



The Royal College of Psychiatrists London Division Newsletter



Editor:
Cyrus Abbasian

Editorial

With General Elections just around the corner and the UK affected by one of its worst financial crises in decades, 'change' is perhaps the most politically correct word to best describe 2010!

The 'New Horizons' document is already leading to changes in mental health services, but unlike its predecessors it does not come with extra money. In fact significant cuts are likely to affect psychiatric services

across London and we have been warned the 'party is over' and even 'Armageddon is here!' In this edition, Fiona Taylor and Diarmuid Nugent have critically summarised the New Horizons document.

There are rumours of public sector cuts affecting the NHS up to as much as 30%! We are observing some of this across London with closure of services, freezing in recruitment and significant reconfigurations and cost improvement policies. For example, Wandsworth adult services are being reconfigured with emphasis on placing senior clinician in primary care focused around poly-systems: to quickly assess, treat or liaise with GPs as required. Despite pressures on services, due to funding restrictions, it is good to know that development continues in some tertiary services; as highlighted in Kevin Healy's articles on development of, and Payment by Results in, Personality Disorder services. Angela Hassiotis in her article has summarised the progress made, as well future challenges, including in recruitment, in the Learning Disability field since the publication of Department of Health's 'Valuing People' document in 2001.

The College has been attempting to increase recruitment into psychiatry for many years, but with mixed success. Mike Maier and Andy Kent from the Executive Committee have shed some light on the situation at London Deanery and across the country. The College is now attempting to engage pre-university students by arranging psychiatric talks and visits. Despite these efforts, however, the number of UK graduates choosing psychiatry as a

career still falls short of the national requirement. It is known that many medical students, despite enjoying their psychiatric attachments, do not become psychiatrists. We have two interesting articles from medical students Kaanthan Jawahar and Jonny Martell; on perceived reasons for this shortage with possible solutions.

This year's Division student prizes were given to Joanne Li Shen Ooi for her essay entitled 'How Loud is the Unquiet Mind' and to Nisha Mehta for her research on 'Public attitudes towards people with mental health issues.' In her well thought-out and researched work Joanne summarizes the life and achievements of William Sargent. Sargent (1907-1988) was a British psychiatrist who is best remembered for his physical treatments in psychiatry such as psychosurgery, electroconvulsive therapy and insulin coma. From her excellent piece of research Nisha concludes that public attitudes towards people with mental illness in England and Scotland became less positive during 1994-2003, especially 2000-2003, and to a greater extent in England. The abstracts of both prize winners can be read in this newsletter, with the full versions placed on the Division's website. There was also a merit handed to John Jackson for his essay; and three merits to Emma Shaw, Michael Cliff and Vivek Datta for their research.

Sadly Phil Steadman stepped down from the editorial team. We were surprised by the amount of interest generated when his post was advertised; many members of high calibre expressed interest in joining making our selection task particularly

difficult. We would like to welcome four new members to the editorial team: Stephen Ginn who is a CT3 trainee and has already contributed to the Newsletter; Angela Hassiotis who is a Consultant at UCL with substantial experience as Editor of College's Learning Disability Faculty newsletter; Fiona Taylor who is a ST3 flexible trainee and Kevin Healy who is the Lead Clinician of Cassel Hospital.

We hope you will enjoy this month's newsletter. As always comments and articles for future editions are welcome.

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New Horizons; New NSF?

The publication of a new public mental health framework will be replacing the old mental health National Service Framework (NSF) this year, after 2 years of consultation with a wide range of national organizations and the public. The twin aims are firstly to improve the mental health and wellbeing of the population, and secondly to improve the quality and accessibility of services for people with poor mental health. There is much in it that promotes hope that the problems we as psychiatrists experience in delivering a good and patient centred service are going to be addressed. The key themes of prevention, stigma, early intervention, personalized care, collaboration, innovation and value for money are so accurately defined, that if realized, could be the basis for world-leading mental health care. However, there are some glaring omissions that can bring you back down to earth with a bump.

An impressive part is the real emphasis on inter-professional collaboration in the exploration of how to introduce policies to help equip people with skills to achieve and maintain good mental health across their lifespan. The document stresses the philosophical change of moving away from the concept of mental illness, and a cycle of disadvantages and inequity leading to social exclusion, to an emphasis on mental health, resilience and recovery. There is recognition of the fact that perinatal, child, adolescent, adult and

older age services cannot work in isolation of one another, and the success of a healthy population depends on laying the foundations of good mental health in childhood and spotting mental health problems early. The other themes which are interlinked are that of transition between services, currently delineated by age boundaries, for example, the transition from child and adolescent services to adult where it is recognized that good facilities exist for psychosis, but poor provision for OCD, autistic spectrum disorders and ADHD, which do not fit easily into an adult mental health model. Older adults are also a priority here, represented by the key themes of equality to access of care, and personalized care, which questions the current transfer of care at age 65 even though the patient may prefer to stay with their existing team.

One large omission is the lack of reference to drug and alcohol misuse, partly because of the overwhelming demand for substance misuse services, and partly because substance misuse compounds social exclusion and stigma, one of the main themes of the document.

