From Chairperson’s Desk...

As chair of the Mental Health Informatics Special Interest Group, I would like to welcome you to the first edition of the newly revived Connect newsletter. I would like to first of all draw the reader’s attention to the excellent work of our editor Himanshu Tyagi.

Himanshu has put together a tremendous first edition drawing on a number of talented writers from diverse backgrounds who have been able to show us just how much informatics touches on every area of clinical practice in a quite significant way.

A number of the articles broach very controversial subjects and we would be very interested to hear your comments and with your permission will include these in the next edition of the newsletter. There are also a number of educational pieces and we hope that the reader will be able to take some valuable lessons away.

While the newsletter has been quiescent over the past few years, the MHISIG has been working away in the background and attendees at the college AGM may have taken advantage of the sessions that the group has organised on topics ranging from time management to online therapy. We are looking to start up a series of small events throughout the next year on informatics-related themes and would again value your suggestions on which areas you would like to see covered.

The changes suggested in the new government White Paper also mean that health informatics will take on a more important role in the NHS and this is complemented by work being done in the college looking at areas that will influence informatics. Indeed we would be very interested to hear your experiences of mental health informatics systems both now and as we see another period of change in the NHS. In particular as we are in an ‘age of austerity’, comments and feedback to the newsletter could provide a forum for discussion of health informatics systems that are producing cost-efficiency savings and making an impact on your work. We hope you enjoy this edition.

Justin

Justin Marley has recently completed dual training in General and Older Adult Psychiatry and is now working as a consultant in Older Adult Psychiatry in North Essex Partnership NHS Foundation Trust. He has been serving as the chair of the Mental Health Informatics Group.

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AUTUMN 2010 Issue

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Special Feature INFORMATICS IN PSYCHOTHERAPY

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Information, informatics and beyond...

Information in its abstract form can behave like a virus. Given the right environment, it can disseminate, multiply, and mutate at an extraordinary pace. Worse still in an information rich environment, it is the host that seeks the agent, giving the agent an unprecedented precision to ‘infect’ and survive. We are currently living in this information pandemic, otherwise known as the information age.

Practice of mental health in the information age is complex, challenging and yet interesting in myriad ways, as you would see through the pages of this newsletter. Informatics, the art and science of information, is transforming every part of our life. Google has made us impatient for quick answers by allowing us to disown browsing as our preferred method of information discovery. Facebook is probably pushing the boundaries of our social definitions of privacy. On the professional front, perhaps we are spending more time in front of a computer than we do with patients. The transformative nature of information technology is radically changing training, service delivery, or service management in healthcare sector. Our generation is fortunate to train and work in these interesting times as most of us can still remember how things were before our society became addicted to easy information through multiple interfaces like smartphones, tablets and computers.

We can look around to see how information technology has permeated in our life. As the new editor of this newsletter, I wanted the reader to reflect on how far we have come. Therefore most of the articles in these pages follow a background theme of reflection, to push a background theme of reflection, to push to have the agent an unprecedented precision to ‘infect’ and survive. We are currently living in this information pandemic, otherwise known as the information age.

Challenges from information technology are continually testing our understanding of trust. Trust has traditionally been an integral component of a successful information exchange in a society. Unlike human beings, algorithms have no intent. Does this make humans the weakest link in the chain of information security? Trish Williams from University of Queensland, Australia explores this topic in the current issue and perhaps gives us an insight into how society and technology can influence a change in each other.

Speculations about impact of information technology on teaching and training were made since the advent of primitive computer systems. Educational researcher Mark Prensky systematically reported it in 2001, about which I have talked in detail in my 2008 talk at the Royal College of Psychiatrists’ annual general meeting. In the current issue you would find a user’s perspective from a trainee at South London and Maudsley NHS Foundation Trust, report on a project funded by Simulation and Technology-enhanced Learning Initiative (STeLI) and the fascinating opportunities in world of E-learning.

Virtual world psychiatry gained momentum when DSM started considering pathological computer use for inclusion in their forth edition. Dr Ion discusses some forms of pathological computer use on page 15. Andy Pulman explains how we can integrate Web 2.0 or the social web into mainstream psychiatry and David Kingdon gives a brief primer on Hyperlinking care pathways on page 20.

Smart phones, text messages are proving to be powerful mediums to engage clients, especially the younger generation. Keelyjo Hindhaugh, Angharad A Rudkin and Louise Theodosiou are reporting from the frontlines about their experience of using this technology in various clinical settings. Fionn Kelly further explores smartphone use in a review article included in this issue.

In addition to articles on technology and its innovative use in clinical and educational settings, we invited a couple of experts to write on the centrality of data in informatics. These articles are included in a dedicated section for ‘mental health analytics’.

As someone specialising in psychotherapy, I am curious about the potential impact of technology on how psychotherapists deliver treatment. I am mindful of the fact that some therapists might find the thought of using technology to connect to patients alien and probably intrusive to the therapeutic relationship. Although the current technology is still decades away from replacing the actual therapist, there are some fringe developments that can potentially help the therapists to deliver their service to a wider clientele, without the usual constraints of geography and time. Throughout the developed world, the delivery of psychotherapeutic treatments is restricted by the expensive and time-intensive nature of the treatment and to some degree by lack of enough skilled practitioners. In business parlance, this would probably be conceptualised as a ‘scaling problem’ i.e. how to match supply with demand in a timely and cost-effective fashion. Technology assisted therapy has the potential to solve this problem. It can particularly be helpful for those clients who require less intensive forms of treatment and have to wait for a long period of time to get that intervention. E-therapy or online therapy, one form of technology assisted therapy, has been around since the early days of internet. However it has failed to gain the momentum that its potential justifies. Therefore, in this issue we invited two articles on this topic. Kate Anthony and De Anna Nagel, both from Online Therapy Institute, explain training in online therapy and Avatar therapy. In the same vein, Sirohi et al. explain the how their team successfully used technology to solve an age-old problem in teaching psychotherapeutic skills to trainees.

It is hugely enabling for a clinician to have the right information at the right time, but equally disabling in case of an unmanaged overload of information. In the last decade, the focus has been on the former, at the expense of the latter. Therefore the theme for the next issue of this newsletter would be on the burden of information on clinicians. If you have something to contribute on this theme, then please do submit to it us before January 15, 2010.

I hope that you would enjoy the new avatar of this newsletter. We would look forward to your suggestions, ideas and comments.

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Informatics in Psychiatry - a trainee’s perspective

Aneesa Mohamad Ali

I had to renew the loan of my library books. But how would I do that when I am not on site. Oh, yes, I had a thought. I searched for the library information card so that I could go online. The good news was I found the card, which had my ID number, but my delight did not last long. The security was as tight as online banking. I could not remember my pass-number. Adding more to my dismay, I could not even recall if it was a five or a six-digit number. Not wanting to explore further, I decided to call the library on the next working day. When the acceptance came in, the awareness followed. This is the world we live in, the world of information technology. Informatics has made our lives easy in many ways with its own limited limitations.

I was wondering how I started to work as a doctor and how things have changed. Should we call this as an evolution of informatics in psychiatry? I started my career writing notes in a clinical record notebook, which was often heavy to carry due to those attached correspondence and information from other disciplinary sources. I am also certain that many of us would have ransacked the medical records section to find the old notes, which had to be first dusted and then used. It is a wonder that options have changed now. We have entered the modern era of computers and information processing.

Well, that does not mean the note-writing system is obscure. It has its advantages over the electronic versions. It appears to take the middle of typing a long documentation and the data has to be awaited until the system is retrieved.

Then why are these new changes? Are we really gaining anything? The answer is simple and it is “Yes”. We have been achieving a lot, some consciously and some without realising it. One of our greatest accomplishments is saving our environment. According to Forest Products Industry Analysis Brief, the pulp and paper industry is the third largest consumer of energy and uses 84% of energy consumed by the Forest Products Industry. I reckon, being healthcare professionals, our responsibility to care for the environment becomes greater and it is incumbent on us to save the planet we live in.

“As trainees, Information Technology has become an integral part of our lives. It plays a major role from job applications to national surveys, examination results and presentations.”
Let’s say in a day’s work, firstly, I don’t need to search for files anywhere. They are available electronically, say for example, ePJS (Electronic Patient Journey System), which is accessible from all trust computers. It takes off the hassle of those space encroaching drawers as well. Thanks to Informatics, we now enjoy more space at work. Although there is a considerably good measure of electronically replaced checklists, I am pleased that it has been made simpler to input data and it frees the mind of having to secure the data in a safe place or a folder. All I have to do now is click the “Save” button. I also find it easy to track the documents under the user-friendly captions, which I believe are well thought and structured. On the surplus, we have options of editing and adding more information without impinging on other professionals’ entries. There is also a facility to attach as much as files as needed and relevant. Another impressive feature is it has made it virtually effortless to know our caseload and to keep a check on them. Thus it has made my life at work simpler, but more systematic.

It is again inspiring that informatics is extending to various disciplines across Psychiatry. For example, psychotherapists are using IAPTUS, which not only ensures patient confidentiality but also paves the way for a more organised, anytime easily retrievable data. As for me and as I believe for others, the informatics has also made non-clinical issues to be dealt much simpler. For some instances, it is possible to book and even complete some courses online. We are helped with large database of journals and information by PubMed and Cochrane database and many more, which not only provides the backbone for Evidence Based Medicine, but also helps in Research, Audit and other aspects of Clinical Governance.

As trainees, Information Technology has become an integral part of our lives. It plays a major role from job applications to national surveys, examination results and presentations. It helps in assisting our supervisions and progress with tools like Workplace Based Assessments, which are again completed through Assessments Online. I was able to completely acknowledge its worth when I had to face a difficult situation. It was not too long ago that I lost my portfolio and relevant documents in the process of moving home. My heart sank. I was about to face my ARCP shortly then. It was these online assessments that I could print out at anytime that came to my rescue and helped me get through. Besides the above, we are also provided with networks like Synapse and others, which helps us in updates, valuable discussions, latest information and other resources. It can also be used as a tool to monitor progress online. Well, why we have to go so far, we could easily realise even the newsletters are being published online.

In this swiftly evolving world of Informatics, it is surprising that there are some of us who still want to stay in the old system. When I try to ponder, a lot of reasons came to my mind. But I would like to outline the most salient ones that I think can make a difference and bring about a change. Foremost I discovered a geographical difference. Not all Trusts have incorporated the electronic systems. It is time to work as a cohort and bring uniformity in data input and processing. This will aid the professionals to work with confidence at all levels and relieve the hesitations to work in an environment of Informatics Psychiatry. Secondly it becomes relevant for the professionals to learn and update the skills involved, which also includes some typing skills. But the most important according to me is the introduction of IT skills to the students at the medical school level and equally to students of other disciplines of Psychiatry. This can make a difference in generations to come who start afresh soon after their graduation.

In brief, both the old and the new systems have their own advantages and limitations. Having said that, I believe the rapidly developing Informatics in the field of Psychiatry has renewed our working models, which have proven to be fruitful to the systems we work in, besides its contribution to the environment and the economy. It is high time we comprehended the vast utility of informatics. At the same time, we should also take into account its limitations. But I envisage that it will overcome its deficits bringing in new advances, novel ideas and great expectations.

