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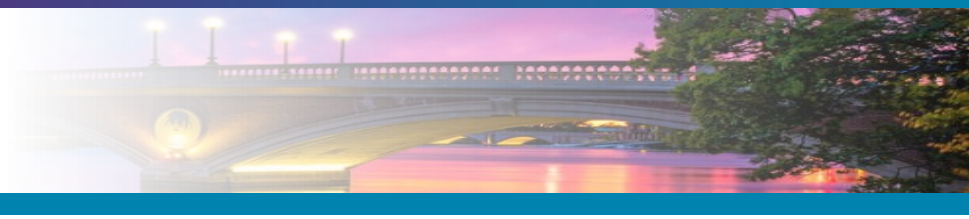
Psychiatry-East

The Eastern Division eNewsletter

Editorial



In this issue:

Welcome to the RCPsych Eastern Division Winter Newsletter 2024. As the year draws to a close, I hope 2024 has been an inspiring one for you. I am confident you will find further inspiration in the articles that follow. Please do read the chair's column by Dr Suresh before delving into the rest of the newsletter.

Dr Helal's article discusses how psychiatric trainees often feel unprepared to manage eating disorder patients due to insufficient training. She highlights new research linking eating disorders to metabolic factors and the gut microbiome, offering promising treatment insights.

In their winning article Drs Astefanei and Charalambous examine the misuse of nitrous oxide (N_2O), which can cause mental health issues such as psychosis and addiction. Popular among young adults for its short-lived euphoric effects and perceived low risk, N_2O demands greater public awareness and research into its long-term dangers.

Dr Jaufer sheds light on violence against healthcare staff in mental health settings, noting how some professionals accept it as part of the job. She emphasises the need to address underreporting and the psychological toll on staff, including PTSD and burnout, which can severely impact job satisfaction.

Dr Fayyaz explores how mental health stigma prevents people from seeking help, worsening symptoms and overall wellbeing. She stresses the importance of education, open conversations and supportive environments to promote understanding and acceptance.

The article by Drs Eze and Ali highlights gaps in CAMHS care for looked-after children in Peterborough and recommends a dedicated care pathway with enhanced assessments and trauma-informed therapies to address their unique mental health needs.

The new interview section features Dr Serebel's conversation with Dr Bakshi, a member for the Executive Committee. It provides practical advice for higher trainees and early consultants, emphasising the value of building clinical confidence before taking on broader responsibilities.

Dr Shivakumar's article highlights problem gambling as a growing public health crisis. He explores its psychosocial impact, offers practical prevention strategies and advocates for stricter regulations and ethical reforms in the gambling industry.

Finally, you will find my report on the Autumn conference. I hope you find it engaging and informative.

Season's greetings to all!

Dr Sep Hafizi, Editor, Psychiatry East

Chair's Column

By Dr Kallur Suresh

The last six months have seen major changes in the political landscape and we could be on the brink of significant changes to Health Care as part of the new government's 10-year Health Plan. The Assisted Dying Bill 2024, if and when becomes law, will signal a seismic shift in the society's approach to dying with dignity. As psychiatrists, we may have a significant role to play in this process. The details of how it will work are far from clear. It is also good to see the revival of legislation to reform the Mental Health Act (1983) based on the recent review. This will undoubtedly lead to a significant change in the day to day practice for psychiatrists and will hopefully improve the participation and involvement of, and care provided to, our most vulnerable patient groups.

Locally, within the Eastern Division, in the last six months we have filled many of our existing vacancies and recruited to new roles within the executive committee. We now have three CPD Leads and a new Academic Secretary who will work together to plan, organise and deliver our spring and autumn conferences and other popular events such as the Consultant Interview Masterclass.

As a Division we have also started to engage with the local Integrated Care Boards (ICBs) within our region to understand the operational aspects of commissioning care, local priorities and to explore how the Division can work with the ICBs to improve services for patients as well as help ensure a better experience for staff working within mental health services. So far we have met with two of our ICBs in our region which are Hertfordshire and West Essex ICB and Suffolk and North East Essex ICB. We hope to continue these conversations next year.

Consultant job descriptions continue to be approved at version one or two in the vast majority of cases. The Division delivered its 2025 business plan following special meetings of the executive committee.

We have also had significant success with our webinars which have attracted more than 100 delegates each. These webinars are about 90 minutes each and cover niche topics that are of significant interest to our members. We have planned to host more webinars for next year on topics such as Acceptance and Commitment Therapy and rTMS. Watch out for publicity over the holiday period.

The autumn conference held at the end of October at the Fielder Centre in Hatfield was attended by more than 70 delegates and included speakers from diverse backgrounds. The Trainees' Conference and the Trainers' Conference in 2024 were very popular and I thank the local School of Psychiatry in the East of England for generously supporting these events.

With the holiday season upon us, I wish you all a restful festive period, with friends and family. It is important not to forget to look after ourselves, no matter how testing and challenging the working conditions in the NHS are. The most important tool we need to do our jobs and to deliver high quality patient care is ourselves.

With best wishes for a merry Christmas and a very happy New Year 2025!

Kallur Suresh
Chair, Eastern Division

Autumn 2024 Poster Prize Awards

Medical Student Category

1st Prize - *Kwan Ching Mars Lee*
2nd Prize - *Fauzaan Ahmed*
3rd Prize - *Isaac M. Gianfrancesco, Maria Solovyeva*

Foundation Year Trainees Category

1st Prize - *Peace Abel, Venkata Gudi, Leo Boswell, Gabriela Martyn*
2nd Prize - *Manteneh Marah, Venkatesh Malipatil*
3rd Prize - *Varada Vartak, Ramona Onita, Varada Vartak, Katie Hammond, Amy Lee, Nikhil Tomar*

General Category

1st Prize - *Karen Moreira, Motolani Aregbesola, Matthew Nelson*
2nd Prize - *Dr Pedro Ramos Barbosa, Dr Nonso Ijeh*
3rd Prize - *Ayomipo Amiola, Sreeja Sahadevan, Ignatius Gunaratna, Regi Alexander*

