 
mcmillan.k.a@gmail.com

Introduction and methods

Smoking both cannabis and nicotine has been widely linked to worse physical health outcomes. Improving the physical health of those with mental illness is a national CQUIN for 2013/2014 as part of NHS England’s strategy to reduce premature mortality in this population.

The CQUIN includes the documentation of smoking status. Smoking can also worsen both depressive and anxiety symptoms; smoking cessation can significantly improve a patient’s mental health. GMC Good Medical Practice requires all doctors to regularly review and audit their own work.

I had identified that a weakness in my practice was offering smoking and cannabis cessation advice routinely to outpatients.

A retrospective review was carried out of all attended outpatient clinic letters between 1st January 2014-28th February 2014 (n=17).

Following an intervention, including smoking cessation advice training, a re-audit was completed four months later (n=22). P values were calculated and data was analysed using Chi-square and Fisher Exact for categorical data.

Results

The most surprising result was how poor I was at documenting the smoking status of patients prior to the intervention (33%). Following the intervention there were significant improvements in my practice. 1) checking of smoking status increased from 33% to nearly 90% (p<0.05) 2) 2/3 new patients who were smokers advised to quit 3) rate of asking about cannabis status doubled from 50% to nearly 100%.

Take Home Messages

1) NHS England has a national target to reduce premature mortality in people with mental illness. Smoking is a predictor of worse physical and mental health outcomes.
2) The GMC requires all doctors to review and audit their work against guidelines
3) Cognitive biases can affect how we practice.

References

2) Very Brief Advice Training Module, National Centre for Smoking Cessation and Training www.elearning.ncsc.t.org.uk/vba-launch

Discussion

Auditing our own practice can highlight gaps we are not aware of. Prior to the intervention I thought I asked the majority of patients about their smoking cessation status. This was not borne out in the documentation. Significant improvements were seen in documenting status and offering cessation advice following the intervention. Cognitive biases are known to affect medical decision making; biases that may have affected my practice include overconfidence effect, stereotyping, aggregation bias and confirmation bias.
The BMI Section of Psychiatry

Established in 1875, the Birmingham Medical Institute (BMI) is one of the oldest medical societies in the country and one of only three retaining its own premises.

In this editorial, Dr Matt Tovey (ST5 Forensic Psychiatry) outlines the role of the BMI’s Section of Psychiatry and its upcoming events.

The Section of Psychiatry operates from within the Birmingham Medical Institute and is designed to offer stimulating and thought-provoking events that are usually (although not necessarily exclusively) linked to psychiatry. One of our aims is to offer a forum for those working within the fields of medicine and mental health to meet outside of the traditional clinical sphere and engage in interesting discussions around the events organised. Typically, the Section of Psychiatry arranges events for the first Tuesday of each month that begin at around 6pm until 8pm.

Examples of previous talks include Prof. Keith Rix speaking on “History Repeating Itself - The Trials of the Expert Witness”, Dr Peter Schaapveld speaking on “Expert Testimony in Death Penalty Cases” and Prof. Craig Jackson speaking on “The Psychiatry of Mass Shooters & Spree Killers”.

The BMI Section of Psychiatry has some interesting events coming up. These include:

- 4th November 2014 - Prof. Kevin Dutton speaking about psychopathy.
- 2nd December 2014 - Three course dinner with a talk by Dr Tony Daniels (Theodore Dalrymple) for £25 consultants, £20 all others.
- 9th January 2015 - Joint meeting with the Birmingham Salon - a debate on NHS & immigration featuring Gisella Stuart MP.

“Our mission is to provide thought-provoking enrichment to the field of psychiatry within the West Midlands”

BMI SECTION OF PSYCHIATRY

BOOK REVIEW:

The Fifth Discipline (2nd edition)
Author: Peter Senge
Publisher: Random House
Date of Publication: 2006
Number of Pages: 464 pages

Reviewed by: Dr Dee Desai
ST5 (General Adult Psychiatry)
Sub-Editor Mind the GAP

‘The Fifth Discipline’

What’s it about?