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Trust: An overlooked information security vulnerability?

Patricia A H Williams

The increasing use of information systems and networks, together with converging technologies, has created a radical shift in how we access and use information. Information is now a resource and our dependence on all sources of information is unmistakable. It creates an opportunity for great benefits in sharing information. Unfortunately, it also creates vulnerabilities by increasing exposure to information security threats. Information security is important in any organization and particularly where personal and medical information is routinely recorded. Thus, the perceived impact of security breaches and the significant legal and ethical compliance demands are important.

Information security is tripartite - protection of confidentiality, ensuring integrity of information, and maintaining availability to information when it is required. Therefore, it is unfortunate, in an increasingly electronically integrated world, that security issues are not taken more seriously by many healthcare providers. A lack of understanding of security concepts, together with an underestimation of potential threats and the difficulty in configuration of security technology countermeasures, contributes to the failure to recognise the seriousness of security threats to patient and practice information. To be fair, this problem is not confined to medicine and healthcare. However, it is complicated by managing highly sensitive patient information and working in an environment which values and fosters high levels of trust. Information security has always been balancing act between the effective protection of information and easy access to it and, therefore, strategies to meet these competing criteria are difficult. Trust, unfortunately, is not one of these accepted security strategies nor is it an effective method of information protection. Yet in the medical profession, particularly in behavioural healthcare, the basis for patient interaction and confidentiality is trust. Consequently, organisational cultures primarily based one trust are not conducive to good information security.

Various factors contribute to an organisational culture of trust and subsequently affect information security effectiveness. These factors include trust in people, over reliance on information systems and unqualified confidence in third parties. Subsequently, insider threats, poor implementation of security measures, capability of staff and lack of relevant knowledge, attitude and adherence to good security practice, and inconsistency between principles and practice, also drive poor security behaviour. Most of these factors are cultural in as far as they relate to the communities of practice that are cultivated within the healthcare environment, of which trust is a strong overarching feature (Williams, 2008).

Trust reflects a strong, but false, sense of security. Indeed from a security viewpoint it reflects an ignorance of the issues and risks that clinical practice is exposed to. As well as trust in staff, the trust placed in software, in conjunction with poor implementation, are serious matters for concern. Further, reliance on third parties, for say IT support, is an issue where uncontrolled access to information is granted, without confidentiality assurances in place.

Clinical practices, such as mental health, generally do not employ IT or security trained personnel, lack competent skills in using security solutions, and rely greatly on trust - all of which inhibit good security practice. Whilst healthcare providers must meet legal requirements, the ethical component of security in the medical environment is underpinned by individual behaviours contributing to information protection. In trustful environments where everyone does not take on the responsibility for information security, there is more opportunity for insider threats to go undetected and potential damage to be done. Also, whether insider threats are malicious or non-malicious, they are difficult to manage in this environment. International research has shown that changing security culture and increasing awareness are necessary as technical resolutions are not sufficient to control insider threats. The issue of confidentiality is a high priority for all physicians and thus is both important and topical in view of the recently publicised breaches of patient mental health information (Dayspring, 2010). In the past three years there have been nearly 300 serious breaches in health data in the UK. Security is no longer a technical issue to be solved; it is a human one. In an environment which fosters a culture of trust, the issues of insider threats are more complex. The culture and social issues cannot be separated from the technological one, as issues of trust impact the success of information security governance.

Another issue is confusion over responsibility role for information security. Significant exposure exists in practices where those charged with this responsibility do not possess the appropriate knowledge of security meas-

Key Points

1. Perception is an important driver in information security practice.
2. Trust is not an effective security strategy.
3. Legitimate access is potentially more damaging than unauthorised access.
4. Policy enforcement and appreciation of the security dangers are essential.
The multiplicity of competing factors means that information security practice is a complex issue. A culture of trust affects policy formulation, and creates confidence in staff to maintain confidentiality and privacy, and to implement security measures correctly without scrutiny. In the medical environment it is often this lack of policy and the reticence to enforce policy that creates an insecure environment. Studies have found that trust in the healthcare environment is driven by group values as well as the trust motivation between individuals. It is the perceptions of security, and its necessity, that have the greatest influence on information security practices in medical environment.

Mental health provision is an area of great sensitivity. It is important to provide high levels of protection and security assurances due to the sensitive nature of the information revealed to the physician. So is there a solution to these problems? Indeed, there are many solutions; yet they need to be tempered with an understanding that the majority of healthcare providers have limited access to IT and information security resources. The future will inevitably bring more connectedness, e-health and more security problems. Technologies such as biometrics, once they have become less intrusive and provide seamless integration with workflow, may hold one of the keys. In the meantime the focus on human factors needs to be taken more seriously. Relying on trust is an insecure strategy.

### Why do we need Information Governance?

Information Governance (IG) ensures necessary safeguards for, and appropriate use of, patient and personal information.

### How is it applied in NHS?

The principles of information security require that all reasonable care is taken to prevent inappropriate access, modification or manipulation of data from taking place. In the case of the NHS, the most sensitive of our data is patient record information.

In practice, this is applied through three cornerstones - confidentiality, integrity and availability

1. Information must be secured against unauthorised access - confidentiality
2. Information must be safeguarded against unauthorised modification - integrity
3. Information must be accessible to authorised users at times when they require it - availability

Information Governance is there to ensure these principles are upheld by setting clear guidelines (policy) for all NHS users.

http://www.connectingforhealth.nhs.uk/systemsandservices/infogov/security

### RCPSYCH ON INFORMATION GOVERNANCE

Page 35, Good Psychiatric Practice, RCPsych 2010

**Information Security**

The Data Protection Act requires adequate organisational and technological measures to be in place to guard against unauthorised or unlawful processing of personal data. The two principal means of enhancing the security and integrity of clinical information are restriction of access and anonymising records.

**Access controls**

Good security practice includes strong physical access controls. In general, access to individual records should only be granted to persons with a direct clinical responsibility for a given patient. Each trust should have protocols for authorising personalised access to information systems. Electronically maintained identity controls and passwords should be used. Additional or alternative access controls include smartcards and electronic fingerprinting. Monitoring is an important feature of security practice. This can be easier with electronically maintained information, for example auditing who has access to what.

**Anonymisation**

Wherever possible, person-based information should be maintained in a non-identifiable form and, for the large NHS databases, reconciliation of such information with patient identifiers should be restricted to appropriate circumstances and designated individuals.

http://www.rcpsych.ac.uk/files/pdfversion/cr133.pdf
Guest Editorial: Informatics in Psychotherapy

William Badenhorst

Fascinated by the birth and rapid growth of cinema, and not beginning to anticipate the even more effective medium of mass-dissemination that is the internet, Walter Benjamin writes: “The situations into which the product of mechanical reproduction can be brought may not touch the actual work of art, yet the quality of its presence is always depreciated.” (Benjamin, 1936). At the root of it, this is what bothers me about using electronic media for our work - are we perhaps just distancing ourselves from a real experience, thereby depreciating it? Although I use computers daily for work and relaxation, the concept of on-line computerised therapy feels alien, precisely because of this sense that it will be a facsimile of a more or less spontaneous experience, rooted within a real relationship. It’s not surprising that a more structured therapy would engage with this medium more quickly, because a structured technique could be reproduced more easily without compromising its authenticity. Of a growing number of computerised CBT packages, NICE (NICE, 2006) has endorsed Beating the blues (for mild and moderate depression) and Fear fighter (for panic disorder). It is worth noting that Beating the blues was developed to be used within a primary care practice, and that Fear fighter relies on direct therapist contact to support the electronic sessions.

Taking steps into exploring other therapeutic uses of the internet, from on-line sessions to e-learning and patient simulations, this issue starts with features by Kate Anthony and DeeAnna Merz Nagel, who outline their clinical and educational work from an integrative perpective. Anthony describes blending face-to-face and on-line training, which makes intuitive sense in broadening the range of learning opportunities available to trainees. Nagel describes one aspect of the work of on-line practitioners, namely the use of avatars. This helps to de-mystify the work for those of us not familiar with it, but raises some key objections in my mind. Firstly, she states that “meeting clients inworld...” allows the client to express parts of the self that might not be easily accessed in the traditional in-person therapy session. I take a different view: that self-expression is not enough, and that the integration of parts of the self that are inhibited or intolerable can only be achieved through hard work within a direct, real relationship with a therapist in the immediacy of the consulting room. I am sceptical too of the list of therapeutic possibilities Nagel attributes to this technology without a clear evidence base, although I do enjoy her sense of creativity. More seriously, her note of caution about patients (particularly those with trauma histories) being left exposed and vulnerable does not fully take into account the risks in working with more disturbed patients or the potential for serious iatrogenic harm.

The last two articles of this issue return to training applications. Chris Blackmore and Digby Tantam describe a research-oriented MSc course that successfully integrated e-learning opportunities. We also learn about their use of the content management system Moodle to organise and facilitate continuing education. This reminds me of the College’s on-line CPD system, where a psychotherapy contribution would be very welcome! (Royal College of Psychiatrists, last accessed 19 July 2010). Finally, Sirohi et al. describe the development of a DVD to demonstrate psychotherapy (and supervision) vignettes to core trainees. Their venture is given added validity by its direct response to a trainee survey on psychotherapy experience. In my experience, psychiatric trainees starting their first psychotherapy case value ‘how to’ guides such as practical notes for a preliminary meeting, and this would be a very welcome addition. I hope this will also help trainees prepare for the psychotherapy CASC questions in the MRCPsych exams, and reinforce psychotherapeutic thinking as a core skill in general psychiatry. Certainly, it adds a learning tool that seems more authentic than the crude virtual patients some of us have designed for trainees so far. Perhaps in the future, combining virtual patient algorithms and DVD recordings will be commonplace.

What is missing from this issue’s feast of papers? Perhaps in addition to what we do with patients and how we learn/teach, we need to think about how we support or contain the therapeutic work. The use of electronic record-keeping systems such as RiO and Jade brings specific challenges to psychotherapy: how to say enough but not too much, how to reframe a rich intersubjective experience into something that sits more comfortably in the medical model without compromising the experience itself, how to avoid drowning in jargon. Many questions indeed - perhaps enough to justify another edition?

Ultimately, the question of whether we are effectively employing new media to further our work - thereby being transformed by it - or simply producing a watered-down version of it for mass consumption remains unanswered. It would depend, among other things, on whether we are using such media creatively or simply to copy. But we can’t deny that our professional landscape is rapidly changing.

References

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Training Therapists in Online Therapy

Training therapists to work effectively online can be done both through face-to-face training workshops and online training programmes. Both can be tailored to the needs of the group in the case of specific organisations, for example concentrating on working with couples online, or with specific client groups such as users of a sexual health advice service. With such a relatively new field, it is often useful to blend online and offline training to assess trainees’ fears around working without a physical presence and alleviate anxiety. Discussion of issues around the differences between online therapeutic work and traditional methods of communication, using experiential exercises and/or demonstrations, often guides the trainee towards being comfortable with the concept of online practice before undertaking more formal and practical training through an online training course.