Multidisciplinary Category

1st Prize - *Verity Chester, Sadie Clarke, Ruth Flowerdew, Nadine Alger, Daniel Boughey, Oliver Farrar, Charlie Freeman, Donna Lakin, Julia Large, Elizabeth Patteril, Andy Smith, Carly Weeks*
2nd Prize - *Verity Chester, Sadie Clarke, Ruth Flowerdew, Nadine Alger, Daniel Boughey, Oliver Farrar, Charlie Freeman, Donna Lakin, Julia Large, Elizabeth Patteril, Andy Smith, Carly Weeks,*
3rd Prize - *Verity Chester, Sadie Clarke, Ruth Flowerdew, Nadine Alger, Daniel Boughey, Oliver Farrar, Charlie Freeman, Donna Lakin, Julia Large, Elizabeth Patteril, Andy Smith, Carly Weeks*

New Eastern Division Essay Prize

Prize Winner - *Kwan Ching Mars Lee*

New Eastern Division Members

Dr Afef Mahmoud - CPD Lead
Dr Shamima Nargiss - CPD Lead
Dr Rayan Gornas - CPD Lead
Dr Lubna Ahmed - Equity Champion
Dr Robert Dudas - Academic Secretary

Keeping Eating Disorders Patients in Mind

By Dr Passent Helal

As I continue my higher training in psychiatry, I frequently encounter other trainees who find managing eating disorders patients intimidating. This is not surprising, considering it was this exact reason that initially sparked my interest in an eating disorder placement. Unfortunately, our training on managing these patients is often insufficient, making it challenging when we do encounter these types of patients. A recent survey conducted locally on higher psychiatric trainees in East of England, showed that five out of nine participants rated their confidence in managing eating disordered patients between zero to five out of ten (personal communication with Dr A Conway Morris).

From my year in eating disorder services, and participation in the eating disorders credentialing pathway as developed by the Royal College of Psychiatrists (RCPsych), I have learnt that managing these patients can be uniquely challenging. For example, anorexia nervosa involves physical risks related to malnourishment and refeeding, the contentious issue of capacity in starvation and low body mass index (BMI), the appropriateness of detention in some patients, the location of care, and the availability of services. The National Institute for Health and Care Excellence (NICE) recommends psychological therapies and weight restoration in community settings unless otherwise indicated (1). However, many services lack the capacity for psychological therapies, and some patients resist weight restoration.

A significant proportion of patients who receive treatment do not fully respond, and around 20% end up in a chronic state (2). This might be due to the core causes of the disorder, which remain largely unknown. Like all psychiatric disorders, eating disorders result from a complex interplay between genes and environment. Most of what we know about the effects of starvation on physical and mental health comes from the starvation experiment led by Ancel Keys in the 1940s (3). The increase in the egosyntonic obsessive thoughts around food, avoidance, mental rigidity, and emotional numbness worsens with lower BMI, impeding recovery and psychological engagement. Thus, increasing body weight is a priority and not just in the acute stages.

Despite limited research, some interesting studies and concepts are emerging. These include reconceptualising anorexia nervosa as a metabolic disorder and exploring the role of the gut microbiome in its pathophysiology (4,5). Studies suggest that patients with anorexia nervosa may harbour less diversified gut bacterial communities when compared to healthy individuals (6–9). This may impact various functions provided by these microbial communities including maintaining the gut barrier, immunity, hormonal regulation, metabolism, and energy expenditure. Interestingly, some of these studies show that even after renourishment, microbial diversity does not recover to healthy levels, suggesting a potential role in relapse (7,9–12).

Despite the slow pace of research, our understanding of eating disorders is evolving, offering hope for future effective treatments. However, we cannot help our patients without first educating ourselves. I encourage you to challenge and expose yourself to managing eating disorder patients.

Please refer to the following link for guidance by RCPsych on recognising and managing medical emergencies in eating disorders: https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2022-college-reports/cr233

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Keeping Eating Disorders Patients in Mind

By Dr Passent Helal

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MindEd

MindEd is a free online educational resource covering mental health for children, young people, adults and older people.

MindEd web tools for those working with young people | Royal College of Psychiatrists (rcpsych.ac.uk)

‘Hippy Crack’ Can Crack Your Life – A Mental Health Approach

By Dr Silvia Astefanei and Dr Andrew Charalambous

The Victorian Era was a time known for its industrial growth, advancements in the arts and sciences and, less commonly, for ‘laughing parties’. Those old-school gatherings where ladies wearing hoop skirts and crinolines and gentlemen wearing frock coats and vests would use ‘laughing gas’ to have a good time (1). Fast forward to today, and history seems to be repeating itself, albeit in a different setting—clubs and festivals.

Nitrous oxide (N_2O), commonly referred to as ‘laughing gas’ or ‘hippy crack,’ is an odourless, colourless, and non-flammable gas. Discovered in 1775 by Joseph Priestley towards the end of the Enlightenment period, its effects are diverse and concerning. Nitrous oxide has three primary effects: anaesthetic, analgesic, and anxiolytic. The anaesthetic effect results from non-competitive NMDA inhibition in the central nervous system, while the analgesic effect is morphine-like, releasing endogenous opioids on opioid receptors. The anxiolytic effect is benzodiazepine-like, mediated via GABA-A activation. Additionally, nitrous oxide is thought to have ketamine-like antidepressant properties (2,3).

Beyond its neurological effects (4), which include cognitive impairment, there is growing evidence of its long-term mental health implications, such as mood instability and psychosis, particularly hallucinations, delusions, and paranoia (5). Recent reports have even documented cases of individuals claiming to be addicted to N_2O, using it hundreds of times a day, turning it into an increasingly expensive habit (6).

According to the Office for National Statistics (latest date from 2022), N_2O usage varies by age group. In England and Wales, between 2.2-2.4% of individuals aged 16-59 used N_2O between 2016 and 2020, with only 1.3% reporting use in 2021-2022. However, among 16-24-year-olds, usage was much higher, peaking at 9% between 2016 and 2017, with a significant drop to 3.9% post-pandemic in 2021-2022. In Scotland, 3% of 16-24-year-olds and 2% of those aged 25-44 reported using N_2O in 2021. There are no available data for Northern Ireland. A 2014 global drug survey suggests that N_2O use in the UK has been significantly higher (2).

