CWMT NEWS

The Newsletter of The Charlie Waller Memorial Trust

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Letter from the Chairman

May I start with some thank yous? I would like to thank Christine who acts as editor and all the contributors to this Newsletter. Some describe the work of the Trust; some describe the fund raising events; some have written extremely informative articles. We appreciate all the effort that lies behind the contributions and the time given to write the contributions themselves. We are particularly grateful to Alistair Barclay for all the work he does totally voluntarily for the Trust and for the grasp he has as shown by his report.

Then there are one or two points that I would like to draw out and emphasise.

The tribute to Ben Walker [pages 17-18] is enormously well deserved. He, with other colleagues of Charlie in the advertising industry, produced our original booklet which won an award and has been circulated far and wide. The road signs were their idea. There is now a new booklet founded on the old. We are pleased with it and are truly grateful for all the work done. I should also mention Principal Colour who have given their time very generously to print the booklets, something for which special thanks are due.

Congratulations are due to Denise Meyer who has been awarded her D Psych for her successful development of the Students against Depression website [see page 4]. The SAD website is used by many professionals as well as by students and she can be proud of what she has achieved an achievement, for which we are also very grateful.

Looking to the future it is clear that we are living in a time of change for the Health Service and the way it is organised. As Naomi Garnett says in her report the Trust is investigating how under the new regime GPs will operate. We will need to examine in this context whether we can improve the assistance that can be given to GPs and Tier One workers in diagnosing and treating depression. This will be a priority this next year.

It is also of interest that there is now available some good online self help of which Dr Chris Williams livinglifetothefull.com is a good example [see page 16].

Thank you for all your support.

Mark Waller

Report from the Treasurer

This brief summary is taken from the audited accounts for 2009. There is a copy of the full Trustees' Report for 2009 on the Charity Commission website and copies will be sent on request from our Thatcham office.

Our charitable activities absorbed £240,000 last year. This was less than in 2008 because the commitments made in previous years to fund the Schools Outreach Worker in association with Young Minds, which was expected to continue throughout the year and into 2010, ended as the post holder resigned. However all other commitments made in previous years to maintain funding for projects continued, absorbing a further £66,500 in 2009.

Our events, though classed as part of fund raising expenditure, help enhance a key objective of raising awareness, as well as drawing in enormous support. Last year fund raising events provided a surplus of £98,000. Adding this surplus to other general donations of £179,000 produced a total of £277,000. This was sufficient to meet our activities but not quite cover full cash outflow.

During 2009 the market value of investments recovered significantly in common with the general rise in market values of investments listed on the London Stock Exchange. At the year end the Charity held unrestricted funds of, £974,600.

Unrestricted funds are held to ensure that on-going project costs can be supported for the foreseeable future and to provide income towards annual operating costs. The unrestricted funds are held in cash deposits and listed investments. At 31 December 2009 the market value of the Charity's investments was £798,408; of this total 40% was held in listed fixed interest stocks and 60% in equity investments.

As might have been expected, in common with so many other charities and appeals, our income up to end July is about 10% down on 2009. Expenditure is similar to the same period last year. Three of our major fund raising efforts (the concert at St John's Smith Square, our Carol Service at St Luke's Chelsea and of course our Christmas Card sales) are yet to come. It really will make a difference to this charity's ability to meet its objectives this year and into the future if those of you unable to contribute or attend these events would never-the-less consider making a donation towards them. You will find full details on our website (www.cwmt.org)

Alastair Barclay (Hon Treasurer)

Report from the Project Director

The last six months have been busy and varied, not least because we are acutely aware of the changes to come in the NHS as a result of the election in May. We choose to take a positive approach to the news that GPs will be responsible for commissioning primary care services in the future. From the Trust perspective it means that we remain committed to supporting GPs to offer and access the best possible mental health treatments and services in primary care. With the launch of the Improving Access to Psychological Therapies Programme there have been increased options for both GPs and patients themselves to access support in the mild stages of depression. However with new funding regimes it is unclear how these services may be provided and financially supported in the future. The Trust is investigating the current situation regarding GPs and mental health issues with a view to being proactive through lobbying, providing information and offering training to ensure any patient suffering with depression gets the support they need.

The Waller Trainers have had a successful six months. Denise Fisher, the Waller Trainer in the North West, retired from her university post in June but has agreed to continue delivering training to her existing network as a Waller Associate. We had an excellent meeting in May hosted by Aileen Moore the Waller Trainer in the North East where the diversity and professionalism with which all our trainers operate was very evident.

There are three areas of our work which currently focus on children and young people. In London Gill Allen's project, to offer a strategic model to joint agencies within the London Boroughs to train non clinical professionals in mental health, continues apace despite the reorganisation of the NHS around her. The second area is in the North East where Aileen Moore is working with a Young People's Mental Health Project in Sheffield using both the Knowledge into Action pack that the CWMT launched in November and developing bespoke materials as required. Lastly Claire Poole, the Waller Trainer in the East Midlands, has finished developing the e-learning course in Young People's Mental Health and it should be available from September at the University of Northampton. We have also offered to support the Cutting Edge Theatre Company in Edinburgh which is developing a drama workshop aimed at encouraging young people to talk about their feelings and to seek help when they need to without feeling stigmatised.

Our student work continues to gain momentum. We are delighted to report that Denise Meyer has been awarded her D Psych for her successful development of The Students against Depression (SAD) website. She received a special commendation for the original contribution the website makes to both the academic and clinical fields of university counselling. The website continues to be well accessed by the students and together with the project Mental Wealth UK we hope to focus on this area over the next academic year. Both the website and Mental Wealth UK will be showcased at the Scottish NUS conference in Dundee during the autumn.

Dr Naomi Garnett

Charlie Waller Chair of Evidence-Based Psychological Treatment

NAME CHANGE

Some of you may have noticed the title of the Chair has changed from Chair of 'Cognitive Behaviour Therapy' to 'Evidence-Based Psychological Treatment.' The reason for the change is that the CWMT and Chair are committed to providing training and undertaking research in any psychological therapy that has scientific support. One of the therapies with strong scientific support is Cognitive Behaviour Therapy, but other therapies have also been shown to work and this is certainly the case in the treatment of depression for which interpersonal psychotherapy and behavioural activation are all very important treatments.

TRAINING

Improving Access to Psychological Therapies

It is the summer break and we have now completed the teaching for the second cohort of Hi Intensity workers and our third cohort of low intensity workers (renamed Psychological Wellbeing Practitioners' or PWPs). We have a fourth cohort of PWP workers currently running, and our fifth cohort will start in September alongside our third cohort of Hi Intensity workers. To date we have enrolled 80 people on the PWP courses and 89 on the Hi Intensity courses. The majority have come from the South Central region with 45 coming from London. We anticipate a further 20 and 27 people on the PWP and Hi Intensity courses this year. We have provided supervisor training and top-up training as part of the programme. Both of these courses are for the qualified staff working in the services and the top-up component involves helping the clinicians implement the skills they have learned in their daily clinical practice. We are very pleased that we were awarded accreditation for our PWP course until 2014 which means that the students become accredited PWP practitioners upon graduation in the same way as those that graduate from our Hi Intensity courses can become CBT Therapists.

Short and long courses in evidence-based psychological therapies

We are delighted that all students from the third cohort passed the certificate and diploma courses and two diploma students obtained a distinction. It is anticipated that our fourth cohort of diploma students will be filled, and that we will have 10 certificate students including one place from the voluntary sector funded by the James Wentworth Stanley Memorial Trust. The short training courses are going well with a total of 789 delegates attending the workshops last year, including those funded by Berkshire Healthcare NHS Foundation Trust and those funded by the Strategic Health Authority as part of the 'top up' programme.

Conferences

All our conferences ran and the feedback from them was excellent. Of particular interest was the conference on the interface between physical and mental health, with a wonderful keynote presentation by Professor Andre Tylee.

New 'flexible training'

New flexible training courses have been developed that allow students to accumulate credits at their own pace, and to create their own training courses from a range of modules according to their specific learning needs. New modules include Cognitive Behaviour Therapy for older adults (with Ken Laidlaw from the University of Edinburgh) and the interface between physical and mental health.

RESEARCH

Anna Coughtrey has now successfully completed her Ph.D. research on obsessive compulsive disorder and will embark on a clinical psychology doctorate at University College London. The three other Ph.D. students are continuing their studies. Of note, as part of his doctoral work Alex Gyani has been appointed as a Research Analyst to help analyse some of the national dataset arising from the 'Improving Access to Psychological Therapies' programme.

WEBSITE AND MARKETING

Our website has been redesigned and we have a brochure specifically to promote our certificate and diploma courses alongside our standard marketing brochure.

OTHER NEWS

Some staff members are leaving - Sarah Holling is leaving to train as a nurse; Dr. Martin Carroll's secondment has ended and he will return to his work within the local NHS Trust. Dr. Elizabeth Gaffan, the Department's Director of Teaching and Learning, is retiring and we will miss her enormously. Dr. Gavin Clark who has been working with us on the top-up programme will take up the post of Course Tutor for the certificate and diploma courses and Elle Ewan and Janine Turner will assist Sarah Liddell in her role as CWI's Manager.

FUTURE PLANS

The workshop programme for 2010-11 includes training on the treatment of depression using problem-solving, behavioural activation and couples therapy and training in a school-based programme to prevent depression that has scientific support. As usual, our leaders come from around the world to provide the training. Additional workshops include the treatment of anxiety disorders, drug and alcohol misuse and family therapy for eating disorders in adolescence. Work to secure research funds and the long-term financial stability of the CWI will also continue.

Prof. Roz Shafran

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Depression: Why and What You Need to Know
5th May 2010 — Emmanuel College, Cambridge

By kind permission of the Master and Fellows of Emmanuel College, CWMT hosted an information morning titled, 'DEPRESSION: why and what you need to know'.

