Newsletter

Faculty of General and Community Psychiatry
Royal College of Psychiatrists

Issue 10 **Spring 2005**

Editor: **RajeshMohan**

Editorial Board: **Michele Hampson**
Nick Kosky

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

From the editor

Thanks to all those who have contacted the faculty executive about various issues of interest and concerning the adult psychiatrists in the United Kingdom. Your ongoing contributions and suggestions are vital for the faculty executive and help us to address the real and pressing issues facing the large body of psychiatrists working with adult populations. This issue carries articles on a variety of such topics, including job descriptions for consultants, the developments in the Mental Health Act legislation, fragmentation in mental health services and how people deal with the mental health aftermath of major disasters. Please do keep us informed on what you would like to see in the pages of the newsletter. Of course we would like your contributions on services in your areas, the unique problems and the solutions that have been found.

As usual we hope to hear your views and comments. I would like to make a special request to trainees to send in their contributions to a new section in the newsletter 'Training matters'.

In the next few months we will be working on improving the content of the faculty web page and expect to have relevant documents and information that will be useful for the members. We hope this will encourage the members to access the web page more often. The excellent work done by the IT team at the College has provided the new design of the College website, which is much easier to navigate. We at the newsletter's editorial desk would like to hear from the members what you would like to see on the faculty's web page. There is no denying that there is a lot of information on the College website and indeed links to other sites on mental health. Perhaps it would make sense to include details of some of these on our web page, without duplicating or making it too cumbersome to navigate. Please have a look at relevant pages, and send us any suggestions and comments on what you would like to see on the faculty web page.

This year's Faculty Annual Residential Conference is in Liverpool in October. We have a range of topics and workshops that will be of interest. A draft of the programme is included in this newsletter. We hope to see many of you there.

Contents

From the editor	1
Contents	1
From the chair	2
Job descriptions in adult psychiatry	3
Mental Health Bill	4
Fragmentation and dislocation	5
Tsunami and mental health	7
From our intrepid reporter	8
Training matters	9
Correspondence	11
Next residential conference	12
Faculty prizes	14
Faculty prizewinning paper	15
Faculty executive	16

If you wish to make a comment or respond any article, email us at adultpsychiatry@yahoo.co.uk

From the chair

Jed Boardman

Many adult psychiatrists are watching the path and development of the proposed new Mental Health Act with varying degrees of apprehension, despondency and incredulity. All of us wish to see improvements in our working conditions and to the services provided to our patients. We are still in the welcome situation of being a priority service with its associated National Service Framework, which is now five years old. The five-year review of the NSF was published in December 2004 (Department of Health 2004 – *The National Service Framework for Mental Health – Five Years On*). This is an important review which examines progress in each of the standards and looks at priorities for the next five years. The importance of this document should not be underestimated, as it provides us with an official version of progress and a glimpse of what we can expect in the near future.

Two particular matters should be noted:

Finance: The report goes some way to acknowledging what the College, Sainsbury Centre for Mental Health and King's Fund have claimed over the last few years – that much of the new monies are not getting down to the services. At least there is some recognition that services across England are not equitably distributed.

Spending on mental health services

Year	% increase over previous year, at 2002/03 prices
2000/01	+ 7.2
2001/02	+ 1.4
2002/03	+ 9.7
2003/04	+ 2.2 (adult services only)

The cumulative increase in spending is 21.9% in real terms, corresponding to an average growth rate of 5.1% a year. While this is a good performance by historical standards, the growth in spending seems to be very erratic from year-to-year and steps need to be taken to ensure a smoother path of spending. The increase in overall expenditure disguises a substantial fall in capital (as against current) spending, as the review also shows that over the three years from 2001/02 capital spending by mental health trusts fell by 22.5% in cash terms, which, allowing for general inflation, corresponds to a fall in real terms of 30.3%. All the figures for mental health spending given in the five-year review are converted from cash to real terms using a general measure of inflation, but more relevant for assessing the true growth in spending on mental health services is to use a measure of inflation which is specific to the NHS. Such a measure is regularly compiled by DH and invariably shows that NHS inflation runs somewhat ahead of inflation in the economy generally. Using this measure would therefore result in smaller real increases in expenditure than shown in the five-year review, a point acknowledged in the report - but no attempt is made to assess its quantitative impact.

If over the four years after 1999/2000 mental health spending increased by 21.9% in real terms or by 5.1% a year on average and (from the 2004 DH annual report), over the same period total NHS expenditure rose by 40.0% in real terms or by 8.8% a year on average. Thus mental health service expenditure declined as a share of total NHS expenditure in the years following publication of the NSF. If this is the case, then what does this reflect about the priority status of mental health services?

The next five years: Key issues for future include DUAL diagnosis, NICE guidelines implementation, social inclusion and a whole-community approach, primary care-based services and inpatient services. This is in addition to the continued development of the moderisation teams, particularly early intervention services, which the report acknowledges are slow in developing. This still leaves improvements in Standard 1 to be made. All these will require that mental health services are given continuing priority status and investment is steadily made.

In addition there are several wider policy matters that we may wish to consider:

- The introduction of Foundation Trusts and the funding methods of 'payment by results' .
- The National Programme for IT in the NHS NPFiT and its relevance for mental health services.
- The implementation of policies related to patient choice.
- Confidentiality and the implementation of the Freedom of Information Act, the Multi-Agency Public Protection Panel Arrangements (MAPPPAs) and differing trust policies regarding clinical ethics and information-sharing.

These matters are highlighted, not because I wish to take on the role of a Cassandra, but because we need to remain aware of the important advances that have been made in the development of our services, the large task ahead of us and many potential snags and traps along the way. All of us share a list of varied aspirations for our services but most would agree that our hopes are of improved quality services for users and carers that pay due heed to their quality of life, aspirations and inclusion in society.

The Faculty Executive would like to hear from members about their concerns regarding the implementation of policy, particularly their experiences with this at a local level.

Updating job descriptions for consultants in adult psychiatry

Graham Wood

Sounds a little dull?

Maybe. But the job description is one of the ways available by which we can influence the working lives of consultants for the better.

The College has issued guidance on consultant job descriptions for Regional Advisers and Trusts for many years. The purpose of the guidance is to help Trusts devise jobs for consultants which are not only do-able but which reflect current thinking about roles and responsibilities. This is not easy in the current situation, as consultants' roles are changing fast in some areas but not in others, so there is increasing diversity. An increasing number of posts are being advertised for consultants in functionally specialised teams, though sector posts still seem to predominate.