What drives individuals to use N_2O despite its side effects? One perspective is the desire to escape reality or relieve global discomfort, especially post-pandemic. Studies of N_2O abusers cite curiosity, boredom relief, and peer pressure as common motivations (5). Another factor could be the lack of widespread knowledge about the hazards of N_2O, leading people to view it as a harmless recreational drug that is easily accessible (6).

As N_2O is often used in social settings (6), we can assume that common narratives about its effects are shared among peers. The method of ingestion—breathing into a balloon—also plays a role. This act, associated with innocent childhood parties, does not carry the same stigma as sniffing, injecting, or smoking a substance. Furthermore, while common side effects like distorted voices, altered reality perception, and hallucinations may seem frightening, they are short-lived, dissipating within minutes. This might make N_2O seem less risky than other drugs like LSD, mushrooms, ketamine, or cannabis, which have longer-lasting effects (7).

Economically, N_2O may be perceived as a lower-risk substance, with the balance tipping closer to 'reward' rather than 'risk.' A commonly reported effect is euphoria, which could be a coping mechanism for individuals with emerging mental health issues, especially those with a history of adverse childhood experiences (8,9). It is understandable that N_2O might appeal to those struggling with low mood, seeking a temporary 'fix,' as well as to individuals without mental health difficulties who simply want to chase a high (10). However, longitudinal research indicates that mental health problems are a risk factor for future substance use, suggesting that N_2O could further increase the risk for those already predisposed (11).

What is urgently needed is greater public awareness of the chronic risks associated with N_2O use (4). More research is necessary to understand the long-term implications, which should be communicated to the public to prevent the next person from casually accepting an inflated balloon, unaware of the potential consequences.

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‘Hippy Crack’ Can Crack Your Life – A Mental Health Approach

By Dr Silvia Astefanei and Dr Andrew Charalambous

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Physical Violence Against Health Staff by Patients with Mental Illness

By Dr Ruzaika Jaufer

Several years ago, I tentatively stepped into the world of psychiatry. As a junior doctor with no previous experience of mentally unwell patients—aside from occasionally encountering depressed or manic individuals during medical school rotations—I can safely say that I was unnerved. On my first day on the adult acute ward, I spent most of my time staring at the acutely unwell patients with a mix of terror and fascination. Walking down the corridors, I constantly looked over my shoulder, checking if I was being followed. At this point, I began to wonder if the paranoia around me was contagious, and that I was catching it!

Two weeks into my placement, I had started to relax. The initial fear began to dissipate, and I felt more comfortable on the ward. Unfortunately, this feeling did not last long. One day, in the middle of a busy shift, I sat down at the nursing station to review some patient notes. Preoccupied with my work, I did not notice a patient had wandered into the office. Suddenly I received a punch on my arm followed by blows to my head. My head reeled from the force of the attack. Despite feeling dizzy, I managed to jump up, step back and put a chair between myself and the patient. By then, a support staff member rushed in, restrained the patient, and took him away. I was trembling all over, my heart pounding. I collapsed into the chair, shaking. I could not believe what had happened. I had just been assaulted, and it was only my third week on a psychiatric ward.

Following the assault, I received tremendous support from my colleagues, consultant, and the hospital. I was lucky to escape without significant injuries. However, the mental trauma I sustained was substantial and it took me several months to recover and regain my confidence.

NHS survey data from 2023 showed that 13.7% of NHS staff who completed the survey had reported that they had experienced at least once incident of violence from patients, service users, relatives or other members of the public in the 12 months preceding the survey (1). Psychiatrists have a 5% to 48% chance of being assaulted by their patients during their career (2). Yet, some psychiatrists have accepted this risk as the cost of working in the field. Doctors are taught that their relationship with patients should always benefit the patient. So, even when a doctor is assaulted by a mentally ill patient, they may believe their main job is to calm and treat the patient, not to focus on their own safety.

Most studies on this issue focus on patients, with little attention given to the welfare of healthcare workers. The consequences of physical attacks on staff and the lack of support from management can have a negative impact on productivity if not addressed adequately. Therefore, in addition to reporting assaults, policies on how to seek redress should be implemented. Also, adopting incident reporting procedures and conducting frequent reviews will help us to understand the causes of violence in this type of environment.

The negative effects of violence against healthcare staff are significant. Physical injuries can include abrasions, lacerations, sprains, fractures or even loss of body parts, sometimes leading to permanent disability (3). Other common psychological reactions to physical violence reported by victims in hospital studies include emotional disturbances such as fear, anxiety, anger, depression, irritability, loss of confidence, post-traumatic stress disorder, and burnout (3). These disturbances may explain the significant association between violence and poor job satisfaction frequently seen among mental health professionals (3).

Violence by mentally ill patients against staff is under-reported, neglected and often endured (4). Mental health professionals commonly accept this as an occupational hazard and minimise the negative impact it has on them. However, this mindset needs to change, and more attention should be given to highlight the negative impact of violence on mental health professionals.

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Physical Violence Against Health Staff by Patients with Mental Illness

By Dr Ruzaika Jaufer

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Key Points

- Violence against healthcare staff in mental health settings is not uncommon, with some professionals accepting it as an occupational hazard
- Physical assaults on staff can lead to significant psychological issues like PTSD and burnout, negatively affecting job satisfaction
- Greater attention is needed to address the underreporting and impact of patient violence on healthcare workers

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The service is available during office hours Monday to Friday

Mental Health and Stigma

By Dr Arooj Fayyaz

Mental health problems encompass a wide range of conditions that affect a person's emotional, psychological, and social wellbeing. These issues impact thoughts, feelings, behaviours, and relationships, often causing distress and impairing daily functioning. According to Mind, a UK organisation supporting individuals with mental health problems, around one in four people experience mental health issues each year (1). These problems range from common conditions like depression and anxiety to more severe ones such as schizophrenia and bipolar disorder.

