



Message from Helen Matthews, Chair



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Spring 2011 has been a time of elections including within the College. Sue Bailey (President) and Nick Craddock (Treasurer) were elected with a forthcoming election for Dean following Robert Howards resignation. The next year will involve elections to the Executive Committee in Wales. I am hoping to arrange these in early 2012 to allow an effective induction and transition.

I am delighted to welcome Manel Tippet to the College in Wales, providing support on policy matters. Her appointment enhances our ability to influence and respond to the agenda set by our new Government.

Recent events have involved the Executive Committee working collaboratively with a range of organisations. A major current focus is to improve the training experience which should result in enhanced recruitment and retention. Improvements will require coordination between clinicians in the Health Boards, academics and the Deanery—the RCPsych in Wales is attempting to facilitate this process.

There has been major activity in the area of Mental Health Legislation. The College was involved in the review and subsequent issue of new guidance on the Approval process for Approved Clinicians.

A revised version of the College (CR149) S136 Policy was then developed. This is the first College document to recognise the Welsh Code of Practice. Development of the Policy involved liaison with police forces across Wales, Inspection bodies

and Government Officials. A Welsh launch is being scheduled for later in the year.

The appointment of Manel Tippet, Policy Administrator was associated in the current round of consultation of the Mental Health (Wales) Measure. I was particularly pleased that part of our response was produced jointly with the Association of Directors for Social Services Cymru.

Health Inspectorate Wales (HIW) - areas identified include contributing to training events for staff and reviewers, enhancing the improvements gained following serious incident reviews and implementation of Statutory Mental Health Law.

An immediate tangible process is the ability for clinicians to raise concerns with HIW through a variety of channels—phone, letter, email to HIW : hiw@wales.gsi.gov.uk an email to Peter Higson: peter.higson@wales.gsi.gov.uk or to Mandy Collins: mandy.collins@wales.gsi.gov.uk

A full article on HIW will be included in the next RCPsych in Wales Newsletter.

This newsletter would not have been possible without the many contributions. Particular thanks to Akshey Nair, Siobhan Conway and Ranjini Rao who has recently joined the established team

With best wishes for a good Summer
Dymuniadau Gorau

Best wishes

Helen

Message from Dr Akshey Nair, Newsletter Editor & Trainee Policy Lead, RCPsych in Wales



Dear RCPsych in Wales member,

It was with great pleasure that I took up post as Trainee Policy Lead in September 2010. During this time I have had considerable input into various projects including Mental Health Legislation in Wales and services for people with developmental disorders. I have been working closely with the Chair, RCPsych in Wales, College Officers in Wales and the staff at Baltic House to ensure that views of the membership in Wales are heard within the machinery of the National Assembly.

At the same time, I took on the role of Newsletter Editor to ensure that all information contained in these pages are informative and relevant to practice in Wales. We are very much looking forward to developing an e-newsletter, which will be totally electronic and in the same format as the College's central newsletter. Both Siobhan and I are attending training for this during September 2011. In line with College policy and the growing need to protect our resources, we are hoping to achieve a completely paper free publication by the December issue 2011.

If you have any Policy related issues (trainees and non-trainees) please do not hesitate to contact me through the RCPsych in Wales office.

Best wishes

Dr Akshey Nair

ST5 Psychiatry



Adopt a Book

The Royal College of Psychiatrists' **Adopt a Book** scheme was launched in 2007. The scheme is aimed at raising funds for the conservation and repair of our unique antiquarian book collection.

The appeal for donations is directed at Members and Fellows of the College, and anyone who is interested in restoring and conserving the collection to a condition suitable for its use by researchers and historians and in its preservation as part of our National heritage.

The collection consists of about 1800 rare books with some dating as far back as the 15th Century.

For more information, please visit the college website at:

<http://www.rcpsych.ac.uk/rollofhonour/thecollegearchives/adoptabook.aspx>



Ringling endorsements for mental health outcome measure

The Manchester Short Assessment of Quality of Life (MANSA) published more than ten years ago by Stefan Priebe (Queen Mary College, London University) and Peter Huxley and Sherrill Evans of Swansea University's School of Human and Health Sciences, recently has been given a strong endorsement for use as an outcome measure in mental health services.

In the National Institute of Health Research Mental Health Research Network paper (2010) (Outcome Measurement in Mental Health: the views of service users) MANSA was rated by experienced service users as a good outcome measure to use in adult mental health services. It was rated as highly as other well-known measures, such as the Beck Depression Inventory, and the Positive and Negative Affect Scale. It was rated more highly than other well-known measures such as the Health of the Nation Outcomes Scale (HoNOS), the Global Assessment of Functioning Scale (GAF / GAS), the Hamilton Rating Scale, the General Health Questionnaire (GHQ), the 12 item short form health survey, the outcomes star and the Euroqol. The reason for its higher ratings is probably because it is not symptom oriented and covers those aspects of life that service users deem of most importance to them, such as leisure activity, health, family life, and work.

This endorsement follows on from support for its use from the Royal College of Psychiatrists (2010) who writing about quality of life measures, said that: *"the MANSA is the most widely used measure and is well validated. As it is rated by Service Users and requires an interviewer to complete, service users with complex needs may not participate... However, it has been used in rehabilitation samples and those who use it have found it quick and easy to administer. Other measures (e.g. EuroQoL) don't seem as popular.*

Furthermore, Murphy and Cutts (2009) found that its use in clinical practice improved working relationships and care planning. They said that

"following the use of the MANSA....care was more service user centred and ...there were elements that were changed in the care plan, (suggesting that).. working in partnership was happening (p945)

"The authors believe that further routine and consistent use of the MANSA will continue to improve practice and care planning over time..(and) further work on a larger scale is needed".

Readers interested in learning more should contact Professor Huxley or Dr Evans in the School of Human and Health Sciences, Swansea University. Contact details here.