'Untenable' is the word that has been used by Professor Louis Appleby, National Director for Mental Health, and many others, to describe the traditional role of consultant psychiatrists. This disquiet has often been most acute for our own specialty and there is a widespread view that roles must change. Our Faculty has been busy producing a revised description of the roles and responsibilities for adult psychiatrists which reflects these changes. Some of the key themes are:

- The specialisation versus generalist debate;
- Defining and limiting consultant responsibility;
- Working towards smaller direct caseloads of patients with complex problems;
- Larger use of supervision, advice and consultation for other team members;
- Posts with greater scope for clinical leadership and service development;
- The importance of training.

New ways of working are being discussed and in the light of this, a new guidance on the employment of consultant psychiatrists from the multi-agency National Steering Group (College, NIMHE, NHS Modernisation Agency) is expected to be published later in the year.

The Faculty intends to update our guidance on consultant job descriptions following these developments, along with feedback from Regional Advisers and members of the Faculty. Here are some ideas we have had so far.

Proposed changes to the College's model job description for adult psychiatrists

These are still at the discussion stage and we are continuing to seek your views.

It is fairly easy to bring the job description up-to-date with the new consultant contract. Programmed activities can be described and a job plan provided. The job plan may possibly be a more accurate way of ensuring a balance of different activities – for example, service development and teaching, as well as direct clinical work – but we shall see how effective a mechanism this is.

For which patients does the consultant have direct responsibility? 'More or less everyone' by implication is changing to an era where patients can be specified according to their characteristics. Some services have already started to describe patients in terms of complexity, role impairment and risk (for example). A statement of this sort near the start of the job description could help to focus minds greatly.

We are thinking of including guidance which encourages features of service design which fit with updated consultant roles and which can greatly affect the workload of consultants. Three examples are provided below:

- A better service will limit the occasions on which a consultant has to respond personally to an emergency, for example, with the use of non-medical or junior medical staff in a crisis team, or a rota for consultants covering daytime emergencies;

- A better service will have shared care guidelines and criteria for discharge from outpatients agreed with the Primary Care Trust(s), thereby limiting the consultant's role in doing routine reviews for stable patients;

- A better service incorporates a triage process before a new outpatient appointment is sent. This could be a non-medical initial assessment, a discussion between the psychiatrist and the team or clear referral protocols with primary care.

These three examples all allow flexibility in response to local needs.

Workload measures

Norms

Ever heard anyone say 'But what about that extra 15,000 population in my catchment area that no-one told me about before I was appointed?' The College norms are meant to prevent such a situation.

Most psychiatrists are aware that the College recommends consultant staffing levels for a given population base. The most widely known figure has been the one for adult psychiatry sector work - a minimum one psychiatrist per 40,000 total population.

There are figures that exist for all areas of work, such as eating disorders, assertive outreach, liaison psychiatry, etc.

Often these figures have been seen as unrealistic, invented by people at the College who are remote from the pressures of the average service. However, they have probably protected colleagues from exploitation and at the same time helped to ensure that quality standards don't slide down endlessly.

However, they are crude measures which don't consider service context or design. It remains to be seen if these will survive in some form in the expected National Steering Group guidance mentioned above – I expect that they will.

Indicative workload figures
These have not usually been included in job descriptions. We have been discussing this idea in our Faculty and we think such figures would prove useful. The figures are rates of clinical activity which can be tied to a programmed activity (PA) in the job plan and can be given for any service, team or department.

Following are some examples of indicative workload figures:

In one PA in outpatients, you might typically,
see 1 new patient, supervise the junior doctor seeing 1 new patient and see up to 6 follow-up patients or 4 CPA meetings.

Or for inpatients,
Typically during 1 PA, a consultant undertakes a ward round/multi-disciplinary meeting and direct patient interviews for between 6 and 8 patients.

Or for assertive outreach,
In 1 PA, the consultant does between 3 and 4 direct patient reviews or CPAs, and participates in the MDT meeting and/or supervision.

Or in a crisis team,
In 1 PA, the consultant would attend a team meeting, do clinical supervision and see 2 or 3 patients, depending on whether they were new or for review and whether they were emergencies or not.

In an early intervention service for psychosis: any experience/ideas?

These figures are better approximates to real workloads than proxy measures such as catchment area size. The College could recommend maximum figures but allow flexibility for local circumstances.

Please let us have your views about anything in this article. Your views on indicative workload figures, and your own examples, would be particularly useful to us.

If you wish to make a comment or respond to this article email us at adultpsychiatry@yahoo.co.uk

Revised draft Mental Health Bill, Letter from Campaign Headquarters, Number 7
Tony Zigmond

The Joint Committee of both Houses of Parliament scrutinising the second version of the Bill requested written evidence of no more than 1,500 words. The College's evidence didn't quite keep to this. It was just under 17,000 words (and even then we had to write three supplementary pieces at the Committee's request, all of which may be read from the College website). However, I know at least the chairman read it all: he spotted, and commented on, a double negative buried deep in the text! The Committee received over 450 written submissions.

In October Greg O'Brien, Sue Bailey, John O'Grady and I went to give oral evidence to the Committee. Altogether, oral evidence was taken from 124 witnesses. The hearings were held in Portcullis House. This is a relatively new Parliamentary Office block with very expensive fig trees in the foyer. Our session seemed to go well. The following day I addressed the cross-bench peers, in the House of Lords, at the request of Lord Rix. Again this seemed to be well received. We also arranged a number of private meetings with many members of the Committee.

The report is available, along with most of the written and oral evidence, from the Committee's website:
http://www.publications.parliament.uk/pa/jt/jtment.htm
The report is damning of the Government's proposals for law reform. The College's evidence is cited over 100 times – more than any other source. There are 107 recommendations, almost all supportive of the evidence given by the Royal College of Psychiatrists and the Mental Health Alliance.

The Committee accepted the importance of the likely impact of the draft Bill on stigma and the need for an ethical and practical framework for a new Act. They praised the new Scottish Act and suggested it serve as a model for England and Wales. They recognised that public protection 'must never be allowed to predominate as the primary objective of reform' and

that fundamental principles should be on the face of the Bill, rather than in the Code of Practice.