Despite its crucial role in overall wellbeing, mental health is often stigmatised. This stigma discourages people from seeking help and support, leading to harmful consequences. To promote mental health awareness and foster a supportive environment, it is essential to understand and address the stigma attached to mental health.

The Stigma of Mental Health

Mental health stigma is deeply rooted in misconceptions, fear, and discrimination. People with mental health conditions are often unfairly labelled, stereotyped, and marginalised, which can lead to feelings of shame and isolation. This stigma may manifest in various forms, such as social exclusion, workplace discrimination, or reluctance to seek treatment. Research shows that while the public may recognise the medical or genetic basis of mental health disorders, they may still hold negative views of individuals with mental illness (2).

Causes of Stigma

Several factors contribute to mental health stigma, including a lack of understanding and education about mental illnesses. Additionally, media portrayals, cultural beliefs, and societal norms shape how mental health is perceived. The fear of judgement or misunderstanding often prevents individuals from being open about their struggles.

Impact on Individuals

The stigma surrounding mental health can have severe consequences. Many individuals avoid seeking help, leaving their conditions untreated and symptoms worsening. This can lead to social withdrawal, impaired relationships, and a diminished quality of life. Fear of stigma can also lead to self-stigmatisation, where individuals internalise negative beliefs about themselves, exacerbating their mental health challenges.

Stigma and discrimination not only worsen symptoms but also reduce likelihood of seeking treatment. A comprehensive review found that self-stigma significantly impacts recovery for those diagnosed with severe mental illnesses (3).

An editorial in the Lancet highlights that stigma's widespread effects extend from reduced political support to underfunding of mental health research which remains significantly lower compared to other health conditions (4).

Experience of Psychiatric Patients

Working closely with mental health patients, I have interviewed a few patients to understand how stigma has affected their lives. Some recurring themes include:

- ***Social Isolation***: Many individuals with mental health conditions reported feeling isolated due to stigma. Fear of judgement or misunderstanding may often lead to social withdrawal resulting in loneliness and limited support.
- ***Discrimination:*** Patients frequently face discrimination in various settings, such as workplaces, schools, and healthcare institutions. This can involve unfair treatment, lack of accommodations, or outright exclusion, which intensifies feelings of inadequacy and hopelessness.
- ***Self-stigma***: Internalising societal stigma can lead to feelings of shame about one's condition, reducing self-esteem and discouraging individuals from seeking help or following treatment plans, further complicating recovery.
- ***Fear of Disclosure:*** Psychiatric patients often hesitate to disclose their mental health status for fear of being labelled or treated differently. This fear prevents them from accessing vital support systems and resources.
- ***Impact on Relationships:*** Stigmatisation can strain personal relationships. Patients may feel that loved ones do not understand their experiences or may fear that revealing mental health challenges will change how others perceive them.
- ***Access to Care:*** Stigma may prevent individuals from seeking help. Those who could benefit from therapy or medication might avoid these options for fear of being judged or labelled as "crazy."

Mental Health and Stigma

By Dr Arooj Fayyaz

- ***Media Representation:*** Negative portrayals of mental illness in the media perpetuate stereotypes and fuel societal stigma. These inaccurate representations can create misunderstandings about mental health conditions.
- ***Crisis Situations:*** In moments of crisis, stigma can lead to inadequate responses from emergency services or the community, resulting in further trauma and marginalisation.
- ***Advocacy and Awareness:*** Some patients find empowerment through advocacy, sharing their stories or participating in campaigns to reduce stigma. This fosters a sense of community and promotes understanding.
- ***Coping Mechanisms:*** Individuals develop coping strategies to combat stigma, ranging from peer support to creative outlets like art or writing. These activities provide an avenue for self-expression and healing.

The stigma associated with mental health is multifaceted and can significantly affect the lives of psychiatric patients. Combating stigma through education, awareness, and supportive environments is essential for improving their quality of life and fostering recovery.

Addressing Stigma

Tackling stigma requires a multifaceted approach involving education, awareness, and advocacy. Promoting accurate information about mental health helps dispel myths and reduce misconceptions. Encouraging open conversations, building support networks, and fostering a culture of acceptance are key steps toward challenging mental health stigma.

Creating Supportive Environments

Creating environments that prioritise mental health is crucial for reducing stigma. This includes implementing antidiscrimination policies, promoting mental wellness programmes, and ensuring access to quality mental health services. Normalising discussions around mental health and encouraging individuals to seek help are essential for building a more inclusive society.

Addressing mental health stigma is a critical step in promoting overall wellbeing and creating a more compassionate society. By challenging misconceptions, fostering understanding, and providing support, we can empower individuals to seek help, overcome challenges, and lead fulfilling lives. Together, we can work towards a future where mental health is treated with the same importance and compassion as physical health.

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Overview of Looked-after Children's Care and Treatment Pathway in Peterborough Child and Adolescent Mental Health Services

Dr Esther Eze and Dr Ayat Ali

Background

Children in care face a significantly higher prevalence of mental health problems compared to their peers. Studies have found that around 64% of children enter the care system due to abuse or neglect, which greatly increases their risk of developing psychiatric disorders both during childhood and adulthood. Issues such as anxiety, depression, posttraumatic stress disorder (PTSD), and suicidal ideation are more common among looked-after children (1).

The Children's Commissioner for England highlighted that in 2022-23, nearly one million children were referred to Child and Adolescent Mental Health Services (CAMHS), with about 32% receiving some support. However, over a quarter of a million children (28% of those referred) were still waiting for help, often for prolonged periods, exacerbating their mental health difficulties (2).

The severity of mental health challenges for children in care is further compounded by long waiting times for specialist support and geographical disparities in accessing mental health services.

The NICE guidelines for looked-after children focus on ensuring stable, supportive placements and improving mental health and wellbeing. Key recommendations emphasise collaborative care across health, social, and educational services, tailored to meet the complex needs of these young people (3).

The guidelines stress timely mental health assessments for looked-after children, suggesting a detailed assessment once trust with a caregiver is established. When specialised mental health support is needed, it recommends direct access to CAMHS without delays, even for those moving placements. Services should provide trauma-informed, long-term, relationship-based therapy, specifically for issues like PTSD, attention deficit hyperactivity disorder, and other common challenges for children in care (3).