References

Murphy N, Cutts H. (2009) Can the introduction of a quality of life tool affect individual professional practice and the quality of care planning in a community mental health team? *Journal of Psychiatric and Mental Health Nursing*, 2009, **16**, 941–946.

NIHR Mental Health Research Network (2010) Who decides the definition of a 'good outcome'. MHRN: London.

Priebe, S., Huxley, P.J., Knight, S. and Evans, S. (1999) Application and results of the Manchester Short Assessment of Quality of Life (MANSA). *International Journal of Social Psychiatry* 45 (1): 7-12.

Royal College of Psychiatrists (RCP) (2010) Recommended Outcome Measures for Use in Adult Psychiatry: Draft for Consultation. RCP: London.

Psychiatrist of the Month—Dr Danny Antebi



Danny Antebi was brought up in Glasgow, went to school there and then medical school. He did his SHO rotation in Bristol and senior registrar in Nottingham. He developed special interests in liaison psychiatry particularly working on burns and plastics units and doing some psychoanalytic training at the Tavistock clinic. He was appointed to his first consultant post in Plymouth in 1992 and has also worked in consultant posts in London and Bristol where he had special responsibility for developing services for ethnic minorities. He has had several spells as a medical manager since then and is currently Divisional Director for Mental Health and Learning Disability services in Aneurin Bevan Health Board.

He lives with Marianne who is an artist and has two children both of whom live in London.

1. *Tell us something about yourself that other people do not know.*

Very few people know that I was an extra in a bollywood movie released in 1985 called 'Mard' which starred Amitabh Bachchan. I also stood for Council elections as a Labour candidate in Kenneth Clarke's constituency when he was a Cabinet member in the late '80s, although the results didn't go quite as well as planned! A slightly more dangerous revelation is that during medical school I shared a flat with Dr Stephen Hunter. Recollections of that are somewhat hazy.

2. *What trait do you deplore in others?*

Inauthenticity and prevarication stand out for me. I like people to be real and truthful. It is hard to have a fruitful dialogue otherwise.

3. *Tell us about either a film or a book that left an impression on you.*

'The Tao of Physics' by Fritz Capra was quite an influential book. It is a book about some of the understanding of modern quantum theory and how they relate to the reflections of ancient Chinese philosophers about the nature of reality. The book prompted me to start my journey into thinking about systems and complexity.

4. *'When not being a psychiatrist, what do you enjoy?'*

Cooking has always been a passion. I have recently started making my own merguez sausages and I certainly believe they are probably the best in the world. Apart from that fish dishes are my speciality

5. *Which people have influenced you most?*

The American author Kurt Vonnegut Jr. whose works include *Slaughterhouse five* and *Breakfast of Champions* has been a big influence. What I like about him is that he takes the frailty and the poignancy of being a human being and makes it digestible through gentle (ironic) humour. The ability to stand back and be at times in awe and at others aware of the ridiculousness of humanity is important to staying sane.

From a psychiatric perspective, the person who influenced me a lot was Dr Peter Eames, a neuropsychiatrist with whom I trained. One of the main influences he had on me was encouraging a sense of discipline about how I approach my work and the importance of being able to justify and properly argue the logic and rationale of my interventions.

6. *If you were not a psychiatrist what other profession would you choose?*

I did an LLM several years ago and loved it. It helped me understand the importance of due process in medicine as much as in the law. I guess I would probably have been a slightly pompous, somewhat irritating and rather theatrical barrister.

7. *How would you best like to be remembered?*

To my children I would like to be remembered as someone who gave them the resources to deal with whatever this world throws at them. To my colleagues as a person who is competent but doesn't take himself too seriously and to my friends as someone who is warm and who usually has something interesting to say. I would like my patients to remember me as someone respectful and who really listened.

Dr Danny Antebi

June 2011

RCPsych in Wales

New Policy Administrator

We are delighted that the College has recruited a new Policy Administrator at the offices in Cardiff. Manel Tippett took up post on 7 March 2011 and works two days per week on a part time basis (Tuesday and Wednesday).

Manel will be working closely with Officers of the RCPsych in Wales, the Executive Committee, Chair's of Faculties in Wales and the wider membership on policy related issues. She will be collating information on Consultations as they are published, and will liaise closely with members working in specific specialty related posts.

Manel will also provide a pivotal role in ensuring that policy issues in Wales are relayed back to the College in London and vice-versa.

Manel has already had a significant impact in her role. She has put together the joint response of the College in Wales and the Associated of Directors for Social Services Cymru on the Mental Health (Wales) Measure: three sets of Regulations, which was submitted on 16 May.

If you have any policy related questions, or would like to become more actively involved in RCPsych in Wales policy work, please contact Manel Tippett at: mtippett@welshdiv.rcpsych.ac.uk or telephone 02920 489006.

Faculty meeting dates 2011

(If your Faculty meeting date does not appear on this list, please contact your Faculty Representative as detailed on page 27 of this newsletter)

- Faculty of Child and Adolescent Psychiatry — Friday 7 October 2011, The Lake House Hotel, Llangammarch Wells
- Faculty of Forensic Psychiatry — Friday 14 October (venue TBC) - one day event
- Faculty of Old Age Psychiatry (Cardiff Psychogeriatric Symposium) - Wednesday 5 October (venue TBC) - Please contact Dr Toyin Adeyemo for further details

New MB BCh Course at Cardiff University—C21: Developing Tomorrow's Doctors

Message from Dr Danny Smith, Senior Clinical Lecturer in Psychiatry, Cardiff University School of Medicine:

Many of you will be aware that in 2013 Cardiff University will be introducing a new medical undergraduate degree course. This development project is called "C21: Developing Tomorrows Doctors" - more details are available on the C21 website at <http://medicine.cf.ac.uk/c21/>

We have established a Learning Outcomes Group in psychological medicine with the goal of developing a core curriculum within the revised MB ChB programme. Our first task has been to create a draft set of core learning outcomes. We would welcome your comments and suggestions on this initial set of objectives. Obviously we are very keen to ensure that psychiatry is fully represented within the new course so any comments or feedback on this document will be gratefully received.