PETER SENGE DESCRIBES HOW TO CREATE A “LEARNING ORGANISATION” WHICH ALLOWS THOSE WORKING IN AN ORGANISATION TO “CREATE THE RESULTS THEY TRULY DESIRE”. EMPLOYEES IDENTIFY AND FULFIL THEIR PERSONAL LEARNING CAPACITY. IN ADDITION, EMPLOYEES NEED SHIFT TO A SYSTEMIC VIEW OF THE ORGANISATION THEY WORK FOR TOGETHER. THESE CHANGES DRIVE IT FORWARD AND ENSURE IT IS COMPETITIVE.

The book describes five disciplines needed that need to be developed to achieve this; systems thinking personal mastery, mental models, building shared vision and team learning. Disabilities, or factors impeding the learning organisation are also described.

A hypothetical scenario or game demonstrates to the reader factors in the organisation and the individual that impede the development of a learning organisation. This is both engaging and a clear way to convey information to the reader. There is a section on the learning organisation and a separate section describing in detail each of the disciplines. The book ends with reflections of the author based on real life interviews and scenarios demonstrating how the material covered in the book relates to the real world.

Weaknesses:

The book is not targeted to health services. The examples are interesting informative, but not specific for the field of psychiatry. The book is lengthy at over 400 pages. It is useful for the general principles but not a text to read cover to cover.

Summary

This book is a recognised contribution to management literature and relevant and interesting to psychiatric trainees and specialists alike as a useful reference text.

If you want to write a book review for the next issue of Mind the GAP, please send your submissions by email to newsletter@westmidsgap.org.uk

Dr Matt Tovey is a BMI Committee Member and ST5 in Forensic Psychiatry
Across
3. Short-acting benzodiazepine (9).
7. 'The ______ of Mental Illness' Book written by Thomas Szasz (4).
8. Credited as being the first antipsychotic drug (14).
9. Commonest form of dementia, ______ Disease (10).
10. Surname of American psychologist and creator of Dialectical Behavioural Therapy (7).
11. Nationality of Carl Jung and Jean Piaget (5).
14. A term for inpatients who are not detained under the MHA (8).
15. Mood stabiliser (7).
17. Pavlov's favourite animal? (3)
18. A false perception in the absence of an external stimulus (13).
20. London Street where the Royal College of Psychiatrists is based (7).
21. Editor of Mind the GAP (6).
22. Receptor acted upon by alcohol & benzodiazepines (4).
23. Lowest frequency of waves recorded by EEG (5).

Down
1. Nickname of the Bethlam Royal Hospital (6).
2. Mental disorder whose name literally translates as “fear of the marketplace” (11).
4. Thought Insertion and Delusional Perception are two of a group of symptoms named after which German Psychiatrist (9).
5. Butyrophenone derivative and inverse agonist of dopamine (11).
6. A term coined by Sigmund Freud in 1896 (14).
12. SSRI antidepressant (10).
16. Pupils associated with opiate intoxication/overdose (8).
19. A syndrome in which a partner experiences some of the same symptoms as their pregnant partner (7).

Answers:
Across
3. Lorazepam
7. Myth
8. Chlorpromazine
9. Linehan
11. Swiss
12. Citalopram
13. WHO
15. Lithium
17. Dog
18. Hallucination
19. Couvade
21. Swalli
22. GABA
23. Delta

Down
1. Bedlam
2. Agoraphobia
4. Schneider
5. Meadowcroft
6. Ciba
7. Meadowcroft
10. Cocaine
11. Prescot
12. Swalli
16. Pinpoint
19. Cocaine