The event was chaired by Professor Roz Shafran, the Charlie Waller Chair in Evidence Based Psychological Therapies. She started by outlining the way in which CWMT had started and the importance of early detection of the signs and symptoms of depression to increase the opportunity for recovery. The first speaker was a long standing friend of the Trust, Dr Brian Marien. He gave a brilliant exposition of the way in which mind and body are linked and how depression manifests itself. He described how events of early childhood can hardwire our brains to react in certain ways and kick start the downward spiral of depression as other life events act as triggers. The subsequent changes in the chemical composition of the body and the working of the brain itself all combine to bring mental ill health. His final message was that despite this predisposition, a combination of medication and cognitive therapy can bring about changes to enable life to be lived in a meaningful way.

The second speaker, the author Jeremy Thomas, described his own, often thought provoking but at times amusing, journey at the hands of his bipolar disorder. From busy times in New York City to treatment including both medication and psychological therapy he described the highs and lows and the complete interruption to life as he knew it. In spite of this he has triumphed as an author and gave the audience some very salient words of advice including some from a friend on his home island of Patmos 'when you find yourself in an ocean don't panic and keep swimming!' Something for us all to remember when life threatens to overwhelm us.

The event was brought to a close by a rousing rendition of the Lifecraft Chorus. Lifecraft is a local Cambridge organisation that supports individuals recovering from mental ill health. A buffet lunch followed where there was an opportunity to meet the speakers and to renew our own commitments to staying well. Many of those who attended reported that they had rarely felt so positive after an event of this nature.

Dr Naomi Garnett
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Eating Disorder

Overview

Most women have been on a diet at some point in their lives, and many are preoccupied with thoughts about their shape and weight but only a minority go on to develop a serious eating disorder that requires professional help. There are three main types of eating disorders – anorexia nervosa, bulimia nervosa and 'atypical' eating disorders; they have many symptoms in common. Most importantly, people with these disorders tend to judge their self-worth largely, or even exclusively, in terms of their shape and weight. Many of the other features of eating disorders arise directly or indirectly from the over-reliance of self-worth on shape and weight. Eating disorders are more common in Western countries, among Caucasians, and among women. This article will describe the different types of eating disorders, the relationship between depression and eating disorders, the development and causes of eating disorders, and the treatment options available.

Anorexia nervosa

90% of those with anorexia nervosa are female. Anorexia nervosa typically starts in adolescence and is relatively rare, with 0.9% of women having the disorder in their lifetime and 0.3% of men. People with anorexia nervosa actively maintain an unduly low body weight i.e., body mass index $\leq 17{\cdot}5$ kg/m^2. Body mass index is calculated by dividing one's weight in kg by one's height in squared metres. A healthy body mass index is often considered to be between 19 and 25 and so people with a body mass index of 17.5 or below are significantly underweight. People with anorexia nervosa judge themselves largely on the basis of their ability to control their eating, shape or weight. Technically, a diagnosis of anorexia nervosa requires menstruation in adult women who are not taking an oral contraceptive to have stopped, although those who menstruate seem to resemble closely those who do not. In anorexia nervosa, the pursuit of weight loss is obtained by severely restricting food intake and any food deemed 'fattening' is excluded. For some patients, the desire to obtain weight loss and restrict food intake is influenced by personality variables such as asceticism, competitiveness, and perfectionism; others appear to have a wish to punish themselves. Many patients engage in a driven type of over exercising, which can contribute to their low weight. Self-induced vomiting and other extreme forms of weight-control behaviour, such as the misuse of laxatives or diuretics, does occur although not frequently. It is not unusual for patients to feel as though they are losing control over their eating and having a 'binge' although the size of the 'binge' is not large and is very different to that in bulimia nervosa.

Anorexia nervosa is associated with a raised mortality rate – either as a direct result of the medical complications that arise from the weight loss or from suicide. Symptoms of depression and anxiety disorders, irritability, lability of mood, impaired concentration, loss of sexual appetite, and obsessional features are common in anorexia nervosa and some can be attributed to starvation and weight loss. With depression, people with anorexia nervosa lose interest in the outside world and become withdrawn and isolated as they are focused on eating, shape and weight. When people gain weight, many of the features including depression and social isolation improve, although sometimes people report feeling more depressed as they gain weight; they say they feel they have lost the only thing they are good at – losing weight – and that they are no longer special.

Bulimia nervosa

Bulimia nervosa affects 1.5% of women across their lifetime, and 0.5% of men. It starts in young adulthood and the weight of people with this disorder tends to be average. This is because their attempts to restrict their food intake are interrupted by a loss of control during which they eat large amounts of food in a short space of time–typically between 1000 and 2000 kcals. Given that people with bulimia nervosa also tend to judge their self-worth in terms of shape and weight, the episodes of binge-eating are highly distressing and aversive and it is usually these binges that motivate the person to seek help. In bulimia nervosa attempts are made to compensate for these episodes by using extreme behaviour e.g., highly restricting their food intake, over-exercising, inducing vomiting or abusing laxatives. The shame that accompanies the binge eating and vomiting can cause a long delay before asking for treatment. As with anorexia nervosa, symptoms of depression and anxiety disorders are often prominent as people become preoccupied with thoughts of food, shape and weight and increasingly isolated and withdrawn. Many are self-critical for being so overly concerned with their shape and weight, and too 'weak', to resist temptation but cannot change without help.

Eating Disorder Not Otherwise Specified

These 'atypical' eating disorders are more common in local community mental health teams than either anorexia nervosa or bulimia nervosa. Most atypical eating disorders closely resemble anorexia nervosa and bulimia nervosa, and many are as severe and long lasting. For example, the patient's weight might be just above the diagnostic threshold for anorexia nervosa due to drinking alcohol although all other features are present. Another person could be eating regularly but vomiting after meals to control her shape or weight. Many such patients have had anorexia nervosa or bulimia nervosa in the past and, as with the other eating disorders, a central feature is the overevaluation of eating, shape, weight or their control. Binge eating disorder is considered as an example of an 'eating disorder not otherwise specified'. It is characterised by episodes of binge eating that are very similar to those in bulimia nervosa. However, there is little weight control behaviour after such binges and so people tend to be significantly overweight. For many, the episodes of binge eating are triggered by low mood and people describe using food to help manage their feelings of distress and sadness. Unfortunately, any relief is short-lived as the resultant weight gain often lowers morale and mood further. People with binge eating disorder tend to be older than those with anorexia nervosa or bulimia nervosa and it is more common with 3.5% of women and 2% of men affected across their lifetime.

Depression and Eating Disorders

One of the key symptoms of depression is loss of appetite, and it is also common for people with depression to over-eat when their mood is low. Eating disorders and depression overlap considerably. One-third of women with binge-eating disorder, 39% of women with anorexia nervosa and half of those with bulimia nervosa are depressed. It is not clear what comes first – the depression or the eating disorder – and there is likely to be a lot of variation. For some, the depression is clearly a result of having an eating disorder. We know this as a result of the timing – such patients will describe becoming depressed only as a result of the preoccupation with shape and weight, the social isolation that resulted from the eating problems or their failure to obtain the desired shape and weight. Other patients describe the depression as coming before their eating disorder. They sometimes say that the eating difficulties resulted directly from a period of low mood. They began to 'comfort

eat' or overeat, and began worrying about their shape and weight as a result of weight gain or inability to control their food intake. For many, however, the relationship is unclear. Their emotional difficulties span the domains of mood, eating, and self-worth and are closely intertwined. For many patients, treating the eating disorder will improve the depression and feelings of self-worth. For some, particularly those with severe and longstanding depression that preceded the eating disorder, then the depression is addressed (often using medication) before starting any psychological treatment so that the person can fully engage with the therapy being offered.

Development and Course of Eating Disorders

It is typical for anorexia nervosa to begin in adolescence, and the most obvious sign is extreme dietary restriction which becomes out of control. For some, the disorder is short-lived and with the support of family, friends and the GP, no specific interventions are required. For others, the disorder lasts for a longer period of time, and for 10-20% of individuals, the disorder has a chronic and severe course. For half the individuals, full bulimia nervosa will develop after a period of anorexia nervosa, and others have significant problems with binge eating. Bulimia nervosa starts slightly later than anorexia nervosa and usually begins with dietary restriction. However, the control over eating cannot be maintained and the dietary restriction is punctuated by episodes of loss of control over eating and binges. The binge-eating causes body weight to reach normal levels since the compensatory weight behaviour such as self-induced vomiting are relatively ineffective and the body still absorbs a significant amount of calories from the binge. It takes about 5 years before people present for treatment and if the disorder is not treated, between a third and a half of people will still have a significant eating disorder. Unlike depression, it does not 'come and go' over time, but rather it tends to change form with patients moving between the various eating disorder diagnostic categories of anorexia nervosa, bulimia nervosa and eating disorder not otherwise specified. It is due to this overlap between the different specific eating problems that an argument has been made to stop separating the disorders but to consider them as different forms of the same problem.

Causes of Eating Disorders

No single cause of eating disorders has been identified but they are likely to arise from a toxic combination of genetic predisposition to certain characteristics and environmental factors. Eating disorders and certain characteristics such as obsessionality and perfectionism run in families, and relatives of patients with eating disorders tend to have a higher incidence of substance misuse and depression. Some known environmental risk factors are the adverse experiences that make a person vulnerable to developing other mental health problems such as childhood sexual abuse. Other risk factors may be specific to causing an eating problem such as childhood and parental obesity and early onset of menstruation. Low self-esteem and perfectionism are common risk factors for eating disorders, and anorexia nervosa is particularly associated with very high personal standards and reacting with self-criticism when those standards are not met. Given that eating disorders are much more common in Western countries, it is not a surprise that societal and cultural explanations have been put forward as a primary cause of eating problems. The pressure for women to achieve a particular shape and weight is widespread among the media and popular culture. Although such pressures are prominent and may focus attention on shape and weight, it is not the full explanation for eating disorders since all women are exposed to such information but only a very small minority go on to develop an eating disorder.