A face-to-face one or two-day workshop allows enough time to introduce trainees to how mental health practitioners are already using technology in their therapeutic services, examples including email, chat, videoconferencing, computerised cognitive-behavioural therapy and virtual environments. However, as most online work currently tends to concentrate on text-based communication (chat, email and forums), the workshop can narrow the focus down on to the theoretical elements of working with text (Anthony, 2000 for example) before demonstrating the practical elements of the nuances of text communication, such as appropriate use of emoticons and acronyms (see Anthony & Nagel, 2010, pp 41-57 for discussion). Often useful, depending on the needs of the individual trainees or the organisation, is some practical experiential work with emails, demonstration of a ‘live’ chat room therapy session via software that can simulate it, and a session within the day of the ethical considerations inherent in working online. Increasingly in the age of Web 2.0, discussion of maintaining a responsible online presence using professional/social networks, blogs/microblogs, and discussion groups within professional organisations is desirable.

Online training offers the opportunity to cover all of the above, and more, in a more intense form of being in the experiential environment. Training without a physical relationship with the trainer is an effective way of experiencing what future online work is like in relation to client work. Many technologies can be utilized to disseminate information.

Incorporating elements of the above into an online training course maintains motivation in what can often be a stark and lonely environment when trainees are traditionally familiar with face-to-face trainings, particularly in light of their previous core training in mental health services. Both online and offline training sessions hold their own advantages and disadvantages. However, using blended technologies – and this may include face-to-face elements – creates an ideal environment for training therapists to translate their skills and experience to the online world, and for becoming an effective online practitioner.

Examples of technologies to disseminate information online
- Online learning platforms (Digital Chalk, Moodle)
- Webinars and videos
- Live broadcasts of seminars
- HTML linking to academic papers and websites
- Submission of coursework direct to the server
- Online tests and questionnaires
- Asynchronous Forums for discussion and announcements
- Chat rooms for synchronous discussions and practice
- Podcasts
- Blogs
- Social networks
- Online bookstores
- Wikis
- Virtual conference centres

(Bloom and Waltz, 2000)

Kate Anthony

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- Online bookstores
- Wikis
- Virtual conference centres

(Bloom and Waltz, 2000)
Avatar Therapy

DeeAnna Merz Nagel

What is avatar therapy and how does avatar therapy differ from online therapy? Avatar therapy could be considered a form of online therapy. Delivering counseling and psychotherapy via technology is not a new concept. We can deliver therapeutic services using email, discussion forums, chat rooms, videoconferencing, and Voice-over Internet Protocol (VoIP). Other variations of delivery exist but these comprise the basic ways in which we can engage with clients through the internet.

Avatar therapy combines chat and audio components with a three-dimensional (3-D) virtual world as the backdrop. One of the most popular virtual worlds is Second Life. Other virtual worlds exist; now children can explore virtual worlds through websites like Club Penguin.

Most virtual world activities fall under the term ‘gaming’ but unlike the popular games such as World of Warcraft and The Sims in which there is a clear beginning and termination with winning as the end goal, virtual worlds such as Second Life do not have a competitive component, thus the concept of winning or losing does not exist.

Instead it might be easier to conceptualize a virtual world like Second Life like a chat room in which the landscape has been enlarged. No longer just a “room,” the chat world is complete with buildings, roads, rooms, landscape, people and animals, both animate and inanimate. Instead of logging into a chat room and creating a user name, one logs into a virtual world and creates a user name and avatar, which is a persona that can move around, talk, and interact. The avatar often looks like a caricature of the individual or a “cartoon” version of the person logging on. But the avatar can be completely different from the person behind the mask in looks and character. Some people choose animals as their avatars or assign a different gender.

Just as in a chat room with potentially only a user name for identification, the person who is actually manipulating the avatar may or may not choose the avatar as a pure representation of self. One can begin to imagine both the hazards and potentials given the open-ended possibilities in creating a virtual world persona.

With a clearer understanding of what an avatar is, imagine meeting a client in a virtual world to be introduced to his or her virtual representation of self. Most psychotherapists that work in virtual world settings create avatars that are a likeness of themselves and they represent themselves as the professionals they are. Names are the same or similar, background information is available to the potential client and the therapist uses the virtual world setting as another office location. Meeting clients “inworld” (a term for being inside a virtual world) allows the client to express parts of the self that might not be easily accessed in the traditional in-person therapy session. The disinhibition effect allows people to do and say things in cyberspace that they might not otherwise (Suler, 2004). This is true regardless of the method of communication. Add the 3-D aspect and the ability to create a visual representation of self, and the disinhibition effect is heightened.

It is easy to imagine the therapeutic possibilities available to the therapist when envisioning such a world without egotistic borders. Therapists might choose to engage in a form of narrative therapy encouraging the client to tell their story and create new endings. Clients can create boards literally filling a 3-D canvas with the images that manifest abundance and joy. Therapists might work with dissociative clients whose parts are represented through multiple avatar personalities. Variations on play therapy and sand-tray therapy are endless.

These are but a few ways that therapists might creatively utilize a virtual world setting with their clients. Therapists should be cautious about this work. Proper client screening and coupled with an appropriately trained clinician is paramount to a successful outcome. Therapists should understand the impact of online disinhibition on avatar therapy and therefore develop skills that will aid in assisting the client’s safe expression of emotions. Preparing the client adequately for therapy in a virtual world is important even if the client has much experience navigating and manipulating their avatar(s). Historical issues can be tapped easily and individuals who have experienced trauma may be at risk for disclosure that could leave the client feeling exposed and vulnerable (Anthony & Nagel, 2010). A strong background in trauma therapy and psychodynamic constructs will assist the therapist in working effectively in virtual world settings.

Virtual worlds offer an avenue for creative self-expression. That self-expression can be a healing force through self-direction or therapeutic facilitation. Clinicians who wish to explore psychological issues with clients in a virtual world setting should be aware of the positive and negative ramifications for clients and proceed with a combination of assuredness and caution.

References


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The image included with the article is author’s own avatar.
Simulated & technology aided learning in Psychotherapy

Hayley Ponsford, Jale Punter, Sheetal Sirrohi, Jenissa Tanna

Utilizing DVD technology to depict a simulated psychotherapeutic session and supervision was fuelled by our own experiences whilst training as junior doctors. An integral component of psychiatry training requires knowledge and experience of the various psychotherapeutic approaches. Some approaches are easier to observe than others indeed for family therapy the use of observers is an important part of the therapy. This is in contrast with psychodynamic and psychoanalytical therapy where observation, in a practical sense is difficult and can in fact be detrimental to the patient’s treatment.

The seemingly mysterious nature of the psychotherapy 50 minute session frequently creates uncertainty and anxiety in most trainees, given its difference from the more familiar psychiatric session. Thus, the undertaking of a long case in psychotherapy can prove to be a daunting task. Reassurance from the trainee’s supervisor and peer support through case discussion groups can relieve some anxiety. Yet, without direct observation of a session it can be difficult for trainees to fully grasp what can be involved and what might be expected of them in their own session, a sure fire way for trainees to compare themselves unfavorably to some unknown ideal. Most trainees are more than likely to feel responsible for events within a session that feel rather uncomfortable though these in actuality might be useful for the building of a solid therapeutic relationship, for example the sometimes terrifying experience of silence and anger. This discomfort is certainly reflected by the popularity of ‘How to’ and ‘Do and Don’t’ guides with trainees. As such we could clearly identify a need within psychiatric psychotherapy training that merited our attention. This was confirmed in discussion with current trainees nearly all of whom felt that the use of a ‘guide’ or a ‘gold standard reference’ during training would be most welcome.

Aims

Thus we envisaged a training DVD which would support trainees in their preparation for the undertaking of a psychotherapy long case. It would be used in conjunction with supervision and case based discussion groups. It would deal with realistic difficulties encountered in therapy whilst also conveying the differences between psychotherapy and psychiatry by providing simulated examples of how therapy and supervision takes place. This would be achieved in the following way; employing actors to read from a peer and consultant reviewed script, the best alternative to directly observing a session, which may otherwise lead to breaches of confidentiality and poor therapeutic outcomes. We would hope such technology would provide trainees with more realistic expectations of the psychotherap—
apy session as well as a learning experience which reduces trainee anxiety by normalizing otherwise unfamiliar experiences thus building confidence and ultimately contributing to better patient care.

**Funding**

The production of this DVD has been funded by STeLI (Simulated Technology enhanced Learning Initiative), an initiative established by the London Deanery’s and NHS London’s ‘Excellence in Education’ strategy and forms a key element in the response to European working time directive. STeLI promotes the use of powerful educational technologies, such as e-learning and simulation, to enrich the delivery of healthcare professional workforce training and promote high quality service delivery.

These facilities allow the development of professional capabilities, such as crisis resource management, effective communications, team work and leadership skills, in an entirely patient safe environment.

Launched in 2008, STeLI has already:
- Provided simulation-based and technology-enhanced resources to all 32 London Acute Hospital Trusts
- Supported educational developments in community-based settings
- Developed a specialist simulation Training Faculty
- Developed a Research & Development strategy to consolidate the theoretical and educational frameworks underpinning simulation-based training
- Raised the profile of multi-professional patient-safety and human factors training within Healthcare across London

Supported Postgraduate Schools in developing ‘Excellence in Education’ plans for curriculum enrichment and innovation

[www.simulation.londondeanery.ac.uk](http://www.simulation.londondeanery.ac.uk)

which all trainees, including us, could easily relate. Of course all personal details were omitted to ensure confidentiality.

All junior trainees within SW London and St George’s Mental Health NHS Trust were contacted and asked to fill in a short questionnaire. In addition, we arranged for trainees to meet locally where their valuable feedback was discussed in detail. Trainees were invited to be involved in the project on an ongoing basis.

Draft scripts were finalized through a review process involving peers, all members of the project team including a senior psychotherapy consultant, as well as the actors employed to read the script. These actors were specially chosen, having participated in Royal College CASC exams, by which we hoped their experience provided a more convincing portrayal of the psychotherapy session. Actors were of differing classes, gender and cultural background to ensure an accurate representation of both patients and trainees. Advice was also sought from an experienced filmmaker and employed in both the editing and filming stages.

**Results**

An exciting day of filming with five actors followed by a lengthy editing process enabled the production of our final product, an educational DVD lasting 30 minutes, certainly a mammoth task given the limited budget! The format of the DVD allows the viewer to follow the entire length of a supervision session including pre and post session trainee discussion and flashbacks to simulated therapy sessions on which the fictional supervision is based.

