

# Rehabilitation and Social Psychiatry Faculty Newsletter



Issue 8  
Spring 2006

Co-editors: Lindsey Kemp  
Alison Gray

## A word from the editors

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By the time you read this you should have recovered from the rather hectic festive season and be back into the thick of work once again. Spring, we hope, is not that far away, with the promise of brighter weather and nature coming to life.

Following on from a highly successful annual meeting in Glasgow, the faculty is preparing a joint meeting with our colleagues in the Faculty of General and Community Psychiatry for October 2006 in Southampton.

This looks like being a year of yet more changes for all of us with the recent publication of *New Ways of Working*, which will affect our day-to-day roles. The F1 and F2 doctors are now apparent in many trusts, heralding the gradual demise of the SHO, as we know them. This will have increasing effects on the

amount of extra work we do and supervision we need to provide as these new posts increase in number.

The Royal College of Psychiatrists are currently producing an updated Council Report on Safety for Psychiatrists (Revision of CR78), which is due to be published later this year. This is an issue for all doctors but particularly those in Forensic, PICU and Acute Units.

The Government is planning changes to the incapacity benefit system, which will have effects on the majority of our patient group. Their Green Paper is expected any day now, having originally been due out in October 2005. The College hopes to be able to give evidence to the Select Committee on this issue. If you have strong views about the proposed changes please make them known.

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Newsletter of Faculty of Rehabilitation & Social Psychiatry.  
If you would like to contribute to the newsletter, please e-mail us at [lindsey.kemp@icc.wkentmht.nhs.uk](mailto:lindsey.kemp@icc.wkentmht.nhs.uk)

### **The rehabilitation consultant: current experience, future prospects**

In June 2005, at its annual Strategy Day, members of the Rehabilitation and Social Psychiatry Faculty Executive Committee spent some time considering the role of the consultant rehabilitation psychiatrist within contemporary mental health services. Here I give a short account of our discussions.

Rehabilitation services vary enormously across the UK (as the national mental health service mapping exercise relating to England confirms: see and then interrogate <http://www.dur.ac.uk/service.mapping/anh/queries/>). Interest and investment in rehabilitation seems to be cyclical: hospital closure programmes were, in the past, a stimulus to service development as are now local experiences of accumulating hard-to-place patients on acute wards and within very expensive out-of-area treatments. There is a clear long-term trend of expansion in consultant numbers and service provision, although this has recently been compromised by the rebadging of some established community rehabilitation teams as Assertive Outreach Teams, and consequent loss of service to the particularly vulnerable client group generally served by a community rehabilitation team. There are also recent anecdotal accounts of well-established services being threatened with cuts or closure, reflecting the financial pressures currently experienced by all mental health services.

#### **Current experience**

Rehabilitation psychiatrists are commonly working in isolation as a lone expert within a larger group of consultant and managerial colleagues, at times receiving personal support only from their multi-disciplinary team. This isolation means that the rehabilitation consultant can readily feel ignored, marginalised and even on occasion bullied, particularly when the rehabilitation service is under financial threat. Finding an appropriate peer group can be challenging: sources of personal and professional support are not always readily available and meeting needs for Continuing Professional Development can be difficult. There is a perception within some mental health services that there is no need for a dedicated rehabilitation service, a perception reinforced by a lack of central guidance from the Department of Health on rehabilitation and continuing care that stands in sharp contrast to the generally frenetic pace of policy production.

One recurring problem is the apparent weakness of the evidence base underlying psychiatric rehabilitation practices. In an era of evidence-based health and social care it is a severe problem for the specialty that Cochrane collaboration meta-analytic reviews are currently unable to address the complexities surrounding the long-term care of people with the most severe disabilities. Disappointingly, the NICE Schizophrenia Guideline (NICE, 2002), which draws on good practice as well as evidence from controlled trials, has little

meaningful to say about the management of the more social disabilities that accompany schizophrenia, and the appropriate interventions for people who are resistant to standard treatments.

However, rehabilitation psychiatrists have a wide range of expertise and much to contribute, locally, regionally and nationally. Rehabilitation principles have wide applicability throughout adult psychiatry and rehabilitation psychiatrists are well used to the need to be resilient and to take a long-term perspective. The specific expertise of the rehabilitation psychiatrist encompasses: clinical skills in the care of people with treatment-resistant psychosis, who now commonly have co-morbid substance misuse; skills in the management of risk and in particular in the calculated taking of risks; consultation skills with medical colleagues and residential and nursing care service providers; and management skills that, for example, involve working with and motivating multi-disciplinary teams, needs assessment, service development and effective working with partner agencies. Many rehabilitation psychiatrists have developed strong links with local providers of supported housing, residential and nursing care and services that offer day care and work rehabilitation.