Aim

To provide insight into mental health care pathways and treatment for looked-after children in Peterborough. This would be a starting point for change and improvement in practice.

Objectives

Review number of looked-after children who were referred to CAMHS in Peterborough between 2021 and 2024, the source of referral, number of contacts with CAMHS, type of treatment and whether there was joint work with other agencies.

Criteria

NICE guideline [NG205] Looked-after children and young people Oct 2021 (3):

Criteria	Target
All LAC should have "health plan"	100%
Collaborative and joint working with all agencies involved in LAC care	100%
Initial assessment (formulation and risk assessment) to be completed for all LAC who had contact with CAMHS	100%
Offer a range of treatments that are tailored to the needs of looked-after children (e.g. trauma informed, and relationship based)	100%

Methods

The administrator from the looked-after children team provided us a list of all the looked-after children in Peterborough and we collected data from all children who were referred to or had contact with CAMHS Peterborough between January 2021 and July 2024. Data were collected from electronic system used by Cambridgeshire & Peterborough NHS Foundation Trust (SystmOne).

Results

Fifty one looked-after children and young people were

Overview of Looked-after Children's Care and Treatment Pathway in Peterborough Child and Adolescent Mental Health Services

Dr Esther Eze and Dr Ayat Ali

referred to CAMHS between January 2021 and July 2024. Ages ranged between 10 and 18 with 80% in the age group 14-18 (30% were aged 17 and 20% were aged 14). One outlier was aged 4 years old. Majority of children were referred during a crisis. Figure 1 shows where the referrals came from including the percentages.

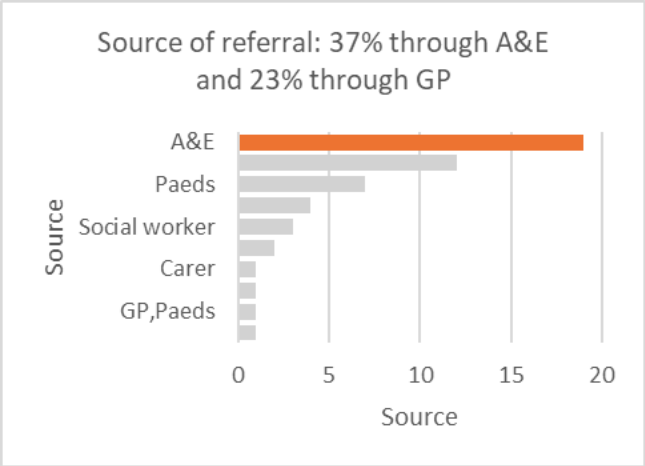

Figure 1: Sources of Referral

Healthcare Plan

Healthcare plans are paediatrics-led with an at least yearly physical health overview. Eight six percent had a healthcare plan document and an annual review. The remaining 14% did not have any evidence for physical health reviews, despite 70% of these having more than three months of CAMHS input.

Collaborative and Joint Working

Only 8% (4 out of 51) had all agencies involved including education (school /college), health (GP or Paediatrics) and social care. Fifteen percent had no evidence of multidisciplinary involvement apart from communicating to GP via letters.

Formulation and Risk Assessment

Seventy percent of cases had a documented risk assessment. Of cases that did not have a risk assessment, half were referred for neurodevelopmental assessments and were not given a diagnosis.

Thirty percent of cases were diagnosed with Complex PTSD and 12% had Complex PTSD with co-morbid depression, anxiety, ADHD or Autism (see Figure 2).

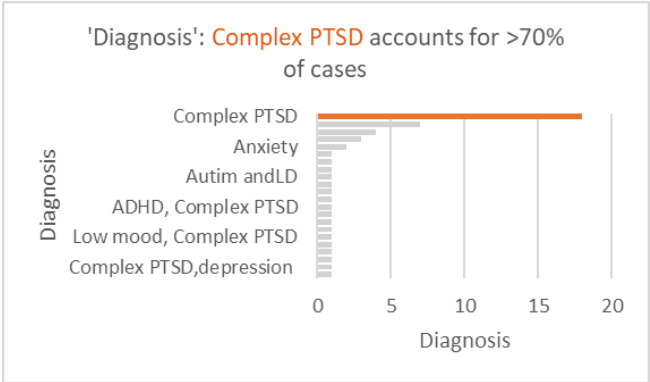

Figure 2: Spectrum of Diagnoses

Treatment

Of the 51 children, 65% did not receive any type of therapy. Twenty three percent were offered supportive psychotherapy ("emotional support") and of these 50% had the diagnosis of Complex PTSD, 16% had "anxiety", 30% had comorbid depression and complex PTSD. Twelve percent had cognitive behavioural therapy for depression, obsessive-compulsive disorder and Complex PTSD. To note, one of these children had Complex PTSD with recurrent episodes with CAMHS over 3 years.

Discussion and Conclusion

Considering the vulnerability of looked-after children and their high comorbidity, complexity and need, data above suggest significant shortcomings. Peterborough CAMHS does not have a looked-after children service and these children access interventions in CAMHS via other pathways, including Core CAMHS, Neurodevelopmental pathway, Forensic CAMHS and Eating Disorders pathways.

Perhaps a starting point could be identifying this unique group of vulnerable children in a modified pathway using existing resources and targeted mental health interventions. Extended formulation and risk assessment, collaborative work and regular contact with all agencies and "healthcare plan" must all be key parts. One recommendation is to have a unique looked-after children assessment, care planning form and health passport.

Overview of Looked-after Children's Care and Treatment Pathway in Peterborough Child and Adolescent Mental Health Services

Dr Esther Eze and Dr Ayat Ali

Training and availability of targeted interventions such as trauma-informed therapy and dialectical behavioural therapy is to be a priority if CAMHS were to take up treatment for this group.

We aim to present the above findings at the CAMHS directorate senior leadership meetings and take up a project to consider all recommendations above.