Treatment Options

Psychological treatments for eating disorders have more scientific support than medication and there are guidelines from the National Institute of Clinical Excellence on the treatment of eating disorders (www.nice.org.uk). There is most scientific support for Cognitive Behaviour Therapy for eating disorders, particularly for bulimia nervosa and binge eating disorder.

Anorexia nervosa

There is relatively little research on the treatment of anorexia nervosa but there are four principles of treatment. The first concerns motivating the person to see that they need help, and that they have a serious problem that warrants treatment. Second, patients are required to gain weight so that the effects of starvation and malnutrition can be reversed. Patients do not need to be hospitalised to gain weight, but if there is significant suicide risk or major medical problems then they may be admitted. The third aspect of treatment is addressing the overevaluation of eating, shape, weight or their control. Family-based treatment is helpful for younger patients and Cognitive Behaviour Therapy tends to be used with adults, despite relatively little strong scientific support. Fourth, as a last resort and only in a small minority of cases, patients can be sectioned and treated against their will.

Bulimia Nervosa

There is much stronger research evidence to guide the treatment of bulimia nervosa with over 50 randomised controlled trials. The evidence shows that the most effective treatment is a form of Cognitive Behaviour Therapy specifically designed for the disorder by Christopher Fairburn and colleagues at Oxford University. The treatment involves 20 individual face-to-face sessions over a period of 5 months. Patients with bulimia nervosa are more motivated to seek treatment than those with anorexia nervosa so encouraging them to engage with therapy is usually more straightforward. The therapist starts by helping the person to understand their eating difficulties and why it persists. The role of overevaluation of shape and weight, the extreme dietary restraint, self-induced vomiting, low mood and black-and-white thinking are all likely to be discussed. Patients are asked to monitor their food intake, drinks consumed and any accompanying thoughts and feelings on a daily basis in real-time. These monitoring records are an essential part of treatment and help the person to see patterns in their eating difficulties. A fundamental part of treatment is helping the person to eat regularly and providing some important information (e.g. about the relative ineffectiveness of vomiting and laxatives as weight control methods.) Patients use problem-solving to deal directly with their moods rather than moods triggering an episode of binge eating. Avoided foods are gradually reintroduced. Patients are weighed weekly, and any repeated scrutinising of body shape is also addressed. The overevaluation of shape and weight and its expressions (such as feeling fat) are usually dealt with once a regular pattern of eating has been obtained and the frequency of the binge-eating reduced. Patients are encouraged to develop other areas to obtain their self-worth other than focusing on shape and weight, and are encouraged to engage in areas of activities that they previously enjoyed before the eating problem developed. The final stage of treatment is the prevention of relapse. Studies show that this form of Cognitive Behaviour Therapy indicate that more than half the patients who complete this treatment make a full and lasting recovery. Interpersonal psychotherapy (a treatment that focuses on relationships rather than thoughts, feelings and behaviours) seems just as effective as Cognitive Behaviour Therapy but it takes longer to work. Self-help treatments also seem effective but only for a subset of patients.

Eating Disorder Not Otherwise Specified

There are no specific guidelines for the treatment of these eating disorders other than binge eating disorder but it is advised that clinicians follow the guidelines for the other disorders. For binge eating disorder, both Cognitive Behaviour Therapy and interpersonal psychotherapy are effective.

NewTreatments

A new 'enhanced' form of Cognitive Behaviour Therapy has been developed by Christopher Fairburn and colleagues in Oxford. It is 'enhanced' in two ways. First, the treatment methods used have been improved (e.g., new ways to address the overevaluation of shape and weight). Second, it is designed to be used with all types of eating disorder based on the premise that the symptoms overlap considerably and they seem to be perpetuated by the same processes. Those who are underweight are given 40 sessions compared to those who are not, largely because of the time taken to regain weight. Surprisingly enough to the many people who struggle to lose weight, even when the decision is made to gain weight, it is often a slow and difficult process. It is easy with the new treatment to try to do everything but the principle of the new treatment is to "do a few things well rather than many things badly". Results of a large study with 154 patients who were not significantly underweight showed that half of the patients who entered the study achieved a full recovery. Those who are underweight also appear to be responding well. There are two forms of this new treatment. The first focuses solely on the eating disorder and the second includes other elements such as addressing low self-esteem, mood intolerance, interpersonal problems and clinical perfectionism – these are likely to be especially important aspects for patients who also have depression.

Summary and conclusions

There is a large overlap between eating disorders and depression. There is a relatively good understanding and treatment for bulimia nervosa and binge eating disorder, but the treatments for anorexia nervosa need to be improved; research into the other 'not specified' eating disorders is at an early stage and no specific treatments have been developed to date. The enhanced form of Cognitive Behaviour Therapy appears to be effective for all forms of eating disorder, and exists in different versions which enable the treatment to be tailored to the individual's specific problems. In conclusion, although eating disorders are disabling and distressing problems, with the right treatment they can be overcome.

JULIANNE – A CASE STUDY

Julianne, aged 16, was a highly successful student at a top school studying for her A Levels when her eating problems began. She was the eldest of three children. Her parents were happily married, and she came from a secure family home; her father was an accountant and her mother was a teacher. As a child, she had appeared in advertisements and modelled clothes for children's catalogues. When she was 14, her best friend moved schools and Julianne began to feel low and isolated with few other friends in her single-sex school. She absorbed herself in her schoolwork and her teachers and parents praised her dedication, particularly as important exams were approaching. Like her peers, she dieted a little but not seriously. When she was 16, she went away for the summer and gained a few pounds. On her return, she decided to diet more seriously. She was pleased and surprised

by how easy she found it, and she lost 7 lbs within three weeks. She continued to diet, but found that her weight loss slowed down. She became preoccupied with both losing weight and the speed of her weight loss. She weighed herself three times a day, and became highly preoccupied with even minor fluctuations in her weight. When the scales indicated that she had gained weight, she felt a failure and was determined to try harder. When the scales indicated that there was no change, she hardened her resolve to be stricter with her diet. When the scales indicated weight loss, she felt a tremendous sense of personal pride and achievement and was spurred on to continue with her dietary restriction. She began lying to her family about when she had eaten, disguised her shape with baggy clothes and used her studying as an excuse to stay in more and more.

After the summer exams, Julianne allowed herself to go out with her friends to celebrate at the pub. She also allowed herself to have a few chips from someone else's plate. When she got home, she was devastated at her lack of self-control. She tried to make herself sick. The next day, she ate a couple of chocolate biscuits from the cupboard and was filled with self-hatred and anger. She found it easier to make herself sick this time, and she began to think that vomiting was the solution to her difficulties. She thought that she could eat whatever she wanted and then just make herself sick afterwards. Although she initially believed she could control the vomiting, within a few months it was obvious that the vomiting was out of control and the food she was eating prior to being sick was becoming increasingly large. She was disgusted and ashamed. Her mother noticed food was missing from the cupboard and sat down with Julianne one day for a discussion. Julianne confessed her difficulties to her mother, and together they went to see the G.P.

The G.P. made a referral for Julianne to see a therapist but in the meantime suggested that she read 'Overcoming binge eating' by Christopher Fairburn. Julianne and her mother read the book together, and Julianne began the programme. By the time the appointment for the therapist was available Julianne had made progress. The therapist was able to support Julianne in the changes she had made, and Julianne continued to do well. By the end of treatment she had made a full recovery.

Prof. Roz Shafran

Charlie Waller Chair in Evidence-Based Psychological Treatment

Acknowledgements

This article used the following resources:

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(2009). Transdiagnostic cognitive-behavioural therapy for patients with eating disorders: A two-site trial with 60-week follow-up. *American Journal of Psychiatry*, *166*, 311-319.

Fairburn, C. G. & Harrison, P. J. (2003). Eating disorders. *Lancet, 361,* 407-416

Whitehead, L. (2009). *Cognitive Behavioural Therapy Book Reviews*, *5,* 1-2

Thanks to Dr. Anna Coughtrey for helpful comments on this article.

Further information

www.edauk.com - Information and help on all aspects of eating disorders, including Anorexia Nervosa, Bulimia Nervosa, binge eating disorder and related eating disorders

http://www.iop.kcl.ac.uk/sites/edu/?id=15 – A range of resources produced by Janet Treasure and colleagues from the Maudsley Hospital includes reference to material about helping loved ones with eating disorders and self-help material to overcome binge eating.

www.b-eat.co.uk - In addition to information on eating disorders within the main site there is a section specifically created for, and with the help of, young people

Feeling Down 'Down Under'

An Exploration of Rural and Remote Mental Health Services in Queensland

With support from The Charlie Waller Memorial Trust I applied for a Winston Churchill Travel Scholarship and last year proved a very exciting one for me. After the application process and a rather daunting interview I was awarded a Winston Churchill Travel Fellowship to visit Queensland. During my visit I spent a week in the capital, Brisbane, then flew to the outback mining town of Mount Isa before travelling by train to Cairns. It was an incredible experience and I learnt so much about rural and remote mental health care provision despite sometimes overwhelming obstacles such as geographical isolation and adverse weather conditions (drought and floods).

During my week in Brisbane I was able to observe E-CYMHS (Electronic Child & Youth Mental Health Services), a co-ordinated telepsychiatry service linking specialist mental health staff (based at the Royal Children's Hospital, Brisbane) with practitioners in rural and remote areas across northern and central Queensland. E-CYMHS provides direct client and family assessment using video-conferencing technology and includes case review, treatment planning and support with interagency collaborative practices, in addition to providing targeted case-based education and professional development to clinicians in isolated areas. Families needing to access metropolitan inpatient services very often have to travel great distances (1,000 miles or more) and this process can be very stressful and disruptive to the families involved. Such assistance as that provided by E-CYMHS is therefore vital as very often the support offered can keep the child or young person much closer to home and therefore community and family support. In the UK Child and Adolescent Services are often 'patchy' and difficult to access in rural areas and although distances cannot compare to those in Queensland nevertheless rural areas in the UK (e.g. the Scottish highlands and islands, North East, North West and South West England and parts of Wales) could find such a service very useful.