Please could you send your comments to Sarah Gape at gapesa@cardiff.ac.uk



Core Learning Outcomes for Psychological Medicine in the New Cardiff MBCh course (C21)

The proposed learning outcomes are arranged in three areas:

- The doctor as a scholar and a scientist (knowledge)
- The doctor as a practitioner (competence)
- The doctor as a professional (attitude)

The Doctor as a Scholar and Scientist

On completion of the module in Psychological Medicine the successful student will be able to:

- Describe the prevalence, clinical presentation, course and prognosis of common psychiatric conditions
- Describe the diagnostic criteria for common psychiatric disorders according to ICD—10
- Explain the biological, psychological and socio-cultural factors which may predispose to, precipitate or maintain to psychiatric illness
- Describe the current, common psychological and physical treatments for psychiatric conditions, including the indications for their use, their method of action and any unwanted effects
- Recognise the risk factors for harm to self and others
- State the doctors duties and the patients rights under the appropriate Mental Health Legislation and Mental Capacity Legislation
- Describe the range of services and professionals involved in the care of people with mental illness
- Describe the role of self help, service user and carer groups in providing support to people with mental illness
- Find, critically appraise and apply information and evidence gained from in depth reading relating to a specific clinical case

The Doctor as a Practitioner

On completion of the module in Psychological Medicine the successful student will be able to:

- Take a full psychiatric history, carry out a mental state examination including a cognitive assessment and produce a formulation of a case, including a management plan
- Prescribe psychotropic medication safely, effectively and economically
- Provide immediate care in psychiatric emergencies, which may occur in psychiatric, general medical or other settings
- Conduct an assessment of risk to self and to others and act appropriately based on this assessment
- Screen empathically for common mental health problems in non-psychiatric settings and recognise where medically unexplained physical symptoms may have psychological origins
- Communicate effectively with patients, their family members and multi-disciplinary colleagues about the nature, diagnosis, management and prognosis of common psychiatric disorders
- Recognise the differences between mental health problems and the range of normal responses to stress and life events (including bereavement)
- Plan which physical and psychological investigations should be carried out when patients present with psychiatric symptoms and when starting psychotropic medication
- Assess a patient's capacity to make a particular decision in accordance with legal requirements and the GMC's guidance

The Doctor as a Professional

On completion of the module in Psychological Medicine the successful student will be able to:

- Recognise the importance of the development of a therapeutic relationship with patients, including the need for their active involvement in decisions about their care
- Act in a safe way towards patients
- Understand the potential to do psychological harm to patients, including by providing untrained/unsupervised psychotherapeutic interventions and fostering inappropriate doctor-patient attachments
- Recognise the limits of their own competence and know when to ask for help from a more senior/specialist colleague
- Accept that illness of the brain/mind are of equal importance as illnesses of other parts of the body
- View psychiatric patients as being deserving of the same high standard of medical care as patients with purely physical illness
- Demonstrate understanding of how patients' opportunities may be affected by the stigmatisation of psychiatric illness and show sensitivity to the concerns of patients and their families about such stigmatisation
- Recognise the importance of multidisciplinary teamwork in the field of mental illness
- Reflect on how working in health settings may impact upon their own health and that of colleagues and understand the importance of seeking professional help if they themselves develop mental health problems.

Trainee Section

Welcome to the new Trainee section of the RCPsych in Wales newsletter. This item will be a regular feature in future editions, and its purpose is to provide all trainees across Wales with current information and a means of communication.

Your Psychiatric Trainee Committee Representatives in RCPsych in Wales are:

- Dr Scott Hall (member)
- Dr Paul Emmerson (member)

Your Higher Trainee Representatives on RCPsych in Wales Executive Committee are:

- Dr Ranjini Rao (ST5)
- Dr Akshey Nair (ST5)

We now have a trainee page on the Welsh pages of the College website. For updates on training, CASC, AC and Section 12(2), please visit:

<http://www.rcpsych.ac.uk/members/divisions/rcpsychinwales/trainee.aspx>

If you are a trainee and would like to submit an article, please contact Dr Ranjini Rao:

drranjinirao@hotmail.com

Your feedback on these pages is welcomed!

Trainee Events 2011

Higher Trainee Study Days:

- Thursday 28 July—Llandough Hospital, Cardiff
- Tuesday 20 September—Llandough Hospital, Cardiff
- Wednesday 23 November—Llandough Hospital, Cardiff

Mock CASC Information

Hyfforddiant CASC Training (HCT) regrets to inform you that due to unforeseen circumstances the next mock CASC exams have been moved to November 2011 (provisionally). Apologies for any inconvenience caused. Full information can be found on website www.hyfforddiantcasctraining.org or email drranjinirao@hotmail.com



Wales Student Psychiatric Society Event
MEDFEST: The National Medical Film Festival
Josie Phizacklea
4th Year Medical Student, Cardiff University

Medicine has long been glamorised by the film world, and to those of us medical students who regularly find themselves discussing the intricate details of another patient's bowel habits, this can seem far removed from the reality of the situation. Yet within this reality lies the many paradoxical extremes medicine has to offer. Routine lies along side the infinitely unpredictable, facts and discipline along side the tentatively uncertain. With each new patient's 'intricate details' we are reminded of the position of trust we assume. With this relationship in mind, film provides us a useful insight into society's perception of the medical field, and a snap shot through the years of how things have changed. It was through this link with medicine and film that the Wales Student Psychiatric Society (WSPS) hosted our most recent event 'Medfest: The National Medical Film Festival'.

Medfest, supported by the Royal College of Psychiatrists, involved a series of events at medical schools across the UK. Each event comprised of an evening of short film screenings relating to the festival theme; 'The Image of Doctors'. Cardiff's leg of the festival aimed to provide a forum in which students could consider the implications of the perception of doctors in film. We also hoped to provide an opportunity for students to find out more about a career in psychiatry, and particularly hoped to in some small way, begin to play a part in addressing the current recruitment crisis that the field of psychiatry faces.