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Key Points

- Looked-after children in Peterborough face significant mental health challenges, with many lacking timely assessments, tailored treatments, and adequate inter-agency collaboration
- Most children referred to CAMHS were in crisis, with 65% receiving no therapy and only 8% experiencing coordinated care between health, social, and educational services
- The authors recommend creating a dedicated care pathway with enhanced risk assessments, trauma-informed therapies, and stronger collaboration to better support this vulnerable group

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Building a Meaningful Career in Psychiatry: Insights from Dr Bakshi

By Dr Ebtihaj Serebel

Dr Kapil Bakshi is a Fellow of the Royal College of Psychiatrists and has a Master's degree in leadership and management. He has been a Consultant Psychiatrist for 15 years. He has held additional roles such as College Tutor and Deputy Medical Director. He serves on the Executive Committee of the Eastern Division and is currently on the Board of a national charitable organisation dedicated to supporting people with mental illness and substance misuse.

INTERVIEWER:

In thinking about training, what kind of advice would you give to trainees right now?

DR BAKSHI:

First and foremost, you need to focus on the clinical work and getting experience and being confident about it. You need to establish clinical credibility, that you are able to independently manage patients to a reasonable degree. Then you can branch into different areas like teaching and leadership, whichever area interests you it is always important to get some formal training in it, not necessarily a degree. I highly recommend the college leadership and management fellow scheme which is of very high standard. I have regularly nominated trainees to those schemes and people have enjoyed the training. I would also recommend the NHS Leadership Academy which does lots of free courses. Once you are a doctor you are always delivering some form of teaching and you are always managing people in teams despite not carrying an official role as a manager.

INTERVIEWER:

For people starting out as junior consultants, are there any sort of tips you'd like to give them?

DR BAKSHI:

I was working in Norwich in my last ST post and I became a consultant there so I had a bit of a better idea but it is always challenging to move on from a trainee role to a consultant role and it is a big shift in your viewpoint as well and what you are responsible for. So, I think you should seek as much support as is possible. There's always a temptation to get involved in too many activities and you will be asked for a lot of things, but the priority should be to establish your clinical credibility and I think for the first year just focus on building that. After that there will be lots of opportunities. Getting a mentor is really useful, you need a group of people, two to four people who you can rely on for their advice and whose opinion and judgement you respect. Having a diverse CPD group where you have people across different specialties or of different levels of experience, that's quite helpful.

The Start Well program I didn't attend, it was not the programme running at my time, but I have heard very good things about it. What Start Well programme does is it gives you a broader overview of what it is like working in a consultant role. It gives you a better context of how you're operating, what the governance is and basic things like job planning effectively, so I would highly recommend that people attend it.

INTERVIEWER:

As somebody who's been working for a long time, the NHS has its challenges. I think life in general has its own challenges and I'm wondering what sort of thing helps you not burn-out?

DR BAKSHI:

I think everyone will have their own strategy of what they find helpful. I think having and improving self-awareness and having reflective practice built into your career is of utmost importance.

Building a Meaningful Career in Psychiatry: Insights from Dr Bakshi

By Dr Ebtihaj Serebel

Some of the things which I find effective: finding some interest outside the clinical day-to-day work is quite important. The variety makes the job interesting and different challenges or different problems solved keeps you motivated and it's another opportunity to network with other colleagues across the region. Additionally, strategies for stress management are essential: what to prioritise, how to focus on your own physical and mental health, those are strategies which are important for everyone.

INTERVIEWER:

I think as trainees we may not know about different opportunities available for consultants but clearly there is a lot going on out there.

DR BAKSHI:

The medical training from CT to ST and ST to a consultant role is very structured, whatever role you are going to from here onwards, is not a straightforward career pathway and it shouldn't be anyways because there is an opportunity to explore a lot more.

Once you are practicing within your field and you are seen as clinically credible, you get offers and the opportunity to become involved in one thing and then it sort of starts snowballing particularly if you are able to work with people, if you have a problem-solving approach and you are able to articulate or communicate well with others. If you speak to someone else, they will be doing things which I had never even heard of and that's always the case. Having said that, you do need to keep an eye out for something like BMJ careers which is still quite informative. A lot of these roles are advertised there. There's no structured way to do it. I still do some work with the local ICB, I work for a voluntary sector organisation, and I'm a non-exec director there. And I think one thing I will add on which I realised in my management training as well, as psychiatrists, we already have a lot of advantage when we are thinking of management roles or working in teams, because our training is very much around self-awareness. Our training is very much around understanding the emotional processes there and that is very helpful. So, my management degree or training was with a group of other professionals, not all were doctors and no one was a psychiatrist in my cohort and for a large part of that training it was all about reflection, about understanding emotional processes, about self-awareness.
People choose things that they might find interesting or enjoyable, but you need to explore wider to know what is going to be of interest to you. A lot of avenues open up once you are a consultant. Our College does a lot of work, NHS England, the Eastern Division, I was briefly involved in one strand of the CCQI there. For three years, I did some work with the health service ombudsman. I was an external advisor to them. And even the clinical work, you see, there are different strands to it. So, there are lots of roles which are available and there are lots of opportunities for you to contribute and to learn new skills as well for example, in service development, quality improvement, teaching and training. But our identity will always remain as a doctor. It is really then important to first focus on clinical aspects, manage things independently, treat patients effectively and you can then build on to that.

INTERVIEWER:

Thinking about things outside of psychiatry, I was wondering if you had any particular interests or hobbies?

DR BAKSHI:

I think some of the interests which I regularly engage in keep changing. I quite like reading both fiction and nonfiction. I very religiously follow cricket. Plus, I have a young child, he keeps me busy. There are always lots of activities to engage with him.

Key Points

- Build clinical confidence first: Dr Bakshi advises trainees to focus on establishing clinical expertise before branching into leadership or teaching roles
- Seek support as a new consultant: consultants early in their career should prioritise clinical credibility, seek mentorship, and gradually expand into other responsibilities
- Maintain interests outside work: to prevent burnout, Dr Bakshi emphasises self-awareness, reflective practice, and staying engaged in activities beyond clinical duties.