But the most worrying oversight of New Horizons has to be the mismatch between funding of research and disease burden. Mental health received only 6.5% of the total funding for health research in 2004/5. With neuropsychiatric disorders projected to take up 14.7% of the Global

Burden of Disease in 2020, and the economic cost of inability to work due to mental illness up to £41.8 billion in England alone, this dearth of investment in research represents stigma in itself. The consultation response by the Royal College of Psychiatrists lists barriers to research, such as NHS trusts having differing policies about facilitating research, and also governance procedures being discouraging to researchers by their cumbersome and intrusive nature. However, it also states that research should be owned by professionals and embedded in normal clinical practice. For older adults, it identified gaps in the research evidence supporting New Horizons, specifically with effective interventions for older people, controlled trials of different models of clinical services, and a detailed national mapping of mental health services for older people. It also drew attention to studies of Telecommunications, which have been shown to make savings by reducing admission rates, and enabling people to remain independent in their own homes. Whether this and other evidence mentioned in the response is taken into account when launching the public mental health framework remains to be seen.

The main concerns about achieving the aims of New Horizons were again highlighted in the

College's response. Firstly, there is a distinct lack of detail regarding how exactly these visions are going to be delivered over the next 10 years. Secondly, it is all too easy to see how money could be diverted from existing resources, which are still underfunded, to a new population-based health strategy. Thirdly, many of the initiatives will need longer-term commitment than can be guaranteed in the current political environment.

At a local level, the main challenges are to reduce fragmentation, and for psychiatrists to become more active in advising commissioners and local service planners, so that commissioning and implementation are more relevant to local needs. Whilst it makes sense to devolve commissioning of services locally, it is not clear how equity of investment in services will be achieved nationally.

Psychiatrists may feel skepticism about the new mental health framework, but New Horizons does show that the place of mental health in society has moved on a great deal in the last 10 years, and there is hope that it will move further in the decade to come.

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New Horizons; Swimming Against Bureaucracy?

December 2009 saw the publication of "New Horizons", a 100 page policy document outlining the government's vision for mental health strategy over the next decade. Following on from the 1999 National Service Framework, through which was mediated a radical overhaul of mental health service provision over last decade, New Horizons must somehow try to maintain this momentum in face of the austerity of the current economic climate.

With the remit "to improve the mental well-being of people in England" the strategy content is no less ambitious, attempting to engage a bewildering array of ten government departments, schools, the Criminal Justice System and employers, in addition to the familiar domains of health and social care. In doing so it aims to tackle a breadth of issues incorporating everything from the mental health needs of Iraq war veterans to the potential mental health implications of climate change. There is a strong public health emphasis with a planned framework to "enable commissioners to take a systematic strategic approach to commissioning services to improve the population's mental health and well-being". As such, the strategy prioritises primary preventions such as: programmes to promote emotional well-being directed at school children,

targeted approaches for families especially from high risk groups, and the treatment of postnatal depression and mental illness in parents as a means to reduce psychiatric morbidity later in life.

Much attention is devoted to the huge financial cost imposed by mental illness, mostly owing to lost productivity. The strategy is explicit in its agenda of seeking to offset some of that cost by facilitating the mentally ill to remain in or return to employment. It also promotes employment as a means to improve well-being. The personalisation of care, for instance through individual budgets or direct payments, is favoured as a means to ensure service users are empowered to take control over their own healthcare and recovery. Also it aims to improve equality of access and treatment amongst those most excluded within society; such as the homeless, black and ethnic minorities and those with learning disabilities.

Publication of the strategy was met by largely positive reactions from both the Royal College of Psychiatrists and mental health charities. Indeed, the mere fact that the strategy exists, and that it reflects a commitment to devote attention and energy to mental health issues, is in itself to be welcomed. The public health message is to

include a campaign "five ways to look after your mental health" which mirrors the "five a day" fruit and vegetable campaign! The benefits of such an approach may not be instantly quantifiable. But nonetheless it conveys a message that psychological well-being, just like physical health, is something that we can take responsibility for and actively attend to, rather than relying on passive recourse to pharmaceutical interventions when problems arise. It does much to destigmatise those with mental illness by encouraging a culture of open discussion. It also reinforces the view that all individuals, not just those diagnosed with a specific mental disorder, have a mental health; in the same way as their physical health.

The strategy is cross-governmental; engaging with multiple other departments and third sector agencies being a key feature. It recognises limits to what we as health professionals can do to deal with the everyday obstacles that people with mental health difficulties face, obstacles which can act as precipitating and maintaining factors in illness. Positive attitude of an employer, teacher or accommodation officer can play a huge role in dealing with potential problems, even preventing them from arising in the first place.