Visiting Mount Isa was a very different experience to cosmopolitan Brisbane. A 2-hour flight (972 miles) and this is real 'outback' country, hot and arid. From a small mining company (in 1924) Mount Isa is now a thriving mining community with shops, schools and a hospital. However social isolation brings specific mental health issues and substance misuse and suicides are serious issues for the community. The services in Mount Isa cover an area of approximately 330,000kms. What I discovered there was the vital role non-health agencies play in supporting the emotional needs of the community. Centrelink is part of this provision, whose role is normally involved in providing e.g. Income Support. Centrelink has set up a Family Support Drought Response Team initiative. The Gulf country north east of Mount Isa has experienced a 10-year drought and the team have found very successful ways of supporting communities where a history of resilience against the odds can impede people accessing help when they become depressed. The team have found that by taking an 'improving quality of life' approach rather than focussing on 'coping' or 'resilience' has been more successful in engaging families and communities. Mental illness can be more stigmatising in rural communities where the culture of 'coping' with disasters has led individuals to feel that they 'should be able to cope'. It isn't until one is actually in the outback that the vast distances become real, when driving for several hours without seeing a single building is awe inspiring and sheep and cattle stations are found to be as big as English counties.

The overnight train from Mount Isa to Cairns leaves at 1pm (with a connection at Townsville at 10am) and one arrives a little travel weary in Cairns at 7pm the following day. During my visit to Cairns I was very fortunate in being able to spend some time with the Royal Flying Doctor Service (Queensland) (RFDSQ) and was thus able to fly out to remote Aboriginal communities across Cape York. There is no drought there but during the 'wet' (January to April) much of the Cape becomes impassable as dirt roads become waterlogged, thus there is a heavy reliance on the RFDSQ to provide both physical and mental health services. I discovered very innovative work being done with the aboriginal communities by enthusiastic and dedicated staff, with the focus very much on emotional wellbeing rather than mental illness.

Herbert Yunkaporta (left) & Emily McKeouh Aurukun Aboriginal community

The emphasis is on utilising the Aboriginal culture through the use of dance, poetry, stories and artwork as well as the elders passing on the more practical cultural aspects of aboriginal life to the young. In particular the 'Creative Recovery' project at Lockhart River, 800kms north of Cairns, has been running since 2007 and this year many pieces of work are being displayed at Expo 2010 in Shanghai.

It is really impossible to give a full picture of my experiences in Queensland however if you would like to read more a full report can be found on the Winston Churchill Memorial Trust website: http://wcmt.org.uk/reports/678_1.pdf

Having submitted my report I was invited to join others at a ceremony at the Guildhall in London to receive a medallion from HRH Duchess of Cornwall which provided an opportunity to meet many Fellows who have also had incredible experiences through their Churchill Fellowship.

Receiving The Churchill Medallion from HRH Duchess of Cornwall

Denise Fisher - Waller Associate (North West)

What Treatments Work for Depression?

At the recent BABCP conference in Manchester a panel of international experts addressed this question in relation to Cognitive Behaviour Therapy (CBT), Interpersonal Therapy (IPT) , Mindfulness Cognitive Behaviour Therapy (MCBT) and Couples Therapy, all of which are recommended by NICE for the treatment of depression.

Robert DeRubeis from Pennsylvania reviewed the latest evidence for the effectiveness of CBT on which there have now been 1500 studies. The most recent research suggests that while CBT is effective for severe depression it has no advantage over anti-depressants or placebo for mild to moderate depression. He also explained that there is a sub-group of patients for whom CBT does not work but for whom behavioural activation is successful.

In discussion Rob also raised possible problems of using both medication and CBT together as recommended by NICE. If you do both it is difficult to know what works and a person might go on taking medication without knowing if it was necessary. Secondly new research is suggesting that medication may get in the way of the treatment process. Rob suggests it might be better to try CBT first and then only use medication if CBT is unsuccessful.

Heather Flynn from Exeter University outlined the advantages of IPT which focuses on social relationships and in particular addresses the discrepancy between reality and what the patient would ideally like. Core strategies in this therapy include communication analysis and helping the patient modify their expectations. This works well where relationship difficulties are key in maintaining the depression.

Kurt Hahlweg from the University of Braunschweig (Germany), spoke about Couples Therapy. There is a .4 correlation between relational distress and depressed mood and a .6 correlation between relational distress and clinical depression. Moreover a partner can be a driving force for relapse. If the relationship is dysfunctional the relapse rate is over 60% but if the partner is supportive the relapse rate is only 10%. These results are cross-cultural and have been replicated in Egypt.

Therapy requires a thorough assessment of the relationship. Kurt says it is particularly important to assess sexual functioning as 50% of couples have sexual difficulties and this can be a side effect of anti-depressants. Twenty to thirty per cent will be having an affair and 15% will be experiencing domestic violence. In view of this it is not surprising that that many partners (50%) refuse to take part.

Therapy involves the development of communication skills, problem solving skills and the introduction of caring days where the focus is on doing nice things for the partner. He emphasised that people should be clinically trained to do this therapy and does not think it appropriate to devolve responsibility to Relate. Couples therapy usually consists of 15 sessions.

When Kurt told us that German insurance companies pay for either 25 or 45 sessions there was an audible envious gasp from the audience!

Mark Williams from Oxford University talked about Mindfulness CBT which can reduce the relapse rate for people who have had 3 or more episodes of depression, from 70/75% to 35/36%. What is different about this group of people ? They have been depressed for longer, usually more than 20 years, developed depression as a teenager (usually aged 13-15) and had a difficult adolescence.

When MCBT is compared with medication for relapse prevention they are both equivalent. However those practising MCBT report a better quality of life and indeed the more Mindfulness is practiced the greater the health benefits.

Finally, Heather touched on the benefits of Behavioural Activation as this is also recommended by NICE. Research has shown this as effective as CBT for treating depression and it is easier to train therapists for this and more cost effective to roll it out as a treatment.

This was an informative and encouraging panel discussion highlighting both the number of effective treatments available and the use of research in guiding future interventions.

Mary Bennett — Clinical Psychologist

Taking Leave by Jeremy Thomas

(Timewell Press, £14.99)

and Believing in Myself by Ernie Larsen and Carol Hegarty

(Simon & Schuster, £7.50)

I make no apology for revisiting Jeremy Thomas. Apart from being an incisive, important and hugely entertaining writer, Jeremy is also becoming a very good friend of the Charlie Waller Memorial Trust. Anyway, when Stephen Fry calls somebody "a complete original, whose life and writing is a whirlwind of brilliance", we all ought to take notice.

I was mightily impressed when I reviewed Jeremy's You Don't Have to be Famous to Have Manic Depression in this newsletter in 2008. This warm and intelligent book examined the number of coping strategies – both medicinal and cerebral – which are now available to the manic depressive. In this book Jeremy, who was diagnosed with manic depression some years ago, discusses these strategies with his doctor Tony Hughes.

I was struck by how amusing Jeremy and Tony were. Of course, manic depression isn't a funny subject in itself, but the old adage "laughter is the best medicine" remains as true today as it did on the day it was first coined. Lithium may well provide a stabilising effect for many manic depressives, but it's another L, laughter, which can lift the spirits and make the world a much more tolerable place.

Laughter is also present in *Taking Leave*, Jeremy's first novel, but it would be simplistic to call this a funny book. I think terrifying would be a more accurate description. For *Taking Leave* chronicles, in devastatingly painful and honest detail, the mental disintegration of its narrator Tim Lomax, a thinly-disguised portrait of Jeremy Thomas himself.

The catalyst for this disintegration, though Tim doesn't realise it, is the death of his beloved mother. Twenty-five-year-old Tim appears to take this untimely death in his stride, as he pursues his superficially successful career in the musical business with manic energy and enthusiasm. I use the word manic advisedly.

The novel is set in 1979, in the immediate aftermath of the punk revolution which had turned the music industry on its head. Anything was possible – and anything went. This febrile and dangerous atmosphere is especially dangerous for a manic depressive like Tim, who, dimly conscious of "a worm in my head", drinks for England – and Scotland, Wales and Ireland, too. OK, so he has a beautiful girlfriend and a prospect of a mega-deal in the United States, but the only properly functioning relationship he has is with his cat.

The strength of this remarkable book is the beguiling manner in which the reader is drawn into Tim Lomax's world. We can see that everything is going terribly, terribly wrong, but Tim ploughs on regardless, leaving a trail of both literal and metaphorical destruction in his wake. The climax is both moving and disturbing, as Tim finally tries to confront what is wrong with him. It is here that Jeremy's bravery and integrity is at its most breathtaking.

Not surprisingly, *Taking Leave* received a number of excellent reviews and was named as Simon Mayo's Five Live Book of the Month. There have been some classic novels about mental disintegration, including Evelyn Waugh's The Ordeal of Gilbert Pinfold and Martin Amis's Money, but Taking Leave, characterised by its searing honesty, does not suffer in comparison.

As a manic depressive, Jeremy Thomas has had to devise a number of coping strategies, and I gather one is a wonderful pocket book called *Believing In Myself*, which, appropriately enough, Jeremy

keeps with him in his pocket – every day. *Believing In Myself* deals with the vexed subject of self-esteem, so crucial to a balanced personality and a healthy, happy inner life.

Authors Earnie Larsen and Carol Hegarty believe that a solid (rather than an exaggerated) sense of self-worth is the single most important factor in determining our happiness in life and our success in work and relationships. With it, virtually all things are possible. Without it, even victories can feel like defeats. That's why raising low self-esteem is an essential part of the healing process for those who are suffering from depression, recovering from addictions and dependencies or feeling the pain of childhood wounds or other hurts.

This enlightening book presents a meditation for every day of the year, complete with an inspirational quote and a thought-for-the-day. It addresses such subjects as: Why self-esteem seems so fragile; how to define ourselves in terms of our own standards and values; why attitude is so important when we make mistakes; the difference between conceit and self-approval; how self-doubt triggers unattractive behaviour; and how self-esteem blooms when we have a sense of purpose in life.