The DVD was presented at our local Academic meeting in which we requested observers (both consultants and trainees, our target audience) to comment on the DVD. To our
great relief we received 100% positive feedback:

“I had an overwhelming sense of inadequacy but I see how this is common”

“The cases are excellent and presented well. From my recollection these types of scenarios were as relevant then as they are now”

“I was impressed by the impact of non-verbal communication in the DVD...it normalizes and familiarizes the psychotherapy long case...I would have wished to see this video before starting my long case”

“It definitely helps to relieve anxiety and increase awareness”

Such heartening feedback suggests that we are close to achieving our goals. It has encouraged us to further develop this project in several ways. Having attended a pod cast training course, ideally we are aiming to transfer our DVD content to pod cast format. This would provide us with a much more accessible and economically viable form of technology that can be uploaded to appropriate training sites and downloaded by trainees as they wish. We are intending to expand the range of scenarios available offering trainees a wide choice of scenarios demonstrating the various psychotherapeutic techniques available. Of course this material may prove to be a valuable resource, generalizing across specialties both within and without Psychiatry. For all trainees the material would essentially provide us with additional tools ones that are inspired by psychotherapy) employable in the management of difficult patients in any setting.

Once this has been sufficiently developed testing the usefulness of this technology in relation to anxiety reduction will be our next important task. This potentially could be achieved by issuing trainees with anxiety rating scales to measure their anxiety pre and post their undertaking of a long case. This would entail two different sites, one site whereby access to our pod casts will be widely available as compared to a control site where it is not. In addition, patients may be approached for feedback or CORE questionnaires perhaps could be supplied in order to investigate the impact of this technology on patient care.

Conclusion

This project has been a wonderful opportunity to experiment with the use of technology for the benefit of psychotherapy training. Despite a limited budget, we feel our project has more than sufficiently met our expectations. We feel optimistic about the prospects for the further development of this project. Having now produced a DVD we have gained a thorough understanding of the functions and aims of STeLI as well as inspiring our future ambitions for this project.

We would also like to acknowledge the support for the project and thank Dr Jim Bolton (Director of medical education) , the STeLI team at London Deanery and all the actors for their invaluable contribution.

Dr S M Mura (ST3, SWL & St Georges) & Dr Margherita Tanzarella (ST4, Tavistock & Portman Clinic) completed a poster presentation in 2006 examining the experiences of psychiatric trainees undertaking psychodynamic long cases. Trainees described their experiences overall as a valuable learning experience but one which was fraught with both anxiety and satisfaction.

The project team were able to attend the London Deanery’s 3rd Annual Simulation conference organised by STeLI on the 1st March 2010; Innovation in education – The engine for change. This conference has informed our understanding with regards to the functions and aims of STeLI as well as inspiring our future ambitions for this project.
As the internet becomes an ever more integrated part of our everyday experience, it is natural that online equivalents are developed for some of our normal activities. But there are some transactions which seem, intuitively, to require face-to-face contact. Surely mental health interventions, and the teaching of relevant mental health theory and practitioner skills, are things which need to take place person-to-person so that the whole range of emotional information via body language, facial expression and tone of voice, are available to both therapist and client?

It appears, from our experience and research described below, that the internet is surprisingly well-suited to psychotherapy practice and training (we have so far concentrated on developing psychotherapy training, but have a suite of online therapy webpages under development.) What might be considered the disadvantages of being online—feeling isolated, not having personal contact and genuine interactions with others—turn out to be the things which make it most interesting as a vehicle for transformative learning.

The course

The MSc in Psychotherapy Studies (www.shef.ac.uk/psychotherapy) is an eLearning programme which offers students the opportunity to learn about mental health concepts by connecting with other students and tutors around the world. The course was launched in 2002 under the name of “SEPTIMUS” in response to a survey of Psychotherapy training in Europe (1) which concluded that access to training was limited by geographical location, family/work commitments and disability issues. It has since been taken by over 500 students in over 36 countries worldwide.

Future Directions

The scope for making use of simulated and technology aided learning within psychiatry is immense. Whilst pod casts permit vicarious learning, learning through direct experience is of course irreplaceable. With further use of simulation and technology trainees themselves could simulate sessions between patient and therapist/doctor. Observation of this simulation using cameras would then enable peers to provide feedback. It would be important to ensure the presence of a trainer or a supervisor to facilitate constructive feedback as well as formalizing the experience, perhaps for work place based assessments. By using trainees to simulate both positions, that of patient and doctor, role playing would provide additional and valuable information with regards to the patient’s experience permitting further empathy and understanding, aiding training and most importantly patient care. Our rather grand ambition then in due course; a training suite available to all disciplines and dedicated to cultivating and refining communication, psychotherapeutic and clinical skills that in future may prove to be indispensable for all those involved in patient care.

E-learning in Psychotherapy

Chris Blackmore, Digby Tantam

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which the internet provides on mental health related topics, but there are also challenges in understanding how to work with these resources effectively, e.g. how to use search engines effectively, how to use online resources without plagiarising and how to judge which sources of information to trust. For the professional, the same wealth of information which can enhance their practice enables clients to seek out their own information via search engines and support forums, information which can vary in its accuracy.

**Transformative eLearning**

For both tutors and students, the emphasis on collaborative learning and self-development provides a surprisingly intimate learning experience. As we invite them to reflect on their personal experiences in light of current theory, and to share this with other group members, students find that they are much more willing to discuss personal issues with one another and to learn through these. There is a surprisingly high level of self-disclosure, which may seem paradoxical to those who feel that the internet is a distancing and even isolating medium. This openness does need careful facilitation, as the online medium, with its lack of contextual information, can sometimes lead to miscommunication; and where online conflicts arise, they can be harder to resolve than in the face-to-face setting. But so long as tutors have the necessary sensitivity and expertise, there is the potential for this kind of honesty and openness to lead to online equivalents of “transformative learning” - a learning process of “becoming critically aware of one’s own tacit assumptions and expectations and those of others and assessing their relevance for making an interpretation” (3). Many of our students have found that their studies have enhanced not only their theory and skill sets, but their personal self-development too.

That’s all very well, but what about student satisfaction and student performance on the programme? We have conducted research into the online course and found that, compared to similar face-to-face courses, eLearners reported higher satisfaction with the course material and tutors than face-to-face learners, and eLearners spent more time on the course materials than face-to-face learners, but less time with tutors. Their performance also seems to be enhanced by access to the wealth of information that the course is able to open up to them (4,5).

**CEP project**

The most recent development in the programme under the title “Continuing Education in Psychotherapy (CEP)”, again funded by the Leonardo da Vinci fund of the EU, has been to move the interactive components to Moodle, the most widely used content management system (CMS) for education world-wide ([www.moodle.org](http://www.moodle.org)). Moodle is a free, “open source” software package designed using sound pedagogical principles, to help educators create effective online learning communities. It can be downloaded and used on any computer, yet it can scale from a single-teacher site to a University with 200,000 students. As of June 2010 it had a user base of 48,000 registered and verified sites, serving 34.8 million users in 3.5 million courses (6). Moodle also has a large and diverse user community with over 923,000 registered users, speaking over 70 languages in 211 countries; it is thus a resource with huge amounts of support from a community of developers. Moodle supports the latest developments in learning technologies, such as Wikis, which facilitate collaborative learning and inquiry-based learning.

**The future**

The CEP project is transferring technological and particularly pedagogical innovation in online tutorial support to partners in the UK (Dilemma Consultancy Ltd), Belgium (University of Leuven) and France (University of Bordeaux). Partners have also been undertaking translation of course materials, meaning that modules are now available in English, French and Dutch. The increased accessibility of materials will help in our vision to establish the online modules as the basis for CPD across Europe in collaboration with the European Association for Psychotherapy (EAP). As part of this vision, a new portal Dilemma training ([www.dilemmatraining.com](http://www.dilemmatraining.com)) has been developed to provide access not only to the SEP-TIMUS courses, but to online learning for the public, and online learning for carers and professionals in the diagnosis and management of autism spectrum disorders.

The move to Moodle has enable the programme to keep up with the pace of collaborative innovation which characterises the “Web 2.0” movement. For example, we have been able to develop a tool which enables students to choose which hyperlinks are displayed on a course page by rating their usefulness, to suggest new hyperlinks for a given page and to flag up broken links. We have also developed a tool which enables students to rate each course page in terms of how they feel about having visited it. With imminent moves towards “cloud computing”, tablet computing and mobile learning, the course will undoubtedly need to keep evolving to reflect the very latest ICT developments and to ensure that learners are provided with the most up-to-date learning experience.

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Today’s Virtual World Psychiatry

Andra Ion

Since the advent of the microprocessor by Intel in 1971, computers and video games consoles have made their way into more and more areas of our everyday life, particularly in the life of children and young people.

Since the creation of the game Pong in 1972, computer games have constantly grown in complexity and accessibility. Because of their massive penetration in the daily life of our children, the consequences of playing video games have become an important topic of debate among specialists in many different fields. Some argue that playing computer games is a waste of time and promote violent, aggressive and antisocial behaviour. Others advocate the view that computer games are valuable tools, permitting the acquisition of significant skills and knowledge, enhancing healthy development and professional success.

In 2001, Mark Prensky(1) coins the term digital native in his work Digital Natives, Digital Immigrants to describe the differences between the new and older generations of individuals in what concerns their capacity to learn and deal with new technologies but also in the way they relate with each-other, and interact socially. The term draws an analogy to a country’s natives, for whom the local religion, language, and folkways are natural and indigenous, compared with immigrants to a country who often are expected to adapt and assimilate to their newly adopted home.

Prensky describes a number of changes that he observed in the “Games Generation” including multitasking and parallel processing of information, random access to information vs. step-by-step, search for interactivity and connectivity vs. passivity in obtaining information, accent on payoff and fantasy, and perception of new technology as friendly and familiar.

Concomitant with the apparition of digital natives, another concept started to develop: The Virtual World. It describes a genre of online community that often takes the form of a computer-based simulated environment through which individuals can interact with one another, use and create objects (Z, Bishop 2009).

Despite the fact that from a material point of view virtual worlds are sealed off from the real world, they have in fact plastic and permeable boundaries: Participants constantly enter or leave the system, each with their individual sets of attitudes and behaviours that become entangled components in the structure and dynamics of the virtual world.

A particular type of virtual world is represented by game guilds where “clans” of players compete against other clans via quests or challenges, and where objectives can vary from having fun in a competitive environment to participating in more serious tournaments and clan wars. Williams et al. (2006) (3) suggested that such guilds represent real social structures hierarchically organised, with single or multiple leaders, co-leaders, and “commoners”.

Typical guilds exist in most MMORPGs (Massive Multiplayer Online Role Playing Game) such as World of Warcraft (Blizzard Entertainment), Second Life (Linden Lab), EVE Online (CCP games), Guild Wars (ArenaNet), or Aion: The Tower of Eternity (Ncsoft). There can be hundreds, or even thousands, of these clans or guilds active at any one time in these popular online games. They developed their own communities, discussion forums, and satellite Internet sites where players meet and socialise online on a daily basis, often for several years on row. Admission into elite clans is usually selective based on gaming skills, longevity in the game, and personal connections. Some very large clans have a council of leaders, usually composed of the clan’s founders and other members who have served for an extended period of time. The cohesion between members is generally sustained by the sense of community created in the individual members and a multitude of real life-like processes are easily identifiable such as democracy, autocracy, leadership, group and crowd behaviours, censorship and auto-censorship of the group members, inter-groups aggression, and groupthink.

