

Newsletter

April, 2009



Chairman's letter

Hello all,

Welcome to my fifth newsletter as Chair of the UKPPG. Since the last newsletter we have held a committee meeting on the 21st of November at Glasgow. We have also held a joint meeting with the College of Mental Health Pharmacists at Gatwick on the 5th February; unfortunately, this meeting was somewhat disrupted by a heavy snow fall.

Psychiatry 1, our weekend course designed as an introduction to mental illness and psychiatric therapeutics for pharmacists new to psychiatry, was for the first time opened up to pharmacy technicians working in mental health. The course was held in November last year. Forty people attended, including pharmacy technicians. The feedback from the participants was very positive and I would like to thank the organiser, Celia Feetam, and all the tutors, Stephen Bazire, Andrew Campbell and Stuart Gill-Banham for their contributions. We are hoping to continue to run Psychiatry 1 each year and, in due course, re-start Psychiatry 2, the second level course for clinical psychiatric pharmacists working at diploma level and above.

The programme for the conference, which this year is being held at Hinckley Island Hotel in Leicestershire from the 9th to the 11th of October, is rapidly developing. Bev Faulkner and Clare Gaskell on the committee have been working very closely with Denny, Graham Newton and Graham Parton in developing conference 2009. For more information including a registration form please check our web-site www.ukppg.org.uk/membership_events.htm. Current plenary sessions at the conference include a Horizon Scanning session entitled, 'New Medicines, New Treatments, New Goals' and a practice-based session. We are also running the market place session as in 2008, and hoping to run another exercise session led by Stephen Guy.

The committee have been supporting the College, in particular Stephen Guy and Dave Branford, in their sterling work with Transcom and the potential new professional pharmacy body. Elaine Weston met with the UKCPA (UK Clinical Pharmacy Association) committee, other specialist groups, Steve Churton (President of the RPSGB) and Jeremy Holmes (Chief Executive Officer of the RPSGB) and I met separately with Jeremy Holmes (Chief Executive Officer of the RPSGB). Dave and myself attended a stakeholder meeting, involving key organisations, at the Headquarters of the RRSGB on the 24th of February.

The clear message from the CMHP/UKPPG is that the new professional body is a positive step forward, particularly the apparent commitment to partnership working, with the many pharmacy organisations. However, the CMHP/UKPPG will require more detail on the structure before we define our exact relationship with the new professional body.

One major event over the last few months has been the publication of the National Dementia Strategy. The document is available on: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_094058. Within the UKPPG, Denise Taylor has taken the lead on this issue and worked very closely with the RPSGB in developing a joint response to the initial draft strategy and I would like to formally acknowledge all Denise's work in this area.

Work on the medication choice web-site is ongoing, led by Steve Bazire. I would encourage everyone to promote this pharmacy-led initiative within their organisations. For more information please check the web-site www.choiceandmedication.org.uk. Steve is also keen for feedback on the site from service users, carers and healthcare professionals.

Finally, I would like to send early best wishes for the summer:

Regards,

Ian

ian.maidment@nhs.net

Disturbed sleep and depression: a symposium at the British Association of Psychopharmacology Conference, 2008

In the 2008 UKPPG conference sleep disorders were considered to be a neglected area both for research and practice. Their importance and their relationship with depression were highlighted in a symposium (sponsored by Servier) at the British Association of Psychopharmacology.

David Baldwin (Southampton) reviewed the importance of sleep disturbances in mood and anxiety disorders. They can broadly be categorised as: dyssomnias, such as insomnia or hypersomnia; and parasomnias in which undesirable abnormal sleep was experienced such as nightmares. There is good evidence for an excess of depressive symptoms in both insomnia and hypersomnia, and depression is often preceded by disturbed sleep. A consistent finding from a number of studies in non-depressed individuals complaining of insomnia is a markedly increased risk of developing depression.

Hypnograms show the major differences in sleep patterns between healthy individuals and those suffering from depression. In depression there is a longer sleep latency (time to onset of sleep), more awakenings through the night, and a shorter total duration of sleep. In addition there is a shorter latency to repetitive eye movement (REM) sleep, greater density of REM sleep and less deep sleep.