After enjoying a Moroccan mezze buffet, almost 50 students settled down to a fascinating exploration of the image of doctors in cinema through the decades. We were fortunate enough to be joined by a captivating bunch of panellists, who deftly lead the discussions examining the relationship between medicine and cinema. Panellists were chaired by Cardiff's clinical lecturer in psychiatry Paul Emmerson, and included Mike Shooter, former President of the Royal College of Psychiatrists, Brian Glasser, author of 'Medicinema: Doctors in Films', Keir Waddington, a specialist in the social history of medicine and comedian Dan Mitchell.

The screening opened with a presentation from Brian Glasser 'The contemporary image of doctors', which thoughtfully guided the audience through the image of doctors in contemporary film, and highlighted the prominent footing medicine holds on the big screen.

This was followed by a viewing of the 1962 'The Family Doctor', a historical NHS film on the role of GPs, which left one member of the audience "feeling all warm and fuzzy inside" whilst others found the paternalistic, authoritarian role played by the rural GP 'patronising and condescending'.

Cntd.....

In stark contrast, the next screening of BAFTA winning short film 'Shadow Scan (2000)', took us on the rapid-cycling, 12 minute journey of two junior doctors. Through the vicissitudes of struggling to cope, substance abuse, the value of a supportive friendship, mental illness and performing under pressure, the audience was left silenced.

Once again, the atmosphere took a u-turn with the bright and breezy 'Beards and Bow-ties (2011)' an animated short film on the image of Psychiatrists. This animation attempted to tackle the stigma faced by not only those patients with experience of mental illness, but often those intolerances from within the medical profession towards doctors who choose to pursue a career in psychiatry. All things considered, an enlightening evening and many of us left the event with a refreshed enthusiasm for pursuing our interest in the speciality.

Huge thanks to all those involved and with another event under its belt, WSPS has been steadily picking up momentum this year. The committee are looking to start planning another academic years worth of events, so if anyone is interested in getting involved or has any questions about the society please email wsps@live.co.uk

Josie Phizacklea

4th Year Medical Student, Cardiff University

Wales Student Psychiatric Society

The Wales Student Psychiatric Society has a facebook account of the same name and an email address WSPS@live.co.uk

The Society are always looking for support and anyone interested can contact Ben Shooter at: docshooter@hotmail.co.uk

Exam Costs Q&A

Questions on the costs of the exams are some of those most frequently asked to PTC reps. Some of these questions were put to Fauzan Palekar, newly appointed Director of Professional Standards and Professor Anthony Bateman, Chief Examiner....

Q: Does the College make a profit from exams?

A: The College does not seek to make profits from exams; any College surpluses are reinvested in the College Educational activities which benefit members and trainees.

Q: Why is the CASC so expensive?

A: The CASC is actually inexpensive in comparison to the RCGP clinical. It is a major undertaking which requires a wealth of resources and investment.

Q: What does the money from the exam fees get spent on?

A: The exam fees cover the cost of producing and delivering all aspects of the examination processes.

Q: How are the exam venues chosen?

A: Venues are chosen based on location, availability and best possible value for money.

Q: Can you give a breakdown in general terms of the costs involved?

A: Costs involve all resources required for the examinations operations including, staff, examiners, role players, venue hire, catering, question writing panels, standard setting, external lay involvement, piloting.

Q: Why has the cost of exams increased recently?

A: The costs related to exams have risen in line with inflationary pressures

(source: PCT Newsletter, RCPsych, May 2011)

Welsh Psychiatric Society

Trainee Prize winner 2011

Dr Sylvia Baker, CT2 Psychiatry

Audit of the Multiagency Assessment Protocol for Autistic Spectrum Disorders. Dr Reddy PS Consultant, Dr Sylvia Baker CT2 and Dr Ruth Cole Specialty Doctor

Introduction:

Autistic Spectrum Disorder (ASD) represents 'Pervasive Developmental Disorders'(1). These are described as 'A group of disorders characterized by qualitative abnormalities in reciprocal social interactions and in patterns of communication, and by a restricted, stereotyped, repetitive repertoire of interests and activities. These qualitative abnormalities are a pervasive feature of the individual's functioning in all situations'. The Medical Research Council review(2) of Autism research suggests that ASD currently affects 60 per 10,000 children under 8 years. The Office for National Statistics(3) indicates 0.9% of children aged between 5-16 years across Great Britain have ASD.

A diagnosis of ASD has lifelong implications for social, educational and employment outcome. Therefore, correct and timely diagnosis is important. The Welsh Assembly Government's strategic action plan for autism in 2008 highlighted: 'Early assessment and intervention is central to maximising opportunities for recognising children's difficulties and needs and for improving their emotional, social, and cognitive development and their health'(4).

The forthcoming NICE guidelines(5) aims to set a model care pathway to diagnosing children with Autistic Spectrum disorder. There are local developments with regard to referral and care pathways to maintain standards of multidisciplinary care and assessment In the interim as outlined in the National Autistic Plan for Children(6). The Welsh Assembly Government's Strategic Action Plan (2008)(4) recommends standardised pathways and the need for multidisciplinary assessments by CAMHS, Paediatrics, Speech and Language Therapy, Educational Psychology and School Reports.

The Aims of this audit is to evaluate 1. The Multidisciplinary Diagnostic Assessment in a large city in Wales against recommendations by National Autism Plan for Children (NAPC), 2. The waiting time standards from first assessment to completion of multiagency assessment (MAA). The main aim is that diagnosis needs to be concluded in a multidisciplinary meeting represented by all the professionals.