The recommendations include:

- No-one should be made subject to compulsion unless they have 'significantly impaired decision-making'.
- That there is a 'therapeutic benefit test'. People with 'serious mental disorders who cannot benefit from treatment' should be dealt with under separate legislation. The Committee's press release used the term 'DSPD'.
- A list of exclusions from the broad definition of mental disorder: substance misuse, including dependence on alcohol or drugs; sexual orientation (rather than sexual deviancy, the term in the current Act, which the College preferred); and people with learning disability or autistic spectrum unless also demonstrating 'seriously aggressive or severely irresponsible behaviour'. They also recommended exclusion on the grounds of cultural or political beliefs.
- 'Protection of others' should be changed to 'protection of others from significant risk of serious harm'.
- Restrictions on the freedom of the patient must be the minimum necessary in the circumstances.
- Sixteen- and seventeen-year-olds to have the same protections as under-16s and CAMHS specialists must be involved. Minors should not be detained on 'adult' wards.
- Tribunals to be able to recommend transfer and leave for restricted patients.
- Medication above BNF levels only with authorisation of a Tribunal 'in exceptional circumstances' 'when all other options have been exhausted'.
- Only two emergency ECT.
- Community treatment orders (non-resident orders) should normally be imposed only after hospitalisation; with evidence of previous responsiveness to, and co-operation with, proposed treatment; and they should only be able to specify place of residence and medical treatment and should have a maximum time limit of 3 years within any 5-year period.

While I have picked these recommendations as being particularly significant, all the recommendations are worth reading.

The Committee is scathing about the Government's suggested workforce consequences. It 'expects the Government to publish realistic plans detailing exactly from where the increased number of members of Tribunals will be drawn'. 'We recommend that no new Act be brought into force until the Government can demonstrate that sufficient resources are available …'.

The battle is won. As for the war? The Government has already made it clear that it disagrees with the findings of the Committee and plans to continue with its proposals.

Subject to the outcome of the Election, we expect a Mental Health Bill towards the end of the year. It is currently planned that this Bill, along with the Mental Capacity Bill, will come into force in the spring of 2007. Plans for our attendance at the Party Conferences are in hand. We have arranged for our new President, Sheila Hollins, to host a dinner at one of the conferences. We will not know if we have booked the dinner at the correct conference until the result of the Election is known!

In Scotland

Mark Taylor

In Scotland, the implementation of the 2003 Act was delayed until October 2005, principally to allow for the recruitment of enough medical members for the new Tribunals.

I have responsibility for devising the training in the new Act for psychiatrists in Scotland - part of the training can be viewed at www.nes.scot.nhs.uk/mha and by then clicking on the 'approved medical practitioner' link. As you know, there is a general acceptance of this 2003 Act but interesting points to note are that 1) health boards will be required by law to provide inpatient accommodation specifically for both adolescents and for sick mothers with an infant under one year of age (i.e. MBU) - you can imagine that we are short of these types of accommodation - and (2) that appeals against excessive security will be allowed from May 2006. But as yet we only have one proper medium secure unit in the whole of Scotland (!) - this has created media interest that offenders will be let free!

If you wish to make a comment or respond to this article **email us at adultpsychiatry@yahoo.co.uk**

Fragmentation and dislocation: major threats to psychiatric Services

Bob Davies

There is a venerable anecdote, much beloved of biologists of an earlier era, in which the Oxbridge penchant for highly specialised education (as a graduate of one and a professional product of the other, I feel

able to quote this without fear of recrimination!) is lampooned. A botanist from one and a zoologist from the other are on a field trip in Africa; neither, in the tradition of their institutions, knows the slightest thing about the other's subject. After a hard day's specimen collecting, they return to their bungalow in a jungle clearing which has a large cabbage patch to provide food and they eventually fall asleep. In the middle of the night, a loud crashing noise wakes the botanist, who goes out on to the veranda to investigate the cause. He runs back in and wakes the zoologist, and gasps: 'There's a HUGE animal in the cabbage patch – I've never seen anything like it.' The zoologist sleepily asks: 'Well, what does it look like?' The botanist replies: 'It's grey, has four legs and an enormous tail.' 'And what is it doing?' asks the zoologist and, wide-eyed, the botanist answers: 'It's standing in the cabbage patch and it's … it's pulling up cabbages with its tail and you'll *never* believe what it's doing with them!'

This anecdote, while very much tongue (or tail) in cheek, illustrates two fundamental problems of super-specialisation: - firstly, that a restricted knowledge base can lead to erroneous conclusions and secondly, that disjunctions in knowledge severely hamper communication. In a complex health system, high-fidelity, low-equivocation communication is essential if the gold standard of continuity of care is to be achieved. It is a fundamental property of communication systems that the greater the number of sequential channels, the greater the equivocation, and therefore, in a health setting, the poorer the continuity of care. It is a matter of common experience, and certainly for those of us who investigate complaints and untoward incidents, that the overwhelming majority of adverse health events have their origins in a breakdown in the continuity of care provided.

The National Service Framework (NSF) and subsequently, New Ways of Working (NWW) have, together, heralded an unprecedented assault on the fundamental principle of continuity of care. At their core is the notion that specialisation is intrinsically better and more efficient than generalism, a notion which, while by no means new, has been taken to new extremes by these policies. Indeed, when the shortening of the mandatory period of higher professional training is considered, the scene seems set for UK psychiatric provision to move to an agglomeration of highly circumscribed services with little place for the broad view - other than at managerial level. The rise of Community Mental Health Teams (CMHTs) in the 1970s and 80s probably represented an optimal solution to the trade-off between the need, on the one hand, to provide a variety of specialist treatments requiring high levels of specific expertise and, on the other, to maintaining fidelity of communication and hence, continuity of care. The NSF and NWW move significantly away from this point in the direction of compartmentalisation and specialisation, and it is inevitable that communication and continuity will suffer *pari passu*.

The extent to which these changes have been effected across England is variable, and I can only speak with any familiarity about the South and West. The NSF provisions have been more widely implemented than those of NWW, presumably because these are required for the requisite number of ticks in boxes, and therefore, stars, so that the traffic light mechanism is not triggered (!), whereas the NWW changes remain at the Good Idea stage – that is, not a part of overt national policy but, nonetheless, a politically favoured solution to a politically defined problem. I have been able to witness the progressive spread of these changes from the standpoint of both a Tribunal member and an independent expert, and can confirm that discontinuities and dislocations in care have been more prominent in the front-runners, and have generally increased as NSF and NWW structural changes have been implemented.

