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BULLETIN
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www.rcpsych.ac.uk/college/sig/trans.htm

SHARING KNOWLEDGE AND SKILLS

Foreword by: Prof. Kam Bhui, Chair TSIG

WACP is a new force in International Cultural Psychiatry offering more opportunities for knowledge sharing than ever before. In April 2007, the World Association of Cultural Psychiatry (WACP) co-hosted a meeting with the Transcultural Section of the World Psychiatric Association (WPATPS), and the Japanese Society for Transcultural Psychiatry. A meeting is planned in September 2007 in Stockholm co-hosted by WACP, WPATPS and the Society for the Study of Psychiatry and Culture based in the US. These international meetings bring together expertise and experiences from all nations in areas such as policy, law, service development, clinical practice and research. These initiatives present great opportunities for members to share expertise in this global community. The newsletter and the official journal of WACP are freely available on the WACP website. Membership of these societies offers voting rights on the running of these organisations and in planning the content of future programmes. I encourage Members of TSIG to participate and influence cultural psychiatry in an international context by joining WACP.

The TSIG AGM takes place in Edinburgh on 20th June 2007 at the AGM of the Royal College of Psychiatrists where election of officers will take place. If you have any views or queries in the interim please contact me directly or the Editors of the Bulletin.

CROSS CULTURAL PSYCHOTHERAPY? THE VIEW FROM COGNITIVE ANALYTIC THERAPY.

By: Anthony Ryle DM, FRCPsych (retired)

Britain is a multicultural society and in most industrial towns a sizeable proportion of the population are immigrants or were born of immigrant parents. Some may still live in communities sharing the same background but the majority are absorbed into the wider culture. Many practitioners of medicine, including psychiatry, are also immigrants. In this situation, it would not be possible to match immigrant patients to professionals from the same background even if it were desirable and in most cases it does not matter. In the case of psychiatry, even if the treatments offered are essentially medical, do need some knowledge of the attitudes and beliefs about illness of the patient's culture. And in the case of psychotherapy some knowledge and curiosity are essential. But discussion of cross cultural psychotherapy is complicated because there are many different brands of it and because attitudes to it among doctors are often critical and ill informed. Despite the lukewarm attitudes of most British psychiatrists, psychotherapy and counseling have become widespread activities in the UK, as in much of the Western world, although it remains the case that both the availability of, and the demand for, professional psychological help is unevenly distributed in terms of geography and social class. Although the ideas on which different models of psychotherapy are based are various, psychotherapists share a common understanding, namely that the emotional problems and associated symptoms occurring in physically healthy people rest on different definitions of illness and need treatments which are distinct from the methods employed in medicine.

The scope of psychotherapy

The emergence of the new profession of psychotherapy is explained in part by the decline in the historical supports provided by churches and the increasingly weakened influence of the extended family and in part by the increasing proportion of people who are literate and self-reflective. In Britain, the idea that talking to a professional is an appropriate way of trying to sort out ones problems is now more-or-less accepted and is far more widely available than was the case 50 years ago and the scope of, and indications for, such treatment are better understood. Psychotherapy aims to help patients with mood disturbances and physical symptoms as they occur in people who fail to cope with the ordinary problems and losses of life or who manage themselves and their relationships with others badly. Such people are not physically ill but, as many of the metaphors used to describe emotional states suggest, physical symptoms accompanying emotions are very common. The boundaries between psychological and physical disorders are not always clear, however, given that there are physical disorders, which generate emotional disturbances, and there are emotional disturbances, which generate physical symptoms.

Moreover, medication may relieve emotional symptoms and the pharmaceutical industry has discovered or created a vast market for mood altering drugs, while psychiatry has increasingly named more extreme forms of emotional and behavioural dysfunction as disorders. There are, as a result, unresolved disputes within psychiatry, between psychiatry and psychotherapy and between different schools of psychotherapy as to the proper scope and aims of psychotherapy. Some psychological treatments restrict their aims to the relief of symptoms but the interests of most psychotherapists go beyond symptom relief and behavioural control and are concerned with problems of living or, to put it more grandly, existential issues. In the absence of any clear consensus about the definitions and indicated treatments for emotional disorders, patients seeking help should have a vote and should be offered clear choices. In general, people who prefer, or have learned, to be passive in the face of distress, or who are generally dependent or compliant rather than assertive, are likely to accept medical rather than psychological explanations for their problems or to choose the more directive rather than the more exploratory forms of therapy. But these may not be the most effective forms of help. As long as the professionals do not agree among themselves patients are likely to be confused.