The NAPC standards(6) recommend assessment through two stages. The first stage recommends children identified with concerns regarding possible ASD to be referred for general development assessment (GDA) within 6 weeks and developmental assessment to be completed within 7 weeks. The second stage which should be completed within 17 weeks in total, recommends that multi-agency referral be made within 6weeks (if appropriate) and Multi-Agency Assessment (MAA) and diagnostic interview within 7 weeks (plus feedback to family within 4 weeks).

Methodology

A random sample of 35 children referred to Cardiff CAMHS over the last year with suspected ASD was used. A proforma was designed and used to retrospectively review the notes. The referral and assessment time frames were identified and collated onto Excel spreadsheet.

Results:

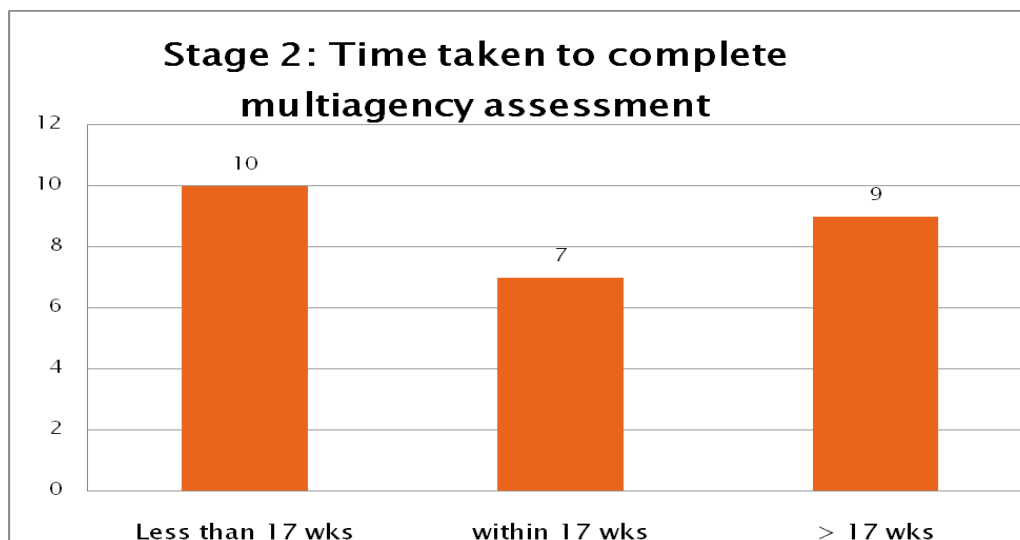
From the time of identification of concerns 20 out of 26(%) were referred to CAMHS within 12 weeks. 28 out of 29(%) had general development assessment completed within 13 weeks. After the initial assessment 21/27(%) were referred to multidisciplinary assessment. Multiagency assessment was completed within 17 weeks in 17 out of 26(%). While 7 out of 30(%) needed second opinion for diagnosis. However, due to the retrospective nature of the audit identifiable timescales were not available for the other young people audited (n=31). See table below to show time taken

Conclusions and recommendations to implement change:

There is a clear standard for a pathway diagnosing ASD that is nationally recognized and evidence based. This audit demonstrates a need to work with all agencies to address the differences in diagnosis time for individual children. We propose this is implemented through multidisciplinary meetings, information sharing, joint working and strong leadership. There are plans to sustain improvements by re-auditing in one year and also the development of a Social Communication pathway to address these issues by working with all agencies.

The Audit was presented as a poster at the Joint meeting of the Welsh Psychiatric Society and the Royal College of Psychiatrists in Wales. It was fantastic experience as a trainee because relevant and positive feedback about the audit was given by many interested psychiatrists. The feedback will be used in the next re-audit. It was also refreshing to see so many different ideas and research posters presented by peers.

Table to show time taken to refer onwards for multiagency assessment:



References:

1. ICD 10 *classification of mental and behavioural disorders*, WHO, 2004.
2. Medical Research Council: *Review of Autism research, epidemiology and causes*, MRC, 2001
3. *Mental Health of Children and Young People in Great Britain*. The Office for National Statistics, 2004.
4. Welsh Assembly Government's *strategic action plan for autism*, 2008.
5. NICE Guidelines (Draft): *Care Pathway to diagnosing Autistic Spectrum Disorder*.
6. *National Autistic Plan for Children*. The Royal College of Paediatrics and Child Health and the Royal College of Psychiatrists working party (2003), in collaboration with the National Initiative for Autism Screening and Assessment (NIASA 2003).

Our Mock CASC Experience

Dr. Scott Hall, Dr. Ranjini R Rao, Dr. Mohtasim Qamruddin, Dr. Rhys Jones, Dr. Omer Minhas and Dr. Indira Priyadarshini

Many of us who are "CASC veterans" were left initially with an acute stress reaction; others suffered a prolonged adjustment reaction whilst some of us are still having reliving experiences! In our experience after having processed most these, we began to reflect on what makes this particular exam so challenging. Is it the perception of being humiliated in front of our seniors? Being herded like cattle along with your peers through a grim stadium in the middle of nowhere? Or worse still, the prospect of forcibly visiting Sheffield! Whatever way we look at it.... it is an experience most of us would have liked to forget. Why then would we wish to repeat the experience over and over again in the form of a mock CASC? Oddly enough, that is exactly what we did and we are now approaching our 4th event.

HCT (Hyffordiant CASC Training) was formed by a group of higher and core trainees many of whom have first-hand experience of the MRCPsych CASC. We set out with two-fold aim. Firstly we aimed to provide a unique and valuable training experience for candidates training in Wales who are undergoing the exam and secondly to achieve greater understand into why people dread and in some cases end up repeatedly failing the exam. The overarching aim is to improve the pass rate for trainees in Wales. HCT attempts to do this by inspiring both trainees and trainers alike. We have been running regular mock CASC examinations for Welsh trainees since 2009. We have successfully managed to raise awareness of the exam within the consultant body and our pass marks closely reflect those achieved in the official exam. A significant proportion of our examiners are officially trained Royal College examiners.