Let's take one thought- for-the-day at random. It's for September 29, a typical enough day. Here goes: "Humour is a little mentioned aspect of self-esteem. If we don't find much to laugh about, we are flying on one wing. To lighten up doesn't mean to lapse into silliness. It means to see the light."

I don't know Jeremy Thomas. But, on the evidence of the two books of his I have reviewed, I don't think it's too presumptuous to suggest that he would agree completely with this simple, yet far from simplistic, sentiment.

Robert Beaumont (Charlie's Uncle)

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Living Life to the Full Online Course

This free online course, which is written by Dr Chris Williams of the University of Glasgow, teaches key life skills that aim to help people tackle problems of low mood and stress. Using the proven cognitive behavioural therapy (CBT) approach, the course contains training modules, free downloads including relaxation tapes, a forum where you can ask questions of others or make a comment and also a series of free online TV documentaries. Content covers commonly asked topics such as how to overcome negative thinking, build confidence, sleep better and tackle problems. Weekly reminder emails are scheduled for 12 weeks to encourage users to keep on track with the process of change. Freely downloadable Planner and Review sheets encourage users to create a weekly plan to apply practically what is learned rather than just reading the course without it affecting the person's life.

The course is widely used, receiving almost 2 million hits a month, and a published research study suggests it is effective as a treatment of depression. Each module contains sufficient information to be worked through alone, and they can also be completed using various accompanying books that use different writing styles to be attractive to different people. A TV version of the course is available for those who prefer to learn through watching how others have worked on problems. The linked books are usually freely available from local libraries. Finally, a top tip is to ask someone to help you stay motivated and really work on the course– like your practitioner or GP.

An updated and revised version of the course is being relaunched in October bringing additional features and a brand new look. You can find out more about the course at **www.livinglifetothefull.com.**
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IN THE FIRST OF A SERIES OF PROFILES OF PEOPLE WHO WORK HARD FOR THE TRUST BEHIND THE SCENES, ROBERT BEAUMONT TALKS TO ADVERTISING GURU BEN WALKER

You may not know Ben Walker, but if you have followed the fortunes of the Charlie Waller Memorial Trust during the past decade, you may well know his work. For it was Ben who was the mastermind behind the brilliant Trust booklet ***Depression And How To Deal With It.***

This booklet, a dazzling, ground-breaking combination of striking images and powerful words, demolished the prevalent view that depression was a self-indulgent emotion, normally the preserve of the weak and the useless.

The images, from the personalised pills with their melancholy faces on the front cover, to the road signs with their warnings about the signs of depression, are stunningly simple and effective. The words, meanwhile, are the ideal roadmap for those who suffer from depression and for their friends and family.

I quote: "Depression is known in medical circles as the common cold of psychiatry and at any time ten per cent of your colleagues are likely to be suffering from it. They will need specialist medical help and advice because, although depression is common, it doesn't take a day off and some Lemsip to cure it."

The centre spread is a simple montage of the names of famous people who suffered from depression. Vincent Van Gogh, Evelyn Waugh, Winston Churchill, T S Eliot, they all knew the score.

Ben has been busy updating this booklet for the 21st century during the past six months, snatching precious moments whilst at work as a creative director at the city of London offices global advertising agency WK. It's been a tough old year for advertising, as the recession bites, but Ben has been able to find time to create a new booklet which should be of immense help to everyone who reads it.

The booklet has added poignancy for Ben, of course, as he was a great friend, as well as colleague, of Charlie himself.

"I'm still coming to terms with Charlie's death, 12 years on, so I can only imagine how Charlie's family feel. My memories of Charlie, a big man in every sense of the word, have driven me on and are the catalyst for this new booklet, which has built on the interlocking themes and images of the original one," he explained.

Once again the images are striking – there's a graphic-driven spread on the things (like exercise and nature) which help depression and the things that don't (alcohol and drugs). An image of two tin cans connected by string, signifying one of those early telephone efforts- the string made up of the numbers you can ring for help and a page emphasising how important the dual approach of medical treatment and cognitive thinking is in the easing of depression.

Perhaps the most effective of all is a still from an old Buster Keaton silent movie with the caption "Silence gets you nowhere. Start talking". It took a long time to get permission to use the still from someone deep in the bowels of Hollywood, but Ben thinks, quite rightly, that it was worth the wait.

Ben and Charlie first met in 1992 at Leo Burnett, the global, Chicago-based advertising agency. They became great friends immediately, Ben loving Charlie's "energy and magnetic personality".

"Everybody wanted to be around Charlie. He was great fun and a fantastic colleague. Nothing was too much trouble for him and he was passionate about his work," recalled Ben.

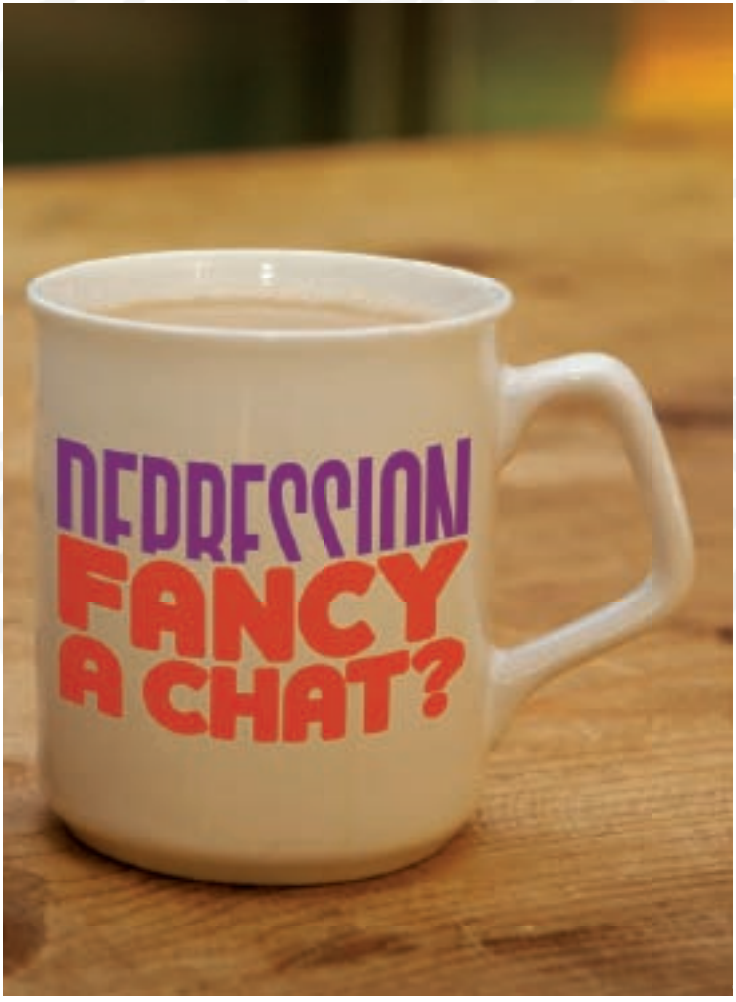
The same must be said of 39-year-old Ben. He, too, is a big man in every sense and takes his work very seriously. He believes that advertising, providing it is focussed, truthful and ethical, can be a

force for good in our lives. Conversely, lazy, untruthful and ill-conceived adverts make Ben furious.

Like many born-and-bred Londoners, he is not afraid to speak his mind and is not a great fan of the city's flamboyant Lord Mayor, Boris Johnson, who he believes doesn't have sufficient gravitas and depth to tackle London's complex challenges.He is happier talking about his beloved Queen's Park Rangers, whom he has supported through thick and thin (mostly thin recently) since he was a little boy. He lives close to QPR's ground in Hammersmith with his wife Debbie and his young son Stanley is named after the QPR legend Stan Bowles.

"Like Charlie, Bowles was a star. He had this most amazing talent and was a true entertainer. OK, he wasn't perfect and had a colourful private life with a colossal gambling habit, but he gave a lot of people a lot of pleasure," said Ben, in admiration.

Conversely Ben Walker's superb new booklet will – hopefully – prevent a lot of people suffering a lot of pain. That's an achievement of which Ben, and the Trust, can be immensely proud.



Copies of the new booklet are available from the office or can be downloaded from www.cwmt.org

Report from the Fundraising Committee

Despite the recession our fundraising continues to be buoyant and we still have major events to come before the end of 2010 which should bring our annual income in line with our projected expenditure.

We would like to thank all those who put on events in the first six months of 2010 which include the Leanda de Lisle Talk at Petyt Hall, Ripon Race Meeting and Bradfield Cricket. There are also many outstanding individuals who have taken part in the London Marathon, Blenheim Triathlon, Borneo Challenge and Kilimanjaro Climb.

A large proportion of our work involves volunteers. We are so grateful for this support, so often unsung, they make CWMT fundraising possible.

Finally, 2011 may prove to be a very difficult year to fundraise as the tax cuts begin to bite so every effort will have to be made to maintain our momentum. All offers of help will be greatly appreciated.