My personal interest in psychotherapy started in the 1950s when I was a GP in a working class part of London. Psychotherapeutic help for my patients was not easy to find; to caricature my experience, I could send my patients to the Tavistock Clinic and receive back profound assessments explaining why they were unsuitable for therapy, or to psychiatric outpatients and be advised to prescribe medication, initially phenobarbitone, later the first fruits of the psychopharmaceutical revolution. But my own experience of talking with my anxious, depressed and somatising patients persuaded me that it was entirely possible to discuss their problems usefully and a research project into families with young children, in which an excellent social worker interviewed the parents of 112 families under my care, confirmed this. (Ryle, 1967).

Not all psychotherapy models are equally well suited to working with patients from other classes and cultures. Psychoanalysis, for example, was created by and delivered to educated and relatively wealthy people. Its established forms of training, involving undergoing prolonged and intensive analysis and delivering the same to a few patients, is irrelevant and if anything disabling as far as work in the public sector is concerned. Psychoanalysts are still concentrated in northwest London, although less exclusively than 60 years ago, but more practical forms of psychodynamic psychotherapy have been developed which are better adapted to the NHS. The main alternative form of psychological treatment, cognitive behaviour therapy (CBT), which is practiced largely by clinical psychologists or other health professionals, is now the most common form provided by the NHS. Compared to psychodynamic forms it has less ambitious aims and less obscure methods, CBT being concerned to cure symptoms and modify behaviours and psychodynamic therapies aiming to extend the patient's capacity to understand and control their lives.

Psychoanalytically trained practitioners, most of whom work at least partly in private practice, used to argue, and maybe still do, that working class patients

should only be offered simpler, more directive forms of help and these attitudes are easily extended to ethnic minority patients. My experience did not support this view but it is clear that practitioners need to make an effort to communicate with patients from unfamiliar backgrounds. As long as the great majority of practitioners are more educated than most NHS patients and hold middle class assumptions, *all* psychotherapy is a cross-cultural activity; my interest has been in developing ways of working which make therapy accessible across class and ethnic divides. I would argue that we can never assume that we understand another human being, even one of the same colour, class, educational level and living next door; this means that *all* professional psychotherapy must be based on establishing mutual understanding and finding a common language. This conviction, combined with the aim of developing treatments which might be provided in the NHS and with the belief that the polarisation between directive and exploratory approaches is unfortunate, led me to become interested in developing an integrated psychotherapy model. Over the years, after assessing and treating or supervising the treatment of many hundreds of patients and working with colleagues in social work, occupational therapy, mental health nursing and psychology, this model emerged as Cognitive Analytic Therapy (CAT). This, I believe, can engage patients from many different backgrounds and can support therapists working with patients from a wide range of class and ethnic backgrounds. A comprehensive account of the theory and practice will be found in Ryle and Kerr, (2002).

The features of CAT

The contrast between psychodynamic and cognitive behavioural approaches to psychotherapy has been described as resembling the distinction between 'being with' and 'doing to'; in CAT, the aim is to integrate ideas and methods and to offer a model of 'doing with'. Working within pre-determined time limits, usually of 16-24 weekly sessions, therapists seek to engage patients in the work of therapy by providing structures and tools but not solutions. Therapy is offered to a wide variety of patients but excludes those with active psychosis and serious substance abuse; patients are not expected to have prior motivation as many have little idea of what the process involves. The early sessions will seek to make this clear and will provide some preliminary experience of the approach in the course of gathering knowledge of the patient's problems, life history and expectations. This process is aided by giving patients written descriptions of the various ways in which individuals may fail to revise ways of behaving despite their negative outcomes. The 'Psychotherapy File' (reproduced in Ryle and Kerr) lists three main patterns, namely Traps, where negative assumptions lead to acting in ways which generate apparent confirmation of the assumptions, Dilemmas, where possibilities for action are reduced to polarised alternatives, restricting exploration of other ways, and Snags where appropriate action is abandoned because of the actual or supposed opposition of, or costs to, others, or due to irrational guilt. These patterns are illustrated by examples and patients identify those they recognise as applying to themselves. In earlier forms descriptions were provided of personality disorganisation or dissociation, but the Personality Structure Questionnaire (Pollock et al., 2001) yields more information. The 8 bi-polar items on this contrast perceptions of unusual inconstancy with those of unusual

stability of self-functions; high scores for inconstancy are reliably associated with Borderline Personality Disorder and associated conditions. The Psychotherapy File also gives instructions in symptom monitoring. The File is usually given at the end of the first session and the patient's responses are discussed in the next. This directs attention to the processes, which cause or maintain symptoms rather than to the symptoms themselves and engages patients in active participation from the start.