We have been extremely lucky to be part of a cohesive and enthusiastic core team, have a higher trainee peer group who always help out on the day and an enthusiastic consultant body who regularly act as examiners and provide constructive feedback to all candidates. The organisational tasks involved often push us to the edge of sanity and the "behind the scenes" work requires months of advance planning. To name but a few tasks; we need to organise venues, obtain funding, arrange catering, write scenarios, recruit examiners, process applications.....the list goes on and on. If you have been involved in one of the events you may have observed us running around like headless chickens in a vain attempt to ensure that everything runs smoothly. It has to be said that it becomes slightly easier each time we put on the event. It is important to acknowledge that we rely on pharmaceuticals companies to provide funding for the events. Despite repeated attempts to obtain alternative sources of funding these have failed to materialise.

This year we are aiming even higher and responding to feedback from both candidates and examiners. We aim to put on a whole day event with the morning session devoted to intensive, CASC-focussed training. We are in the process of recruiting both SpR's and consultants who will undertake small group teaching supported by specially prepared video clips illustrating the skills that candidates often find so difficult to master. The afternoon will involve a traditional mock CASC exam with feedback loops including both single and linked stations so that candidates can get an idea of where they stand before embarking on the "real thing".

If anyone is interested in getting involved either in organising the event, as an examiner or even as a candidate please do not hesitate to get in touch. This event is truly unique in that it brings core and higher trainees, medical students, consultants and pharmaceuticals companies together to work towards a common educational goal. We look forward to the event going from strength to strength in the coming years.

Email: drranjinirao@hotmail.com ; <http://www.hyfforddiantcasctraining.org>



NHS
WALES
GIG
CYMRU

Taking forward our shared responsibility for making a difference – the Mental Health Programme Board

A Programme Board that makes a difference to people's lives, without having any authority to insist that change happens; this sounds like a contradiction. That is the intention and it can only be achieved through both a sense of shared responsibility and action that conveys everything that shared responsibility stands for.

Programme Boards are not 'delivery vehicles' to use the management jargon, so we have to find ways of influencing others to change the way that they do things and as ever, that is about building relationships so that people listen and act on what they hear.

So how is it different? I am one of two co-chairs. I am a social worker by trade and currently a Corporate Director in Newport City Council. My co-chair is Mary Burrows, Chief Executive of Betsi Cadwalader University Health Board. Together we are a symbol of shared responsibility between the NHS and local government and regularly remind each other of the need to include the world of the other in everything that we say and do.

We recently sent out a letter, a letter that we had to send to ourselves in our respective organisational roles, setting out priorities for the care of older people with dementia. There is no bigger or more important priority, when we see the number of older people with dementia in local general hospitals and understand the significance of the growing number of older people in the population. They are in hospital for treatment and /or surgery, which usually has little to do with their dementia, but their dementia has an enormous impact on the people who are delivering that treatment or surgery and subsequently on the quality of the service that they experience. It can frighten staff when they do not know how to react and that in turn can frighten the older person and leave their relatives concerned about their safety and the care that they are receiving. Competence comes from confidence and the lack of both is a dangerous cocktail. Hence the 'Dementia Care' priorities and our call for action that can improve services where there is a high impact on people's lives, that we believe can be put in place by 'reshaping the existing resource'. In other words, a lot of the change is achievable without additional resources and we honestly believe that changing behaviour has the greatest impact and it normally costs nothing, other than admitting that it is necessary to do things differently. It has to be worth a try and contributes greatly to one of our three top priorities, *improving hospital-based care*.

We have also embarked on *promoting a programme of joint procurement* amongst Health Boards, another of our top three and we hope that eventually leads to joint procurement between Health Boards and local authorities. The initial target is on packages of care for people who are eligible for Continuing Health Care funding, where the care is provided by independent sector providers. The aim is to improve the quality of what is being provided, guarantee safety for people and strive for value for money. The recent Panorama programme, about the private hospital outside Bristol, has sharpened our resolve to take this forward and quickly. The third of the top three priorities is *improving the management of 'high risk patients'*, with the aim of enhancing medium secure services and expanding community support across Wales.

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The Programme Board is made up of people who all have an interest in improving services. Mary and I could be described as usual suspects on this kind of board and there are others in a similar position: senior Welsh Government officials, clinical directors, a general practitioner, and colleagues from NLIH. However there are also service users, carers and people from voluntary organisations, who are regularly left without a voice and we are keen to redress that imbalance.

The aim has been to generate a conversation in board meetings to ensure that we all learn from each other and go away enriched by the experience. A rather grand aim maybe, but one to which we will aspire, as when it happens, people want to come back for more. Every other meeting is held as a workshop to encourage learning and the topics covered so far include tackling inequality, workforce development and the next workshop is on housing and its significance in contributing to recovery. Recovery features high on our agenda; we believe that it is both desirable and possible, but only with shared responsibility amongst all professionals and agencies involved in this endeavour.

The conversation remains the most important tool that we use. Sian Richards, the Programme Manager, has visited all Health Boards to identify what works and to spread the word; similarly to understand where people are struggling and to offer support, almost always from elsewhere in Wales. A Compendium of Good Practice will shortly be available to all Health Boards and local authorities and it is all part of our message that change is possible, when people can see that it is necessary. The conversation has to be mature, facing up to differences and talking them through so that mutual understanding develops. I was thrilled when the Royal College and the Association of Directors of Social Services (ADSS), Cymru submitted a joint response to a recent consultation on the Mental Health measure, as it confirmed yet again that shared responsibility has to be our future.

We want the impact of the work undertaken by the Programme Board to be long term, for people to take it seriously, to listen to each other and to convince those who doubt that we are stronger together to understand the importance of relationships between professional groups in making a difference to people's lives. There is so much more that we can achieve together – let's all try it, prove it to ourselves and to others.