Rehabilitation psychiatrists have been at the forefront of service innovations, including most obviously the successful mental hospital re-provision programme, and have enthusiastically embraced the recovery agenda (Roberts and Wolfson, 2004). In some areas, placement into residential and nursing care and out-of-area hospital treatments is well organised, with the rehabilitation psychiatrist playing a key role in the placement panels that commit

expenditure, and helping to structure the review process.

### **Future prospects**

Active regional representatives have been able to foster a support network for the isolated rehabilitation consultant. Strengthening the community of rehabilitation psychiatrists must be a major priority for the Faculty. This may involve drawing in psychiatrists who are working in some of the new “functional” community mental health teams, particularly Assertive Outreach Teams and Early Intervention in Psychosis teams, where rehabilitation and recovery skills are obviously relevant. The rehabilitation community also needs actively to embrace psychiatrists undertaking rehabilitation tasks within Forensic Mental Health Services and in independent hospitals. The support network should extend across regional and national boundaries, making best use of new technology.

The training of future specialists in rehabilitation psychiatry is a major issue, and a major concern, as postgraduate medical education undergoes a period of turbulence and reform. There is an opportunity to clarify the skills underlying the effective practice of rehabilitation psychiatry and to develop formal programmes that will provide the required clinical and managerial skills. Rehabilitation psychiatrists, both those practising and those in training, need access to the best current evidence in recovery, rehabilitation and continuing care and best practice in the health and social care domains that the specialty straddles. The research community must be galvanised to address key issues of concern in rehabilitation. Partnerships need to be developed at a national, regional and local level with a multiplicity

of stakeholders in the shared enterprise of improving outcomes for the patient/client/user who experiences disability and disadvantage as a result of severe mental illness.

### Next steps

There are strong grounds for optimism about the future of rehabilitation psychiatry as a specialty. The Faculty newsletter and regional representatives have a crucial role in communicating good practice and providing opportunities for peer support. Opportunities for developing training in the skills painstakingly acquired by established rehabilitation psychiatrists will be explored. More work is required on establishing the evidence base for the speciality, although much has already been achieved in the writing of the

forthcoming Gaskell publication of *Enabling Recovery: The Principles and Practice of Rehabilitation Psychiatry*. Position papers have already been prepared on the need for rehabilitation in contemporary mental health services and the management of out-of-area treatments, and a joint document from the Rehabilitation and Psychotherapy Faculties on Psychosocial Interventions is soon to be published. The Faculty executive will be seeking to influence the future training of psychiatrists and will be active in consolidating existing partnerships with other bodies concerned with the treatment and care of people with severe and enduring mental illnesses and developing new strategic alliances.

Frank Holloway, Chair, Faculty of Rehabilitation and Social Psychiatry

## **FORENSIC REHABILITATION: CAN WE IMPROVE THE RECOVERY PROSPECTS FOR THOSE WITH TREATMENT-RESISTANT ILLNESS IN SECURE SETTINGS?**

Many service users within longer-term secure settings, at high, medium and low levels of security, share many characteristics with those in rehabilitation and recovery services. They suffer from treatment-resistant mental illness with functional difficulties and co-morbid problems, such as substance misuse, cognitive deficits and personality difficulties. Like the rehabilitation and recovery client group, they may be perceived as being likely to have a poor outcome in terms of achieving personal goals and autonomous lifestyles. Yet there is evidence that therapeutic relationships with a well-functioning team, working with shared goals, maintaining hope, a systematic approach to meeting needs and appropriate environmental support, can improve outcomes. All of these are basic elements of a rehabilitation and recovery approach.

In addition to the characteristics outlined above, service users within secure services may have committed serious offences or exhibited challenging behaviours in hospital settings, often over prolonged periods of time. There is a very good case for the adoption of rehabilitation and recovery approaches in high, medium and low secure settings, as well as addressing needs relating to risk. This would improve the outcome for individual service users, enabling people to live in the least restrictive settings possible (remember that very sensible Reed Review?) - but also would enable the whole system actually to function effectively. More about that later...