This work, the data gathered about past and present relationships with others, the patterns of self-care and the way the patient relates to the therapist are drawn together into a draft *Reformulation letter* which is discussed with the patient at around the fourth session. This completes the reformulation phase. The letter acknowledge the patient's distress, will suggest how present difficulties can be understood as the result of behaviours and thoughts derived from early experiences, either by repeating old patterns or by relying on dysfunctional alternatives developed as attempted ways of coping. The ways in which these may become manifest in the relationship with the therapist are anticipated. The aims of therapy are listed as the relief of distress (Target Problems, TPs) and the revision of the identified dysfunctional patterns (Target Problem Procedures, TPPs). These patterns may be summarised in *sequential diagrams*, either then or in the next sessions, and monitoring them replaces or is combined with symptom monitoring. The letter, revised if necessary after discussion, is read out in a session and a copy of it is kept by each. Patients are commonly deeply moved to receive this letter as it both demonstrates that they have been carefully attended to and offers a preliminary basis for understanding, recognising and in due course revising their own contributions to the maintenance of their distress. It commonly serves to indicate the irrationality of negative judgments of the self but also seeks to name directly and clearly what the patient is or has been responsible for. A good working alliance usually follows the reformulation sessions. In all cases, but especially when the therapist is idealised, negative feelings will usually emerge after a few sessions, as has usually been predicted in the letter. Meeting the expression of these by understanding rather than rejection allows the patient to acknowledge and integrate them.

The process of acknowledging and naming experiences and of linking them to the descriptions of dysfunctional processes developed during reformulation is repeated many times through the course of therapy. Particular procedures may be the object of diary keeping and specific treatment of some symptoms may be included, although commonly these fade without direct attention, but in every session the understandings reached in the reformulation of the whole person, usually summarised in the diagram, will be referred to. In this way the patient acquires a new basis for self-reflection and, as this is established, a new ability to control or revise damaging patterns. The diagram also serves to alert therapists to the ways in which patients will repeat problem patterns in the therapy and will strengthen their ability to avoid confirming these by offering the expected reinforcements. Through the process of therapy, Informed enhanced self reflection and a non-collusive relationship with the therapist provide the main agents of change. At the end of therapy 'goodbye letters' are exchanged tracing what has been achieved and noting what remains to be done.

Theory

The underlying theory of CAT rests on the concept of Procedures. These are reiterated sequences linking context or event, aims, perception, appraisal, action, consequences and re-appraisal. Linking thinking, feeling and action and involving both intrapsychic and external events provides a fuller understanding than do models of cognitive programs stored 'in the head'. Role procedures expressed in relationships have, as the aim, the response of the other. They are derived from early relationships between children and caretakers. Individuals manifest a consistent repertoire of these by selecting others who offer, or can be induced to offer, the expected reciprocations. Describing an individual's repertoire of *reciprocal role procedures (RRPs)* provides a powerful basis for treatment and management. This is particularly important in the case of Axis 2 Cluster B personality disorders where the repertoire is dissociated and patients switch between contrasting patterns, causing confusion and placing considerable pressures on clinicians to collude. In these cases the reformulation letter and diagram need to describe the full range of dissociated RRP's, as they shape relationships with others and self-management. The concepts of the self as constituted within a system of RRP's with past and present others and the idea of thinking as essentially dialogic are difficult to grasp for those formed by the essentially monadic view of the self which dominates Western thought and influences both cognitive and dynamic models. But this understanding provides a powerful support for therapists in using what psychoanalysis identifies as transference-countertransference interactions therapeutically, and in practice non-therapy staff in Community Mental Health Centres and the patients themselves usually grasp and value the concept. In less individualistic cultures it may be even more acceptable.

Summary

CAT offers an expressly collaborative and unmysterious style of therapy, which involves patients in joint activity with the therapist from the start, notably in the process of descriptive reformulation and the construction and use of diagrams. Those understandings therapists may have applied to the patient's story and behaviours which are derived from their personal and professional backgrounds are not imposed, they are offered for consideration; providing drafts in writing allows the patient to revise them. The provided descriptions of the general patterns which prevent revision of dysfunctional procedures offer a basis for their description, recognition and revision and most patients make good use of the Psychotherapy File. In addition, the personal difficulties of patients are often lived out in their relationships with their therapists and the diagrams of dysfunctional reciprocal role procedures which have been constructed allows them to be recognised, challenged and replaced rather than inadvertently colluded with. In these ways the model offers a way of circumventing the obstacles to understanding which are always present to some degree but are particularly problematic where therapist and patient do not have the same class and ethnic backgrounds.

References:

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Pollock,P.H., Broadbent,M., Clarke, S.,Dorrian, A and Ryle, A. (2001). The Personality Structure Questionnaire(PSQ): A measure of the multiple self states model of identity disturbance in Cognitive Analytic Therapy. *Clinical Psychology and Psychotherapy*, 8, 59-72

Further information: www.acat.me.uk

AUDIT ON THE POLICY OF COPYING CORRESPONDENCE

By: Dina Munim (SHO), Aditya Appaya (Clinical Attachee), Leicester

Introduction

The Mental Health National Service Framework (Department of Health, 1999) emphasises the importance of the involvement of service users/patients in the planning and delivery of their care and of providing them with the information that is necessary to do this.