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Introduction

Delusions can occur in isolation or as part of Schizophrenic spectrum Disorder. In Delusional Disorder the most common Delusions are persecutory in nature yet somatic Delusions are also common. Patients with somatic delusions do not present noticeable evidence of any impairment of functioning except for their Delusions. Their behavior features are influenced by their emotional state & are consistent with the nature of the delusions. These patients usually do not have hallucinations other than tacue or oscurory ones, which are related to the theme of the delusion. Their thoughts are disturbed, although thought processes are not usually impaired. Patients usually lack both judgement and insight. A hypersensitive and argumentative personality is also characteristic. The precise aetiology of delusional disorder has not been fully elucidated. However, the roles of genetic, biological (hyper-dopaminergic states) and psychological factors have been considered. Delusions can develop as a response to stress and may serve to preserve a positive self-image. Somatic Delusions are quite difficult to treat per se, as evidenced by a treatment success rate of approximately one-third.

Case Study

Mrs X, 54 year old Caucasian female was admitted to Psychiatric Hospital under Section 2 of MHA in November 2013 following an incident of stabbing herself in the stomach four times by hitting a knife into her stomach with a mallet. She also tried to set fire to her bedroom to prove that she would not be hurt/burnt as Buscopan had formed a layer under skin. After recovery from Surgery, she was admitted to psychiatric where she reported multiple Somatic symptoms including a pulling sensation in her stomach, her brain not being attached to her body, no tendons or muscles in her arm, “moving/pulling” sensations around her stomach/feet and that medication (Buscopan) had crystallised under her skin. She believed that as her Cranial Nerve is in stomach now which she swallowed, she has “pulling/moving” sensation in her stomach/body. She also wanted a DNA test on her hair and skin, believing that they don’t belong to her. Other psychotic symptoms like hallucinations, illusions etc. were not reported or observed. She held these Somatic delusions with absolute conviction. She lost quite lot of weight due to avoidance of food as it caused pain in her stomach. She appeared distressed and frustrated due to these unusual physical experiences, and hence was suicidal.

She first reported pulling sensations in her stomach beginning of July 2013. Over next few months, she presented to A&E on several occasions due to abdominal pain/cutting on arms to see what is inside. She was cutting herself to prove her beliefs to the family. She was seen by numerous physical health Consultants and complete organic workup including MRI, Lumbar puncture, blood investigations etc. which revealed no abnormality. She did not believe medical opinion and remained convinced with own belief system. She was referred to Psychiatric Services in August 2013 with no previous history of psychiatric illness. According to family; she had always been very fixated on somatic bodily symptoms like strange sensations/pain in her stomach/body. She visited her GP numerous times with somatic complaints in past; hence the GP prescribed her long-term Buscopan. She was on regular Buscopan prescription for last 7 years. She was diagnosed with irritable bowel syndrome, ovarian cyst and gastric ulcer in the past. Her past psychiatric history, Family history Drug/Alcohol history, Financial history were non-contributory. She was happily living with her 2nd husband without any family problems.

She was commenced on Quetiapine which was changed to Olanzapine & Mirtazapine later. Sertaline and Mirtazapine were also tried. She continued to express Somatic delusions around her physical health as described above & remained distressed/ agitated due to her physical experiences. Second opinion was taken regarding her medication. ECT was also explored as treatment option. After recommendation from SOAD, Clozapine was commenced with gradual titration. February onwards, her mental state improved gradually. Her mood, motivation, sleep, appetite improved. She put on weight & her constipation also improved. Her distress/anxiety caused by Somatic Delusions also significantly reduced and she stopped contemplating suicide/DSH. Her insight into her illness improved gradually. She was discharged from Hospital on Clozapine(around 5 months stay) with aiming at Psychotherapy (CBT) in future.