There are major changes occurring in forensic services at present, with high-security hospitals retracting and an expansion of NHS longer- term medium secure units, to meet the needs of people who have been detained in high security, sometimes for many years, who did not need to be there. There is also an increase in demand for secure out-of-area treatment (OAT) beds, as the NHS provision cannot meet the current demand in spite of a considerable expansion in provision over the last five years. The issues relating to OATs have been outlined by Steffan Davies, Susan Mitchell and colleagues from our Faculty, in their excellent paper which can be found on the College website.

It is a more than a little depressing that large mental hospital beds appear to have been replaced one for one, often by increased secure beds. This is in spite of major advances in community services, including the development of assertive outreach and crisis teams. These issues and some welcome solutions (which begin with the letter 'R') have been explored in another excellent paper by the chair of our Faculty, Frank Holloway, also on the College website.

What is going on? Why are forensic and other secure services expanding like 'Topsy', and why has security become such a major issue in mental health? Remember those days when locked wards were considered retrogressive and frowned upon? It may have been the last century, but actually it wasn't that long ago!

There is evidence that a more risk-averse culture is influencing public policy and the new Mental Health Bill (in contrast to its predecessors) could be seen as an example of this.

At a clinical and service level, I think there is a need for increased attention to rehabilitation within secure services; improved interface working between services which would enable service users to move more freely through the system (both up and down the levels of security); and the development of community service infrastructure which could potentially support this higher-risk client group outside hospital. Much more attention to what is required at the community end of the chain is essential, and surprisingly absent from the national plans around the retraction of the high security hospitals.

While the majority of users of secure services are men with severe enduring mental illness, there is reason for considerable concern about the plight of women with complex mental health needs in prison, often convicted of offences which do not represent grave risks to public safety. These women may be denied access to services because of a system of psychiatric labelling which categorises them as suffering from 'untreatable' personality disorder, when there is an increasing body of clinical experience and evidence that they may do well with treatment with medication and psychological interventions. I think our Faculty will be giving further consideration to the issue of the unmet need for mental health services for this group of women over the next few years.

I think there are many clinicians within our Faculty who either work in secure settings or work with high-risk patient populations in other settings, including the community (most of you, I expect!). We are currently drawing together a strategy paper outlining some proposals to support the development of rehabilitation approaches in secure settings, to support training and CPD activities in forensic rehabilitation, and to improve interface

working in conjunction with the Forensic Faculty. The strategy paper is in one of many drafts – we would greatly welcome comments. Please send me your e-mail address if you want to see this paper and if you want to be informed of any forensic rehabilitation events.

Just advance notification of one event planned for 2006:

Mersey Care NHS Trust is holding a one-day conference in Liverpool on Forensic Rehabilitation on 5<sup>th</sup> April 2006. This is a multi-disciplinary conference with national speakers from rehabilitation psychiatry,

psychology and nursing backgrounds. Come along to the glorious City of Culture 2008 and bring your teams!

Our clinical psychologists are also organising a conference on psychological approaches for psychosis in forensic settings at the end of August 2006. This should also be very interesting and I will have more details soon.

Pat Abbott  
Mersey Care NHS Trust  
e-mail [pat.abbott@merseycare.nhs.uk](mailto:pat.abbott@merseycare.nhs.uk)

### **The Douglas Bennett Prize**

Awarded annually for the best paper on Rehabilitation Psychiatry presented by a psychiatrist\* (maximum length 2000 words)

For further information contact:  
Michelle Braithwaite, Conference Office,  
Royal College of Psychiatrists  
e-mail: [mbraithwaite@rcpsych.ac.uk](mailto:mbraithwaite@rcpsych.ac.uk)

Closing date for applications:  
1st September 2006  
Please send 3 copies per submission

\*To include consultants within two years of appointment, basic and higher trainees and non-career grade psychiatrists

### **An interview with Geraldine Strathdee**

#### **Developing targets that should actually help**

Geraldine has been seconded to work part-time with the Health Care Commission (HCC) for almost a year. With wide experience in adult psychiatry, including general adult, primary care liaison, rehabilitation, AOT, service development (with the Sainsbury Centre), or the last seven years, in Bromley as Clinical Director AMH (where, with a strong management team and support from Trust and partnership Chief Execs,

serious service "re-engineering" is ongoing) Geraldine is, in my opinion, well qualified to be two-thirds of our senior psychiatrist representation at the HCC (Jed Boardman is the other third).