The NHS Plan (Department of Health, 2000) states that, although patients have the right to see their medical records, “in practise, much communication between professionals is not available to the patients concerned. Patients often do not know why they are being referred and or what is being said about them.” The policy on copying correspondence requires that “letters between clinicians about an individual patient’s care will be copied to the patients as of right.” (p89)

Purpose of audit

The policy of copying correspondence was implemented in the Leicestershire Partnership Trust in January 2006. This audit aimed to elicit the views of service users/patients their GP’s consultants and secretaries. This audit also aimed to obtain feedback from service users/patients about the implementation of this policy and how they believed that the correspondence could be improved so as to meet their needs better.

Process

Once the policy was implemented, every patient attending the outpatient department at the Brandon Unit from the City East locality in Leicester was personally asked whether they wished to receive copies of their correspondence on a special consent form. Those patients saying yes on this

consent form and who had been sent copies of their correspondence entered the sample group for this study. Fifty of these patients were randomly selected in July 2006 to provide feedback anonymously through the post with a reply paid envelope. GP's General Adult Psychiatrists and their secretaries were also sent questionnaires about their views on the policy.

Results

Twenty replies were received from patients in all. This was a response rate of 40%. Not all patients answered all the questions.

47 forms were sent out to City GP's. 30 completed forms were received. This represented a return rate of 64%. Not everybody answered every question.

23 forms were sent out to general adult psychiatrists in this Trust. 15 completed forms were received. This represented a return rate of 65%. Not everybody answered every question.

23 forms were sent out to the medical secretaries of the general adult psychiatrists. 14 completed forms were received. This represented a return rate of 61%. Not everybody answered every question.

Discussion

- From the information obtained from patients themselves almost all (95%) of the patients who responded were happy with their decision to receive copies of the correspondence and wished to continue to do so in the future. 95% of the respondents had read their copies of correspondence with the majority (80%) reporting that the letters were easy to understand. 60% believed that the letters told them more than they knew about their illness whilst 45% thought that the letters told them more about their treatment than they already knew. Maintaining the confidentiality of their care was not a problem for most patients (90%). 95% wished to continue to receive copies of their correspondence. Even though only a small number of patients replied (40% of sample), an overwhelming majority reported satisfaction with the service and the correspondences they had received.
- Feedback from GP's indicates that most GPs (79%) found the new format of letters to be satisfactory at least and wished the practise of sending copies of correspondence to patients to continue as it did not generate extra work for them. Their patients receiving correspondence also told them that they found this practise to be satisfactory (100%).
- Information from general adult psychiatrists indicates that 81% of General Adult Psychiatrists had complied with this policy even though 88% though it generated additional work. 75% had changed the format and content of their letters. Only 1% of consultants reported that patients had asked for language specific letters though this could not be accommodated by the Trust. 40% of them reported that patients had raised clinical issues from

their letters though the relationship with patients was not compromised by this. As expected, the policy had little impact on the quality of care for patients or the approach to patients.

- Reports from secretaries reveal that only 28% of the secretaries of the General Adult Psychiatrists who responded appeared to be happy with this policy as it clearly generated more work for them (56%). 50% of secretaries felt that the content of the letters had changed with the implementation of the new policy. Only 3% of secretaries reported that patients who received letters are phoning more than others while 57% reported that patients appeared to be happy with their decision to receive copies, which were largely not going astray. Few patients (7%) wanted to reverse their decision regarding receiving copies of correspondence. 30% of secretaries reported that between 1/3 – 2/3 of patients had asked for copies of their correspondence.

Conclusion

This audit suggests that this policy facilitates care by promoting greater involvement of patients in their own health care and management. Copying correspondence should therefore be continued in keeping with Trust policies. Patients and their GPs were also supportive of this policy. General Adult Psychiatrists and their secretaries appear to have largely embraced this policy even though it clearly generated extra work.

This policy can be improved by making correspondence available in different languages if patient's wish as the correspondence is currently only available in English. A small number of patients specifically asked for simpler English and less jargon.

The extra work that this policy generates detracts from clinical time with patients. Steps need to be considered so that patients are not 'short changed' of face-to-face time with clinicians.

References:

1. Policy on copying correspondence to service users. (Barnet, Enfield Haringey NHS Trust)
2. Policy on copying clinical correspondence to service users. (Mersey Care NHS Trust)

AN OUT OF PROGRAMME EXPERIENCE

By: Dr Alex Bowers, Cairns Base Hospital

An out of programme experience (OOPE) allows higher specialist trainees to be accredited for training overseas for up to a year with the advance agreement of the regional programme director, college regional speciality adviser and postgraduate dean.