Rachel Waller

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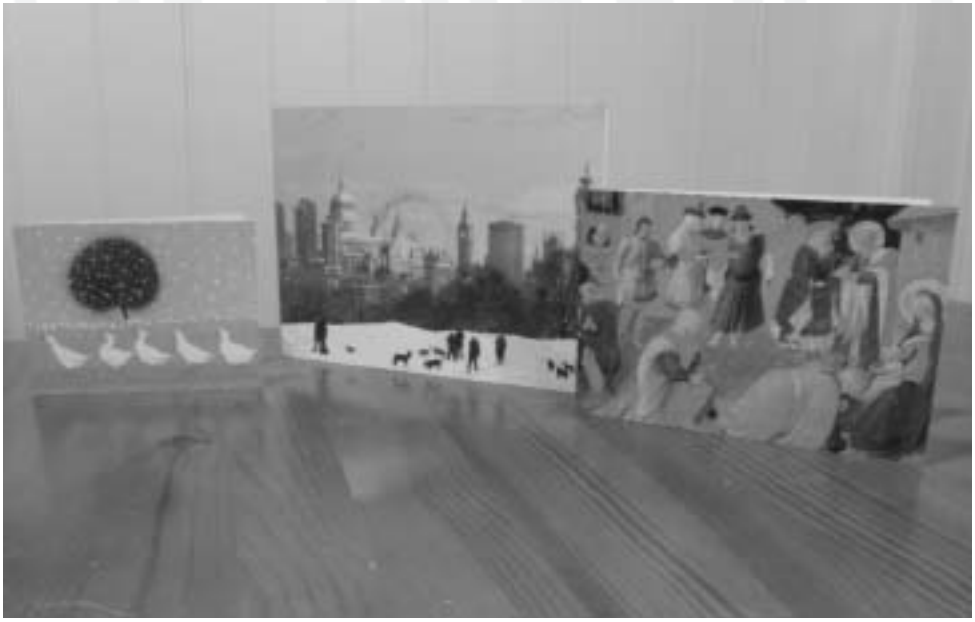
Message to All Who Recieve CWMT News by E-mail

This is to let you know that CWMT CHRISTMAS CARDS are now available.



Cards and prices can be viewed on the website www.cwmt.org where you will also be able to download an order form
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The Young Committee

Don't Grow Up! Picnic in Hyde Park

The inaugural 'Don't Grow Up' party was approached by the Sharky and George team with some trepidation. How to entertain 80 of London's top young professionals in the style of a 5 year old's children's party?

Well we needn't have worried as it turns out none of them had really grown up from the days of jelly, ice cream and a good game of Grandmother's Footsteps! Having substituted the Ribena and Umbongo for Pimms and light ales everyone's competitive streak came to the fore with a tug of war tournament, sock wrestling and a water bomb catapulting all into a race to make the highest human pyramid!

Every team made a fantastic effort with great costumes and an after party at Kitts club meant there were no tears before bedtime!

Charlie Astor

The Ponzi Dinner Party Scheme

In March we launched the CWMT Ponzi Dinner Party Scheme (Ponzi being the first well publicised architect of a pyramid scheme in the 1920s) Taking inspiration from the disgraced Bernie Madoff, we converted his illegal Ponzi Scheme into a legal, awareness and, we hope, fund raising juggernaut.

The idea is very simple. The Young Committee (10 of us) each hold a dinner party at home, inviting around 7 guests asking them to bring a bottle of wine, a fiver and most importantly the promise to hold their own Ponzi Party in the future. The host hands out some information on CWMT, talks for a minute or two about the danger that depression presents to young people before having a fun evening with some old friends.

For the first round of Dinner Parties we cast our social net far and wide, inviting old friends, who we do not see regularly, to broaden the pool of potential hosts. Each of the guests then hold their own Party with their guests carrying on the promise and the pyramid soon grows. Our aim is to get four 'generations' of hosts to hold Ponzi Dinner Parties this year.

Already 5 second round dinner parties have been completed and many more are in the pipeline. With everyone's help to make the maths a reality, together we can raise £140k and crucially introduce or remind 28,000 people of the dangers of depression and, hopefully, help banish the stigma of mental illness. All this in the first year of the scheme!

Rose tinted sums they may be, but the upside is unlimited and the downside is, unlike Mr Madoff's scheme, nonexistent...

Charlie Vaughan-Lee

You can check out the progress on http://www.justgiving.com/CWMTponzi

For more information on the scheme, or if you would like to host your own dinner party and help us grow the pyramid quicker than planned, please email pyramid@ponzi.org.uk. Bernie or Charles will send you a PDF explaining more!

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Dinner and Auction at Ripon Races

By any standard the amount raised on 16th June was a remarkable achievement – and all the more astonishing when we consider the financial straits the country is in. But the real tale of this wonderful night is far, far bigger than just a number at the bottom of a balance sheet, no matter how large that number might be. The true prize here was that the Trust gained a small army of new supporters who have become ambassadors alongside the band of dedicated recruits already signed up to the cause.

I should have known what to expect. Week in and week out, during the football season, I sit next to Robert Beaumont, Charlie's uncle, sharing the agony – and very occasional ecstasy – of following York City FC's misfortunes. In short, Robert is a dear friend – and I know just how much Charlie meant to him – and how important is the work of the Trust, in which he is heavily involved. So, I was delighted when Robert suggested an evening involving three of my four favourite activities: eating, drinking and horse-racing. (And no, not what you were thinking, music is the fourth.) What this supposedly-cynical journalist wasn't prepared for was an evening of incredible emotion intermingled with a lot of fun too.

Charlie's father, Mark, described with moving candour just how the symptoms of Charlie's depression had eluded him and other members of the family – and how the determination grew to do something practical to help other sufferers of depression and their families and friends.

The work of the Trust has gradually become much bigger than anyone could have imagined when it started after Charlie's death in 1997. To illustrate the point, Mark listed some of the Trust's achievements. Working with Professor Andre Tylee, from King's College Institute of Psychiatry to
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help GPs recognise the symptoms of depression... led to a need for trainers to make sure the message is delivered. There are six CWMT trainers now. But there is no point in training people to recognise the symptoms if there is a six to nine-month waiting list to see a counsellor... so counsellors are being trained too. The impressive list continued: a student depression website, an e-learning programme for nurse training... funding for a Chair in Evidence Based Psychological Therapies at Reading University.

For those of us who had known only a little of the Trust's work, the message was clear: to be effective, the Trust needs both a wide range of activities – and great depth too, with lots of work laying foundations for the future.

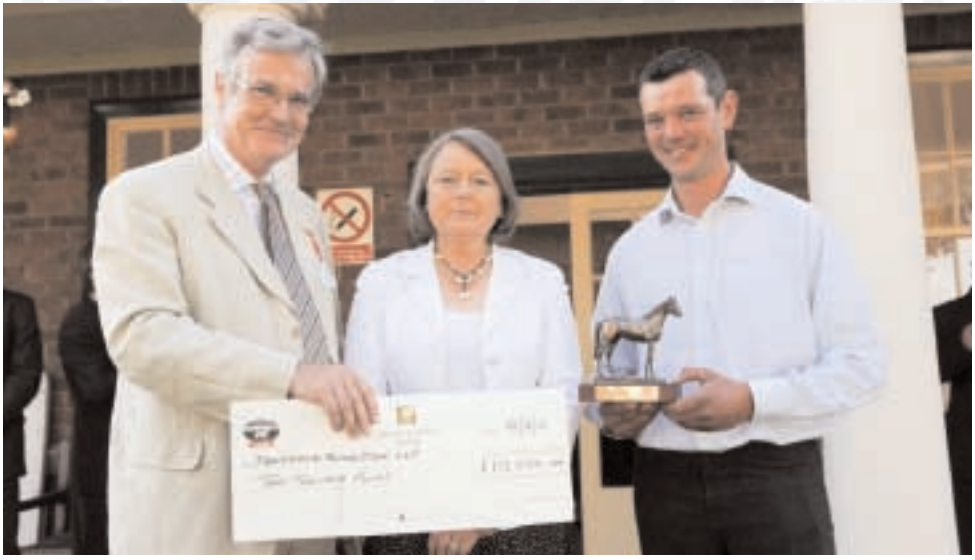
When the time came for the Auction, we knew what we had to do: bid, bid, bid, and bid again and that is just what happened. Mark Durden-Smith, Charlie's friend and a presenter of "TV shows nobody watches" (his words not mine) led the proceedings with an entertaining mixture of waspish humour and fund-raising focus, teasing great prices from the audience of North Yorkshire's elite, bringing bidders amusingly down to earth with instant nicknames. - Posh, Becks and Baby Spice spring to mind.

There was also a flash of disarming insight into the camaraderie of Mark's long friendship with Charlie: "We were close friends. But not too close. It has been suggested that we shared socks. That's true, but it was all one-way traffic – and I never borrowed his!" It was a lovely moment, a small detail and a touching reminder of the real person behind the name on the Trust's badge.

Oh, I nearly forgot to mention the racing! Thanks to the helpful tip-sheet, supplied by top amateur jockey, Annabelle Armitage, whose parents Gillian and David are long-time CWMT supporters, most of us managed to find the first two winners. Sadly, though this was flat racing, things went downhill after that, with most people ending up supporting not just CWMT charity, but also the Bookmakers' Benevolent Fund.

This was a tremendously successful event, for which many thanks go Mr & Mrs Andrew Firth, who provided and sponsored the wine and to James and Jane Hutchinson of Ripon Racecourse, 'the garden racecourse', surely one of the loveliest places to enjoy this sport anywhere in the country.

David Nicholson



Mark and Rachel Waller present the trophy and cheque to the trainer of Defence Council, the winner of The Charlie Waller Memorial Stakes

The Grey Girls — an Untold Story

On 15th April an audience of over 100 assembled at the lovely Petyt Hall, attached to Chelsea Old Church, to listen to the acclaimed historian and author Leanda de Lisle.

Mark Waller, Leanda de Lisle, Sue Shenkman

Leanda, contributes regularly to many national papers and magazines, including the Guardian, Daily Mail, Spectator and New Statesman.

We were treated to a lively talk illustrated by many slides depicting Lady Jane Grey and her little known sisters, Katherine and Mary.

Based on her recent book, The Sisters Who Would be Queen, Leanda's lecture threw great light on the brief and grim times of Lady Jane Grey and her two younger sisters. We were given real insight into the drama of these Tudor times through Leanda's sensitive and amusing account of the lives, loves and eventual downfall of this tragic trio.

A greatly appreciative audience awaits her next book with enthusiasm.