Geraldine explained to me what the HCC, established in April 2004 as the newest of sixteen independent national regulatory bodies, is trying to do.

Currently the statutory health and social care agencies collect statistics to feed over 20 national datasets, collecting over

1000 separate fields annually! In addition, there are several regulatory processes eg CNST, PEAT, HSE etc which take place in each trust, covering the hospital inpatient services as well as the community sites (up to 120 sites in our largest Trusts). This data has not previously been pulled together and presented in a way that helps services know if they are achieving the best outcomes for their service users.

Service inspections by CHAI (every three years), the Commission for Social Care Inspectorate (every five years), the Mental Health Act Commission, the National Patient Safety Agency and Ofsted (for children's services) COULD all occur in the same year! (Let's not forget Royal College/PMETB approval visits.) Huge amounts of clinical and management time are consumed preparing for these visits.

The Health Care Commission replaces CHAI, and uses the "Core" and "Developmental" standards described in "National Standards, Local Action" (DoH 2004) instead of "star ratings". (A good read for rehab services and compliance with NICE Technological appraisals is "Core" – a must do now – just in case someone is trying to stop you prescribing NICE drugs.) The HCC will work with other regulatory bodies aiming to rationalise the inspection process, improve the usefulness of data collected for local service evaluation, and help to facilitate local service planning and development. (Do see their website for the formal terms of reference!) Ministers have already announced that it will work in integrated partnership with the Commission for Social Care Inspectorate which, no doubt, will be a great relief to the managers and members of integrated CMHTs.

Users of our services access a broad range of services, including housing, employment and education. Support to gain and sustain employment may well affect acute bed-occupancy levels; the range of supported housing services undoubtedly affects the length of stay on rehab and acute wards. In working on new standards for community mental health services, the aim is to look at the whole system with a view to facilitate whole-system thinking and working. (See Fact Sheet 12, Local Implementation of the Social Exclusion Unit Report for some ideas of local data that may be helpful – find it @ the Office of the Deputy Prime Minister's website.) The HCC aims to help local services identify service gaps and prioritise local development through partnership working.

Currently (2002-03), mental illness costs British society about £46 billion per year. £21 billion are direct costs to the Exchequer, of which £10 billion are spent on benefits, £0.9 billion on GPs' time, £4.9 billion on Mental Health Trusts, £0.8 billion on drugs and £1.4 billion on social services (Richard Layard 6/12/04). About 38% (c. 900,000) of the people living on incapacity benefit are disabled by mental health problems, frequently depression (Hansard 15/06/05).

The whole-system approach is clearly an agenda with which we must engage! We also need to look after ourselves. We work the longest hours in Europe; we have seriously under-developed systems for childcare for the average earner; and poorly developed systems for occupational health. Food for thought!

[Dr Louise Petterson](#)

Consultant Psychiatrist in Rehabilitation

### **Wanted**

#### **College Assessors on Advisory Appointments Committees**

There is a shortage of people to act as a College Assessor on AACs for rehabilitation psychiatry posts. Assessors have to be a member of the College and to have held a substantive consultant post for at least three years.

This is an essential role, for which training is provided, and which allows colleagues an excellent insight into the workings of other services.

Anyone who is interested should contact Frank Holloway  
(f.holloway@iop.kcl.ac.uk) who will pass your name on to the College.

### **Towards equity and access**

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A mental health assessment requires good communication between professional and service user. Ideally, the two share a common language and a common culture. There are mental health professionals from many different cultures and language groups working in the UK. However, there is one native language group within the UK, which has produced few mental health professionals and no doctors. That is the Deaf community. “Deaf” with capital “D” is used to mean those deaf people who use British Sign Language (BSL) as their first or preferred language and who identify with Deaf culture. Deaf people do not view themselves as disabled but as a cultural and linguistic minority. Small “d” deaf is used to identify those who are deaf, but who identify with the hearing community and communicate through English. There are doctors who have become deaf (often as young adults), having acquired English. Such deafened people generally do not learn to use sign language (relying on lip-reading and residual hearing); few join the Deaf community.