Dr Ebtihaj Serebel
Higher Trainee in Psychiatry, Essex Partnership University NHS Foundation Trust

Winner Winner, No Money for Dinner

By Dr Shivakumar Ajay Kumar

In a lively casino corner, a roulette table takes the spotlight. Players eagerly fidget with their chips, eyes fixed on the spinning wheel. The ball jumps between numbers, each bounce met with gasps or cheers. A young couple bets on red odds after noticing a streak of black evens. Their faces light up as the ball lands in their favour. "Winner, winner, chicken dinner!" the dealer shouts. As the night goes on, their early excitement fades. Free soft drinks keep coming at the push of a button, but so do their losses. When the ball finally lands on zero, wiping out their last bet, they are left feeling both drained and oddly energised—perhaps as a result of all the caffeine. For this couple, it's a thrilling evening. But for others, nights like this may be the start of a much darker journey.

Gambling: More Than Just a Game

While often seen as harmless fun, gambling can take a dangerous turn. Small bets among friends and family may create lasting memories, but according to the 2023 Health Survey for England 2.8% of adults are at risk of problem gambling (1). Recognised as a risk factor in the UK's Suicide Prevention Strategy 2023–2028, harmful gambling remains a silent epidemic (2).

Adults in the UK have cited "making big money" and having "fun" as reasons for gambling, yet the consequences can be devastating (3). Recognising and admitting having a gambling problem is challenging, and many suffer in silence. Problem gamblers find themselves trapped in a losing cycle, lured by highly stimulating environments. After experiencing "near misses," they feel compelled to chase their losses. In particular, fast paced online betting makes it difficult for players to walk away. Gambling operators use deceptive tactics, such as offering jackpots, bonuses, celebratory sounds and flashing graphics, even when players win back less than their original stake (4). These tricks condition gamblers to keep playing. A concept known as loss aversion explains why gamblers often continue despite losses, as losing feels far worse than winning feels rewarding. Chasing losses signals a shift from recreational to problem gambling and is linked to impaired self-control, with poor executive function and inhibition driving impulsive decisions. Neurocognitive models further suggest that emotional distress plays a major role. Negative feelings from losses fuel impulsive betting, a behaviour referred to as negative urgency**.** This emotional cycle traps individuals, making it hard to break free from harmful gambling patterns (5).

A Public Health Crisis

The Lancet Public Health Commission has identified gambling as a growing public health threat. Beyond financial destitution, it leads to mental health issues and strained personal relationships (4). The UK Gambling Commission highlights severe outcomes such as relationship breakdowns and reduced spending on essentials. Additionally, gambling-related harm often manifests as embarrassment, guilt, stress, and anxiety (3). Alarming data also links commercial gambling to domestic violence (4). In the UK alone, the gambling industry generated over £15 billion in profits last year, with £6.5 billion coming from remote casinos and betting platforms—a sector that continues to expand (6). The online gambling revenue is projected to reach $205 billion by 2030, making it the fastest-growing segment of the industry (4). Without stricter regulations, the financial and societal toll will continue to rise.

Research and Ethical Concerns

The gambling industry's 'voluntary donations' fund the UK's gambling support infrastructure and were estimated at over £49 million in 2023-2024 (7). However, this reliance raises ethical concerns about potential conflicts of interest. A previous government had proposed a statutory levy on gambling operators, projected to raise £100 million annually to support research, prevention, and treatment initiatives. However, it remains uncertain whether this measure will be adopted under the new government (8).

Diagnosis and Screening

Stigma often delays diagnosis. Tools like the Problem Gambling Severity Index (PGSI) are helpful for screening but may be impractical in busy clinics (9). Instead, the Lie/Bet Questionnaire can effectively identify problem gambling with just two questions. A "yes" to either question suggests a gambling problem (10):

1. Have you ever lied to people important to you about how much you have gambled?
2. Do you feel the need to bet more and more money?

Alternatively, a one-item screening tool: "Have you ever had an issue with your gambling?"—has been successfully used in Australian medical settings (11). Routine screening in healthcare settings like GP surgeries may not be feasible for every patient, but it is essential for those with psychiatric disorders (e.g. depression,

Winner Winner, No Money for Dinner

By Dr Shivakumar Ajay Kumar

anxiety, or substance misuse) or financial problems. Embedding these questions into initial assessments, similar to those for smoking and alcohol use, could enhance early detection (12).

Management and Support

Establishing a strong therapeutic alliance encourages patients to open up. Motivational interviewing can help patients recognise their gambling problem and take the initial steps toward recovery (9). Referral to specialised services, such as the National Gambling Support Network offers free, confidential, and personalised support (13).
While treatments like CBT and medications such as naltrexone and olanzapine have shown mixed results, practical resources can provide immediate harm reduction (9). Tools like GAMSTOP and Self-Enrollment National Self-Exclusion (SENSE) enable individuals to self-exclude for a fixed period from online and land-based gambling, respectively (14,15). Additionally, healthcare providers can advise patients at risk to block IP addresses of gambling websites on home routers or contact their internet service provider to limit access to gambling sites (16).

For the couple at the roulette table, the lesson became clear as the dealer spun the wheel one last time for the night, declaring, "No more bets, please!" As they collected their coats, their faces revealed the weight of their loss and regret over losing a significant sum, enough to buy multiple chicken dinners. The attendant, sensing their disappointment, offered a gentle reminder: "Gambling is entertainment, but every form of entertainment comes with a cost." Their real win would have been knowing when to walk away.

Resources

1. Find local support: https://www.gambleaware.org/tools-and-support/support-in-your-area/

2. East of England Gambling Service: https://www.eofegamblingservice.nhs.uk/

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Eastern Division Autumn Conference 2024 Report

By Dr Sepehr Hafizi

This year's Eastern Division Autumn Conference was held at the Fielder Centre, University of Hertfordshire, with the theme *'New Advances in Diagnosis and Treatment.'* The event covered a wide range of topics, including early identification of children's mental health problems, social media's impact on mental health, and classifications of personality disorders. Other highlights included insights into novel obesity drug treatments, practical approaches to managing insomnia, and the effects of suggestibility on functional neurological disorders. The day was a resounding success, featuring high-quality presentations by notable speakers, poster sessions, and awards for the best essay and poster presentations. Below are summaries of the six lectures.