Nonetheless, the strategy is explicit that “there will be little scope, if any, for new resources in the foreseeable future”. If funds are finite and priority is to be given to primary prevention projects which improve the mental health of the nation as a whole, it does beg the question whether this will come at the expense of those with severe and enduring mental illness. Service-users raised this concern during the consultation process for the NH strategy. Similarly, the issue of employment could act as a double-edged sword. Undoubtedly for those at the less severe end of the spectrum, accommodating and empathetic practises from employers can do much to minimise the burden of illness. There are also strong arguments that employment can be therapeutic and a maintaining factor for well-being; providing motivation, promoting independence and helping self-esteem. With too strong a focus on incapacity and the benefits systems we risk entrenching individuals in the sick-role characterised by dependence. However, many individuals who are genuinely incapacitated by the severity of their condition, often in ways that are less immediately obvious and verifiable as a physical handicap. If promoting employment requires that they should be subjected to regular and intrusive scrutiny in order to receive the benefits on which their livelihood and dignity depends then such policy would be deeply flawed.

The implementation of New Horizons must therefore remain true to its values of a personalised approach to care.

With the advent of Payment by Results more attention shall be devoted to measuring outcomes “vital for effective commissioning” and indeed for the financial future of mental health trusts. Nonetheless, the obligation to record outcomes can increase the administrative burdens of staff and reduce time spent in therapeutic engagement. There needs to be a genuine commitment to invest in technical solutions to streamline processes by which outcomes are recorded, to ensure that they are user friendly and efficient. This can only be achieved through on-going consultation and dialogue with front-line staff: edicts from upon high for yet more form-filling is only likely to produce disaffection ultimately counterproductive to the basic aim of improving service provision.

Broadly speaking, it is difficult to disagree with the central tenets of New Horizons. Of course we all want to provide better and more accessible services, tackle stigma, promote social inclusion, improve the mental health of the nation, facilitate those with mental illness to have an active say in the care they receive and ultimately facilitate service-users to lead as full and as independent lives as is possible. To see that vision laid out in print is affirming and possibly even inspiring; but with almost

every action point requiring reference to another planned report, review, strategy or working group, it is not an easy document to interpret. The specifics of how to achieve the vision remains in the ether! When swimming against a tide of bureaucracy, inertia and lack of leadership on the ground, it is all too easy to slip into a mentality of learned helplessness; feeling disconnected and alienated from decisions taken. Yet as clinicians we are increasingly called upon to be leaders in the design and direction of the services we provide. The first step to achieving this is surely to engage in active dialogue and consultation from the first conception of policy right through to commissioning services on the ground.

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Payment by Results: PbR in Psychotherapy Practice

The Department of Health is committed to making national mental health currencies available for use in 2010-11. Colleagues in Yorkshire and the North East have developed the 'care cluster currency' that focuses on the characteristics of a service user, rather than the interventions they receive as the best approach to use in mental health. Mental health professionals will rate service users on a number of domains (e.g. depressed mood, problems with activities of daily living) with a score from 0 (no problem) to 4 (severe to very severe problem). Based on the scores in these domains mental health professionals should be able to identify a cluster whose profile matches that of the service user they are assessing. The final decision, on which cluster to allocate a service user to, is that of the mental health professional. Because clustering is linked to payment the Department is understandably exploring

options for review, audit and validation of these decisions. The care clusters as a currency unit are therefore based primarily on the characteristics of a service user rather than their diagnosis. Expected diagnoses are given for each cluster, but the same diagnosis could fit to multiple clusters. The exact format of the care packages to meet the needs of each cluster will be decided locally, although taking into account NICE guidelines and national policy documents. It supports the local development of innovative approaches to care. The clusters are mutually exclusive in that a service user can only be allocated to one cluster at a time, and are designed on the premise that people should be treated in the least restrictive setting possible. The clusters cover extended time periods and may contain multiple different care interactions. While it is important to define payment periods for clusters, the appropriate duration for a service user to be in a cluster is likely to be a matter for local agreement between commissioners and providers and will be linked to scheduled reviews, perhaps in turn best linked to CPA review

times. In the draft guidance on PbR there are 21 mental health clusters with maximum cluster review intervals ranging from 4 weeks for psychotic crisis and for severe psychotic depression, to 8 weeks for common mental health problems (low severity), to 6 months for 9 particular clusters, to 9 months for non-psychotic (severe) and substance misuse clusters, and to annual review for 6 other 'complex enduring problem' clusters. Medical Psychotherapists are likely to be working with individuals in the 6 non-psychotic (moderate severity, severe, and very severe, overvalued ideas, high disability, chaotic and challenging) clusters. In addition they may be supervising or consulting to counsellors and therapists working with the more common mental health problems. Allocation to clusters will occur at three points - on initial referral/assessment, at a cluster review interval/ planned reassessment, and in the event of a significant change in need (unplanned reassessment). Some services are not yet covered by the care clusters. These include Child and Adolescent Mental Health Services; Forensic Low, Medium and High Secure Services; Learning Disability Services; and some specified others. Ideally the clusters will apply to both IAPT and non-IAPT services. I believe this is a welcome initiative that in addition



to the important background driving issue of payment and finances, and the quality issues of results and of clinical outcomes, will also challenge us to focus as medical psychotherapists and as psychiatrists on developing more integrated planned care pathways to further improve patient care.

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“Hope and Change: does the recovery model apply to Personality Disorder?”