In 2003 BSL was recognised as a community language by the Government. There are estimated to be around 70,000 deaf people and around 120,000 who use BSL regularly. This is a similar number to those who speak Scottish Gaelic (2001 census) and the two languages have similar legal status. There are two major differences between the situation for BSL users and Gaelic speakers. First, native Gaelic speakers are predominantly found in the Scottish highlands and Western Isles. The Scottish Parliament has a Minister for Gaelic and in the Western Isles public notices and road signs are bilingual. The Deaf community is spread throughout the UK, with larger communities in cities. There are no Deaf MPs in the UK (unlike e.g. South Africa, Iceland, the Netherlands and Uganda). The second big difference is that there are very few mono-glot Gaelic speakers: almost everyone can speak and understand English. Spoken English is not an option for

Last week one of my inpatients said that James Bond and Winston Churchill would be visiting him that day. He knew this because they had sent a message via the nurses. My immediate thought was that this was a new delusion, but on questioning I found that “James Bond” was the sign name for a friend and “Winston Churchill” the sign name for his brother.

most in the Deaf community. New arrivals in the UK can, in time, learn to speak some English. Deaf people must rely on interpreters and on others learning to sign.

The geographical spread means that most psychiatrists will only meet a few Deaf people in their professional career. The cultural differences mean that a normal but distressed Deaf person may well be perceived as being mentally ill. For example, BSL uses facial expression as well as hand movements for communication. This facial expression may seem very exaggerated to a non-signer and may lead to the psychiatric team querying mania. BSL requires eye contact, so signers use tapping of shoulders and stamping of feet to attract attention, which can appear odd, intrusive or overly familiar to hearing people. Telling stories in BSL involves the signer taking on different people's roles - one minute being the angry young man, the next the sad old lady. This can be misinterpreted as rapidly shifting affect.

Ten per cent of deaf children are born to Deaf parents. They have an accessible language from birth; they show the full range of intelligence and normal psychological development. The ninety per cent of profoundly deaf children born to hearing parents have a different experience. Often they do not have access to a full language until after the time for optimal language development is passed. This results in language-deprived adults who cannot communicate fully in speech or in sign. 'The deaf are virtually the only neurologically normal people who make it to adulthood without having acquired a first language' (Pinker, 1994).

Often families of our service users have never learned to sign; they may have been advised by professionals "don't learn to sign, they will never learn to speak if you do." The Deaf person is then cut off from many interactions and isolated within their own family. They cannot overhear, and so they miss much of normal family life. This results in delayed acquisition of Theory of Mind, with some Deaf people never fully acquiring this (Peterson and Siegal 1995).

Deaf people have difficulties in accessing medical care. Simple things like not being able to phone up for an appointment place barriers in their way. Once they see a GP, communication is an issue: 87% of GPs reported that their communication with deaf and hard-of-hearing patients was good - the Deaf person's experience was of communication difficulties in more than 60% of interactions (RNID 1999). Most GPs felt that writing questions down would provide good communication, but Deaf people commonly have difficulties with reading English (due to an inaccessible school curriculum) and may not really comprehend. The doctor may ask "Do you understand" and the Deaf person commonly will nod out of embarrassment and a desire to please. There are too few fully trained BSL Interpreters and most GP interviews go ahead without formal interpretation. Similarly for those attending hospitals (not in an emergency), 42% experienced difficulties communicating (RNID and BMA 2004).

Given the difficulties in accessing care, it is not surprising that Deaf service users have difficulty getting into secondary mental health care. In the National Deaf Mental Health services, Birmingham, we commonly see people whose psychosis has been untreated for years, the psychosis having been masked by their deafness. On the other hand, we see

people who have been diagnosed psychotic due to communication difficulties and misunderstandings around Deaf culture.

The challenges involved in providing services for Deaf people have been recognised as far back as 1886, when the difficulties in educating deaf children were blamed on “thinly scattered communities, small classes, transport problems and the lack of special training for teachers”. This directly echoes the issues in providing mental health services for this community today.

The Government has produced a consultation document “Towards Equity and Access” (TEA; Department of Health, 2005). This makes a number of recommendations - those that are particularly relevant for rehabilitation psychiatrists include:

- All PCTs and hospital trusts should provide Deaf awareness training for staff.
- Mental health staff should be encouraged to learn sign language and those in specialist services should develop a high level of competence.
- Attention should be given to increasing the numbers of Deaf people employed in mental health services.
- Specialist CPNs should be recruited for areas with greatest need.
- The needs of Deaf carers should be considered.