In anxiety disorders there is less research into the importance of disturbed sleep. In generalised anxiety disorder (GAD), disturbed sleep appears to be common but the latency for REM sleep is not reduced as it is in depression. In post-traumatic stress disorder (PTSD), there is often an increased latency to the onset of sleep, with increased density of REM and nightmares. As in depression, insomnia often persists despite successful treatment of anxiety.

Andre Tylee reviewed the epidemiology of sleep disturbance and depression. In Europe a survey of over 15,000 subjects found that nearly one in five were experiencing at least one symptom of insomnia that affected daytime functioning and that nearly 30% of people with insomnia also had an identifiable psychiatric disorder. The risk of developing depression was much reduced if the insomnia was treated effectively, leading to the conclusion that chronic insomnia predicts depression. In the elderly, one in three report subjective sleep disturbances which are associated with female gender, being unmarried, living alone, disability and current or future depression, but not dementia or older age. The strongest predictor of future depression was current insomnia.

In the UK, a survey of members of Depression Alliance found that 97% reported suffering from sleep difficulties when depressed, which one in three rated as being very distressing. Two thirds of the respondents were receiving antidepressants of whom half thought that the sleep disturbance was not helped or was made worse by the antidepressant. Overall, two thirds had sought treatment for insomnia.

Alan Wade (Glasgow) reviewed the pharmacological management of disturbed sleep in depression. There is

a major crossover between the symptoms of insomnia and depression including irritability, impaired cognitive function and impaired executive function. Insomnia predicts depression and many GPs consider it to be a core symptom of depression, and this has led to a temptation to regard insomnia as a component of depression and not to treat it as an independent condition.

Treatment with antidepressants may compound problems of insomnia as many of them, including tricyclics and SSRIs, suppress REM sleep. A study of paroxetine and citalopram showed both drugs significantly reduced the severity of depressive symptoms, but although the quantity of sleep increased, the subjective quality of the sleep did not improve. When treating depression it is worth asking the question whether antidepressant treatment can be augmented to target insomnia as a comorbid but independent condition. In primary care, about 10% of patients prescribed an antidepressant are also prescribed a benzodiazepine or similar hypnotic. In depression, disturbed sleep is often the most important symptom to patients. However, early treatment may not address this crucial symptom: when treating with SSRI it may be six weeks before any improvement in disturbed sleep is seen. In contrast, treatment with mirtazapine is associated with an increase in total sleep time, increased REM sleep, fewer awakenings and improvements in the subjective perceptions of sleep quality, and are noticeable in the first five weeks of treatment. There are some data to suggest that combining mirtazapine with SSRI, at least during the early weeks of treatment, may be helpful.

There is also some evidence to suggest that adjunctive treatment with benzodiazepines may be helpful. A meta-analysis of studies where a benzodiazepine was combined with an antidepressant found that patients given a benzodiazepine were less likely to drop out of treatment and had a better initial response but this was not sustained beyond six weeks.

There are also some positive open-label studies that give tentative evidence of benefit from the addition of the atypical antipsychotics olanzapine or quetiapine to an SSRI or venlafaxine.

Overall, the symposium emphasised that the long-term management of insomnia and depression presents many challenges with many questions that remain unanswered. It is difficult to define chronic insomnia and insomnia that is comorbid with depression: there is a need for greater precision and clarity in the diagnosis. Is it the chronicity or the insomnia that underlies the association between disturbed sleep and depression? What age and gender differences exist, if any? Can depression be prevented by the effective management of insomnia? Current treatments are non-specific sedatives, not specific treatments for insomnia: are there any adverse consequences from long-term sedative treatment? When treating depression with comorbid insomnia, which antidepressant would be the optimal initial choice, and which, if any, augmentation strategies are the most beneficial?

John Donoghue

Effectiveness of newer antipsychotics

The last five years have witnessed the introduction of two novel antipsychotic preparations: risperidone long-acting injection (RLAI), the first long-acting atypical, and aripiprazole, a partial dopamine antagonist. While the efficacies of these new preparations have been demonstrated in RCTs, there is limited data on whether they are effective in a 'real-world' setting. The RCT has become the gold standard in clinical trials. However they are not perfect, and most RCTs will exclude many patients that we commonly encounter in our clinics. Many new studies have employed a more 'real-world' methodology, e.g. CATIE. Neither aripiprazole nor RLAI have been included in these studies and there is limited naturalistic data available on their effectiveness. Naturalistic studies also provide information on prescribing patterns, including reason for use and reason for stopping, as well as an insight into tolerability.