A prime example of the kind of problem experienced in tribunals is as follows: a patient with severe and enduring mental illness is detained under a Treatment Order and appeals. Has there been a Section 117 meeting prior to the Tribunal (required under Tribunal rules)? No. Why not? It takes a long time to organise these meetings. If the patient is to go home on discharge, we need to involve the Assertive Outreach Team. Yes? Well, they need to assess the patient first and that will take about a month. But we're not sure that this is the right option, and perhaps the patient will require more supportive accommodation, and so we need to ask the Housing Liaison Team to assess this and, yes, that will take a month, and they have a waiting list. Well, what happens if the patient is discharged today? He will revert to the care of his community psychiatrist, who isn't here to explain what follow-up will be provided. And so it goes on.

This illustrates both fragmentation and dislocation. The patient's care is fragmented in that, depending on the outcome of assessments, different teams will be involved in his or her care, and these assessments are carried out, not by the immediately responsible team, but those which *may* need to be involved; overall medical responsibility is also fragmented, with no guarantee of concordance in the views of the inpatient and community psychiatrists on the patient's follow-up requirements. The system is dislocated in that each component of the service operates to its own schedule, and there seems little chance of all parties getting together and producing a mutually agreeable solution. The late Douglas Adams coined the term 'SEP' – Someone Else's Problem – and the proliferation of disjoint specialist teams makes the growth of the SEP culture in psychiatry inevitable.

.

As an independent, I have arrived on a ward with an appointment to see a detained patient to be told that he

is on leave. Where? 'At his parents,' we think. Telephone call to parents – no, he's in his new accommodation with a member of the Home Treatment Team, we think. Back to ward – did you know about this? No. How do I contact the home treatment chap? We don't know – we don't have a telephone number for the flat, and the office is closed. OK – where is the new flat? We don't know.

This, on the face of it a fairly trivial example, is actually deeply worrying. The inpatient team had no idea of the whereabouts of a detained patient for whom they were responsible, *and did not seem particularly concerned*. They were clearly not privy to significant components of their patient's care plan, which constitutes a serious communication failure, and the insouciance that was evident strongly suggests a degree of demoralisation. Many of the members of the new NSF teams have been recruited from experienced inpatient staff, which has had the effect of diluting the amount of therapeutic expertise available, and casting inpatient teams more and more into a purely custodial role, a sure recipe for demoralisation, which, of course, is worsened by the 'sexy' image of home treatment and the demonisation of inpatient treatment. This tension alone could form the basis of another article.

It would, of course, be an absurdity to suggest that specialist teams are, of themselves, a bad thing; in a well-resourced service with comprehensive provision, specialist *tertiary* services cannot but enhance the quality of treatment. Unfortunately, the NSF and NWW have impacted on an already struggling service, and have only been implemented by the leaching of resources, both human and financial, from already hard-pressed conventional teams. A further problem is that these new teams are not truly tertiary – they are, in fact, autonomous wings of secondary services and, indeed, possess few skills which are not present in CMHTs. Their creation, therefore, is purely an organisational matter, and as so often happens when organisations become more complex and boundaries proliferate, communication and continuity suffer.

While it is unlikely that the communication problems suffered by the zoologist and botanist in the opening anecdote will be experienced in the new structures for some little while, as skills which are redundant in the new settings are lost spectacular communication failures of this sort may be anticipated in the not-too-distant future. What *is* already evident, however, is a burgeoning of boundary disputes, and a sort of rutting behaviour in the establishment of dominance relationships between teams, with the further sapping of morale and the poor patients as piggies in the middle.

This well-known saying of Caius Petronius, the author of the *Satyricon*, amply describes the current plight of British psychiatry in the wake of the NSF and NWW:

'We trained hard, but it seemed that every time we were beginning to form up into teams, we would be reorganised. I was to learn later in life that we tend to meet any new situation by reorganising, and a wonderful method it can be for creating the illusion of progress, while producing confusion, inefficiency, and demoralisation.'

It is a great shame that, nearly 2000 years on, this excellent insight is flagrantly ignored, and changes which have pushed Trusts to the brink of bankruptcy and pervasive demoralisation are imposed, with little rationale other than the creed that change is good for its own sake – and for star ratings.

If you wish to make a comment or respond to this article email us at adultpsychiatry@yahoo.co.uk

Post-tsunami mental health needs in Thailand

Dinesh Bhugra

On 26 December 2004, a tsunami hit several nations in the Indian Ocean and its repercussions were felt as far away as Somalia on the east coast of Africa. There was a fast response to the disaster, both locally and internationally. Money, medicines and medical aid, along with counsellors by the planeload, poured into all the countries. However, out of the affected nations, India, Thailand and the Maldives declined international aid.

WHO South East Asia Regional Office (SEARO) has been looking to the mental and physical health needs of survivors in the different nations. I was invited to join the team in assessing the mental health needs in Thailand. This one-week trip turned out to be a real eye-opener. The health care community in Thailand was invigorated and stimulated in not only a quick response, but in an appropriate and timely one. There is no doubt that Thailand had several advantages over the other affected nations in the region. The Thai economy is strong, the community very cohesive and the health care infrastructure is well developed, with very good basic health care, especially in the six provinces which were particularly badly affected in the south of the country. A cynical view may be that as these areas attract more foreign tourists, the quick response and organisation was essential in order to reduce the number of deaths and the rates of communicable diseases.

Structures: six out of 72 provinces were affected. Each province has districts and sub-districts, and at the latter level there exists a community health centre which also

looks after the mental health needs of the local population. Each district has a district hospital, with a regional hospital functioning at the provincial level.

The disaster management committee was set up within hours and the mobile mental health team were on-site within 48-72 hours. The mobile mental health team consisted of a psychiatrist, a psychologist, a social worker and two or more nurses. The referrals to mobile mental health could be direct or through health workers. Each village had one or more health care volunteers who were chosen by the villagers themselves. These individuals were trained by psychologists and social workers in basic psychiatric conditions and screening methods. They liaised with health care workers who were trained in mental health. In total, the country has something like 800,000 health volunteers and 200,000 or so health care workers. Each volunteer looked after no more than ten families.

In the disaster, there were a total of 5,395 dead (1,953 foreigners and 1,926 Thais; the rest had no identification). A total of 2,392 foreigners were injured as were 6,065 Thais. Nearly 3,000 people remain missing and over 1,000 bodies remain unidentified. A total of 928 children lost both their parents and all bar two were adopted by their kinship and extended family – a mind-boggling achievement, reflecting the overall cohesion of the society.