Lecture 1: *Towards the Early Identification of Children's Mental Health Problems*
Speaker: Dr Anna Moore, University of Cambridge

Dr Anna Moore, Assistant Professor in Child Psychiatry and Medical Informatics, delivered a presentation on using technology and data-driven approaches for the early detection of children's mental health challenges. Her NIHR -funded, multi-centred research combines mental health expertise with tools like TIMELY and predictive analytics to identify risk factors such as adverse childhood experiences. This approach improves diagnostic precision and intervention pathways. She discussed her involvement in projects like D.CYPHYR and expressed enthusiasm about the forthcoming Cambridge Children's Hospital, envisioned as a national centre of excellence. Her clear presentation and high-quality slides made for an engaging session.

Lecture 2: *Suggestion, Hypnosis, and Functional and Dissociative Disorders*
Speaker: Dr Devine Terhune, King's College London

Dr Devine Terhune, Reader in Experimental Psychology, examined how suggestion modulates experience and its implications for functional and dissociative disorders. He highlighted the variability in suggestibility between individuals and its predictive value for treatment outcomes, including pain management and psilocybin response. He explained the association between high suggestibility, dissociative psychopathology, and elevated symptom severity, and its use in diagnosing functional neurological disorders. Additionally, Dr Terhune touched on mass psychogenic illness, including the Havana Syndrome, and said that high suggestibility may predispose individuals to dissociative psychopathology.

Lecture 3: *Newly Licensed Obesity Drugs*
Speaker: Dr Adrian Park, Addenbrooke's Hospital

Dr Adrian Park, Consultant Bariatric Physician and Diabetologist, reviewed advancements in obesity

Eastern Division Autumn Conference 2024 Report

By Dr Sepehr Hafizi

Poster Presenters at the conference

management, focusing on GLP-1 receptor analogues such as semaglutide. He advocated for a tiered approach, combining these drugs with lifestyle changes to bridge the gap between dietary interventions and bariatric surgery. Using case studies, he illustrated the mechanisms behind GLP-1 analogues and their role in sustained weight loss. He also discussed their broader potential in managing type 2 diabetes and Alzheimer's disease, while acknowledging challenges like accessibility and side effects.

Lecture 4: *Latest ICD Classification of Personality Disorders*
Speaker: Professor Peter Tyrer, Imperial College London

Professor Peter Tyrer, Emeritus Professor of Community Psychiatry, presented a thought-provoking talk on shifting from categorical to dimensional diagnoses for personality disorders. He argued that this approach reduces stigma, eliminates terms like "borderline personality disorder," and focuses on traits and strengths. The dimensional model also emphasises severity and dysfunction, improving patient engagement and early intervention for young people. Professor Tyrer suggested that most individuals (65%) have personality difficulties, advocating a more holistic approach. It was a privilege to listen to Professor Tyrer as a world-renowned expert in his field. As is his custom, he concluded with a humorous poem, adding a light-hearted touch to his insightful lecture.

Lecture 5: *Brief Behavioural Interventions for Insomnia*
Speaker: Dr Hugh Selsick, UCLH

Dr Hugh Selsick, a renowned expert in sleep medicine, shared practical tips for managing insomnia. He emphasised consistent wake times, morning light exposure, and maintaining a sleep efficiency above 90% (calculated as total sleep time divided by time in bed). Dr Selsick recommended keeping a sleep diary, avoiding daytime naps, and creating a "buffer zone" before bedtime to encourage relaxation. For those with middle insomnia, he suggested going to bed later while maintaining the same waking time to achieve deeper sleep. During the Q&A, he highlighted the benefits of CBT for insomnia, particularly for individuals with comorbidities.

Lecture 6: *Social Media and Its Effect on Mental Health: Can We Use It to Our Advantage?*
Speaker: Dr Ruth Plackett, UCL

Dr Ruth Plackett, Senior Research Fellow, explored the complex relationship between social media use and mental health. She explained how excessive passive engagement is linked to issues like cyberbullying and low self-esteem, while active and moderated usage fosters peer support and community retention. She discussed innovative digital health interventions, including the use of Moderated Online Social Therapy (MOST) in Australia and the PRIME app for schizophrenia. She called for more research to identify who would benefit most from these interventions and advocated for social media's use in public mental health campaigns to reduce stigma.

Looking forward to the next conference in Spring 2025.

Dr Sep Hafizi
Editor, Eastern Division

Upcoming Eastern Division Events 2025

Delerium: Recognition and Management (Online)
31 January 2025

Consultant Interview Masterclass (Online)
11 Feb 2025

Transcranial Magnetic Stimulation and Treatment Resistant Depression: The BRIGhTMIND Trial and Beyond - 2025 (Online)
27 Feb 2025

Acceptance and commitment therapy: an introduction to the model (Online) **25 March 2025**

Eastern Division Spring Conference
30 Apr 2025
Fielder Centre, Hatfield Business Park, Hatfield Avenue, Hertfordshire
Our annual Spring Conference suitable for Psychiatrists of all grades. The event will run face to face again with excellent speakers, Poster Awards and Medical Student Essay Prize competition.

For more information on all of our events please see our webpage:
Eastern Division events (rcpsych.ac.uk)

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The Royal College of Psychiatrists is the professional body responsible for education and training, and setting and raising standards in psychiatry.

The Eastern Division is made up of members from Essex, Hertfordshire, Cambridgeshire, Bedfordshire, Norfolk and Suffolk.

We would like to thank all members for their contributions towards Eastern Division activities throughout the year.

Eastern Division Medical Student Essay Prize Summer

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 30 Apr 2025 at the Fielder Centre, Hatfield, Hertfordshire.

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: 18 April 2025
Submissions should be made to:
Moinul Mannan
Divisions Committee Manager
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Deadline for next edition
Submit your articles for Summer edition by 30 May 2025 at psychiatry.east@rcpsych.ac.uk

Royal College of Psychiatrists - Eastern Division E-Newsletter

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