The data presented will briefly summarise data from two published studies conducted by collaboration between Whitchurch Pharmacy department (myself and Paul Deslandes) and Cardiff University (Bob Sewell). The data was collected retrospectively from patient records. All patients prescribed either study drug (as monotherapy) were included. The RLAI data was collected in March 2007 and the aripiprazole data in March 2006.

Aripiprazole

Data were available for 70 of the 94 patients prescribed aripiprazole. Ten were excluded as they were co-prescribed clozapine and 14 were lost to follow up. Over half were started due to a perceived ineffectiveness with their current antipsychotic, 30% due to other side-effects and 15% due to weight gain with current antipsychotic.

At six months, 60% had discontinued aripiprazole, two-thirds due to a lack of effect. Adverse effects, mainly agitation, were responsible for 30% of discontinuers. Further analysis of the results found that almost half the discontinuers had previously received clozapine, which may account for the large drop-out rate.

RLAI

Data were available for 84 patients prescribed RLAI. Unsurprisingly, the main reason for starting RLAI was non-compliance with current antipsychotic. At two years, 56 (66%) had discontinued RLAI, the main reason being a lack of effect, followed by patient refusal. Adverse effects accounted for less than 10% of discontinuers. The continuers at two years ($n=28$) spent 72% of their time as outpatients and there was only nine re-admissions in this group. A major finding of the study was again the high rate of prescribing to treatment-resistant patients, over a third had previously received clozapine.

Conclusions

These studies show that lack of effectiveness is a major contributor to the high rate of discontinuation seen in newer antipsychotics when they first become available. However, this may be due to poor patient selection. Neither drug is licensed for use in resistant schizophrenia, therefore, use in this patient group may negatively bias the perceived effectiveness of newer antipsychotics. Patient outcomes are improved when used in non-resistant illness. Both drugs appear to be relatively well tolerated.

Arwel Thomas
Specialist Mental Health Pharmacist

Do the mentally ill suffer unnecessarily from distributive injustice?

In 2008, I published *Do the mentally ill suffer unnecessarily from distributive justice?* with chipmunkpublishing, the mental health publisher. It can be ordered from any book shop, or online book shop, quoting ISBN 9781847478153 (£10). I would recommend it to undergraduates from a number of departments, and postgraduates specialising in any aspect of mental health. My second work, *In The Dark Backyard*, will be published later this year and is highly informal narrative prose.

In 2004 I was employed by Manic Depression Fellowship (MDF), The Bipolar Organisation Wales as Public Relations Officer. I spent two years in post during which I attended numerous conferences, as well as preparing and delivering training talks to a variety of clients. At the same time, I also studied for MA in philosophy with the Open University. It was at one particular event, the launch of the Formal Investigation of the Disability Right's Commission, that I stumbled across a way of bringing my academic work into sync with my work for a mental health charity.

At the launch of the Formal Investigation, various preliminary findings were revealed to those in attendance. Appalling levels of neglect were being discovered in relation to people with severe mental illnesses, as well as those with severe learning difficulties. The form that such neglect took struck me as being truly worrying in the context of the rights presupposed of citizens of an advanced, 21st century liberal democracy.

Collectively, mentally ill people experience, in addition to their mental illness: high mortality rates due to historically poor physical health care; long-term unemployment due to stigma; and exclusion from family and society in the broadest possible terms due to a whole host of equally combatable factors.

During my studies, I encountered a number of philosophical positions on social justice. I felt compelled to launch my own enquiry into how this thing, social justice, can be understood with regards to the disabled and especially those with a mental illness. In an 18,000 word dissertation, I tackled some of the key aspects of contemporary theories of justice and how they can be understood in the light of the most challenging research findings as they pertain to the mentally ill.