Twenty-three temporary sites of residence were set up within 24 hours. The residents were encouraged to stay within the same village group, e.g. all survivors from one village were put together in the same camp, and if village leaders were available they were encouraged to take the lead in managing the survivors. In the two camps we visited, the reconstruction had already started and people were beginning to get their lives together. The survivors were given land by the Government within one mile of their previous place of living if it was possible on geographical grounds. Students from universities were released to do voluntary work to help rebuild communities. Monks, as well as other religious personnel, opened the doors of temples and other places for temporary shelter, food and support and to act as collection centres for donations.

The magnitude of loss in human emotional and economic terms can only be imagined. However, rebuilding of the communities is already under way and the most significant achievement has been the emphasis on mental health and its re-integration into mainstream health care delivery. Like India and the Maldives, Thailand has succeeded in demonstrating that it can look after its own and keeping foreign medical aid away may have helped in dealing with the disaster in a mature and culturally appropriate way.

If you wish to make a comment or respond to this article email us at adultpsychiatry@yahoo.co.uk

Hot news from the East

By our intrepid reporter: Zsarina Sciocco

News has reached us of a dramatic breakthrough in psychiatry. A source close to an innovative mental health research group was quoted as saying: 'Finally we have found a perfect outcome measure in psychiatry'. For far too long, psychiatrists have had money and resources thrown at them in the vain hope that they would account for themselves. Instead, they have stubbornly refused to measure outcome and have spent their time on the golf course at the expense of the global pharmaceutical industry. Things are about to change and from now on they will have to show that they can be of some use to society.'

Although details are sketchy, it is believed that the new outcome measure will be called HONOS (Health of the Nation Output Scales -see photo below). Rigorous evaluation is under way but the scales have proved their worth from the minute they were first used. In the first experiment, the scales were tested on a female borderline patient who had been in contact with psychiatric services for 20 years. She had wasted expensive resources by constantly ringing 999, claiming to be suicidal and getting herself admitted to hospitals (almost on a monthly basis) during that 20-year timeframe. Her psychiatrist declared the situation hopeless and as there didn't appear to be any particular outcome, the researchers collected all available psychiatric case notes to see what had really been achieved in all that time.

Having applied the *new* and *improved* HONOS scales, the researchers calculated the output on an annualised basis. Using dichotomous variables they were able to show that the total output for the period 1981-1991 was 1.2kg compared to 5.6kg for the period 1991-2001 ($p>.0000005$). It won't have escaped the dedicated reader's attention that 1991 was the year in which the CPA (care programme approach) was introduced to England and Wales. As everyone knows, that's the only sensible way to deliver psychiatry in the modern world. Our source was quoted as saying: 'This proves that the CPA has a demonstrable effect on outcome. In this woman's case the outcome was increased by 400% and it is clear that her psychiatrist was talking utter nonsense. Despite his claim that there was no difference in the woman's behaviour over two decades, the non-medical staff obviously became very productive after the CPA became available to them. Using these new

Output Scales, we finally have a perfect way to call the psychiatrists to account.' Although the Department of Health hasn't had the opportunity to evaluate the research findings, it has judged it prudent to require all Trusts and hospitals to start using the new scales from next month. A consultation period of eight days will precede the implementation date and everyone will be given the opportunity to contribute to the debate. In the meantime, an executive version of the scales, with re-enforced titanium backing, can be purchased from the website totalbureaucratic.madness.nhs.com

Health of the Nation Output Scale (HONOS) pre CPA

N==1, pre CPA weight = 1.2kg

Health of the Nation Output Scale (HONOS) post-CPA

N=1, post-CPA weight= 5.6kg

Next issue: Back care exercises for the jobbing psychiatrist, by Zsarina Sciocco.

If you wish to make a comment or respond to this article email us at adultpsychiatry@yahoo.co.uk

Training matters!

Management of personality disorder: need for more training in psychotherapy

Vineet Singh

Studies have shown that there is a high prevalence of personality disorder in people with mental health problems. The co-occurrence of personality disorder in people with enduring mental illness makes their management difficult, and the services struggle to cope with these demands in view of the lack of skills and resources. Studies have consistently shown that those with personality disorder and mental illness can be heavy users of mental health services as well as have significant morbidity. This highlights the need for more skills and resources in dealing with this complex client group. It also indicates the need for integrating more psychotherapeutic and psychosocial models into the management of these patients.

The evidence base for psychotherapy has expanded; hence there is a need for a revision of the curriculum in the light of this. The resentment over compulsory treatment, substance abuse, lack of insight and non-adherence with medication commonly present as barriers to a positive therapeutic relationship. The inability of clinicians to deal with personality disorders causes splitting within teams, low morale and a sense of therapeutic paralysis, which can significantly impair the overall functioning of the team. The Cognitive Analytical Therapy (CAT) model of management, described by Anthony Ryle (1997), has been used with good success in patients with borderline personality disorder. The collaborative nature of the reformulation process in CAT does offer scope in developing a joint sense of purpose with the patient. However, there are very limited avenues for clinicians to acquire such skills. Therefore, there is a need for more training and more resources put towards enhancing the use of these approaches. There is evidence that patients with mental disorders and co-morbid personality disorders actually have a better outcome under a hospital-oriented programme of care, therefore the role of day hospitals should be carefully considered.

At the present time there is not enough provision for adequate training in psychotherapy during specialist training for future consultants. Although the College

accepts that every trainee needs experience in psychotherapy, and has included 1 year in long cases and 2 years in short cases separately as part of the curriculum, it has been noticed that many trainees fail to achieve this aim. There is a need for more attention to this aspect of training in order to enhance the level of care for people with personality disorders. The times ahead are going to be difficult, given the issues surrounding the new Mental Health Act, which is almost certain to challenge the treatability aspects of personality disorder. If measures are not taken to train doctors and nurses in dealing with this complex client group, it would have a detrimental impact on the inpatient services, which have already reached a breaking point in most of the regions of England and Wales.

Overseas trainees: the good, the bad and the 'what shall we do'?

Trevor Turner

A recent article in *Hospital Doctor* outlined what were considered to be 'inhumane' difficulties for international medical graduates. The latest figures apparently reveal that the 'average international graduate in medicine makes 517 applications for a PRHO post and 277 applications for an SHO post'. To what extent this applies also in psychiatry is uncertain, but anecdotal feedback from overseas trainees reports regular rejection despite numerous applications. Psychiatry has certainly become much more popular in the last 5 years, and now it is routine to have 100 to 200 applications for, say half a dozen posts, on a London-area SHO rotational scheme.