There are many benefits in making use of this accredited time: gaining speciality specific insights into differing cultures, awareness of differences in service provision and adapting to a new work environment and social climate. The life of a trainee doctor requires frequent changes of workplace and for many it can be an unsettling experience. The process of moving to a different country entails stretching ones flexibility and adaptive skills to the maximum. Challenges which face an overseas trainee include rapid assimilation of local policies and procedures, awareness of culture specific nuances and integration into a different system.

Cairns Integrated Mental Health Service (CIMHS)

Cairns is located in Far North Queensland, Australia, and is situated in a world renowned Heritage Area with the Great Barrier Reef and tropical rainforest on its doorstep. City dwellers enjoy a tropical lifestyle with temperatures ranging between 17°C and 31°C all year round. The Cairns Integrated Mental Health Service (CIMHS) is a rapidly expanding service with the Queensland Government committing funding of \$366.2million, across the state, over five years to improve the quality of, and access to, mental health services.(1)

The CIMHS is comprised of:

- 34 bed inpatient acute care mental health unit (8 high dependency, 5 special purpose, 22 low dependency) located on the Cairns Base Hospital site.
- Consultation Liaison Psychiatry Service
- Community Old Age Psychiatry Service
- 2 Community Treatment Teams
- Acute Care Team
- Community Intensive Rehabilitation and Recovery Support Team
- Homeless Mental Health Outreach Team
- Child and Youth Mental Health Service
- Outreach services to Port Douglas, Mossman, Innisfail, Tablelands
- Extreme outreach service to Cape York and Torres Strait Islands
- Links with James Cook University Medical School Psychiatry Program
- 13 Consultant Psychiatric positions, 1 conjoint clinical academic (JCU) Psychiatric position, 4 Psychiatry PHO positions and 6 Training Registrar positions, spread across the service.

Training Experience

In line with the scale of reciprocity agreed between the College and the Royal Australian and New Zealand College of Psychiatrists in February 1996, fifth-year registrar posts in Australia or New Zealand (Advanced Trainee) may count towards higher specialist training.(2)

Clinical work forms the main portion of an advanced trainee's working day. Given the high rate of indigenous individuals inhabiting the area experience in cross-cultural psychiatry is excellent. In addition to the day to day case load, the advanced trainee is expected to participate in a number of other clinical and non-clinical duties:

- All registrars rotate through an on-call rota with Consultant support
- Presenting at local and hospital wide educational forums is encouraged
- There is an active educational department at Cairns Base Hospital that runs courses on all aspects of clinical and non-clinical work
- Opportunities exist for trainees to develop special interests (e.g. Addiction Psychiatry) and participate in quality improvement activities

Organisation

Being able to take advantage of such an opportunity requires advanced planning and an organised approach. Prior to my OOPE, I allowed six months (anything less will certainly overwhelm and frustrate even the keenest trainee) to make enquiries through respective recruitment agencies to locate a suitable workplace. Once I had achieved this, I negotiated terms and conditions of employment, gained approval from the local Medical Board, obtained an appropriate visa and prospectively accredited this post with the Royal College of Psychiatrists.

In the lead up to departure, depending on whether or not you are a home owner, arrangements need to be made with regard to letting your house if required and redirecting mail to your base hospital address.

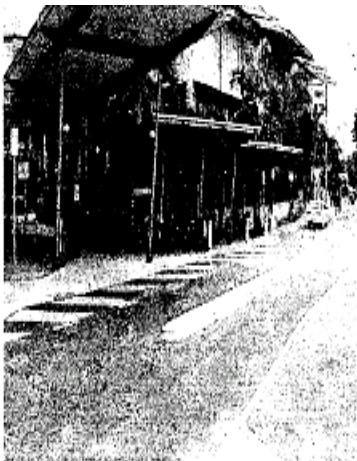
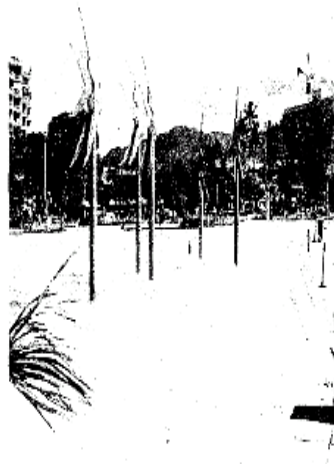
If one chooses to take family members away this certainly adds another dimension to planning an overseas experience. The human resources department can be helpful initially regarding local childcare services, locating suitable accommodation and finding one's feet in regard to regional amenities.