I endeavoured to grasp the essence of mental illness in terms of political philosophy and the philosophy of personhood and arrived at a series of conclusions relying for the most part on the work of Iris Young, a key advocate of a certain type of justice.

This dissertation was successful enough for me to be awarded MA in philosophy, an achievement that years of acute manic depression could not deny. I believe that the work I undertook provides insight into aspects of living with a mental health condition, or intellectual disability, and also identifies strategic options for those seeking to improve their lot in the face of all the evidence that suggests they need to do so.

MR Hamden

Developments at the Royal Pharmaceutical Society of Great Britain (RPSGB)

The impending split in the functions of the RPSGB will result in the formation of two new bodies; one focusing on regulation and the other on professional leadership (as yet unnamed). Discussions and consultations about the structure and function of both new bodies have been extensive and the College of Mental Health Pharmacists and UK Psychiatric Pharmacy Group have participated in all stages.

Our mental health pharmacy organisations, in common with many of the other specialist groups, are keen to work closely with the new professional body and to find a way to work more in partnership with the whole profession. Some members of the RPSGB are also keen to reciprocate.

This new move towards working together has resulted in:

- Collaborative working between all the many special interest groups.
- Collaborative working between the RPSGB and the special interest groups.
- Extensive involvement of the specialist groups with the working groups for the new professional body (Transcom).
- The prospectus for the new professional body being heavily influenced by the programmes of the specialist and clinical groups.

However, despite the progress, there still remains a tension between those who wish to maintain the *status quo* and develop a new professional organisation similar to that of the current RPSGB, and those that want to see something quite different. During the extensive consultation about the new professional body, it was made clear that many of those that participated wanted a professional body that could lead and support the whole profession, but they did not want to see a rebadged RPSGB.

The remaining year and a half will be a challenging time for the Council of the RPSGB as it makes a change to the new body. The specialist and clinical groups have identified that lack of representation on Council is a major barrier to change. They are putting up the joint candidature of David Branford from our College of Mental Health Pharmacists and Graeme Hall professional secretary of UKCPA, as a way of securing at least two seats. Both candidates are hoping to exploit the potential votes from many of the specialist and clinical groups who, until recently, have felt very excluded by the RPSGB.

Members of the CMHP and UKPPG and being encouraged to vote in the RPSGB election and to vote for both David and Graeme.

Dave Branford
Chief Pharmacist, Derbyshire Mental Health Services NHS Trust

Ten ticklers from Stevie Bazire

Antidepressants in diabetes control

In a two-year study of insulin-dependent diabetics with depression, insulin use increased by 16% over that period, but remained unchanged if the depression was treated with tricyclics and actually reduced by 13% if treated with an SSRI ($n = 133$, Knol *et al*,

Pharmacoepidemiol Drug Saf 2008;**17**:577–86). So, some good news for the SSRIs as they seem to have a positive effect.

St John's wort

SJW was ineffective in improving symptoms of ADHD ($n = 54$, RCT, d/b, p/c, 8/52, Weber *et al*, *JAMA* 2008;**299**:2633–41), so don't waste your money.

Onset of action of antidepressants

There is still a view stated that antidepressants take four weeks to work. Well, they might take four weeks for an optimal effect but the onset of action is much quicker than that, and two recent studies have illustrated this. With paroxetine, self-rated efficacy in the first three days has been shown to predict response at 4/52 ($n = 29$, Inagaki *et al*, *Prim Care Companion J Clin Psychiatry* 2008;**10**:129–32), and in a study of venlafaxine vs nortriptyline in older people with depression, improvement occurred over 12 weeks, but the greatest effect was in the first week ($n = 81$, 12/52, *Int J Geriatr Psychiatry* 2008;**23**:769–71). So, don't tell people that the antidepressants take four weeks to work, because they'll feel better after a couple of weeks and they won't realise it's the drugs wot did it.

Switching to aripiprazole

Switching to aripiprazole can be a problem, particularly as an abrupt change can be very unsettling for the person. In a comparison of two different switches to aripiprazole in Japanese patients, the two methods (either add aripiprazole, wait 4/52, then taper prior antipsychotic; or add aripiprazole then simultaneously taper prior antipsychotic) were of similar efficacy, subjective tolerance was similar and were well-tolerated ($n = 53$ [c = 48], RCT, open, 14/52, Takeuchi *et al*, *J Clin Psychopharmacol* 2008;**28**:540–3). Aripiprazole was started at 12 mg/d, then increased to 15–30 mg/d, and the previous antipsychotic was reduced by 25% bi-weekly.