How has this come about? Should we be encouraging overseas graduates to come and work in the UK anyway, given the shortages of trained doctors, particularly in many 'third world' countries, and the immense health problems they face? Is it reasonable to consider that at least we are offering doctors a good quality postgraduate training, which it is hoped they will pass on when they go back to their country of origin? For example, I am told by Indian trainees that in their country, even with its vast output of medical graduates, there are nevertheless a very limited number of training posts in psychiatry. Furthermore, as a recent clinical assistant pointed out to me, he finds it hard to persuade his mother that he 'really is a doctor' when working in psychiatry. Yet the continuing shortages in the psychiatric workforce situation in the UK would seem, on a pragmatic level, to make it well worth our time to attract such individuals, because of the quality, diversity and range of skills they bring (they have often worked in government general medical clinics for a number of years) to the NHS.

My own view is that, if at all possible, we should try to train overseas graduates, and welcome them as a much-needed asset, particularly in the inner city areas where diverse ethnic backgrounds can be extraordinarily helpful in providing a properly diverse medical workforce. At the same time, at the highest levels of the Colleges and the BMA, we should be striving to generate an international medical outlook, whereby doctors are properly supported in funding (for example, by the WHO?), so as to equalise their earning abilities globally. This may sound ridiculously idealistic but, to anglicise the most famous of voluntary doctor groups, medicine should be without frontiers.

In terms of current realities, we at Homerton University Hospital Psychiatry Department have strongly encouraged clinical assistant attachments in accordance with GMC guidelines, especially over the last five years. We have found the great majority of overseas trainees to be polite, committed, keen to work, and well trained in clinical practice. We have always insisted that they have passed the second part of PLAB before joining us, and that they obtain a clinical assistantship also at another hospital (as advised by the GMC), before applying for jobs. We have encouraged quality by offering to provide references, and by the use of a locum bank have enabled a major reduction in locum costs. A number have joined our rotation or nearby rotations, although many fewer than we would have liked because of the major pressures (i.e. 100 to 200 applicants per six months) involved. We are always clear in advising trainees that, particularly more recently, the job market is very tight and they may have to be prepared to take on a number of short-term locums until they can get a regular or a rotation post.

What is so annoying is that because of central control (from Leeds, or wherever) we are not allowed to expand our SHO training numbers, without considerable bureaucratic wheeling and dealing via the Deaneries. We know there are considerable shortages in the consultant grades of psychiatry already, but we can't expand the SHO and SpR training grades sufficiently to fill this. Given the hard-pressed nature of a number of Trusts, particularly (but not only) in the inner city, it would seem to me very sensible for specific funding to be allocated to training posts for overseas trainees, say half a dozen per Trust, so as to use and develop this workforce asset.

Despite all these problems, however, I would strongly encourage colleagues, especially clinical directors and medical directors, in Trusts that do not routinely take overseas trainees as clinical assistants, to reconsider. Provided they are appropriately assessed and screened, and supported, they can provide additional skills, both clinical and social, a useful locum reserve on an in-house basis, a reliable source of potential trainees, and perhaps even an asset for the future. One needs to be absolutely realistic in pointing out the difficulties and limits on job availabilities, and one has to be quite clear as to expectations in terms of the role of the clinical attachment/assistant. Help with developing CVs,

supported training, and appropriate advice about the GMC rules are all required, but most importantly we must put pressure on the Government to expand training posts so as to take on board a real workforce asset.

If you wish to make a comment or respond to this article email us at adultpsychiatry@yahoo.co.uk

Correspondence

Evidence base for Home Treatment Teams: 'function creep' is a major challenge

Andy Bickle

CT Sudhir Kumar's article on Home Treatment Teams makes several important observations and reminds us that the empirical evidence base for this kind of community treatment is relatively weak. In Nottinghamshire we will be investigating factors which predict eventual hospital admission from our new CRHT teams. We hope that this will lead to a better understanding of patient suitability and allocation of resources and, unsurprisingly, we would agree with the author that the selection of patients is a 'key area' in developing services. Yet, taking this aspect as an exa mple, there are only two existing studies which have attempted to find factors that predict transfer to inpatient care and neither of these examined services which would closely fit the model set out in the DoH's Mental Health Policy Implementation Guide (MHPIG). Indeed, it may seem obvious, but it is worth remembering that the services used to develop a valid evidence base for CRHT must be similar to those to which it will be applied. In practice, there is considerable potential for services to be different and applicability cannot be assumed.

The key functions of the nationwide CRHT teams set out in the NHS Plan and the MHPIG are to gate-keep access to services, to offer an alternative to inpatient treatment and to support discharge from inpatient care. A clear vision but, as we all know, when new services are actually implemented in the real world they are influenced by a range of factors and buffeted by other service demands and political directives. They can find themselves taking on all sorts of roles other than those originally intended, and while these may sort out problems owing to shortfalls elsewhere in the system, they inevitably dilute the model. Teams in this Trust, for example, have received requests to provide liaison cover in an A & E department to help ensure compliance with junior doctors' hours and to assist community initiation of clozapine. And where, for example, do CRHT teams stand if their Trust has signed up to reducing four-hour waits in A & E – are they expected to make this one of their primary objectives? More subtly, the function of such a service can 'creep' when they become involved in deserving 'sub-threshold' cases, such as in supporting a patient at home who undoubtedly benefits and receives better care, but who wouldn't have been admitted to hospital under the previous system anyway. Or perhaps some teams find that their function is being distorted as CMHTs become reluctant or slow to take over patients safely allocated to their care? Furthermore, the staff composition of CRHT teams appears very different at this stage, with levels of medical input in particular being highly variable.

The scenario that could play out is of hundreds of somewhat different CRHT teams, sculpted by local pressures. This contrasts with the NHS Plan vision of 335 teams providing a uniform service across England. If the former were to occur it would compromise generalising research from individual or small groups of relatively idiosyncratic teams and present a major challenge to developing a meaningful evidence base for CRHT. This need not be a cause for despair, but it does mean that research in CRHT should describe carefully the nature and function of the services studied, so that readers can judge whether the results apply to their practice – this cannot automatically assumed just because it has the CRHT label.

SHOs and research

Stephen J Cooper

I would like to comment on the recent article on 'SHOs and research' in the Faculty newsletter of Autumn 2004.

There are reasons why it is impractical for SHOs to become involved in research but there are also reasons why this may be inappropriate. At that stage of training doctors need first and foremost to develop their clinical skills and theoretical knowledge and demonstrate these to their examiners. Research is something that will be built upon that base. Further, the SHOs themselves are generally so focused on the demands of the examinations that they are rarely able to focus properly on research. In our own unit there have been perhaps two or three very able SHOs who have managed to contribute to publishable research in the last 5 years, but for most it is not the main focus of their lives. Further, small academic departments and busy clinical units cannot provide the time required for the proper supervision of research by relatively junior staff when they must provide this for those at SpR level.