The annual residential Summer School for those working with Personality Disorder, run by the Cassel Hospital and the National Forensic Psychotherapy Training Programme, is once again happening at St Anne’s College Oxford; from Tuesday 7th September to Friday 10th September 2010. The summer school combines daily masterclasses facilitated by eminent clinicians and researchers, daily facilitated community meetings, faculty led small group discussions, opportunities to learn from each other, and also networking with interesting group of people with similar challenges at work. The four days and a follow up day to be held at the Cassel Hospital will cost £850. Previous participants have found the Summer School to be excellent value for money.

If interested in finding out more please contact:
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The Development of Personality Disorder Services in London

Following on from ‘Personality disorder: no longer a diagnosis of exclusion’, the excellent policy implementation guidance produced by the Department of Health in 2003, most mental health trusts across London have been busy developing their own personality disorder strategies and services. Services for the majority of those with personality disorder are being delivered in a more thoughtful way through primary care, and in secondary care through community mental health and other more specialised community teams. In addition most trusts have begun to develop specialised teams to work with individuals with personality disorder and to support and train others in doing this work. In line with more recent guidance from the National Personality Disorder Programme at the Department of Health, which is pushing for the integration of services for individuals with personality disorder across health, local authority, criminal justice and the national offender management systems, some trusts have begun to integrate generic mental health services for personality disorder with more specialised forensic services that are also largely community based. The London Specialist Commissioner for Mental Health Services in London has commissioned a review of services for individuals with personality disorder across London. This ‘Framework for London’ is awaiting its official

launch.

All of this work has been coordinated in a loose way under the umbrella of a ‘London Personality Disorder Steering Group and Network’ set up and managed originally by the NIMH London Development Centre. The group and network has been meeting every three months for the past 7 years and has been the focus for lively debate and information exchange. The new London wide body ‘Commissioning Support for London (CSL)’, replacing the London Development Centre, is no longer prioritising the development of personality disorder services as it focuses more on other commissioning issues and will not now support this initiative. Those actively involved are now developing other coordinating and support services for this very helpful learning forum across mental health, criminal justice and personality disorder education and training systems.

The ‘Tier 4 Residential Personality Disorder Consultation in London and the South East’ decided in November 2009 to support the development of one Regional Outreach Team in each of the four regions involved in the consultation. The team in London will seek to develop a Managed Clinical Network (MCN) for Personality Disorder that supports the development of local personality disorder initiatives and services and supports the development of

integrated care pathways for individuals diagnosed with severe and complex personality disorder. All 4 regional MCNs will in turn be supported by one specialist residential personality disorder service, which may be delivered on a number of sites, and will be integrated as part of the Managed Clinical Network with the patient's care pathway to ensure longer term treatment is delivered as close to home as possible. Commissioners are working to having these services in place by April 2011.

Training and the 'Knowledge and Understanding Framework' is the final element in personality disorder developments I wish to highlight. Training on developing awareness in those working with and in contact with individuals with personality disorder

is centrally funded and is being rolled out through the Regions. Each sector in London is being offered awareness training for those working in mental health alongside our partners in local authorities, in criminal justice services, and service users, our partners in our clinical services. Ask your trust PD lead how to access this training. Its well worth the effort involved. Feel free to contact me to find out more about any issues raised or not raised in this brief article.

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Practice Update in the Psychiatry of Learning Disabilities

Since the publication of 'Valuing People' document in 2001 (1) there has been a lot of ground covered in terms of improving the lives of people with learning disabilities. Some notable examples include the impact of the Michael Inquiry (2) on the health inequalities faced by people with learning disabilities, and the joint publication with the British Psychological Society of the important practice guidelines on dementia (CR 155) (3), and on challenging behaviour in this population (4).

For a while now the Faculty of the Psychiatry of Learning Disabilities (RCPsych) has fostered on-going work with carer and service user groups, which have led to the production of accessible information on a variety of topics. An example is the resource bank and the good practice guidelines for service users belonging to Black and minority ethnic group.

There remains also a number of challenges. An important one that is cross-cutting associated

with the low recruitment rate of new trainees in Psychiatry. At the Faculty level we are seeking strategies to help attract more interest through influencing career choice from school to college level. One useful method would be to work with Trusts and Deaneries to create Foundation Year training posts in LD specialism and/or provide research conducive environment - in collaboration with medical schools - for undergraduates who are about to embark on higher or intercalated degrees.

The membership of LD Faculty are concerned about the lack of clear care pathways for adults with learning disabilities and mental health problems, as well as for younger persons in transition to adult services. The current implementation of Payment by Results (PbR) policy in London is likely to have further impact on how service users move through services. We are, in my view, further encumbered by the number of different service configurations across England,

which follows the diversity of organisational lead for our services.

Particular problems on a clinical level are lack of: a) the same electronic record keeping systems across organisations (in my area there are three systems in operation within adjacent boroughs; RIO, Framework I and Protocol); b) mental health and/or challenging behaviour specific outcomes. However some progress is being made on PbR by a group of Consultants and Managers outside London; which is complicated by attempts to unpack various elements of care packages based on a lifelong disorder and in block contract basis.