Each participant creates their own virtual character or characters with which he interacts in the game. These characters (or avatars) are very often fantasy projections of the player’s ideal self and are invested by the player with many (if not all) of his or her own desired attributes. Average players spend months and even years in leveling up their characters, developing their skills and power, and improving them with equipment upgrades that are only available as prizes for completing difficult quests. In many instances, after intense play, the boundaries between the player’s self and the virtual character that he created can become blurred and the individual can go as far as perceiving his gaming character as an extension (the ideal part) of his own person. For these reasons, the loss of such a character can have dramatic effect in the real life of the player.

In September 2005, a corrupted patch in the online game War of Warcraft created the “Corrupted Blood plague”. Players’ characters were sickened by a debuff called “Corrupted Blood” which would periodically sap their life. In within hours the “plague” infected a majority of players with low level characters being killed within seconds (Wikipedia(4)). Many of the players later described symptoms of emotional distress, hopelessness and even depression (World of Warcraft Forums)(5). Many experienced the virtual loss more severe than the potential loss of a family member.

More serious is the case of Xiao Yi, a thirteen year-old boy, from the Chinese province of Tianjin who in 2005 threw himself from the top of a twenty-four storey tower block (6). Before killing himself he wrote a suicide note in which he spoke of his MMORPG game and his hope of being reunited with fellow video game players in heaven. The note was written through the eyes of his main gaming character with whom
he appeared to identify completely.

Another case that resulted in suicide related to video games is Shawn Woolley, a 21-year-old video games buff from Wisconsin, who was suffering with epilepsy, depression and schizophrenia, disorder, and who was reported to spend over 12 hours per day playing an MMORPG called Ever Quest (7). He shot himself and was found dead at his computer, which was still running the online game. Shawn started playing the game in 2000, and his mother described how after less than a year, he suffered several serious epileptic episodes related to spending most of his time playing on his computer, lost his accommodation, and was admitted for severe self-neglect. Inquiry into his death related his suicide to events happening in the game, including a long time online associate who stole Shawn’s virtual character’s money, and being rejected by his virtual girlfriend.

But the impact of video games on young people’s mental state does not only involve risk to self: In the UK, a video games player, Matthew Pyke, was murdered by a fellow War Games player who flew from Germany to take revenge on his gaming rival (8). David Heiss, a 21-year-old German online gamer, became infatuated with a British girl, who along with her boyfriend, Matthew Pyke, was an administrator of the Advance Wars fan site Wars Central. After a number of relatively minor online conflicts related to the game and to the interpersonal relationships that developed on the game’s chat board, Heiss traveled to the UK and stabbed Matthew Pyke to death.

Sadly, this is not an isolated case, and over the past ten years many crimes including school shootings, rapes, and abductions were related to specific video games and the virtual social interactions that developed between members of gaming chat rooms, gaming related sites and MMORPGs gaming environments (9).

It became apparent that in the younger generations there has been a shift in what can and should be considered “normal”. One can hardly consider that a teenager with dozens of online friends, and daily virtual social interactions that last for hours as “socially isolated” or as lacking social skills just because he appears to limit his activities to his room. In the same way, one cannot underestimate the impact of potential virtual events on the mood and levels of anxiety of a young patient when assessing, for example, a depressive episode or more generally the mental state.

Psychiatrists are more and more often confronted with a particular “digital” language, that they will need to learn, understand and manipulate in order to effectively communicate with children, teenagers or young adults who present to the Psychiatric services. Moreover, as technology changes so quickly, and as new games and online resources evolve so rapidly, we will all need to adapt our understanding of the Mental Health to the context of one of the most influential revolution that took place in the modern ages: The Digital Revolution.

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The Internet versus the Psychiatrist

Dinal Vekaria

Over the last few years, I have noticed an increase in referrals regarding patients who are convinced they are suffering from a mental disorder, which has been confirmed by on-line testing.

A significant part of the problem may stem from the easy availability of diagnosis, symptoms, and classifications on the internet. Also, given the rise in celebrities and those in the public sphere describing their mental disorders (Bipolar Disorders seem prevalent!), it is no surprise that many people tend to draw parallels with aspects of their own moods or presentations.

Another issue is the globality of the internet.

Google is the most widely used search engine with a default search option of “search the web”.

Using search criteria of “Internet self diagnosis psychiatry”, I accessed an American site, (http://www.mentalthreads.com/p71.html) which prompted me to use “Decision base software” to “prompt individuals to seek professional help for their untreated mental illness”. Given the nature of private practice and the financial aspects of self-referral in USA as opposed to our public health system, many people accessing similar websites may have unrealistic expectations from their health provider.

Also, the internet has been used by many to exploit people financially, and this is very
widely seen especially in the context of purchasing non-prescribed medications. A study carried out by Ivanitskaya et al. in April 2010, showed that higher education American students were very vulnerable to fraud by illegitimate Internet Pharmacies.

A caveat is that many people would have correctly flagged up symptoms which need further assessment and possible treatment, following similar internet searches, thus reminding us that the internet can be a powerful tool if used wisely. Also, the use of Computer CBT and self help websites can be of great support for patients.

However, the double edged sword nature of the net shows its ugly side in Pro-Anorexia and Self Harm Promotion websites, together with the alarming amount of child pornography.

I have personally been shown new diagnoses “from the DSM- five, that’s the American one, Doctor”. I have also spent time sifting through print-outs from the net convincing me of the diagnosis. More worryingly, I have been told by several patients to whom I have refused mediciations (especially Benzodiazepines) that they “would buy it off the net”.

Despite warnings against self-diagnosis and sterling gate keeping work by our colleagues in Primary Care, I fear that this self-diagnosis will continue and increase.

The ongoing challenge lies with us to ensure we are aware of the positive and negative aspects of the internet, and can educate and inform our patients accordingly.

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INTERNET AND PSYCHIATRY

Integrating Web 2.0 with Mental Health Care

Andy Pulman

Web 1.0

Berners-Lee’s (1999) original vision of the Web was of a collaborative workspace where everything was linked in a single, global information space - a web of information. An early development in his career led to the development of a web browser which allowed users to browse and edit documents simultaneously. However, as they continued to be developed, none of the newer browsers included edit functionality. Crucially, this left people regarding the web as a medium where few published but most browsed. This version of the Internet could be defined as Web 1.0.

Web 2.0

The term Web 2.0 was coined during a discussion on a potential future conference about the Web (O’Reilly 2005). It is important to note that the term was not designed to capture the essence of an identified group of technologies, but an attempt to capture something far more amorphous. Anderson’s (2007) definition of Web 2.0 technology reflects an enhanced generation of web-based communities and services, which aim to facilitate creativity, collaboration, and sharing between people.

Differences

Web 2.0 could be viewed as connecting people and facilitating new kinds of collaboration whereas Web 1.0 focused on connecting computers and making information available. From this perspective, Web 2.0 should not be viewed as competing with Web 1.0, but as aligning more closely to Berners-Lee’s original vision.

Relevance To LTC

In 2008, it was acknowledged (DoH 2008) that people wanted services that would support them to remain independent and healthy and have increased choice. These views were considered when drawing up five high-level outcomes for people with Long Term Conditions (LTC). For the delivery framework four areas of support were identified to help create empowered and informed patients. It was also noted that some of the options that health and social care communities could use to support people with LTC could include sets of technological tools (DoH 2008). There are a number of Web 2.0 tools that encourage social networking and collaboration, which could be utilised as potential tools for supporting LTC. In the area of mental health, applications could be used in service delivery, in the community, or in the home and targets could include monitoring medication compliance - an issue for community psychiatry.

Blogs

A blog is a method of publishing information on-line, similar to keeping a journal and writing entries about what someone might be thinking, ideas they might have, or events experienced. AdrienneR (2010) has been writing a blog for Everyday Health (2010) detailing her day-to-day experiences of living with anxiety. Blogs by mental health professionals are sparser as a review by James (2006) found, largely due to the fact that employers might object. However, some blogs do exist...
like Mental Nurse (2010) - a group blog by a number of mental health nurses. James (2006) noted that one reason people struggling with a mental health diagnosis blogged was that it helped to achieve catharsis - allowing the open sharing of thoughts and experiences in anonymity, so encouraging candid blog posts. One example is Mike, the father of a 26-year-old man diagnosed with schizophrenia who started blogging in 2004 (Mindriddles 2010). As with blogs in other disciplines, ethical concerns and confidentiality mean that bloggers who use real names need to be careful with what they post. As an example, Harvard Weblogs contained a blog where a student posted internal memos from Diebold Election Systems suggesting their machines faced problems. The company threatened legal action against the student and Harvard (Downes 2004). To avoid litigation, online diaries can be kept private so there is no need to let the whole world read these diaries but the same time as privacy is protected the ability to link up and communicate with like minded people for support is immediately lost if the world is locked out. One further problem with blogs is whether they are truthful. In “Munchausen by Internet” (Feldman 2000), an individual seeks attention by playing out a series of dramatic near-fatal illnesses alternating with recoveries that increasingly strain credulity and blogs are one method of distribution used.

Microblogs

A microblog is a short blog post whose appeal is encapsulated in the ability to provide quick, immediate, portable communication. Twitter is an example of an online microblogging application, which allows users to provide bite-size updates. Twitter works with mobile phones and other messaging clients, which make it an easy way for mobile users to stay in touch anywhere - by choosing to follow a user, you can be notified when a person posts a new tweet. For chronic conditions, Twitter allows easy access to users geographically displaced or unable to travel to document short posts about how they were feeling or ask questions of others. This could possibly cultivate and inspire private, focused group conversations between people with specific conditions (Pulman 2009) such as someone coping with depression documenting when exactly they felt depressed and what if anything had triggered the feeling which could then be tracked over a period of time. It could also provide an effective targeted information channel for practitioners to provide support materials (Pulman 2009). As an example, the charity Rethink (2010) uses their Twitter feed in conjunction with other social media for passing on news, encouraging fund-raising and highlighting campaigns.

Podcasts and Multimedia

The popularity of multimedia web sites which enable the sharing of digital content on web applications like YouTube (for video) and Flickr (for photos) has grown significantly in the last five years. A podcast is an audio file that can be streamed or downloaded from a web source onto a computer, MP3 player or mobile phone whilst a vodcast (video podcast) integrates visuals with audio. Recently, the Mental Health Foundation (2008) launched a series of podcasts, which could help relaxation and improve a sense of wellbeing. The BBC Headroom campaign (2008) launched in the same year included a range of short videos covering stress, dealing with loss, anxiety and depression, as well as tips on personal happiness. Meanwhile in Ruby’s Room (2008) Ruby Wax tackled a range of different mental health issues, interviewing the people experiencing them. The films were also made available on YouTube.

Wikis

A wiki is a group of web pages which allows users to add content but which also permits others (sometimes without restriction) to edit that content. Wikis offer the potential of working collaboratively to compile and edit health related web pages without the need for advanced technical know how. Seeman (2008) suggests that customised wikis could advise local patients as to which agencies to visit for education, nutrition, counselling or rehabilitation services; or how to access telehealth or culturally specific services.