If the College genuinely wishes to foster research at an earlier stage then it needs to speed up the examination process. The requirement to spend 30 months in clinical practice at SHO level before being allowed to sit the MRCPsych Part 2 examination seems rather prolonged. It certainly holds back the most able

trainees who might well wish to enter research early on. It also potentially disadvantages trainees in psychiatry whose peers in other specialties can dispospe of their membership examinations earlier, become involved in research earlier and be able to take up Research Fellowships without compromising their clinical training. My experience locally is that the current arrangements in psychiatry often result in four years at SHO level and a short three-year spell at SpR level. This often leaves insufficient time to reach the academic standards necessary for an SpR to become a serious competitor for Research Fellowships with, say, physicians who have completed their MRCP within 12-24 months of gaining full registration and been able to focus on research for longer.

Perhaps new training arrangements with a single training grade may allow more flexibility. However, a prolonged period before achieving the MRCPsych does not allow junior doctors to properly focus on research if that is what they wish to do.

Dates for your diary!

Annual Residential Conference 2005

Faculty of General and Community Psychiatry
and
Collegiate Training Committee

Crowne Plaza Hotel, Liverpool

13th – 14th October 2005

Draft Programme

Thursday, 13th October, 2005

Theme: Psychopathology and Service Delivery in Mood Disorder

9.00 **Welcome:** Dr Jed Boardman

9.10 **Plenary Lecture:** Professor Richard Morriss, University of Liverpool. Psychological Treatment and Service Delivery in Bipolar Disorder.

9.50 **Plenary Lecture:** Professor Jonathan Hill, University of Liverpool. Developmental Approaches to Adult psychopathology: Evidence in Unipolar Depression and Personality Disorder.

10.50 Introduction to the William Sargant Lecture

10.55 **William Sargant Lecture:** Professor Wayne Katon, University of Washington, United States. Clinically and Cost Effective Population Based Service Models for Mood Disorder.

11.55 Vote of thanks for the William Sargant Lecture

12.00 A Chief Executive’s Perspective: Mr Alan Yates, Chief Executive, Mersey Care NHS Trust

1.30 **Workshops:**

- Anti-psychotic-induced osteoporosis and metabolic syndrome. Dr Peter Haddad, Consultant Psychiatrist and Honorary Senior Lecturer University of Manchester.
- Setting up services to work across the primary-secondary care interface in the NHS. Professor Linda Gask, University of Manchester.
- Family and group approaches to schizophrenia with substance abuse. Professor Christine Barrowclough, University of Manchester.
- Pharmacological approaches to treatment-resistant depression. Professor Allan Young, University of Newcastle.
- CTC
- Assessment of capacity. Dr Mark Taylor.
- Management of somatisation and chronic fatigue syndrome/ME. Professor Richard Morriss, University of Liverpool
- Preparing trainees for MRCPsych part 2 examination. Dr Anne Bird.

3.30 Workshops repeated

5.00 End of workshops

5.15 Industry-supported symposium on schizophrenia/bipolar disorder - Janssen

7.00 Reception and SpR poster session

8.00 Faculty Dinner? (to be confirmed)

Friday, 14th October, 2005 Theme: Early Intervention for Psychosis and Talking to Patients

8.00 Industry-supported symposium on depression or attention deficit syndrome - Lilly

9.15 **Workshops:**

- Patient agendas and talking to patients in primary care. Professor Christopher Dowrick and Professor Peter Salmon, University of Liverpool.
- Early intervention for psychosis - a special interest? Dr Mark Agius.
- Management of eating disorder. Dr Janet Treasure, Institute of Psychiatry.
- Basic neuroscience review; serotonin and noradrenaline. Dr Hamish McAllister-Williams.
- Child protection issues. Dr Anne Worrall Davis.
- Self-help cognitive therapy for depression and anxiety. Dr Christopher Williams.
- Services for self-harm patients. Dr David Owens.
- Setting up Assertive Outreach Services. Dr Robert Higgo, Mersey Care Trust.

11.15 **SpR/new consultant research session**

1.15 **Business meeting** and announcement of medical student prizewinner

1.50 **Plenary:** Talking to Patients with Serious Mental Illness. Professor Stefan Priebe, Queen Mary's Hospital, University of London.

2.30 Early Intervention Services: Professor Max Marshall, University of Manchester.

3.00 What are SIPS and SOPS? Dr Surwan Singh.

3.30 Setting up a service – view from the coalface. Dr Paddy Power.

4.0 Meeting finish

Faculty prizes 2005

Oral and Poster Presentation Prize for Trainees and New Consultants

The Faculty of General and Community Psychiatry has established a prize for the best poster and oral presentation, to be awarded annually at the Faculty/CTC residential meeting. The value of the prize is £250.

Regulations

1. The prize is open to all psychiatrists in training grades and to consultants in their first year of practice.

2. The prize is awarded on the basis of originality and relevance to general and community psychiatry of submissions for poster presentations and a short oral presentation to the judging panel.

3. Applications will be invited at least 3 months before the annual residential meeting through a Faculty mailing; the prize will also be advertised in the Faculty newsletter.

4. Short-listed applicants will be advised approximately 2 weeks before the meeting. The prizewinner will be expected to provide a summary article for the Faculty newsletter and the full text of the poster presentation for inclusion on the Faculty web page.

5. The judging panel will consist of the Faculty Academic Secretary and two other elected members of the Faculty Executive.

Closing date Entries should be sent to the College Assistant Conference Manager no later than one month before the annual Faculty/CTC residential meeting in October.

Medical Student Essay Prize in General and Community Psychiatry

The Faculty of General and Community Psychiatry has established an annual essay prize, valued at £500, to be awarded following competition. The Faculty wishes to encourage interest in and awareness of psychiatry among undergraduates as a stimulating and challenging career option.

Regulations

1. The prize is open to all clinical medical students in the UK and Ireland.

2. The format of the prize will be an essay. Criteria for judging merit will be explicit and will include clarity of expression, understanding of the literature and evidence, cogency of argument and overall ability to convey enthusiasm and originality within a set word limit.

3. The topic and criteria will be announced in the Student BMJ and circulated to medical school deans yearly.

4. Entries will be short-listed and judged by a panel drawn from the Faculty Executive Committee, comprising the Academic Secretary, Honorary Secretary and an external psychiatrist with special interest in or knowledge of the chosen topic. This panel will meet at the end of July each year to consider the entries. Should a minimum standard not be achieved, the prize may not be awarded.