Stewart Greenwell

Corporate Director, Care and Customers, Newport City Council

Lead Director Mental Health, ADSS Cymru

Addiction Psychiatry in Wales- Current Status and Future Challenges

Dr Raman Sakhuja

Dr Raman Sakhuja is a Consultant Psychiatrist in Addictions. He works in Cwm Taf Health Board and represents the Royal College of Psychiatrists in Wales- Faculty of Addictions. His special interest is in teaching and development of services. He is an Honorary Lecturer in Psychiatry with Cardiff School of Medicine and is pursuing an MBA from University of Leicester.

Correspondence Email- Raman.Sakhuja@wales.nhs.uk

Psychiatrists often have been regarded as culprits in managing their emotions in a more intelligent and professional way for which the jargon nowadays is 'emotional intelligence' and I was in a position to remain emotionally intelligent in one such meeting. The reason for conducting myself professionally was instigated by a statement from a member of the audience -

"I disagree with you. I think, they should be further stigmatised and penalised in whatever they are doing. Only then they will learn to stop" – Anonymous

This, however, gave me the opportunity to seek out the reasons for such a statement to be prevalent in the 21st Century and the evolutionary models of addiction went flashing past my Cognitive Paradigms that have been developed over the years of being in Psychiatry and while working with people with various Addictions. That gave me a starting point for this article.

This article discusses these evolutionary models of Addictions, the current thinking about Addictions, and then discusses the current status of service delivery in Wales, the achievements and key challenges for future.

Evolutionary Models

When it comes to one of the primary models of Addictions, which is very much similar to thinking about people with Mental Health problems, the **Moral model** takes primacy over any other model. This model had argued that addiction problems arise from certain inherent weaknesses and bad morals that people fundamentally have in them. This model was a model that dominated a major part of the 21st Century and resulted in nothing more than further perpetuating stigma and marginalisation for people with addiction problems.

Fortunately, it was soon realised that people with strong morals i.e. the ones who are deemed to be the elite educated professional class of people in our society also actually had problems with Addictions and perhaps these Addictions were being carried out secretly.

Obviously, the moral model was not in a position to explain the Addictions in its entirety and this led to the thinking whether there are any specific personality traits in an individual that leads to addiction. This model of Addictions that emphasised Addictions as a **symptom of underlying personality** again had its drawbacks which were highlighted when conceptualisation of Addictions in the form of a **Disease model** stated becoming more relevant. It was Hirschman (1995) who first highlighted a genetic disposition of certain individuals to develop problems with Addictions. This was further complimented by Jellinek's model of alcoholism (Jellinek 1960). The disease model saw Addictions as a disease, thus arguing that there is no cure for this and only a symptom or an urge suppression might be possible. The 12 step AA philosophy has borrowed heavily from the disease model and Wilbanks (1989) and Schaler (1991) have argued that the admittance to powerlessness emphasises further learned helplessness and a victim position by the individual suffering with Addictions. One of the major drawbacks of the disease model had been that it disregarded the environmental influences altogether.

As the understanding of Addictions grew further, a **Social Learning model** was conceptualised as an explanation for maintaining addictive problems and it was seen as a conditioned response to the environment or a learned behaviour which was reinforced by different rewards. This was seen particularly when studies were indicating that the peer group of a person has influences on the maintenance of the addictive behaviours. More recently, Bernard and McKagney (2004) have argued that the parental use of substances increases the susceptibility of children to take up the use of different substances of dependence. Edward and Gross's concepts of a **Bio-psycho-social Model** for Addictions was a landmark in the evolution. The current classificatory systems borrow heavily from the criteria for dependence syndromes put forward by them.

Since then, research into Addictions has moved on a lot and the current thinking for Addictions points to it being a **Chronic Brain Disorder**. There is increasing evidence to support this, and this includes the Genetic Vulnerability of Addictions which ranges from 40-60%, having effective neurobiological interventions and the expanding range for these interventions. There are characteristic brain abnormalities found in people with Addictions. The role of hedonic dysregulation mechanisms (Koob 2008) in Addictions further throws light on brain abnormalities. There are now animal studies suggesting the role of stress axis (Koob 2008) and the role of the CRF1 receptor antagonist in addiction to substances.

The field of Addiction Psychiatry has been fortunate to develop an evolving understanding of the Neuroreceptors and neurotransmissions involved by knowing more on Dopaminergic system, Glutaminergic system, Serotonergic system and GABA system.

Further to this, Pharmacogenetics for patient selection and treatment responses (Vallender et al 2010) is at its infancy at present but holds a promising future.

The Structure of Substance Misuse Services in Wales

The structures and the financial streams of the services for Addictions in Wales are highly complex.

Broadly speaking, the services in Wales, in principle, work similarly to services in other parts of the UK and comprise of a Tiered system. *Figure 1* depicts the structure of these services.

<p>Tier 4 Interventions: Drug specialist inpatient treatment and residential rehabilitation</p> <p>Interventions comprise residential specialised drug treatment which is care planned and care co-ordinated to ensure continuity of care and aftercare</p>
<p>Tier 3 Interventions: Structured, care-panned drug treatments</p> <p>Interventions comprise community-based specialised drug assessment and coordinated care-panned treatment (all NHS and other Statutory Services like Drug Intervention Programme come under this).</p>

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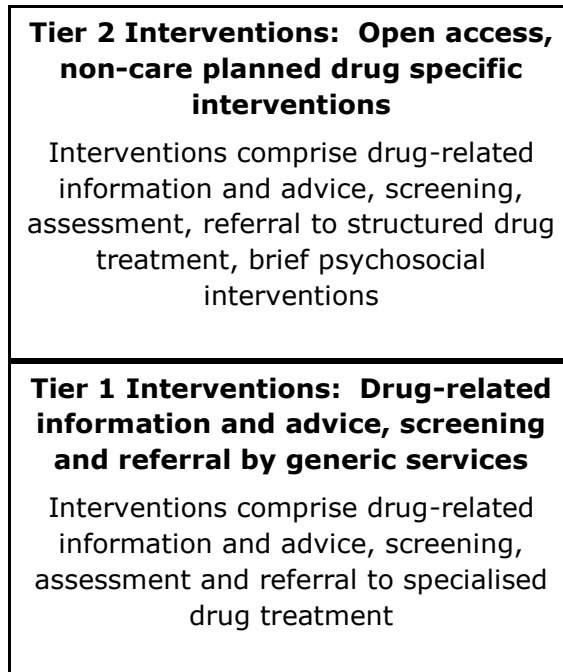


Fig 1. Tier System of Substance Misuse Services- Wales

Recent Achievements

'Working Together to Reduce Harm- The Substance Misuse Strategy for Wales 2008- 2018' has 4 Priority action areas (Fig 2). A greater focus on management of Alcohol related harm is reassuring from a clinician's point of view.