Facebook and Social Networks

Facebook and MySpace are examples of social networking sites. Facebook supports online meetings, conversations and collaborations. Globally, Seeman (2008) found around 1,200 Facebook communities advocating for cures for different chronic conditions. Rethink

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(2010) uses their Facebook page to promote and engage support for their iCare campaign aimed at obtaining 10,000 signatures for a recent General Election petition.

Apps

A recent United Nations report shows more than half the global population now pay to use a mobile phone (Tryhorn 2009), whilst a survey by Anderson and Rainie (2008) predicts that by 2020, most people in the world will be using a mobile device as their primary means of connecting to the Internet. Although not officially deemed a Web 2.0 technology, Mobile web applications - known as “Apps” (Apple 2009) - harness the power of the Internet and on occasion Web 2.0 concepts and software with the simplicity of multi-touch technology on a small Smartphone screen and have seen huge recent growth (Pulman 2010b). Health Apps offer tremendous potential for users and could be specifically designed for particular conditions and purposes. Some already released include the Mayo Clinic Meditation (Apple App Store, 2010), a clinically validated method of meditation developed by Mayo Clinic, which aims to help users feel more focused and relaxed throughout their day. In the UK, the free NHS Drinks Tracker developed by NHS Choices (2010) allows you to keep a drink diary and get feedback on drinking habits. With some reworking, a similar system could be utilised as a personal tracker of medication monitoring although it would require trust on the part of the person making the entries to ensure that they were truthfully entering them onto the system. Similarly, imagine an enterprising clinician devising a mobile application that could be used on a mobile device in the event of a panic attack to calm a person down.

Potential and Problems

The current and potential use of Web 2.0 applications, the emergence of mobile technology and the imminent launch of the iPad and the possible emergence of tablet sized portable devices offer an exciting future for developing a wide variety of mental health and social care resources both for practitioners and clients. However, current definitions concerning the integration of health information and support with Web 2.0 technology (Pulman 2010a) are primarily concerned with approaches from a healthcare or medical perspective. They do not effectively consider how this might work from the viewpoint of the patient and also fail to consider how patients could already be using Web 2.0 technology or might want to adapt it in the future. There is a need to design a patient centered framework, encapsulating the use of Web 2.0 technology for people with LTC who might want to support, mitigate or improve their own quality of life (Pulman 2010a).

It is crucial that the patients who will be using technology for mental health issues are included in discussions regarding how they might best utilise it. It also key that proactive practitioners start looking at the technology around them and seeing if they can apply it to their own practice rather than waiting for technologies to suggest what they could or should do with it. If the clinical quality of some existing mental health applications is questionable, then it requires forward thinking psychiatrists in the UK to actively work on clinically accurate versions which could then be used in the mobile world. It also requires prudent sensible strategic policy to avoid costly haphazard adoption of Web 2.0 and mobile technology within the health sector without understanding why it is being implemented, what benefits it will bring and whether it is the right thing to be doing in the first place.

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AUTHOR

Andy Pulman works for the School of Health and Social Care (HSC) at Bournemouth University in the UK, where he is involved in the management and creation of web resources and e-learning developments and initiatives. Andy started a part-time PhD in October 2008. His research interests concern exploring educational solutions around Web 2.0, gaming experiences, personal narratives and simulation. Andy is also the author of the Palgrave Pocket Study Skills book Blogs, Wikis, Podcasts & More, published in August 2009.
Hyperlinking Mental Health Care Pathways

The term, care pathway, has been used to describe:

- Multidisciplinary/ multi-agency outline of anticipated care, placed in an appropriate timeframe, to help a patient with a specific condition or set of symptoms move progressively through a clinical experience to positive outcomes or more neatly:

- Treating the right patient right at the right time and in the right way (Bandolier)

They must therefore be ‘a good thing’ but in practice, a multitude of disparate projects with outputs ranging from a page of interconnected boxes and arrows with rather banal entries to thick and indigestible wads of paper. Certainly the idea of a ‘mental health care pathway’ (MHCP) accessible and used by patients, carers, primary and secondary care would seem overwhelmingly complex and unworkable. So it seemed to us - until someone invented ‘hyperlinks’ which allow links within websites and to other websites - and we realised that these could allow information to be made available when and where in a person’s progress through services it was needed.

The MHCP therefore commences as:

‘Mental health’ links to the ‘Foresight 5’ [Give, Connect, Take Notice, Be Active, Keep Learning] - information from the Office of Science project on developing mental capital and wellbeing. Then ‘Coping with problems’ links to sites on social issues, e.g. work, benefits, and relationships. The pathways are divided into Service Pathways (for separate PCT areas) linking to different services and quality and outcome measures. Separate
services may have ‘acute care pathways’, etc, which each provide further links to information on assessment, safeguarding procedures, relapse prevention techniques, etc.

Diagnostic care pathways have been developed which start as broad categories (similar to those developed by the College in its submission to ICD11 and DSM-5) [Kingdon et al., 2010]. These individual pathways include diagnosis (ICD-11 is linked) medication and psychological management (with links to relevant guidelines and source information) and links to NICE guidelines including the Key issues for implementation.

Finally Payment-by-Results is now with us: the ‘Clusters’ are linked to the individual pathways and access to perform clustering (required on all patients by 31st December 2011) is simplified. Currently the MHCP prototype is a PowerPoint presentation [freely available from dgk@soton.ac.uk] developed within NHS South Central (Clinical Director: Alain Gregoire) who established and are supporting the project. A website [www.southcentral.mentalhealth.nhs.uk] is scheduled for launch in May 2011.

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Author

David Kingdon is Professor of Mental Health Care Delivery at the University of Southampton, UK, and Director of R&D and honorary consultant adult psychiatrist for the Hampshire Partnership NHS Trust. His research interests are in cognitive therapy of severe mental illness and mental health service development on which he has published many papers, chapters and books including co-authoring ‘Cognitive Therapy for severe mental illness’ (2008) [winner of BMA Mental Health Book of the Year 2009] & ‘Back to life: Back to normality’ (2009). He fell in love with a Sinclair ZX81 many years ago and, sadly, still spends more time with his computer than his family (but one of them does now work for Apple).
Your couch versus your therapist’s couch

Treating clinical depression on the telephone is nearly as effective as face-to-face consultations, a new Brigham Young University study finds.

The trial run included 30 people newly diagnosed with major depression. Instead of eight scheduled visits to the clinic, the participants covered the same material during a series of phone calls with the therapist. Calls varied in length, ranging from 21 to 52 minutes. The patients did not receive antidepressant medication.

At a six month follow-up, 42 percent of participants had recovered from depression. For comparison, similar therapy conducted in person has a 50 percent recovery rate.

“Offering a phone or webcam option for psychotherapy does appear warranted from an efficacy point of view,” said Diane Spangler, a BYU psychology professor and a co-author on the study. “It’s more user-friendly - no commutes, more flexibility of place and time – and has no side effects.”

Over-the-phone therapy may not be for everyone. One-third of eligible participants declined the option for telephone consultations, preferring the psychotherapist’s couch to the one in their living room. But for those comfortable with phone calls, therapy could soon be cheaper, more convenient and minus awkward waiting rooms.

Though a sample of 30 people is not large, the BYU researchers cite a previous antidepressant drug trial that happened to include a telephone counselling component. In that trial, the added benefit from phone counselling matched the results attained by the new BYU study.

Source: Brigham Young University, The study appeared in the June issue of Behavior Therapy.

Internet complicates doctor-patient relationships

Patients who ask their doctor about information they have read on the Internet, or webs that better inform them of their diagnosis, are no longer a rarity. A study undertaken by Spanish researchers reveals the advantages and disadvantages of online medical enquiries. Some 31% of doctors believe that the Internet complicates their relationship with patients and undermines their credibility.

Health information on the Internet is changing the relationship between doctors and patients. “Although the e-patient is a new phenomenon that is growing exponentially, very few studies analyse it from a doctor’s point of view,” José Joaquín Mira, main author of the working paper published recently in the journal entitled ‘Atención Primaria’ (Primary Health Care in English) and a researcher at Miguel Hernández University explained to SINC.

As a result, the researchers analysed the opinion of 660 doctors who all work for the Spanish National Health System (330 in primary health care and 330 in hospitals) in the provinces of Alicante, Madrid, Zaragoza and Huesca. Results show that 96% of the doctors surveyed have been questioned by their patients about information they have read on the Internet. Furthermore, almost three out of every 10 professionals recommend websites to their patients.

The doctors who work in hospitals devote more time to the Internet, take more advantage of resident training resources and cooperate more with specific websites than their primary health care counterparts. But opinions coincide when the influence of the Internet on their relationship with patients is analysed. According to 31% of doctors, Internet complicates their relationship with patients and undermines their credibility.

As regards the advantages that the Internet provides to the people who go to the doctor, the first (42%) is that it helps patients to learn about their illness. However, only 20% of the doctors surveyed said that the Internet increased patient independence. “All the specialists agree that they do not believe the Internet favours patient independence”. Moreover, many believe it can undermine the credibility of doctors. As a result, doctors do not normally suggest websites to their patients for complementary information, Mira clarifies.

Source & Picture Credit: FECYT - Spanish Foundation for Science and Technology

Reference: Mira Solves, José Joaquín; Llinás Santacreu, Gilberto; Lorenzo Martínez, Susana; Albar Remón, Carlos. “Uso de Internet por médicos de primaria y hospitales y percepción de cómo influye en su relación con los pacientes”. Atención Primaria; 41(6):308 junio de 2009.
How do you spend your evenings?

Maxwell E Hughes

I’m at a lecture in Sheffield, wearing my pyjamas at home in Devon...

...or, “what’s it like doing a distance learning MSc in Health Informatics?”

It is becoming increasingly common for psychiatrists and other professionals to pursue a postgraduate degree, whether in the form of a Masters degree or a PhD. There are a number of perceived advantages in doing this, including intellectual satisfaction, career enhancement and diversification (Leonard, D. et al. 2005). The choice of a suitable course needs to consider a variety of factors (Lightfoot, 2008). The MSc Health informatics by distance learning at Sheffield University is one such course (Sheffield University, 2010). The joys and tribulations of this are discussed and a few similar courses are mentioned.

Ok, that’s the textbook answer, now give me the real reasons:

I did my undergraduate training at Sheffield and was quite satisfied with that. The fees are in the midrange, currently £2250 per annum, with no hidden extras. There is a possibility of getting an intermediate qualification (e.g. diploma) if the course gets too much.

And does it get too much?

Sometimes it does. The academic work is fairly straightforward, but the assessments do take a long time to research and reference.

What are you hoping to achieve with this?

Ideally, this will allow me to do consultancy work, rather than just providing a clinical angle to projects which are otherwise dominated by IT professionals. Because health informatics is a new subject, it’s easy to lose sight of the path when you’re exploring some esoteric area, and a formal education helps achieve some perspective. The discipline of referencing and researching has been good for my own development.

What would you do differently next time?

• Pursuing an MSc has become de rigueur for many psychiatrists but there is a substantial commitment, especially in terms of time involved, in achieving this, as well as a variety of financial costs (Prospects, 2010).