5. Applicants should send their essay in triplicate to the Faculty Honorary Secretary at the College.

6. The prizewinner will be invited to the Faculty annual residential meeting for presentation of the prize, and his or her name will be included on the list of prizewinners at the presentation ceremony at the College annual meeting.

7. The prizewinner will be required to provide a summary for publication in the Faculty newsletter.

Closing date The closing date for submissions is 30 June.

Winner of the trainee poster and presentation prize 2004

Mental health problems in the Crisis Open Christmas medical service

Marianne Baker

Introduction

Raised rates of psychosis, neurosis and substance misuse have repeatedly been demonstrated among homeless populations (1). Psychiatric provision for this group is often limited, and the impact of psychiatric symptoms on treatment offered by generic health services for the homeless is unclear. This study investigated the recorded prevalence of mental health problems among attendees at the medical centres of open access winter shelters run by the homelessness charity Crisis. It also assessed the effect of current psychiatric symptoms on treatment received.

Methods

The case records for all attendees at the 2002 Crisis Open Christmas medical centres were examined. Demographic information and data on reported lifetime and current mental health problems and substance misuse were collected using a semi-structured proforma. Outcomes, recorded as treatments offered, referral to other medical services and re-presentation to the shelter medical service, were compared between those with and without current psychiatric symptoms.

Results

Data was available for 597 of 649 attendees (92.0%), of whom 202 (33.8%) attended more than once. Recorded lifetime mental health problems were common; 36.0% mental health problems, 39.1% excess alcohol use, 35.4% excess drug use, 5.4% psychosis, 20.4% co-morbid mental health problems and excess substance use. 187 attendees (31.3%; 95% CI 27.6-35.0%) had current psychiatric symptoms recorded. Presenting complaints among these people (<4/person) were most commonly physical (62.5%) or substance misuse-related (intoxication, withdrawal or detoxification request - 28.8%) Other presenting complaints included depression, anxiety or suicidality (25.0%), medication requests (13.0%), social problems (12.0%) and psychotic symptoms (6.0%).

Diagnoses given following assessment were predominantly substance misuse related (62.1%: drug misuse 26.3%, alcohol misuse 21.2%, physical complications of substance misuse 14.6%) or physical (18.2%). Psychosis was diagnosed in 7.3% and common mental disorder in 6.6%. Current psychiatric symptoms were associated with an increased likelihood that attendees would receive assessment and advice only ($p<0.001$), as a small increase in psychotropic medication prescription ($p<0.001$) was overshadowed by a large reduction other prescriptions ($p<0.001$). Acute referral to the shelter drug team ($p<0.001$) and external health facilities ($p<0.001$) were more common among those with recorded psychiatric symptoms, as was re-presentation to Crisis services ($p=0.05$).

Discussion

This large, cross-sectional study identified a high prevalence of self-reported psychiatric symptoms, consistent with previous research (2). Psychiatric and physical symptoms often co-existed (3). Substance misuse was commonly identified, but diagnosis of common mental disorder was infrequent. Many more attendees were diagnosed with substance misuse than were referred to the shelter drug and alcohol team. Rates of external referral suggest that current psychiatric symptoms were associated with serious pathology requiring acute intervention, while the rates of re-presentation point to less acute unmet health need. Better training for staff in the detection and treatment of mental health problems and good links with substance misuse teams, psychiatric and general health services are essential to meet the treatment needs of this neglected population.

Conclusions

The prevalence of lifetime and current psychiatric morbidity in this group is high. The presence of current psychiatric symptoms is associated with increased use of health services. Mental illness in the homeless is a major concern to clinicians and research evidence must be translated into needs-based services for this vulnerable group.

References

1. Scott, J. (1993) Homelessness and mental illness. Br J Psychiatry 162, 314 - 324
2. Gill, B. et al, (1996) Psychiatric morbidity among homeless people. London: HMSO
3. Bridges, K. W., Goldberg, D.P. (1985) Somatic presentation of DSM III psychiatric disorders in primary care, J Psychosom Res, 29, 563-569

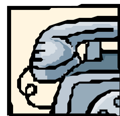
A big thank you from the Faculty to all those who participated in the competition.

Faculty of General and Community Psychiatry: The Executive

Chair:	
Dr Jed Boardman	(Elected: 2003)
Honorary secretary:	
Dr Suresh Joseph	(Elected: 2003)
Finance officer:	
Dr Geraldine O'Sullivan	(Elected: 2001)
Executive committee members:	
Dr Pradeep Arya	(Co-opted: 2003 - alternate CTC rep)
Dr Anne Bird	(Co-opted: 2002 - GOAPSAC)
Dr Alan Currie	(Elected: 2003)
Dr Lenny Fagin	(Co-opted: 2003 - academic secretary)
Dr Brian Ferguson	(Co-opted: 2003)
Dr Cliff Haley	(Co-opted: 2004 - Irish College of Psychiatrists)
Dr David Hall	(Co-opted: 2003 - CAP interface working group)
Dr Michele Hampson	(Elected: 2001)
Dr Anna Higgitt	(Observer: Department of Health)
Dr Stephen Hunter	(Co-opted: 2003 - Welsh Division)
Dr Robert Kehoe	(Elected: 2001)
Dr Nick Kosky	(Elected: 2001)
Dr Mike Lowe	(Co-opted: 2005 - Regional reps group chair)
Dr Rajesh Mohan	(Co-opted: 2002 - communications)
Professor Richard Morriss	(Elected: 2001)
Dr Paddy Moynihan	(Co-opted: 2003 – Northern Ireland Division)
Dr Stephen Pereira	(Elected: 2001)
Dr Brian Robinson	(Elected: 2001)
Dr Manoj Sukumaran	(Co-opted: 2005 - alternate CTC rep)
Dr Mark Taylor	(Elected: 2003)
Dr Trevor Turner	(Elected: 2003)
Dr Graham Wood	(Elected: 2003)
Professor Allan Young	(Elected: 2003)

How to contact us

Faculty of General and Community Psychiatry
Royal College of Psychiatrists
17 Belgrave Square
London SWIX 8PG



Phone: 020 7235 2351
Fax: 020 7259 6507

Email: adultpsychiatry@yahoo.co.uk
Website: http://www.rcpsych.ac.uk/college/faculty/gencom.htm

Don't forget to mail or email us with your responses and articles for publication!