There is a risk that the impact of TEA will be confined to those who are already aware of the issues. A panel has been convened to consider how to disseminate and monitor progress and how to use the resources linked to TEA.

Unfortunately there is no acknowledgment of BSL skills in the ‘Agenda for Change’ grading of posts. There is no financial inducement for hearing staff to learn BSL. The Deaf nursing assistants in the tertiary services could earn more money in less stressful situations (such as social services care workers). Hence recruitment and retention to Deaf services are very difficult.

Mental health services for Deaf people in the UK are based in three centres, all having inpatient beds. These are in Manchester, London and Birmingham. The inpatient units aim to provide a fully signing environment where all interactions are accessible to Deaf people and where expertise in the subject can be developed. Often patients who have been very distressed on a hearing ward are much more settled once they enter a situation where they can be easily understood. There are specialist CPNs or CPN-led teams in Bristol, the North East and Nottinghamshire, and plans to recruit in other areas.

Medium secure provision is privately run by Alpha Hospitals in Bury, and Rampton Hospital offers secure provision for Deaf men.

Working with Deaf people is fascinating and challenging. Resources are limited and there are many research questions unanswered. Supporting Deaf people in getting equal access to their local services is our ongoing challenge.

Alison Gray

For further information on Mental Health and Deafness read the 2003 APT article by my predecessor in Birmingham, Dr Margaret du Feu.

### References:

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du Feu, M Fergusson, K (2003) Sensory impairment and mental health *Advan. Psychiatr. Treat.* 9: 95 – 103

Education Department; H.M. Inspectors (1886) *Education of deaf and dumb children in the Metropolitan, Manchester and Swansea inspection districts* [www.bopcris.ac.uk](http://www.bopcris.ac.uk) accessed 29.11.05

Peterson CC & Siegal M (1995) Deafness and theory of mind. *Journal of Child psychology and psychiatry* 36(3) 458-74

Pinker, S. (1994) *The Language Instinct*. London, Penguin.

RNID (1999) *Breaking the sound barrier*. London, RNID  
RNID & BMA (2004) *A simple cure*. London, RNID

### Contact details for the specialist services

**John Denmark Unit**, Bury New Road, Prestwich M25 3BL.

Tel: 0161 772 3400; minicom: 161 772 3407; fax: 0161 798 5853

Alpha Hospitals, Bolton Road, Bury BL8 2BS. Tel: 0161 761 6039; fax: 0161 761 6035

**National Deaf Mental Health Services**, Denmark House, Queen Elizabeth Psychiatric Hospital, Mindelsohn Way, Edgbaston, Birmingham B15 2QZ. Tel: 0121 678 2178; minicom: 0121 678 2185; fax: 0121 678 2179

**National Deaf Services**, South West London and St George's Mental Health Services NHS Trust, Old Church, 146a Bedford Hill, Balham, London SW12 9HW. Tel: 020 8675 2100; minicom: 020 8675 2200; fax: 020 8675 2266

### Top Tips - physical healthcare

Do you have difficulty persuading your (non-diabetic), (female?) patients to attend to their feet? IF they have funds (£25), some nail bars offer (mechanical) back massages at the same time. (Very nice!)

Routinely checking prolactin levels, if one has the slightest suspicion of problems, can cause one to worry. (One has to advise changing the drug with levels of 5000!) A recent literature review by one of our pharmacists found little information for or against the combination of clozapine and aripiprazole; a couple of psychiatrists at a workshop at the 2004 residential meeting had used it without problems. (Not yet sure whether I will suggest it or not.)

There is a lot more coming, it seems, on the issue of hyperprolactinaemia and atypicals, so watch this space. I have been routinely checking fasting cholesterol and triglycerides in my inpatients and opc / community rehab / AOT when they are together enough to fast for

Newsletter of Faculty of Rehabilitation & Social Psychiatry.

If you would like to contribute to the newsletter, please e-mail us at [lindsey.kemp@icc.wkentmht.nhs.uk](mailto:lindsey.kemp@icc.wkentmht.nhs.uk)

the last few years. Nearly all are now on statins - many are in their 20s and most are on clozapine. It's one of those things – if you don't check you don't know. L.P.