Given the number of colleagues who may also run services for people with neurodevelopmental disorders, e.g. autism spectrum or ADHD, there is a debate within the Faculty and wider Membership about expanding our role in this field. Clearly the implications of such a prospect are far-

reaching and may require a novel approach; even to re-drawing existing service boundaries.

'Valuing People Now' document (5) published in 2009, although welcomes the achievements of the previous five years; it points to the number of areas that have not developed as well and sets out the strategic aims for the next three years. The key focus of this strategy is to make that

vision a reality. Each chapter, therefore, sets out key cross-government commitments and actions to set the environment to enable change to happen, and summarises local and regional actions, based on good practice to grow capacity and capability for local delivery. In practice 'Valuing People Now' encourages the inclusion of difficult to reach groups such as people with severe and complex needs, including

offenders; adopts a person centered approach to service provision; discusses the need for fair access to health and social care in order to improve quality of life and finally maintains the principle that adults with Learning Disabilities must be considered within a societal context with citizenship rights.

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Stigma and a Career in Psychiatry

I remember being asked at my medical school interviews whether I knew what I wanted to specialise in. At that point I had little experience with clinical specialties and thus found providing an answer challenging. Now in my 4th year of medicine, and following my psychiatry rotation and intercalated BSc in psychology, my answer would be psychiatry. I find the subject content fascinating and the clinical aspect stimulating as no-one patient is the same and treatment is tailor-made. It is also rewarding when you witness your interventions profoundly improving a patient's quality of life. But when I tell my peers that I am considering psychiatry training after the foundation years I am invariably met with a shocked expression. Curiously, this is then followed by "Actually, I found my psych rotation really interesting – but I could not be a psychiatrist". Why is this?

Psychiatry is rarely portrayed in a positive light in the media. Stories such as the BTK (Bind, Torture and Kill) strangler from the 1970s and the recent Fort Hood Shooting are

the types of psychiatric stories that are picked up. Add to this high security institutions such as Broadmoor and the now defunct psychiatric asylums, we can start to see that outside of a medicine, psychiatry has a skewed view. This was my view of psychiatry before medical school and, no doubt, the view of many others. Furthermore, one will struggle to find a medical specialty that garners as much stigma as psychiatry. Few of the general public will be able to distinguish a psychologist or therapist from a psychiatrist. Moreover, there are some medical practitioners who do not see them as doctors and consider them to be to be 'odd' and 'weird' individuals.

The approach in psychiatry is very different to medicine and surgery. The lack of diagnostic and definitive laboratory tests means that the main intervention is symptom relief. This differs from general medicine where symptom relief is invariably an interim approach whilst the underlying cause is treated. Whilst I find this aspect positive, many feel that psychiatric patients never get better and

cannot see themselves working in such a 'depressing' environment. It is true that interventions take time before results are seen, but this places great importance on the doctor-patient relationship, which is seldom seen elsewhere in medicine.

Outside of a psychiatry rotation, psychiatric teaching is given little time, despite being part of the curriculum. A systems based approach tends to lump together neurology, ophthalmology and psychiatry. With such a finite time to experience three important specialties, compromises on teaching quality and availability can happen. We must also consider psychiatric OSCE stations – these have gained notoriety as it is hard to know what to do and cover in such a short period of time. In my experience, they have served only to put people off the specialty. I agree that psychiatry needs to be examined. But the station needs to be longer – how can you complete a mental state exam or even effectively assess presenting symptoms in six minutes with a severely depressed patient?

The training programme for psychiatry does offer fast progression and the lifestyle is an attractive factor. These reasons would suggest that posts should be over-subscribed, yet this is not the case. This may result from a lack of clinical exposure or negative experiences in medical school and in foundation training. Whilst there are some FY2 psychiatry posts, the focus on medicine and surgery from medical school through to foundation training will skew clinical experiences. If you have not seen a psychiatric

patient since your medical school rotation, why would you apply for CT training in psychiatry?

Whilst it would be ideal for all foundation doctors to have a psychiatry placement, the logistics of such a scheme would prove impossible. Instead, interest in psychiatry needs to be fostered at medical school. Active psychiatry societies, more effective didactic teaching and clinical experiences will all play a part. The aim would be to dispel preconceptions and stigma associated with the profession and it must be asserted that

psychiatry is at a very exciting point in its evolution. The gap between observable pathology and symptom presentation is closing all the time. It is inevitable that psychiatry will 'join' the other 'more medical' specialties in the future.

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Tackling Psychiatry's Image Problem Critically

An admissions tutor in my medical school interview poured a helping of caution on my wary expression of interest in psychiatry. "That often changes after your rotation in it," he quipped, as if this was an old medical education in-joke.

Now sampling some 'real medicine' as the hackneyed jibe goes, I'm still digesting my psychiatry rotation. I'm starting to see how the specialism's relationship with medicine is fraught with unrequited love. The tender issues of identity related to this are all too plain for undergraduate students to see. Sinclair's masterful anthropological survey of a London medical school in the nineties, 'Making Doctors, An Institutional Apprenticeship,' remarks that the stigma attached to psychiatry and the profession's dubious ranking on the hierarchy of specialty sex-appeal are part of the informal curriculum. That this sub-text is so deeply entrenched to show itself to one potential psychiatrist before even starting medical school, is a sign of how great a challenge the Royal College faces in boosting recruitment.