Hyperprolactinaemia

While we're on aripiprazole, use of this novel antipsychotic as an adjunct or alternative to other antipsychotics to reduce prolactin and minimise sexual dysfunction has now been looked at in a small open study. Aripiprazole was used as an alternative (45%) or adjunct (55%) to another antipsychotic and ANNSERS (antipsychotic non-neurological side-effect rating scale) and sexual functioning questionnaire (SFQ) used to assess outcomes. There were significant effects by week 12 on reduction of prolactin, improvement in libido, reduced erectile and ejaculation dysfunction, and reduced menstrual dysfunction. All these effects remained significant at week 26 ($n = 27$ [c = 22], 26/52, open, Mir *et al*, *J Psychopharmacol* 2008;**22**:244–53).

Time marches on

Are statins another method of preventing dementia? Apparently the use of statins in general population is associated with a lower risk of developing Alzheimer's disease compared to never using them, although non-statin cholesterol-lowering drugs did not show this effect ($n = 6992$, 15 years, Haag *et al*, *J Neurol Neurosurg Psych* 2009;**80**:13–7).

Risk factors for olanzapine weight gain

Weight gain with olanzapine is well known, but the risk factors are perhaps unclear. In a one-year study, in which 60% of completers gained >7% baseline weight, the two main risk factors were the cumulative olanzapine dose, and age. The latter has a negative

correlation as it was more common in younger people, with the net gain reduced by 0.6kg for every extra 10 years of age (n = 118; 12/52, Smith *et al*, *Int Clin Psychopharmacol* 2008;**23**:130–7).

Which antidepressant is best?

Although this meta-analysis is quite well-known now, I felt it had to be included. Cipriani *et al* (2009) have compared bupropion, citalopram, duloxetine, escitalopram, fluoxetine, fluvoxamine, milnacipran, mirtazapine, paroxetine, reboxetine, sertraline, and venlafaxine for the acute treatment of unipolar major depression in adults. They have concluded from the 117 studies that mirtazapine, escitalopram, venlafaxine, and sertraline were significantly more efficacious than duloxetine, fluoxetine, fluvoxamine, paroxetine and reboxetine (with reboxetine significantly less efficacious than all the other antidepressants tested). Escitalopram and sertraline showed the best profile of acceptability, leading to significantly fewer discontinuations than did duloxetine, fluvoxamine, paroxetine, reboxetine, and venlafaxine. They concluded that clinically important differences exist, both efficacy and acceptability in favour of escitalopram and sertraline and that sertraline might be the best first choice because it has the most favourable balance between benefits, acceptability and acquisition cost (s = 117, n = 25,928, RCT, Cipriani *et al*, *Lancet* 2009;**373**(9665):746–5).

Steve Bazire
Chief Pharmacist

Norfolk and Waveney Mental Health NHS Foundation Trust

Foundation trusts and community pharmacy chains in addition to the pharmaceutical industry.

Individual UKPPG committee members were aligned with individual companies to act as a conduit for communication. The College of Mental Health Pharmacists had refined an approval process and this is currently being piloted.

The UKPPG membership requested an overall evaluation of the scheme at the AGM in October 2008 and a meeting has been arranged for September 2009, where corporate partners and the UKPPG/CMHP committees will undertake this process.

Payment has been received from four corporate partners to date. The delay in payment of six of the companies raised the issue that the UKPPG is neither a registered organisation nor a charity. Had the old 'conference sponsorship' route alone been in place this year, the majority of sponsors would not have been able to pay the UKPPG due to this issue. The recent changes in governance within the pharmaceutical industry could have meant the end of the UKPPG as we know it! The status of the UKPPG will therefore be addressed at the April committee meeting.