Sue Shenkman

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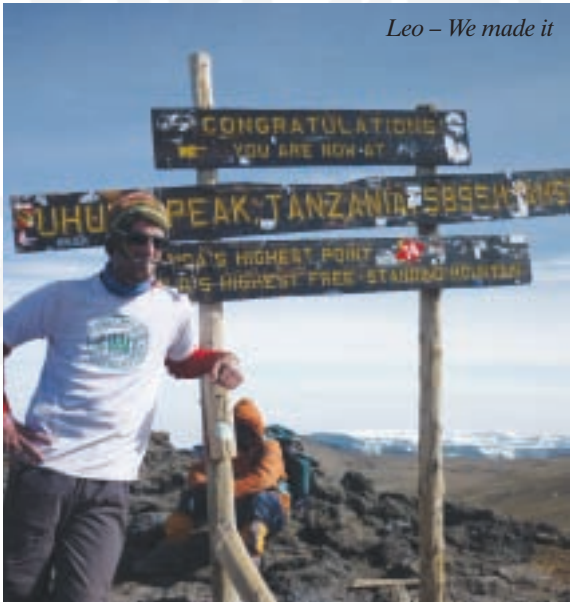
Kilimanjaro Climb

Thank you to everybody who has generously sponsored me for the Kilimanjaro climb. It really inspired me to reach the top in what was the hardest physical challenge I have ever done. We used the Marangu route which takes just over 3 days to reach the summit (5895m).



Leo – We made it

Whilst being the quickest route it leaves the shortest time to acclimatise to high altitude. When I reached the summit I felt like a chain smoking 85yr old who had just run a marathon using a bottle of JD for hydration! The final ascent occurs at night time, when it is freezing cold, so you can watch the sunrise from the summit. twenty five out of twenty six of our team reached the mountain top as a team which apparently is very rare. Sticking together enabled us to achieve our goal.

Leo Hacking
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Challenge Borneo

The twelve of us met at Heathrow; I had never met four of the faces and most people didn't know one another. The "Challenge Borneo" team was made up of both sexes, ages ranged from thirty two to twenty. Every person, bar a couple, had personally experienced depression or knew of a close relative who had done. The team were all au fait with the mental torture those with the illness face, the road to recovery – that can be long for some – and the stigma associated with it. Some of us spent time throughout the trip discussing our experiences. The team morale was second to none. All of us were raring to start the adventure. Two goals of the trip, raising awareness of the trip (and indirectly, depression itself) and fundraising had both been highly successful.

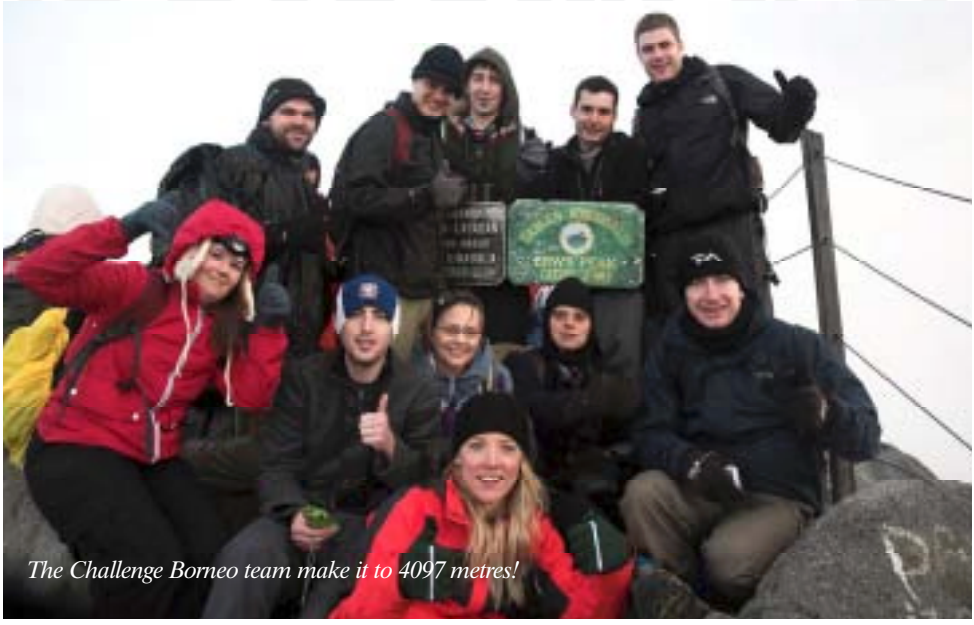
The journey took fifteen hours, crossing various time zones, before we arrived at Kota Kinabalu (KK), the capital of the Sabah state in Malaysian Borneo. Many people of Sabah are of Chinese origin and this showed in the excellent food we ate throughout the trip, which was all freshly produced.

The first part of the trip was spent within the vicinity of Mount Kinabalu, a jagged peak strutting up at 4093 metres high. After the highly demanding but stunning climb to the summit, we spent time cycling and trekking across the mountain's foothills, sleeping at various traditional locations. The humidity made the cycling extremely challenging. The last part was spent on Sabah's east coast, spotting orangutans and drifting down the Kinabatang River, a truly sensational experience.

My aim is to run the same trip each year, so that a new set of like-minded people can embark on an unforgettable experience and can continue to spread the word about CWMT, raise funds and ultimately help change the face of mental health care delivery. The website will still be www.challengeborneo.co.uk. The fantastic operator who delivered the challenge was Fieldskills (www.fieldskills.com)

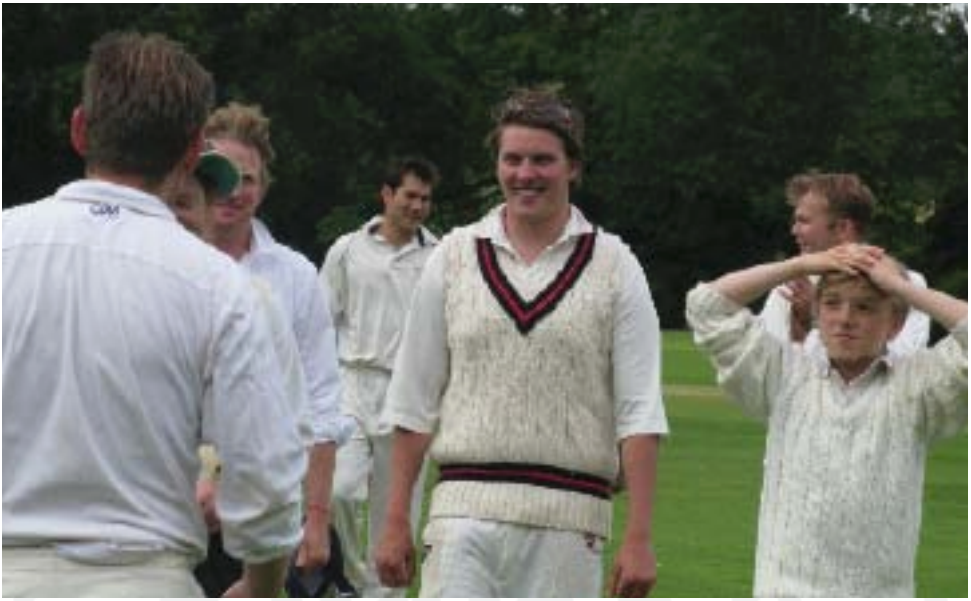
I am now back studying medicine in my final year and am in the process of developing an online tool to help bridge the gap between the supply and demand of service provision for acutely unwell depressed patients. Watch this space,

Lukas Kalinke lkalinke@gmail.com

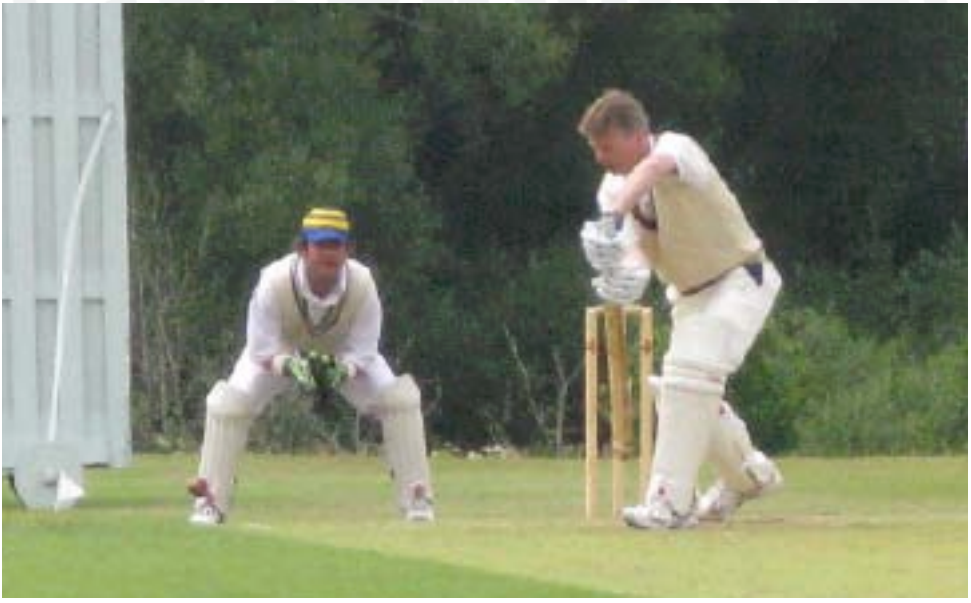


The Challenge Borneo team make it to 4097 metres!

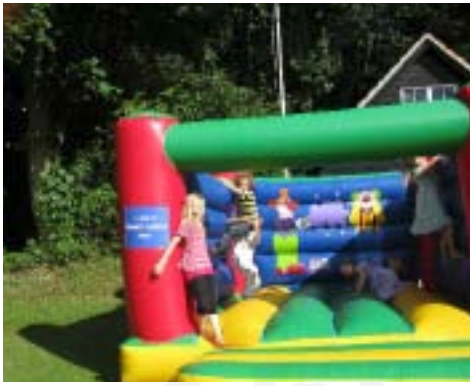
Annual Bradfield Cricket Tournament



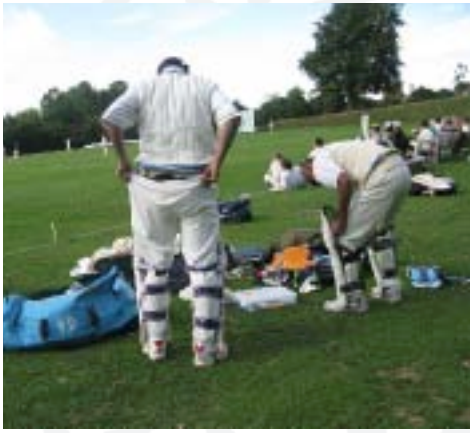
Making good use of the things that they find – The Champion Wombles.