• Health informatics is a new subject and career paths are relatively unclear, however, formal education in the area can be very beneficial (Prospects, 2010). The benefits of postgraduate study in general are, however, surprisingly poorly studied, so that anecdotal evidence is the main guide to deciding whether to pursue this option (Leonard, D. et al, 2005).

• There are textbook reasons to choose a course, as well as more idiosyncratic personal choices to be made (Lightfoot, 2008)

I would still do the course, but I might try for some sponsorship from industry.

Finally, there are some other courses, aren’t there?

There are a bewildering number of these now available, and a simple web search will provide plenty of leads. Some useful questions to ask may include the background of the proposed lecturers, the viability of running the course (many collapse after the first year) and past testimonials, although, with such a new subject, these may not be available, and, in any case, are usually handpicked by the institutions themselves!

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Texting young people as a way to improve outpatient attendance appointments

Last year we accepted 257 referrals, low mood was the commonest presenting complaint and depression the most common diagnosis. The team is to engage vulnerable adolescents with limited support. To increase attendance we offer our appointments across the city in a wide range of venues, for example Connexions offices, General Practices and Youth Offending Services.

The team functioned as a Tier 1 service because of the city’s young population. In Manchester, young people make up a greater proportion of the population compared to the national figures; 18% (n=69,349) of people in Manchester are aged between 16 and 24. We cover the whole city and accept any new referrals (apart from emergencies) of 16 and 17 year olds with mental health problems. The three child psychiatry services based in the north, south and central of the city keep their open cases until they reach 18.

I have found that young people respond well to appointment reminders. Homeless young people ask us to text addresses and names of professionals as their phones are the one thing they never lose.

Missed appointments in psychiatry are a serious problem. National NHS data showed that in England from 2002 to 2003, 19.1% of outpatient psychiatry appointments were missed, compared with an average of 11.7% outpatient appointments across all medical specialties (1).

As well as the economic implications of outpatient non-attendance, the literature shows that there may also be different clinical outcomes. A prospective controlled study by Killaspey et al. (2) found that those who fail to attend a follow-up psychiatric appointment were generally more unwell, more functionally impaired, and had a higher chance of subsequently being admitted to a hospital, compared with those who attended.

Downer et al. (3) evaluated the operational and financial efficacy of sending text message reminders to patients with scheduled outpatient clinic appointments at the Royal Children’s Hospital, Melbourne, Australia. They found that the missed appointment rate was significantly lower in the trial group than in the historical control group. They concluded that the reduction in missed appointments, in addition to the increase in patient revenue, suggests that reminding patients using text messages is a very cost effective approach for improving patient attendance.

Sending text message reminders has been shown to be a simple and cost-effective way to improve non-attendance at ENT outpatient clinics (4). The use of text reminders for ophthalmology outpatient appointments “was associated with a reduction of 38% in the likelihood of patients not attending their appointments, compared to no appointment reminder” (5). The use of text reminders may also be more cost-effective than traditional appointment reminders and require less labour (5).

However, there is some controversy in the literature. A randomised controlled trail by Fairhurst and Sheikh (6) “failed to demonstrate significant reduction in non-attendance rates, as a result of texting appointment reminders to patients who persistently fail to attend their general practice appointments”.

Although a number of studies have shown that

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6. Fairhurst and Sheikh (6)

AUTHOR

Louise Theodosiou is a consultant child and adolescent psychiatrist working in a community based team for 16 to 17 year olds. She has an interest in developing services for vulnerable adolescents, particularly young people using drugs and alcohol or involved in the criminal justice system.

Text message appointment reminder system pilot

Keelyjo Hindhaugh, Angharad A Rudkin

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Although a number of studies have shown that

Website: www.rcpsych.ac.uk/mhisig
telephone reminders within a week of an outpatient appointment can improve attendance rates in community mental health clinics (7-10), there is minimal literature on the use of text messaging specifically in mental health.

Donaldson and Tayer (11) conducted a feasibility study in their local general adult psychiatry outpatient clinics, which revealed some difficulties. Although the number of patients who owned a mobile telephone was in keeping with the national average, only 74% could remember their telephone number and only 53% were agreeable to being contacted by text message. The authors were concerned that psychiatric clinics would not provide as impressive results as those reported in other settings.

The Pilot

South West London and St George’s Mental Health NHS Trust (the Trust) has recently completed a second twelve-month text messaging appointment reminder pilot with the aim of reducing the number of missed appointments and determining whether or not this is a service that service users and staff would find useful.

The first pilot ran for twelve months from December 2007 and involved eight teams. However, owing to a lack of implied consent, this initial pilot was unable to produce enough data to prove or disprove the success of text message appointment reminders in reducing missed appointments.

In April 2009, the second pilot, using an implied consent model that allowed service users to ‘opt out’ of the service if they wished, commenced in fifteen teams across the Trust. These teams encompassed a variety of subspecialties including general adult, child and adolescent, community drug and alcohol and neuropsychiatry teams.

For each face-to-face appointment entered into a clinician’s diary on the electronic patient records system (RIO) a text message was sent out to the service users reminding them of their appointment. At the end of the twelve-month pilot, the following text was sent to all the service users of the teams who participated in the pilot:

“Our text appointment reminder trial ends 30 April. Your feedback is important to us. Please text YES if you found this service useful.”

Feedback forms were also sent out to all team members involved in the pilot.

Outcomes

During the course of the pilot, a small drop in missed appointments across the Trust was observed. The reduction in missed appointments was marginally greater within the pilot teams than across the Trust as a whole. In the pilot teams, missed appointments fell from 19% (13,543 missed appointments) to 17% (11,761 missed appointments) and Trust-wide missed appointments reduced from 14% (74,378 missed appointments) to 13% (66,230 missed appointments). Any reduction in missed appointments results in an increase in contact rates and means improved productivity through the reduction of waste. This increased productivity could potentially produce cost savings.

A drop in DNA rates is important as it improves efficiency and results in more people being seen with the same resources.

The response rate to the feedback request text to service users was 34%. 95% of service users who responded stated that they had found receiving text message appointment reminders useful.

No incidents or complaints concerning breaches of confidentiality were reported during the course of the pilot project.

There were additional benefits to the pilot, one of which being that using the text system proved a useful tool for reporting to teams when incorrect mobile phone numbers were held on record, thus helping to ensure that accurate service user contact details are held.

There were, however, some limitations to the pilot, most notably that 34% of all the service users in the pilot teams did not have a valid mobile phone number recorded, meaning that they were unable to participate in the pilot. Another challenge exists in that, as the text messaging system used runs directly from information extracted from RIO, text reminders will only be sent out if the appointment is entered into a clinician’s diary sufficiently prior to the appointment taking place (typically three days). Any delay in this data capture will result in service users not receiving the reminder text.

Based on the feedback from staff and service users and the minimal costs of implementation, it has been decided that the system will be implemented Trust-wide for all teams who wish to offer this service.

Improving the experience of service users is a goal of both the Trust and the NHS as a whole and providing a choice to receive appointment reminders supports service users to retain control over their healthcare.

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AUTHORS

Keelyjo Hindhaugh is a ST5 in General Adult Psychiatry on the South West London and St. George’s training scheme. Angharad A Rudkin is a Project Manager in the Service Development and Performance Department of South West London and St. George’s Mental Health NHS Trust. She manages a wide range of NHS projects including new technology implementation, service reviews and large multi-site service development projects.
Mental Health and Smartphones: Amusing toys or useful tools?

Fionn Kelly

Obedient to Moore’s Law desktops, laptops, PDAs and smartphones are doubling their capacity every eighteen months. Given their greater power and capabilities desktops, laptops and PDAs have been used to aid clinical practice over recent years but it has only been over the past eighteen months that the latest smartphones have had the processing power to be truly useful clinical adjuncts. This article will explore some of the areas in which smartphones are currently most useful and highlight areas in which they can be expected to be even more so in the future.

The key benefits which accrue with the use of smartphones over desktops, laptops or books are:

**Portability:** With modern smartphones being smaller than many wallets and weighing less than 500 grams they are exceedingly portable, often seeming to be surgically grafted to trainees’ hands.

**Accessibility:** Trainees are far more likely to have their smartphone to hand when seniors are unavailable than they are to have large reference works or desktops/laptops.

**Ease of Use:** Smartphones are designed to be accessible and easy to use and have passed the test of the marketplace in ensuring reliability and ease of use. As such even when delivering complicated medical information they are much more accessible than equivalent purpose-built information systems.

**Familiarity:** Patients are familiar with smartphones and so are, in my experience, unperturbed to see them consulted or used as extraporeal translation devices.

**Currency:** With the ease of updating smartphone applications automatically it is much easier and feasible for applications to be continuously up to date, providing trainees with the most current evidence-based advice.

As a psychiatry trainee I often found myself wishing for a small pocket-sized reference which would unobtrusively fit into my pocket and could be consulted whenever a psychiatric case proved puzzling, a patient complained of a complex medical condition or was on an unfamiliar medication. Sadly, I found the handbooks available to be too bulky, obvious and often several years out of date. Nowadays however, trainees can download continually updated references to their smartphone which can be consulted at any time. I think that this represents a clear improv-
ment in portability and accessibility and makes it far more likely that the trainee can access the information of most immediate importance for them at three in the morning... when the most troubling quandaries inevitably arise.

Screening tools are well-validated theoretically and useful practically but it is also impractical to carry around the myriad of screening tools which may be used in pocket-bursting bundles. Smartphones offer the ability to store an endless number of screening tools in a portable, accessible manner, complete them using the smartphone to store the patient’s answers and then email them for later printing out and incorporation into the patient’s paper chart.

In recent years we have all had to see increasing numbers of non-English speaking patients with a resultant increased requirement for translation services. Unfortunately, in my experience, arranging in-person or telephonic translation can require inordinate amounts of time and can create a barrier to the creation of rapport. On an ad hoc basis other trainees and I have been using translation software on smartphones to interact with patients and have found it to be an immediately available, accurate, rapid means of translation which is acceptable to patients and does not appear to impact negatively on the creation of rapport. In recent months I, personally, have used my smartphone to conduct two-way interviews in Polish, Lithuanian, Russian, German and Chinese when, previously I would have had to ask the patient to wait for several hours while suitable translation services were arranged.

The ubiquity of smartphones also impacts patients’ own experiences of their mental health difficulties and their interactions with psychiatrists. There are three strands of application aimed at patients. The first aims to inform and assess while the second aims to treat and the third provides information regarding accessing psychiatric/psychological services. Examples of the first strand are the range of self-assessment tools available for iPhones, exemplified by mood diaries and screening applications, applications aimed at increasing patient understanding of mental health issues and programmes such as PsychHelp which uses one’s GPS location to provide a list of local counselling, psychology and psychiatric service providers which the user can, with a single tap of the screen, call.