**A date for your diary!**

**Joint Residential Meeting**

**Faculties of General and Community Psychiatry, the CTC  
and the Rehabilitation and Social Psychiatry Faculty**

Leonard Fagin and Helen Killaspy

*Conference theme: Tailoring services to the needs of patients with long-term conditions*

**De Vere Grand Harbour Hotel, Southampton**

**19<sup>th</sup>-20<sup>th</sup> October 2006**

We are now well advanced in the preparations for the above conference, which we think will be of great interest to the members of both our faculties. We have invited an array of national and international speakers, and there will be opportunities for focusing on subjects in symposia and entering into interactive dialogues in a large number of workshops.

In order to whet the appetites and start you running to your new diaries, let us give you a flavour of what will be covered in the conference.

We will start on Thursday with Professor Rob Peveler giving an account of current research and approaches to physical health in schizophrenia. Professor Zoltan Rihmer, from Hungary, a world expert on clinical and biological aspects of mood and anxiety disorders, will be talking on "Mental states predisposing to suicide behaviour". We have also invited Professor Eduardo Vieta, from Barcelona, to speak on "Psycho-educational approaches to schizophrenia and bipolar affective disorder".

We have organised a symposium on long-term conditions (LTC), inviting Professor Lynne Stokes from King's College, David Colin-Thome from the Department of Health and Helen Lester from Birmingham, in particular looking at shared care arrangements with primary care. Another symposium will focus on different aspects of physical care for patients, and we have invited David Osbourne from the Royal Free, as well as consultants in cardiology and endocrinology, to address medical consequences of mental illness. We also have a symposium on 'International Perspectives in Assertive Outreach', and have invited well-known speakers from Australia, Canada and the UK to address these issues.

Our workshops cover a wide variety of interests, such as improving standards in in-patient care, alternatives to hospital treatment, safety for psychiatrists, working in partnership with commissioners, management of mental disorders in prison settings, improvements in training in general psychiatry and in rehabilitation psychiatry,

mindfulness approaches to long-term conditions and the therapeutic potential of creative writing.

On Friday afternoon, we are repeating the workshops to give delegates an opportunity to attend at least two each; we will have symposia on out-of-area placements and re-institutionalisation (Professor Stefan Priebe, Dr Stefan Davies, among others), on epidemiological and psychological aspects of psychotic disorders (Professor Glyn Harrison, Dr David Kingdom and Gill Haddock), and on preventative approaches in common mental disorders and timing of treatment (Professor Munk-

Jørgensen from Denmark, Professor Graham Turpin from Manchester).

The meeting will round off with a plenary from Professor Norman Sartorius, Emeritus Professor of Psychiatry at the University of Geneva and ex-president of the World Psychiatric Association, speaking on European perspectives on long-term conditions in mental health.

We hope that you will agree that this year's conference will be well worth your while, and look forward to you joining us in what we hope will be a stimulating and enjoyable event.

### **Books and papers for users and carers ... and the rest of us!**

The long-awaited textbook of rehabilitation, compiled and written by many of our colleagues in the Faculty, is about to be published. Information is already on the Gaskell section of the College website.

### **Enabling Recovery: The Principles and Practice of Rehabilitation Psychiatry.**

**Edited by Glenn Roberts, Sarah Davenport, Frank Holloway and Theresa Tattan**

**ISBN 1-904671-30-6**

**Due for publication in 2006**

### **Royal College of Psychiatrists info**

#### **Advance Notice**

**Faculty of General and Community Psychiatry, CTC  
and**

**Faculty of Rehabilitation and Social Psychiatry**

**Joint Meeting**

**De Vere Grand Harbour Hotel, Southampton**

**19th – 20th October 2006**

Contact College Conference Office

Tel: 0207 235 2351 x 142

[mbraithwaite@rcpsych.ac.uk](mailto:mbraithwaite@rcpsych.ac.uk)

Newsletter of Faculty of Rehabilitation & Social Psychiatry.