One approach would be to incorporate an element of critical psychiatry into the undergraduate curriculum. For those at the helm of the profession's recruitment efforts, giving space for dissent might seem counter-intuitive. However, such a strategy might resonate strongly with those students whose response to their first experience of psychiatry was largely negative. Encouraging discussion

conducive to critical thought might protect against marginalising their experience as non-conformist and so inconsistent with pursuing a career in the specialism. It would allow them to see that their instinctive doubts as to the efficacy of the profession's pharmacopoeia and the ethics of its coercive tendencies are shared and hotly debated by many at the top of the profession. In addition, it might serve as an early lesson in the value of tolerating ambiguity and uncertainty, transforming the clichéd critique levelled at psychiatry -of 'wooliness'- into something richer in possibility.

An awareness of the critical psychiatry movement and the culture war within the profession would give students a more favourable portrait of the specialism's willingness to engage with and accommodate dissenting voices. Undergraduates deserve being granted a broader perspective with which to make sense of their responses to psychiatry and more effectively challenge its epistemological frailties. With a more sophisticated understanding of the forces and philosophical concerns underpinning the profession, those deciding to join its ranks might be in a stronger position to more meaningfully participate in its evolution.

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Student Essay and Research Prize Winners

Joanne Li Shen Ooi, winner of Division Essay prize 2009 entitled: 'How Loud is the Unquiet Mind' –

Abstract

WILLIAM Walters Sargant (1907-1988) is credited, for better or for worse, with putting physicalist psychiatry on the map – at the expense of the dictum 'primum non nocere' (first do no harm). He was an outspoken supporter and practitioner of what he termed the "practical rather than philosophical approaches" to the treatment of mental illness. In my dissertation I hope to examine Sargant's fascinating career, beginning with the reasons behind lifelong passion for radical psychiatry, then discussing the various physical treatments he pioneered and publicized during his three decades at St Thomas' including prolonged ECT, insulin coma therapy, dangerous combinations of antidepressants, and most notably, prefrontal leucotomy. His heady mix of dogma and charisma enabled him to get away with flying in the face of evidence-based medicine – but not without courting the considerable controversy and contempt that was to so blacken his reputation posthumously. I end with comments on misguided and misplaced enthusiasm in the history of therapeutics, acknowledgement of Sargant's positive contributions to psychiatry, and finally a reminder not to be tempted to pass post-hoc judgment on the man or his legacy all too quickly.

Nisha Mehta, winner of Division Research Prize 2009 entitled: 'Public attitudes towards people with mental health issues in England and Scotland, 1994 – 2003.'

SYNOPSIS

I studied medicine as a second 'degree' in order to become a psychiatrist. The main reason for this was because a close friend at the time of my first degree developed a severe mental illness, subsequently committing suicide. I noticed that she and others with mental health issues seemed to suffer from an unacceptable level of stigma, for reasons I found difficult to understand. After a year of working in the Civil Service, where I became interested in public health and the organisation of public institutions, I decided to become a doctor.

I wanted to become involved in research and contacted the Dean of the Institute of Psychiatry, King's College London (where I had transferred for my clinical years), to ask about research opportunities in my areas of interest. Professor Graham Thornicroft, head of the Health Services and Population Research Department, also had an interest in fighting stigma and discrimination. He suggested various projects for me and the one I chose involved analysis of trends in public attitudes towards people with mental illness in England and Scotland, using Department of Health Attitudes to Mental Illness Surveys between 1994 and 2003. We analysed these trends for 2000 respondents in each survey year (6000 respondents in

1996 and 1997) using quota sampling methods and the adapted Community Attitudes Toward the Mentally Ill scale.

We found that comparing years 2000 and 2003, there was a significant deterioration for 17/25 items in England and for 4/25 items in Scotland. Neither country showed significant improvements in items between 2000 and 2003. From this we concluded that public attitudes towards people with mental illness in England and Scotland became less positive during 1994-2003; especially in 2000-2003, and to a greater extent in England. The results were consistent with early positive effects for the publicly funded, high profile 'See Me' anti-stigma campaign, which began in 2001 in Scotland and of which there was no equivalent in England.

I undertook this work during my spare time, devoting weeks of my holidays to completing important sections of the project. I worked closely with all the co-authors and we submitted the paper to the British Journal of Psychiatry during my fourth year at medical school. I am very grateful to Professor Thornicroft and his team for all their guidance, support and expertise they so willingly shared with me. This was my first foray into academic medicine and I thoroughly enjoyed the whole experience. I am now completing an Academic Foundation Programme at King's College London, hoping to continue a career in academic medicine at the next stage of my training.

Executive Columns

Recruitment and Training in Psychiatry

The current recruitment crisis facing psychiatry has raised concern at the College. The Dean has highlighted it as a problem in his last two newsletters and it was discussed at some length at the last meeting of the London Division Executive Committee. Two questions arise. Just how bad is it and what can be done about it?