Dawn Price
Vice Chair

Association of the British Pharmaceutical Industry (2008) *Code of Practice for the Pharmaceutical Industry*. Available online at: www.abpi.org.uk/publications/pdfs/pmpca_code2008.pdf [last accessed 25th January, 2009]

Department of Health (2008) *Best Practice Guidance on the Joint Working between the NHS and the Pharmaceutical Industry and other relevant commercial organisations*. DoH, London. Available online at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082370 [last accessed 25 January, 2009]

The UKPPG corporate partnership scheme

Background

The Corporate Partnership Scheme was developed to enable the UKPPG to change funding streams over the historical conference sponsorship arrangement for a number of reasons:

1. To modernise funding streams. Sponsorship as a funding mechanism is becoming a less viable option for pharmaceutical companies to support UKPPG within the revised 'due diligence governance' that emerged from the new APBI code of practice I and the Department of Health's Commercial Partnership Working guidance (DoH, 2009).
2. To enable prospective planning of new improvements, including electronic delivery of the current education and training events, web-casting of the conference, work towards two conferences per year and videoconferencing of committee meetings.
3. To pilot the mechanism for the CMHP's robust Quality Assurance process for approval of mental health pharmacy education material.

Development of the terms of reference was performed in consultation with the United Kingdom Clinical Pharmacy Association (UKCPA) and British Oncology Pharmacy Association (BOPA) during 2007, and following agreement of the UKPPG membership at the AGM in October 2008, the UKPPG launched the scheme.

Progress from October 2008

To date, ten applications for premium partnership were received from pharmaceutical companies, even though the CPS is potentially open to any registered organisation or company, including NHS

Celia's short pieces

Return to a level playing field?

The 2009 update of the National Institute for Clinical Excellence (NICE) Schizophrenia Guideline puts patient choice very much at the top of the agenda and seems to confirm what many of us have thought for a long time. Nowhere are the words typical, atypical, first generation, second generation or conventional found in the document. Also, with the exception of clozapine and chlorpromazine, the update mentions no antipsychotic by name. In contrast, the 2002 guideline mentioned the word 'atypical' 43 times and 'conventional' 24 times with olanzapine, risperidone and amisulpride, quetiapine and zotepine appearing respectively 11, 7, and 5 times each. Now, for both first episode and relapsed patients, the recommendation is just to '...offer oral antipsychotic medication...'. This is followed by the rider that the choice of antipsychotic should be a joint decision, taking into account the preference of the service user not to experience specific side-effects (NICE, 2009). The updated guideline appears to agree with Leucht *et al* (2009). In their recent meta-analysis of seventy-eight head-to-head studies, they found only small to medium differences in effect size between atypical antipsychotics,

and where differences were shown, not all were clinically relevant. They concluded that while substantial differences exist between individual patients in terms of response to antipsychotics and physical risk factors, large differences in side-effects are often more important for patients than small efficacy differences. The balancing of efficacy and side-effects must be tailored to the individual patient.

National Institute for Clinical Excellence

(2009) *Schizophrenia Guideline*. NICE, London.

Available online at: [www.nice.org.uk/nicemedia/pdf/](http://www.nice.org.uk/nicemedia/pdf/SchizophreniaUpdateDraftNICEGuidelineForConsultation.pdf)

[SchizophreniaUpdateDraftNICEGuidelineForConsultation.pdf](http://www.nice.org.uk/nicemedia/pdf/SchizophreniaUpdateDraftNICEGuidelineForConsultation.pdf)

[accessed 7th January, 2009]

Leucht S, Komossa K, Rummel-Kluge C, et al (2009) A meta-analysis of head-to-head comparisons of second-generation antipsychotics in the treatment of schizophrenia. *Am J Psychiatry* **166**: 152–63

Pharmacology in psychiatry — panacea or pariah?