Discussion

Persistent Delusional Disorder is an uncommon, yet not rare, psychotic disorder. Because of lack of research in this area, no definitive clinical guidelines are available on its treatment. The treatment of delusional disorder involves both medication and psychotherapy (cognitive or insight-oriented therapy) however there can be difficulties in developing a therapeutic alliance. Treatment of this can be very difficult challenge for Psychiatrist. There is very limited data available in research literature to suggest any drug of choice. We were able to find only couple of Case Reports where Delusional Disorder was treated with Clozapine. These case Reports show that they had some success in treating symptoms of Delusional Disorder & overall functioning also improved on Clozapine. We also had the same experience. Further research in the form carefully designed RCT will be very helpful to suggest the efficacy of Atypical Antipsychotics/Clozapine in treatment of Delusional Disorder.

Take Home Message

Clozapine is a powerful antipsychotic which can be helpful in treatment resistant psychosis and should be considered at the earliest opportunity as per NICE guidelines.

MCQs

1. Which of the following side effects of Clozapine are not dose dependent?
   A. Agranulocytosis
   B. Tachycardia
   C. Hypersalivation
   D. Weight gain
   E. Cardiotoxicity

2. Which of the following medications are known to reduce suicidality?
   A. Lithium
   B. SSRIs
   C. Clozapine
   D. Risperidone
   E. Quetiapine

References


MCO Answers Overleaf…..
News in Brief…Junior Doctor Contract Negotiations

What’s the background?
Negotiations between the BMA and NHS Employers to change the contract for doctors in training as well as the contract for consultants have been on-going since early 2013. Government ministers had imposed a deadline of by the end of October to agree changes. The BMA junior doctor negotiations have focussed on improving patient safety and safeguarding the wellbeing of doctors in a cost neutral manner. They had asked for a reduction in the number of consecutive long night shifts that could be worked and asked that clear work schedules detailing clinical hours and training time as well as on call rotas should be available to all doctors in training in advance of starting a post. NHS employers have pushed to end automatic pay progression and wished to increase “plain time” hours to 7am to 10pm seven days a week.

What’s the situation?
No agreement was able to be reached and last week the BMA has reported they have withdrawn from a negotiations focussed on reaching an agreement based on what they state is an “arbitrary” political deadline. They called for further negotiations based on robust models of how the changes would affect doctors which as yet has not been provided by NHS employers. Consultant contract negotiations have also stalled.

What happens now?
It is unclear what happens next. The BMA hopes NHS employers will continue to negotiate based on providing robust data on the proposed changes with models of how this will affect doctors and services. For the consultant contract the fear is that NHS employers could impose a contract for newly appointed consultants was significantly different terms and conditions than those on the old contract. Local negotiations could also occur and the BMA is working to train LNCs which are likely to be much more important in this case. This is clearly a time of huge uncertainty when changes could be introduced that effect not just training contracts but how the current trainees work as Consultants. The BMA is committed to regularly updates on the progress that will be available here along with some FAQs and the opportunity to have your say.

More information can be found at: http://bma.org.uk/working-for-change/in-depth-junior-and-consultant-contract

Dr Kath McMillan
ST5 (General Adult)
Sub-Editor Mind the GAP

Want to add to your list of publications?
The new and improved West Midlands Deannery Newsletter, ‘Mind The Gap’ offers medical students and psychiatric trainees in the West Midlands the opportunity to publish articles of interest. Prospective authors are required to follow the following Author Guidelines:

RESEARCH. AUDITS. REVIEWS.
1. Submissions should be no longer than 1000 words with a maximum of three key references
2. Please include your name, place of work and contact email address
3. Authors are encouraged to submit a photo of themselves
4. The use of images/graphs/diagrams is also encouraged
5. Submissions should be accompanied by three ‘take home messages’
6. Please include two relevant MCQs to support any clinical material

MCQ Answers (Page 9): 1 A & E 2 A & C

The Mind the GAP Editorial Team is keen to publish:
- Research
- Clinical Audits
- Case Reports
- Book Reviews
- Conference Reviews
- Important Dates
- Reflective Practice
- Personal Experiences
- Interviews
- RCPsych News
- Course Reviews
- Correspondence

If you are interested in contributing the next edition, please email submissions to: NEWSLETTER@WESTMIDSGAP.ORG.UK