Conclusion

Coming to the end of my OOPE I can say with confidence that it has been an extremely worthwhile period of training. Having overcome the initial mountain of red tape and paperwork it has been tremendously rewarding. I have improved my clinical and managerial skills through the training provided. I have also had the opportunity to live and work abroad and get to know a different group of patients and their pathology. This experience has widened my horizons and I recommend it to all trainees.

References

1. National Action Plan on Mental Health 2006 – 2011, Council of Australian Governments (COAG)
2. Higher Specialist Training Handbook, Occasional paper, OP43, March 1998, Royal College of Psychiatrists, London



INTERPRETERS IN PSYCHIATRIC CLINICS

**By: Dr. Punita Grover, SHO in Psychiatry
Dr. Thomas, SHO in Psychiatry
Dr. Muhammad MRCPsych, Consultant Psychiatrist, Leicester**

Introduction

Effective communication is necessary when assessing patients in all branches of medicine including Psychiatry. Language barriers can seriously disrupt care (1). An interpreter is able to facilitate communication. An interpreter will provide an oral translation between speakers of different languages. Facilitating communication through an interpreter can however perpetuate misunderstanding too if adequate training has not been made available for interpreters.

It is not uncommon to encounter clinical situations where interpretation is needed in Britain's multi-racial society. This is particularly the case in Leicester with its high percentage of people of multi ethnic origin including refugees and asylum seekers. The population of Indian origin in Leicester is 72,000, which is 25.7% of the total population. 38.17% of the population of Leicester is neither British nor Irish (2) in origin. Consequently there is a high demand for interpreting services.

Method

We wished to audit the usage and efficacy of the Interpreter service available in the outpatient department of the Brandon Mental Health Unit, Leicester. A semi-structured questionnaire was completed prospectively for all patients attending outpatient clinics by their assessing psychiatrist. The data was then analysed and measured against our Standards.

The standards for audit were:

- 1) An official interpreter should be available on every occasion when needed.
- 2) The interpreter must arrive on time or give advance cancellation notice.
- 3) The interpreter must meet clinicians prior to and after each session.

Guidelines considered for this audit included those from the Victorian Transcultural Psychiatry Unit, (Australia) (3) and Standards for Healthcare Interpreters, (California) (4).

Results

574 patients were seen by psychiatrists over a period of 7 weeks from 30.11.2005. Of these, 83 outpatients were recorded as speaking a language other than English.

- 1) Did the request for official interpreters meet the standard?

	Frequency	Percent
Yes	45	54.2
No	38	45.8
Total	83	100.0

Official interpretation was needed on 45 occasions. 40 official interpreters were used in all. Where official interpretation was not used (38 occasions) either the assessing psychiatrist reported being fluent in the language in which the patient communicated or patients had asked that the person accompanying them, e.g. relative, care home staff etc., should interpret for them. Even though the latter was not considered to be ideal (5) patients wishes were respected.

- 2) Did time keeping for interpretation meet the standard?

	Frequency	Percent
Interpretations on time	36	80
Interpretations not on time	9	20
Total	45	100

80% of the interpretation took place on time. Of the 9 interpretations which did not, 2 provided the 24 hour notice required by this standard. Reasons included non availability of interpreter for language, incorrect time being booked and 'already interpreting for another patient'.

- 3) Did the interpreter meet the standard to attend Pre and Post-briefing meetings?

Out of the 40 interpreters used, a pre-briefing meeting took place between the interpreter and the doctor in only one case (2.5%). A post-briefing meeting took place in 4 cases (10%). Pre and Pos-briefing meeting together for the same patient did not take place at all. The five clinicians (12.5%) who undertook briefing meetings reported that the time allocated was sufficient.

Discussion

The availability of official interpreters for people from non English speaking backgrounds is considered to be essential. However National guidelines for Interpreting Services do not exist and most NHS Trusts rely on local protocols to meet local demands. These need to be proven to be satisfactory in all regard. The under utilisation of Mental health service by people from non-English speaking backgrounds is well documented. Studies have also reported lower rates of access to allied health professionals for this population (2). Many reasons have been considered including the availability of interpreters.

This audit demonstrates the high demand that is made on psychiatric services for a city like Leicester. This demand has been recognised and planned for locally with a well developed and accessible interpreter service. Where available bilingual health professionals are best placed to facilitate communication. However some patients specifically declined the use of a particular interpreter or clinician because of previous social or professional contact. These views were taken into consideration locally. The first audit standard was therefore met.

80% of planned interpretations took place at the booked time. Even though this was a good outcome, 7 out of 45 interpretations did not meet the standard. This was inconvenient for patients and their clinicians. A more robust system should help minimise this inconvenience. The second audit standard was largely met

Pre and post-briefing meetings between interpreters and clinicians was considered to be valuable (3)(4). However the uptake of this was low (3). The experience of clinicians is that an interpreter mediated interview takes much longer. Discussion of the goals of the interview and feedback should enhance the quality of the process. This audit standard was not met.