Well, it is quite bad. According to the London Deanery the ratio of applications for the 100 CT1 posts in London (nearly a quarter of all of the posts available in England) dropped from 6 to 1 in 2009 to 2 to 1 in 2010. If a significant number of these applicants go on to other specialties in time, the problem is magnified.

London has fared particularly badly, having the lowest ratio of applicants to posts across all of the 13 deanery schools in England. The closest runner-up is the West Midlands, where the ratio has dropped from 7 to 1 to 3 to 1. The impact certainly seems to have been smaller on the smaller schools, perhaps because of geographical effects. Peninsula, for example, has pretty much held its own with a stable ratio of 6 applicants for each of its 13 posts. We can take some consolation from the fact that recruitment into any specialty tends to fluctuate, and this is certainly true for psychiatry, but ours has always been a 'Cinderella specialty'. It is more vulnerable to the some recent factors affecting recruitment, such as the reduction of non-EU applicants from overseas. They are bound to have a differentially greater effect.

The worst case scenario is that we will struggle to fill all our posts with good candidates and

the overall quality of applicants coming into the specialty in London as a whole may be adversely affected. It is clearly essential that we do all that we can to prevent this and show our specialty in its best light.

Much as we might like to, it is obviously unethical for undergraduate educators in psychiatry to start acting like recruiting sergeant majors. Such behaviour risks breaching fundamental ethical principles like autonomy and beneficence, as recently argued by the Directors of Medical Student Education in Psychiatry in the United States. In any event, teachers are rightly preoccupied with their responsibility to meet the educational needs of the 96% of medical students who will not enter the specialty. For many of these students their undergraduate training will be the last chance to give them the core psychiatric skills that they will need to be good doctors, especially as only 1% and 2% of F1 and F2 posts respectively are currently in psychiatry.

The over-riding message must be to demonstrate by example and not pressure just how exciting and rewarding our specialty is in the course of our day to day work. This really should not be too hard. We work in one of the most interesting and therapeutically optimistic branches of medicine, and recent research shows that psychiatrists are just as happy with their lot as any other group of doctors.

Andy Kent
Consultant Psychiatrist



From the Chair

The Department of Health has required SHAs to separate commissioner and provider roles, particularly in Postgraduate Medical and Dental Education and Training (PMDET). It believes that "this approach ensures a dispassionate performance challenge to education and training providers" and that it will improve the quality of provision. So over the last few months we have been working at the London Deanery to achieve this separation. A call was made for expressions of interest to be Lead Providers for training and education, and we are currently in the process of dialogues with the organizations that have expressed an interest.

Current trainees should be blissfully unaware of any changes, as they will probably notice no difference in who they relate to; i.e. Training Programme Directors and Clinical/Educational Supervisors. The School of Psychiatry will become a Commissioner for training and as such will, I believe, be able to drive quality in a better way than is possible in the current system.

The structure of the Deanery will also change, and most of the day to day activities will become 'Support Services'. What functions these 'Support Services' will retain and what will devolve to the Lead Providers is still being considered. Core Psychiatry, together with Core Medicine and Surgery, is part of the first phase of the commissioning development. Higher Training in Psychiatry will be dealt with later as it is a more complex issue, with higher training extending to parts of Kent Surrey and Sussex.

As a result of workforce planning calculations done by NHS London, we have reduced the London core training numbers by 14 this year. This will rise to 17 (i.e. a further cut of 3 posts) next year and another 2 the year after. It is likely that a similar reduction will need to be made at the higher training level, when this reduced cohort reaches the higher training intake. There are, however, some unknowns in the workforce planning calculations. It is uncertain what the male/female split of the future workforce will be and how

popular flexible working will become. Additionally, we have no idea how future developments in patient management will impact on workforce numbers.

This cut comes as a result of the impression that we are producing too many doctors in psychiatry. This is probably correct in London, although things are different elsewhere. I remember a decade ago there would be a handful of trainees applying for any Consultant job, where only one or two would be from a recognised training schemes. Today Consultant jobs in London attract applicant numbers often in the 10's and 20's and the majority are from UK training schemes.

There is clearly no benefit in producing unemployed doctors. It is wasteful of tax payers' money and is also likely to drive salaries and work conditions downwards. To get some idea of what is happening to our doctors after they leave training, we are planning to conduct exit interviews at ST6.



It is no secret that Psychiatry still struggles to fill all the training posts and this has become a more serious issue since the UK has become a less friendly place to work for non-EU trainee doctors. Psychiatry has for a long time been supported by doctors in large part from India and Pakistan. Some of these are now going elsewhere. We are also being challenged by GP training which is in the process of significant expansion. Trainees who find psychiatry appealing are also those who would be thinking of a career in General Practice, so competition is increasing. Unless we can do something about making psychiatry more appealing to medical students and to Foundation Year Trainees then we are going to run into a serious recruitment problem.

The London Division spring meeting will be looking at some of these issues. The Journal of the Royal Society of Medicine published a study recently which showed that psychiatrists and general practitioners are the most content doctors amongst all the specialties. So the task is to get doctors to consider and try psychiatry, because once in they will not want to leave!