This was the title of Professor David Taylor's inaugural lecture delivered at King's College London on the 17th March, 2009. David, who recently accepted a joint appointment as Professor of Psychopharmacology in the School of Biomedical and Health Sciences at King's was warmly welcomed to the School and acknowledged as bringing with him a unique track record of research, education and training combined with high level service delivery. He began his lecture by saying that psychiatric medicines have a poor reputation and may be considered as both panacea and pariah, or neither. To illustrate the point he went on to describe his various research interests as catalogued by his numerous publications. These include the prevalence of extra-pyramidal side-effects as a consequence of co-prescription of antipsychotics, treatment-resistant schizophrenia and delay in initiation of clozapine, discontinuation symptoms and antidepressants, antipsychotic efficacy, weight gain and the metabolic syndrome in schizophrenia and deficiencies in lithium monitoring in bipolar affective disorder. In describing a disappointing lack of cost-effectiveness for the long-acting antipsychotic injection he asked whether such new, expensive formulations could be better targeted. Medicines do have a place in psychiatry but such research clearly demonstrates that we could be using them more safely as well as more effectively. David concluded by acknowledging the significant contribution to his research made by various collaborators, mentioning many of them by name. David is the first mental health pharmacist to hold such an academic position and, as such, continues to be not only a professional role model but also an inspiration to all.

Celia Feetam
Postgraduate Tutor
Aston University

Managed Entry Template

The Managed Entry Template featured in the August 2008 UPPPG newsletter was developed with an unrestricted educational grant from Servier Laboratories Ltd. Ian Maidment, Steve Bazire, Graham Parton, Dawn Price, Elaine Weston and Celia Feetam, all recent members of the UKPPG committee,

or the CMHP council have undertaken consultancy activity for Servier Laboratories Ltd. The template is designed as a generic template suitable for all newly-launched medicines. Full declarations of interest will be included in any future newsletter articles that are connected in any way to a pharmaceutical or other commercial company.

Clare Gaskell, Committee Member,
UK Psychiatric Pharmacy Group

Stephen Guy, President, College of Mental Health Pharmacists

Bursary awards, 2009

Are you an **undergraduate** or **pre-registration** student with a project in mental health? Would you like to attend the next UKPPG annual conference for free and present your poster? If so, please consider entering for the UKPPG bursary award, see website ukppg.org.uk for entry details. Submissions to be in by the end of June 2009.

2008 winners were:

Emma Kirkham: *An audit on the combination prescribing of antidepressants*

Sagira Khatun: *The impact of smoking cessation initiatives on psychiatric out-patients taking clozapine*

Collision – a novel by John Donoghue

In a psychiatric hospital, a disturbed young woman believes she is possessed by the Devil; the psychiatrists tell her she is mentally ill. When she asks for an exorcism, they insist she takes medication, but it does not help. Caught in the middle is Edward Plant, a trainee psychiatrist whose life is one long party; trivial and purposeless — until he is drawn irresistibly into this case. When he meets an extraordinary woman who shows him that in order to receive love he first must learn to give love, he begins to doubt the certainties that once ruled his world. Against the teaching of his mentors, Edward confronts the possibility that demonic possession may be a real phenomenon — with unexpected consequences. *Collision* combines dark suspense with shining hope as it follows Edward's journey of self discovery through belief, mental illness, evil, love and redemption.

To buy a copy, go to the Amazon website and put the ISBN number: 978-1-84923-190-9 into the 'search' box. It will cost you £7.99 with free delivery in the UK. The novel has been nominated for the Wellcome book prize (go online to: www.wellcomebookprize.org/index.htm for details).

If you enjoy it, please recommend it to your friends.

John Donoghue
Full-time phantasurrealist and aspiring writer
with an interest in the hypnotic effects of monotonists
Liverpool

UKPPG corporate sponsors



Diary

Please let the editor know of any dates to be added to the UKPPG events and diary listings, either by post (Stephen Bazire, Chief Pharmacist, Hellesdon Hospital, Norwich NR6 5BE) or e-mail: sbazire@ukppg.org.uk

Friday 12th June 2009: UKPPG committee meeting

Friday 25th September 2009: UKPPG committee meeting

Please let Ian Maidment e-mail ian.maidment@nhs.net or Marina Davidson marinadavidson@sky.com know of any item you would like to raise.

Friday–Sunday 9th to 11th October 2009: 34th Annual (16th International) Psychiatric Pharmacy Conference, new venue! Hinckley Island Hotel, Hinckley, Leicestershire

List of useful names/addresses

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Membership details and application form available from the website: www.ukppg.org.uk

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Editors note: Sadly, we hear that Arwel Thomas died in October 2008 and decided to go ahead with publication as a mark of respect.