This study suggests that further work is needed to improve the process for using interpreters in psychiatric outpatient clinics. The quality of the interpretation itself was not addressed by this audit and merits further investigation.

References:

1. Farooq S. & Fear C. Working through interpreters. *Advances in Psychiatric Treatment*.2003; 9: 104-109
2. 2001 census: Leicester City Council. Available from <http://www.leicester.gov.uk/index.asp?pgid=1009#Eth>
3. Guidelines for Mental Health Professionals: Victorian Transcultural Psychiatry Unit 2001. Available from <http://www.vtpu.org.au/resources/publications/guidelines.php>.
4. California Standards for Healthcare Interpreters. Available from <http://www.chia.ws/standards.htm>
5. Phelan M. & Parkman S. How to Do It: Work with an interpreter. *BMJ* 1995; 311: 555-557.

COMMENT

By: Derek Summerfield

Re: Vieda Skultans in Soc Sci Med 2003,56,2421-31: "From damaged nerves to masked depression: inevitability and hope in Latvian psychiatric narratives".

She notes that psychiatric language in Latvia has been invaded by the diagnosis of "depression", key promoters being the translation into Latvian of the ICD and the conferences organised by pharma companies to educate psychiatrists and GPs about the new diagnostic categories. This is a radical departure from the older languages of somatic distress that were central both to Soviet psychiatry and to lay conceptualisations of distress. It is displacing the discourse of *nervi*, the connective tissue between individuals both in lay discourse and in med consultations. To ask about *nervi* is to invite a life story, to illuminate temporal and social aspects of the self. The doctor-mediated shift from *nervi* to depression, a move from somatoform to psychological framing, represents the internalisation of a heightened sense of personal accountability for one's life cir- at the very time when for most people the post-Soviet Latvian economy and society has lost much of its former sense of stability and security, with few opportunities for real change in one's situation. Previously, talking about *nervi* was in part a critical commentary on Soviet-dominated society, economics etc, with disorder and unpredictability attributed to the society. The discourse of depression switches the focus inwards to the person, who is to hold himself or herself individually responsible for events. Thus people who in fact have very little control over their (now more insecure) life sit blame themselves. The narrative structure of these new accounts of distress indicate that people have internalised the values of capitalist enterprise culture and the responsibility for personal failure that goes with it. "Depression" decontextualises their lived life, whereas "*nervi*" embodied it. It is this shift in officially endorsed version of personal identity, the shaping of a different kind of citizen, (and one rather convenient for a Western political order) that can be seen as invoked in the globalisation of "depression", and yet is risibly invisible in mainstream psychiatric accounts and their assumptions of benignness and progress.

FORTHCOMING EVENTS

19th – 22nd June 2007

Royal College of Psychiatrists Annual Meeting. Edinburgh, UK

Email: conference@rcpsych.ac.uk

20th June 2007

AGM – Transcultural Special Interest Group at AGM of College. Edinburgh

Email: k.s.bhui@qmul.ac.uk

25th – 28th July 2007

Remembering, Repeating and Working Through in Psychoanalysis and Culture Today

International Psychoanalytical Association Congress. Berlin. Germany

Website: <http://www.wipa.org.uk>

NOTICES

Article 14 Evaluators required

The Royal College of Psychiatrists is in the process of setting up a large forum of psychiatrists from all specialties to assist with the assessment of Article 14 applications.

The college's role is to assess individual applications for Specialist Registration in Psychiatry according to the conditions set out under Article 14 of The General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003. The College works closely with the Postgraduate Medical Education and Training Board to ensure that a robust system of assessment is established for all applicants who apply for specialist registration under this route.

The evaluator's role is to assess applicants' qualifications, training and experience under all 6 Good Medical Practice headings and to determine whether the applicant meets the criteria specified by the PMETB and the College, and to further determine whether their competences are equivalent both in clinical and theoretical content to those of a UK holder of the Certificate of Completion of Training (CCT) in psychiatry.

Specific responsibilities

- To review individual applications for Article 14, and apply the agreed standards according to the evaluator's assessment notes
- To recommend further training, experience, examinations, assessments or other tests of competence necessary to demonstrate the applicant's equivalency to a UK qualified specialist.

Each application is normally scrutinised by 3 College evaluators, this has proved insufficient to cope with the high number of applications we regularly receive from the PMETB. The PMETB have set strict deadlines which the College is obliged to meet under the current arrangements with the Board.

We therefore need evaluators, who are reliable, IT competent, comfortable to work with complex documents on=screen and be able to devote 4 to 5 hours (or more) per application. All applications are sent to evaluators on a CD-Rom.