Contributing factors for the low interest in psychiatry as a career are several. Firstly, the fact that Mental Health Trusts are geographically separate from Acute trusts makes psychiatrists invisible to medical students for a large part of their medical school experience. We are not usually present in medical grand rounds, nor in the canteen for informal discussions; but instead some miles away on another site.

Many of the units that medical students are attached to are too often under-staffed and with demoralized staff. Psychiatrists owe it to medical students on attachments to be optimistic and not to confuse the issues with resources and services with those of psychiatry as a specialty. We are also "bad-mouthed" by our medical and surgical colleagues, and the old prejudices still remain alive. One of my SpRs, some time ago, told me that when he was a House Officer in ENT and told his Consultant supervisor the planned to train in psychiatry, the Consultant no longer spoke to him for the remainder of his attachment. Whether we can do something about these deeply ingrained prejudices is something I worry about.

Now that we have paid off the gambling debts of the bankers, the rest of society will need to carry the burden of significant financial constraint. This will inevitably lead to thoughts about how to make the money go further. Cheaper services are an answer: services delivered by cheaper staff is an obvious solution. Although there may be some scope for releasing psychiatrists from delivering all aspects of the service, we must exercise caution on behalf of the patients. Psychiatry is a medical specialty with a robust and extensive knowledge-base which takes a minimum of 6 years to learn. If more non-medical staff are used to deliver services that doctors once delivered, we should ensure that quality is not compromised and that patients get the value added benefit that often comes from being seen by a medically qualified practitioner.

Should patients be told that the person treating them does not have the full range of knowledge that a psychiatrist has? Most patients would not know this, but I think that they should be told.

PMETB in the Generic Standards for Training has under Domain 1, which refers to Patient Safety, the following. I have replaced the word "Trainee" with "Doctor", since if it applies to a junior doctor it should apply to all doctors:

"Doctors (Trainees) must make the needs of patients their first concern."

You should also be able to replace the word doctor with "Trusts" or "hospitals" and it should be just as valid. I know what happens to a doctor who forgets to make the needs of their patient their first concern, and what sanctions society exercises through regulatory bodies. I'm not so sure about what happens to an organization that forgets this.

Michael Maier
Chair, London Division

LONDON DIVISION



A DATE FOR YOUR DIARY

Spring ACADEMIC MEETING

Thursday, 20th May 2010

At

CENTRAL HALL, WESTMINSTER

Who wants to be a Psychiatrist?

These are interesting times for psychiatry. Inside the profession, debate goes on about what psychiatrists should be doing and for whom. This uncertainty isn't doing us any favours: some 95% of entrants into psychiatric training today are from overseas. Home-grown young doctors, it seems, are seeking their inspiration elsewhere. On the other hand, a recent review found psychiatry to be one of the most satisfying careers in medicine. Psychiatry appears to be the only branch of medicine where you have to read the newspapers.

This year the London Division delves into these issues. What role do portrayals of mental distress play in perceptions of our career? What skills will psychiatrists need in a world where Mind is as important as Matter? Who are the new heroes of psychiatry? How best do we sell psychiatry in the 21st Century?

We have lined up a series of top-notch speakers to take a look at the answers to these important questions. The morning session will focus on the problems faced by psychiatry. The afternoon will look at possible solutions and will also be open to medical students interested in psychiatry as a career.

Provisional speakers to include: Prof Rob Howard, Dean; Dr Peter Byrne, Chair Public Education; Prof Ania Korszun; Dr Phillip Timms, College Educator of the Year 2009.

**PLACES ARE LIMITED AT CENTRAL HALL, SO TO
AVOID DISAPPOINTMENT, BOOK EARLY FOR WHAT
IS PROMISING TO BE A LIVELY AND THOUGHT
PROVOKING DAY**

For registration form visit the website:

<http://www.rcpsych.ac.uk/college/divisions/london.aspx>

and follow the links to forthcoming London Division events
or contact

Susan Ranger, London Division Manager

0207 977 6650, e-mail: sranger@londondiv.rcpsych.ac.uk

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The London Division has Regional Representative Vacancies in the following areas:

N Central & N East London	Addictions Forensic Liaison Rehabilitation & Social Psychotherapy
S East London	Addictions CAMHS Learning Disabilities Psychotherapy
S West London	Liaison Rehabilitation & Social
N West London	Liaison Rehabilitation & Social Psychotherapy

Please note that some of these will become vacant later in the year.

Regional Representatives are nominated by the Chair of the relevant Faculty, in consultation with their Executive Committee and the Chair of the relevant Division. The joint nomination is then forwarded to the Court of Electors, which makes the final decision to appoint. Regional Representatives may hold other offices, such as membership of the Executive Committee of a Faculty or Division. They may also be Specialty Tutors.

Anyone interested in taking up this post should forward a copy of their CV along with a statement containing a short profile of the attributes and experience they feel they could bring to the post and also reflect on the time commitment required in meeting of deadlines assuring your capacity to act in the advisory role to:

Susan Ranger, London Division Manager
6th Floor, Standon House
21 Mansell Street
London E1 8AA

Or email to: sranger@londondiv.rcpsych.ac.uk

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