The second strand comprises a large number of applications aimed at applying CBT principles to the treatment of various mental health issues (e.g. anxiety, panic disorder, depression, obsessive compulsive disorder, post-traumatic stress disorder and phobias) under the guise of eCBT (electronic Cognitive Behavioural Therapy), a form of computerized

- **Smartphones are becoming increasingly more capable.**
- **Useful to professional as reference library, translator and a repository of screening tools.**
- **Patients may use them for self-screening, education, computerised treatment or for finding services.**
- **Need to be aware of this growing potential and study it to provide an evidence base for its use.**

CBT which is beginning to gain an evidence base. Examples of this second strand would be the CBT-based treatment for panic attacks with “Let Panic Go” and the CBT-based applications available for the treatment for post-traumatic stress disorder, depression and stress e.g. eCBT Mood, eCBT Trauma, eCBT Calm.

In the future we can expect to see integration of the myriad applications into fewer, wider-ranging applications so instead of separate applications for screening tools for each mental health issue, other applications providing reference information and other applications again providing psychopharmacological information we can expect to see all of the above integrated into a single application. Such consolidation will, however, take at least several years as specialized mental health applications are currently only beginning to emerge.

Translation is one of the areas which will most benefit from more capable smartphones. Current translation software is limited by literacy as both sides of any exchange must be typed in. This is both time-consuming and a stumbling block if one’s patient is illiterate. Already the first iPhone software which can translate the spoken word is becoming available and in future this will greatly aid time-urgent interactions with those who do not speak English and also improve rapport between psychiatrists and these patients.

Lastly, I think the prospect of increasingly patient-accessible tools such as mood diaries and anxiety-management applications has the possibility of improving patient buy-in and adherence to treatment and that we, as mental health professionals, should be actively leading the way in developing these tools to ensure that patients have clinically rigorous, evidence-based tools available.

At present the use of smartphones as clinical tools is in its infancy but potential is clearly present. As with all potentials though there may be both positive and negative impacts. Improving our ability to communicate with patients, check doses, access abrestrue medical facts and long screening questionnaires are all, evidently, positive possibilities. The greatest negative potential lies in the possibility of unsupervised screening tools giving patients false positives and of eCBT and other eTreatments leading to unsupervised treatment of non-existent issues. So, to borrow the words of a Napoleonic general, let us “move forward, but with caution.”

References

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Dr Fionn Kelly MRCPsych graduated from The Royal College of Surgeons, Ireland in 2002. Since graduation Dr Kelly has helped to implement medical and mental health informatics solutions during his assignment to various hospitals. Dr Kelly is currently working as a Clinical Tutor with The Royal College of Surgeons, Ireland.
A quantum leap forward in mental health data...

Netta Hollings

The NHS Information Centre’s latest release of annual statistics from MHMDS annual returns in November 2009 was received with enthusiasm.

Dr Veena S Raleigh of The Kings Fund commented ‘The MHMDS is a quantum step forward in terms of mental health data...’ and a recent report from CQC on monitoring ethnicity amongst mental health inpatients highlights that ‘The Information Centre’s recent report on access to community and inpatient services by various demographic characteristics, including ethnicity, illustrates the wealth of information that is available to providers and commissioners of services.’

The NHS Information Centre is now providing information from the MHMDS in a variety of formats and covering an increasing range of topics.

The annual release now consists of:

- Mental Health Bulletin: Third Report from MHMDS annual returns, 2004-2009 available from [ic.nhs.uk/pubs/mhbhmhmds0809](http://ic.nhs.uk/pubs/mhbhmhmds0809). This bulletin includes national statistics about working age and older adults accessing NHS secondary mental health services, including inpatient, outpatient and community services.

- MHMDS Online - [mhmdsonline.ic.nhs.uk](http://mhmdsonline.ic.nhs.uk)

This web site presents most of the same analyses broken down by provider / commissioner trust and with some SHA / peer group comparisons using a graphical interface.

- MHMDS Data Tables - [ic.nhs.uk/pubs/mhbhmhmds/dd](http://ic.nhs.uk/pubs/mhbhmhmds/dd)

Trust and SHA level results to download as Excel spreadsheets.

The November publication included five years information (up to March 2009) about the number of people in contact with NHS secondary mental health services and the number who are detained in hospital or on CPA, as well as volumetrics about inpatient, outpatient and community service activity. It also introduced some new analyses for 2008/09 comparisons.

- Rates of access to mental health services by different combinations of characteristics (age, gender, ethnic group) and different geographies - SHA, PCT, plus PCT peer group comparisions.
- Experimental statistics about Supervised Community Treatments
- Information about people on CPA aged 18-69 - the denominator group for National Indicators 149 and 150 covering accommodation and employment (see chart above).

Now that a regular flow of MHMDS has been established the NHS IC is also publishing routine quarterly MHMDS reports, which include data quality reports and the provisional Service Performance Indicators, that are being developed as part of the DH’s Performance Framework for mental health trusts. These can be downloaded here: [ic.nhs.uk/services/mhmds/quarterly](http://ic.nhs.uk/services/mhmds/quarterly).

The NHS IC has been working with provider trusts to make it easier for them to interrogate their MHMDS submissions earlier in the data flow. The IC is also supplying PCTs with record level MHMDS data on request. This is making much more timely information available to the service.

Used together with the Adult Psychiatric Morbidity in England, 2007 survey ([ic.nhs.uk/pubs/psychiatricmorbidity07](http://ic.nhs.uk/pubs/psychiatricmorbidity07)), which was published last year, the MHMDS is the key source of information for defining the characteristics of people who use specialist mental health services and understanding local needs. MHMDS will also be the data source for currencies for payment by results for mental health and the Advance Notification for these changes was published at the end of last year ([connectingforhealth.nhs.uk/dscn/dscn2009/advance/an0609.pdf](http://connectingforhealth.nhs.uk/dscn/dscn2009/advance/an0609.pdf)).

Information from MHMDS has just been published for the first time in Neighbourhood Statistics so that the number of adults accessing specialist mental health services at local authority level can be seen within the context of other socio-economic data ([neighbourhood.statistics.gov.uk](http://neighbourhood.statistics.gov.uk)).

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Website: [www.rcpsych.ac.uk/mhisig](http://www.rcpsych.ac.uk/mhisig)
Why should a mental health professional care about business intelligence?

Tobias Mettler

The burden of mental illness on health and productivity throughout the world has long been underestimated. However, since the collection of a vast amount of health data is no longer restricted to universities and other institutions with highly sophisticated and costly information technology (IT) infrastructure, almost every mental health professional is nowadays able to organise specific databases [1] that help to reveal the real impact of mental illnesses on society and record particular medication processes.

But what about data analysis? What is needed when several databases (e.g. using different connotations for the same concept) from different sources (e.g. external from the own institution) should be studied?

In order to improve the timeliness and quality of inputs to the decision process [2], distinct analytical IT-tools - commonly referred to as business intelligence tools - such as online analytical processing (OLAP), data mining, or reporting engines [3] are used today in organisations (may it be private or public ones) for aggregating and visualising multi-faceted, complex and competitive information. The term business intelligence (system) appeared for the first time in the seminal work of Luhn.

He defined business as ‘a collection of activities carried on for whatever purpose, be it science, technology, commerce, industry, law, government, defence, et cetera’ (and healthcare!). In a broad sense the intelligence system is ‘the communication facility serving the conduct of a business’ [4]. Many studies showed that business intelligence helped to reduce time as well as costs for information gathering. However, key benefit of business intelligence is the ability to make more informed decisions. It enables collective data to be analysed for trends as well as for every subset of data to be drilled down and analysed individually.

So why not using business technology (at no or low cost [5]) for analysing and visualising health data? Why should a mental health professional care about business intelligence? Here is just some food for thought:

- The world is becoming a “global village”: the study of specific diseases is no longer confined to regional or national phenomena; the analysis of wide spread data needs specific tools that extract the data from external sources, transform it to fit the desired needs, and load it into the own database.

- Medical practice is getting more and more complex: sensors automatically record quantitative health data, internet-based surveys and online-forms facilitate the collection of quantitative health data; the manual analysis of such a large amount of data is hardly possible anymore.

- Research is getting more and more competitive: publishing high quality papers is getting a major concern for many academics; a good presentation and visualisation of complex data is often mission critical for publishing in high-ranked scientific journals.

So why bother about business intelligence tools?

References


What is business intelligence?

Business intelligence is a broad concept encompassing the processes, software and technologies for gathering, storing, analysing, and providing access to data to help users make better decisions. In essence, it is “the art of sieving through large amounts of data, extracting information and turning that information into actionable knowledge.” A given business intelligence system exploits numerous tools in order to meet specific goals, with progress measured using key performance indicators against best practice benchmarks.

As a store of static summary data from multiple internal and external sources, a data warehouse is a database repository providing ready access to population and health systems data that has been integrated from across the organisation (analogous to a library). A data mart similarly consolidates data, but only for a specified program area or reporting purpose (analogous to a section in a library). These repositories are fed by operational systems, such as an electronic patient record system (providing up-to-date data on individual clients) or a clinical data repository of real-time operational data about groups of patients often within a particular healthcare programme.

www.connectingforhealth.nhs.uk/newsroom/worldview/proti10


AUTHOR

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MHISIG is a special interest group of the Royal College of Psychiatrists, UK and works alongside the Informatics Committee to promote the use of information technologies to improve mental health care & training.

Join Mental Health Informatics Special Interest Group Online at:

www.rcpsych.ac.uk/mhisig

Call for submissions @ Connect - Newsletter of MHISIG 2011 Spring Issue
We encourage exchange of ideas and innovation through our newsletter

Articles for connect may cover any aspect of mental health informatics, information governance, technology, media, communications and user experience and may be targeted at any level of informatics experience or computer user from absolute beginner to the most advanced. The only absolute requirement is that the topic of the article should “connect” both mental health and informatics.

Submission Guidance
Article length is ideally 400 to 1200 words. Longer articles can be considered after discussion. Authors should include a list of bullet points for inclusion in a ‘summary box’. Contributors are also encouraged to provide website addresses (either included within the article or as a separate list) so that readers can find further information on the topic. Reviews should be of same length and include a picture of the reviewed book, item, website, blog or article. Letters may be up to 250 words.

We are also able to publish brief notices relating to events appropriate to our readership.

Please submit your articles to connect@mhisig.org.uk

Submission deadline: 15 January 2011

More information: www.rcpsych.ac.uk/mhisig

I had met Sudhir at two of the college AGM’s and remember him fondly as being very warm, intelligent and accomplished having already become a medical director at a very young age. At the second college AGM, Sudhir held a special screening of the film ‘Some Voices’ starring Daniel Craig and invited screenwriter Joe Penhall to take questions from the audience. This was very well received. Afterwards we went for drinks and it was all too easy to listen to Sudhir talking passionately and knowledgeably about film. I was shocked to learn earlier this year that Sudhir had passed away and I like many others will miss him. My thoughts are with his family.

JM

My memories of Sudhir, like Justin’s, centre around the college AGM where we CIPSIG-ers would have our rare meetings in “real life”. Despite being a very active member of the group Sudhir was as far from the stereotype of the computer geek as it was possible to be. He was warm, witty, irreverent and thoroughly fun to be around. We also collaborated on a writing project and despite a relaxed attitude to deadlines he always produced the goods. His unexpected passing leaves a gap in our little group and we will miss him.

FL

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