If you would be interested in offering your services to assist the College please contact Miss Lena Hartley at the details below for an evaluator remit and further information.

Miss L Hartley, Article 14 Administrator
Royal College of Psychiatrists
17 Belgrave Square, London SW1X 8PG
020 7235 2351 x 139
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LETTERS TO THE EDITOR

Dear Editor

I have just had the misfortune to read the article by Derek Summerfield in the most recent issue of the Bulletin of the Transcultural Special Interest Group of my College. This was only drawn to my attention by a member of another committee that I belong to.

I was shocked by Derek Summerfield's article; as a long time member of some of the organisations that he purports to represent it is causing me to reconsider my membership of those organisations.

Certainly all is far from well in the Middle East and I would by no means condone the behaviour of the Israeli Government or all that it does. However, the partisan views expressed by Derek Summerfield in his article are prevalent of bias and racism. He chooses to represent only one side of an extremely

complex argument; similarly to apologists of the Muslim world who try to show that all the problems in the Middle East, and all the conflicts in the Arab Nations have been due to the fact that Israel remains within their midst.

There were and are real threats by Israel's neighbours to annihilate Israel and its Jewish inhabitants, and it is perhaps no surprise that they have chosen to fight, as they saw it, for their lives. Israel as a Nation has had to continue to content with animosity, enmity and violence from its immediate neighbours throughout its 59 year history.

People born and brought up in Israel have known no culture other than that of having to defend their State, and they undoubtedly grew up with a biased view of their neighbours, in the same way that their neighbours are educated to have a biased and partisan view of them.

One cannot describe the situation of Israel as anything other than being within a state of economic, moral and physical siege. People living within a siege State undoubtedly develop different ways of viewing the world and different ways of reacting, and many of the things that we see, and Dr Summerfield alludes to, are those related to a siege mentality. Is this going to be resolved by making that siege worse? There are many people, probably even more than half the population in Israel, who do not support many of the actions of the Israeli Government. It is a sad side effect of having a democratic society, where the proportional representation system allows many minority parties to be elected, and coalitions to have to be formed. However, Israel is the only true democracy within the Middle East.

I have little doubt that some of those things found by Amnesty are true, but of course this is a two way process. Israel is faced with suicidal bombers on a regular basis (56 in the last 6 months); it is faced with katyusha rockets coming from the Gaza Strip and from Lebanon, even at times of so-called cease fire. It is faced with major neighbours in Iran who still talk of wishing to wipe out the Israeli State, and it faces the ignorance of people, such as Derek Summerfield, who sadly have allowed themselves to develop a partisan view of the work and can no longer see a balance.

When we look at the countries surrounding Israel do we see democratic institutions or proper ways of treating their citizens? I would argue not. By and large we see despotic regimes run by dictators with suppression of their citizens, suppression of freedom of the press and no opportunity for a democratic vote. None of that is true in Israel.

I do not support the idea of academic or indeed other boycotts in any Country. I would not wish for there to be an academic boycott of Iran or Iraq. However, I find it is interesting that people such as Derek Summerfield argue for an academic boycott of the only State that actually supports and treats citizens of all nationalities, races and religions, that has free and democratic votes for all citizens whatever their ethnic backgrounds, which allows academic freedom, freedom of speech, and the opportunity for academic inflow and outflow. What

possible justification can there be for an academic boycott of this Country, unless it is based on some form of racism?

I think for a group that purports itself to be a Transcultural Special Interest Group of the College to publish such an ill informed, prejudicial and racist document is highly suspect.

Dr Mike Harris
BSc, MB, BS, MRCS, LRCP, FRCPsych
Consultant Forensic Psychiatrist

Reply:

One would not find a single Palestinian subsisting under Israeli occupation who would recognise the picture of the country Harris paints and some Israelis would not either. If Harris would prefer Israeli reference sources to International ones like Amnesty, Human Rights Watch, Red Cross etc., he could turn to the websites of B'Tselem or Physicians for Human Rights: their output is entirely consistent with the substance of my article, and indeed I quote them. Harris should be more careful about the word 'racist', which he uses 3 times. It is more likely that if this article had been about medical collusion with Fourth Geneva Convention violations in a different state, Sudan say, Harris might have approved of its publication? But the supporters of Israel, medical or other, claim that theirs is a special case: this is selective moral blindness of a destructive kind.

Derek Summerfield

This is a publication of the Transcultural Special Interest Group. The views expressed here are not necessarily those of TSIG or the Royal College of Psychiatrists.	If you would like to contribute to the newsletter, please contact Dr D Khoosal, Brandon Unit, Gwendolen Road, Leicester, LE5 4PW. Email: deenesh.khoosal@leicspart.nhs.uk
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