If you would like to contribute to the newsletter, please e-mail us at [lindsey.kemp@icc.wkentmht.nhs.uk](mailto:lindsey.kemp@icc.wkentmht.nhs.uk)

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## Your representatives – the Faculty of rehabilitation and social psychiatry

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**Chair** Frank Holloway  
**Hon. Secretary** Robin Arnold  
**Finance Officer** Tom Harrison (Also Regional Rep for West Midlands)

### Members (E= elected; C= co-opted; O= observer):

Pat Abbott	Forensic link	C; Ashworth
Andrew Ashley-Smith		RR, West Midlands
Rosemary Ball		RR, London south west
Jed Boardman	G&C Faculty link	C; London
Clare Brabbins		RR, Mersey
Louise Brink	SAS	C; Clitheroe
Tom Craig		RR, London south east
Mary Creaby	Welsh Division	C; Cardiff
Sarah Davenport	Ex-officio (immediate past chair)	C; Preston
Steffan Davies		E; RR, Trent
Claire Dibben	CTC	C; Cambridge
Bridget Everett	SAS	C; Bradford
Alison Gray	Co-editor of the newsletter	C; Birmingham
Giles Harborne		RR, Wales
Linda Heaney	SpR Representative	C; Bristol
Anna Higgitt	Department of Health	O; London
David Hughes	Chair of Regional Representatives	C; RR North West
Lindsey Kemp	Co-editor of the newsletter	E; Maidstone
Helen Killaspy	Academic secretary	E; RR, London west
Ena Lavelle	Irish College of Psychiatrists	C; RR, Dublin
Moira Ledger		E; Southampton
Godfrey Luyombya	Hon. Sec. Regional Reps	C; RR, London north
Shawn Mitchell		E; Northampton
Susan Mitchell		E; York
Debbie Mountain	Scottish Division	C; RR, Edinburgh
Jane Mouny		E; London
Julia Nehring		E; RR, Oxford
Aideen O'Halloran	Forensic link	C; London
Tor Petit	Web site editor	E; Cheadle
Rob Pugh		E; London
Glenn Roberts	CPD online	C; Devon
Brian Robinson	Curriculum working group	C; RR, South west
Ruth Sagovsky		RR, Estern
Theresa Tattan		E; Bristol
Jane Throssell		E; RR, Yorkshire
Sandra Tough		RR, Northern

Regional Reps required for Kent, Surrey & Sussex (1), Wessex (1) and Northern Ireland.  
Anyone interested please contact Dr David Hughes.

National Conference on Forensic Rehabilitation  
5<sup>th</sup> April, 2006

Crowne Plaza Hotel, St Nicholas Place, Princes Dock, Liverpool L3 0AA

**Therapeutic Approaches in  
Longer Term Secure Settings**

Mersey Care NHS Trust is a major provider of mental health and learning disability services, including high, medium and low security. This conference draws on expertise within Mersey Care and brings together speakers with proved track records of innovative clinical practice.

In addition to an excellent programme, there will be a good range of poster presentations demonstrating some of the clinical projects being implemented in the Trust.

There will also be an exhibition of award-winning art work from the Trust's service users.

**The cost is £95 per delegate**

*(Limited free places are available for Mersey Care NHS Trust staff)*

To request a booking form or further information please contact

Lyndsay Ore, Communications Officer, Mersey Care NHS Trust, Trust Offices, Parkbourn, Maghull, Liverpool, L31 1HW.

Tel: 0151 471 2310, Fax: 0151 473 2863 or email: - [Lyndsay.ore@merseycare.nhs.uk](mailto:Lyndsay.ore@merseycare.nhs.uk)

The booking form is also now available from our web site: - [www.merseycare.nhs.uk](http://www.merseycare.nhs.uk)

## Newsletter contact details

Email: [lindsey.kemp@icc.wkent.mht.nhs.uk](mailto:lindsey.kemp@icc.wkent.mht.nhs.uk) or [Alison.Gray@bsmht.nhs.uk](mailto:Alison.Gray@bsmht.nhs.uk)

Write to: Dr Lindsey Kemp,  
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Faculty of Rehabilitation and Social Psychiatry,  
Priority House, Hermitage Lane, Barming, Maidstone,  
Kent ME16 9HH

Website: [www.rcpsych.ac.uk](http://www.rcpsych.ac.uk)  
Click on College, then click on Faculties, then click on Rehab & Social

**We warmly welcome contributions to the newsletter. These could include letters (up to 200 words), articles (300-700 words), short tips, cartoons etc., etc. Suggestions for articles include topical issues, recent developments, personal views, career experiences, articles from users and carers, book reviews or summaries of conference presentations.**

**If possible, please send contributions to the above email address with the article as an attachment in a Word document. Alternatively, send a hard copy to us by post at the above address, preferably with a copy on disc as a Word document. Thanks.**

This is a publication of the Faculty of Rehabilitation and Social Psychiatry. The views expressed here are not necessarily those of The Royal College of Psychiatrists.