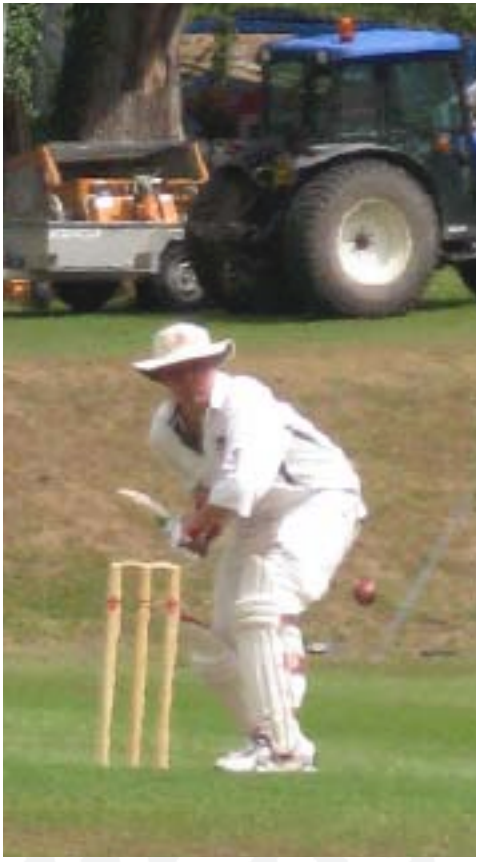
Classic day, classic pose – Guy Barker eases one through the covers.



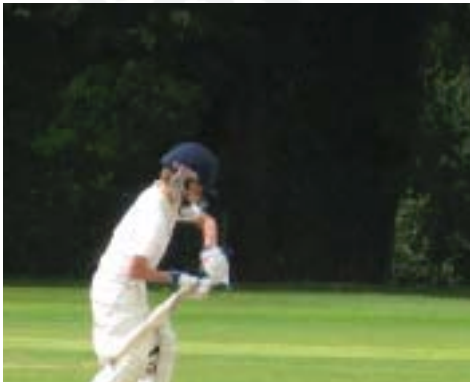
No pads needed.



Padding to protect the padding.



Agricultural from Richard Fuller (that's his tractor behind)



Technique from Callum Butler (he could play for Scotland one day).

Not everyone is riveted by the cricket. This lot focused more on London 2012.

Blewbury (Oxfordshire) Tennis Club

This year nominated CWMT for its charity tennis tournament. Huge thanks for their generous donation.

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Grand National Lunch

Susie Reynolds and Henny Hales held a hugely successful Grand National Lunch in London in aid of CWMT. We are immensely grateful to them for organising this fun event.

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2010 Mazda Blenheim Triathlon

After a little persuasion from a friend, Edwin Case was persuaded to compete in this triathlon. Not only did he complete this physical challenge, he also exceeded his fundraising target for CWMT.

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Edinburgh Marathon

Nick Cumming-Bruce got out his running shoes to compete in this marathon for CWMT.

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London Marathon 2010

Thanks to Henrietta Andrews, Edward Bond, Helen Brown, Clara Hebblethwaite, James Henderson, Charlie Kilner, Richard Openshaw and Antonia Wainman for their months of training, getting up early and completing the course on our behalf.

Help CWMT by Making us More Efficient

An ongoing challenge Marigold and I face is keeping our database up-to-date so we would be grateful if you could take the time to inform us if:-

(a) any of your details are incorrect. The information required is given below

Change of Address

Change of Name

(b) I/we would like to receive future editions of the Newsletter by Email

(c) I/we would like to be removed from the mailing list

Bronwen Sutton

Making a Donation

There are various ways to make a contribution to the Trust all of which would be greatly appreciated:-

REGULAR DONATIONS

A Banker's Order form (including a Gift Aid Declaration for UK taxpayers) can be found on the reverse of this page

ONE-OFF DONATIONS

If you simply wish to make a one-off donation please enclose it with the completed Gift Aid section on the reverse of this page, if you are a UK tax payer

JUSTGIVING

In 2006 CWMT embraced the 21st Century and became part of the virtual world by registering with the Charity Website JUSTGIVING.

The site is extremely convenient as it allows you to donate securely online, using a credit/debit card (**www.justgiving.com/charliewaller/donate**) JUSTGIVING can also be accessed by using the link on the CWMT website.

The Importance of Gift Aid

The Gift Aid scheme, covering charitable donations made by UK income tax payers, is becoming increasingly significant both to charities and donors. Our Gift Aid tax recovery alone covers a considerable part of the annual support costs of a Waller Mental Health Trainer, as we are able (at present) to recover 28p on each £ donated by a UK tax payer. But equally important, providing the donor declares the donation on his or her tax return and is liable to income tax at the higher rates of 40 or 50%, the higher rate tax will be refunded by Her Majesty's Revenue and Customs to the donor or, alternatively can be paid by HMRC directly to a charity; and the refund itself would qualify as a further donation for Gift Aid tax relief. A virtuous circle indeed!

If you have not already lodged a form with us and would like to make your past or future donations under the scheme, please complete the form overleaf and send it to us.

BANKER'S STANDING ORDER FORM

Please complete your details below in block capitals, sign and date the form then return it to:

Mrs. B. Sutton, Secretary, c/o Charlie Waller Memorial Trust, 16a High Street, Thatcham, Berkshire RG19 3JD

Name & address of donor(s) To.....

bank in full: of .....

Please pay to:
National Westminster Bank (56-00-13), Aldwych Branch, PO Box 221, Connaught House, 65 Aldwych, London WC2B 4EJ for the credit of the Charlie Waller Memorial Trust (Account No.86310232)

The sum of.....

(in words).....

Date when payments should start: Every month ☐ Every quarter ☐ Annually ☐

Starting on the .....(day) of.....(month).....(year)

Please allow at least one month from the date of sending this form to CWMT.

Signature: .....

Date: .....

Full name in capitals: Title.....

Name.....

Account to be debited: .....

Account No. .....

Sort Code: .....

This instruction cancels all previous instructions in favour of the Charlie Waller Memorial Trust (Registered Charity No.1109984)

giftaid it

Simply sign below and the government will refund the appropriate tax credit.

Please regard this and any future donations to the Charlie Waller Memorial Trust (Registered Charity No.1109984) as Gift Aid. I confirm that I am a UK taxpayer and will have paid sufficient income tax or capital gains tax during the current tax year to cover the tax reclaimed on this donation.

Signed: .....

Date: .....

Name: .....

Address: .....

.....

.....

Postcode: .....

NOTE: You must pay an amount of income tax or capital gains tax equal to the tax which the Charity reclaims on your donations; you must remember to notify the Charity if this ceases to be the case.

FORTHCOMING EVENTS

TUESDAY 12TH OCTOBER 2010

AUTUMN LUNCH

Babylon Roof Garden Restaurant, Kensington

FRIDAY 15TH OCTOBER

THE YOUNG COMMITTEE'S STAND UP COMEDY EVENING

Union Chapel, Islington

Comedians include Tom Basden, (best newcomer at Edinburgh Festival 2007), Sanderson Jones, Johnny Sweet (best newcomer at Edinburgh Festival 2009), with lots more to confirm. Tickets can be bought directly from the venue's website — Union Chapel http://www.unionchapel.org.uk/events.php

TUESDAY 2ND & FRIDAY 5TH NOVEMBER

AGA COOKERY DEMONSTRATIONS

2nd Nov (Preparing for Christmas) and 5th November (Cooking for Men)

Contact Diana Wainman - Tel: 01256 770253, email: diana@wainman.net

TUESDAY 16TH NOVEMBER 2010

CONCERT BY THE LONDON CHARITY ORCHESTRA

St John's Smith Square, London

MONDAY 13TH DECEMBER 2010

CAROL SERVICE

St Luke's Church, Chelsea

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TUESDAY 25TH JANUARY 2011

QUIZ NIGHT

St Columba's Church of Scotland Hall, Pont Street, London

WEDNESDAY 9TH MARCH 2011

CLASSIC FILM NIGHT

The Coronet Cinema, Notting Hill Gate

SUNDAY 17TH APRIL 2011

VIRGIN LONDON MARATHON

Runners Welcome

SUNDAY 10TH JULY 2011

CRICKET TOURNAMENT, BRADFIELD COLLEGE

To keep up-to-date with future events please visit our website www.cwmt.org or contact the office, Tel: 01635 869754: e-mail: admin@cwmt.org
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Sources of Help and Advice

CWMT is not in a position to offer advice. If you or anyone you know is feeling depressed, then medical help must be sought. However, listed below is a small selection of organisations where help may be obtained. The services offered by these agencies are intended to augment, not replace, medical advice.

NHS DIRECT 0845 46 47

NHS STRESS LINE 0300 123 2000

SAMARITANS 0845 790 9090

YOUNG MINDS PARENTS HELP LINE 0808 802 5544

(For parents with a concern about their child's emotional problems or behaviour)

PAPYRUS HOPE LINE 0800 068 4242

(For practical advice on suicide prevention – particularly teenagers and young adults)

STUDENTS Visit www.studentdepression.org.uk

We hope this short list proves useful. For further information go to *Sources of Help* at www.cwmt.org where contacts are listed by Region and Nationally

Inclusion here does not mean that CWMT recommends or endorses any of these agencies above others working in the same field, nor can we guarantee that the organisation will have a solution to your particular problem. It should be remembered that information on the Web is not always reliable and some of it must be treated with a touch of caution; special care **MUST** be taken if consulting sites claiming to offer medical or pharmacological advice.

All details correct at time of going to press.

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