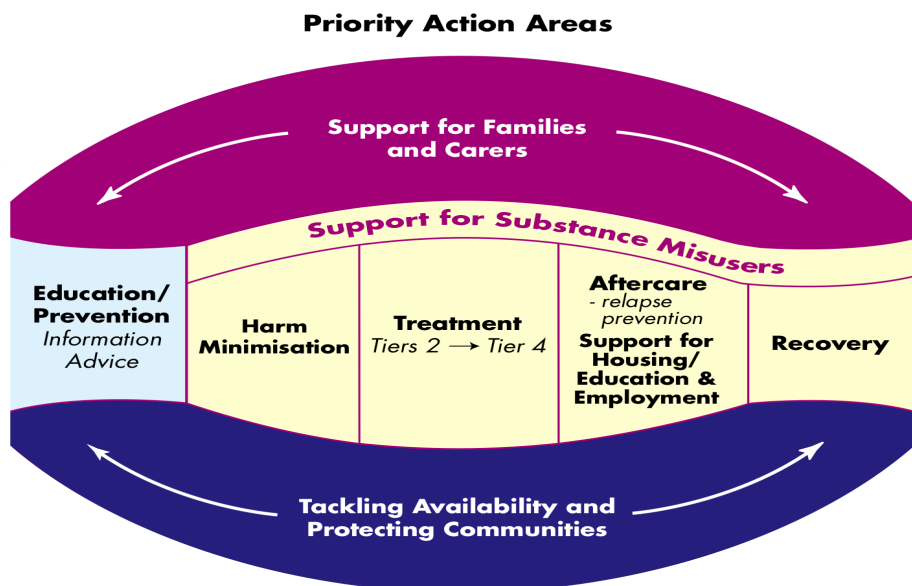


Fig 2. ' Working Together to Reduce Harm'- Priority Action Areas

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The Substance Misuse fund for 2008- 09 was £25 million and the Welsh Strategy promises more funding in the future (Working Together to Reduce Harm). As part of the implementation of the strategy, newer projects have been successfully launched.

1. Take home Naloxone Project.

The pilot take home Naloxone project funded by WAG has been very successful in three demonstration sites including Cardiff, Gwent and Swansea and this has seen a reduction in the number of drug related deaths associated with overdoses. This is gradually being rolled out into Cwm Taff Health Board and the plan is that this will be rolled out Wales wide.

2. Integrated Family Support Team (IFST)

The Integrated Family Support Teams is an initiative by WAG which has been first piloted in Substance Misuse services in Wales with the aim of providing supportive family interventions for people with substance misuse. Once this is successful in Substance Misuse, the plans would be to roll this out into the wider General Mental Health services as well and the success of this would obviously increase the 'value' created for the patients accessing health services in Wales.

3. RIOTT

The use of injectable Diamorphine treatment versus oral optimised treatments of methadone in opiate dependence (Randomised Injectable Opioid Treatment Trial) are being currently looked at by **SWAG (Specialist Welsh Addiction Group)** to understand it from a Welsh perspective. The group would be advising the Welsh Assembly Government accordingly.

Key Challenges for Addiction Psychiatry in Wales

Primary Activities	Inbound Logistics	Interventions	Outbound Logistics
	Human Resources		
Secondary/ Support activities	Technology		
	Clinical Governance		

Fig 3. Service Value Chain in NHS (Sakhuja 2007- Adapted from Porter's Value Chain)

When delivering any service, it is important to understand the 'value' that we can create for the patients accessing health services. *Figure 3* illustrates the various points where this value can be created. Looking at the Service Value Chain model (Sakhuja 2007), the first *access (inbound logistics)* to health services becomes an important element and the primary care logically seems to have a crucial role over here. Early screening and a comprehensive assessment at the point of access into the health service system for Addictions remains a key challenge in Wales as there is a wide variation in the local practices across areas of Wales.

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When thinking of the *interventions* that can be offered to people with Addictions, most of the NHS prescribing services in Wales are fortunate to have a combined service provision for both drug and alcohol problems unlike England where separate drug and alcohol services, mutually exclusive from each other operate in many parts. This presents Wales with a unique opportunity for pioneering research projects for newer treatment interventions. The Addiction psychiatry services in most areas of Wales fall under the Mental Health umbrella which further strengthens the case for research in Dual Diagnosis treatment interventions.

New treatments in Addictions need to be understood from a clinical perspective and the implications of such treatments in the population of Wales need to be a priority for the medical professionals and WAG. Using the expertise of the Local Consultant Psychiatrists in Wales to bring in new treatments has been an area of challenge as their involvement has been inconsistent in Research and Development fields with an unwarranted reliance on experts from outside of Wales. The various research group networks and the WAG initiative for encouragement of research in areas of neurosciences and mental health potentially holds a positive future for addiction psychiatry in Wales.

The *outputs* of the Service Value Chain are important and it is here that the GP Shared Care models are useful in Addictions. A '*step down approach*' has the advantage of primary care taking on stabilised patients who need less intense input and a '*Two-way Model*' can operate efficiently. This two-way model emphasises the importance of having no barriers between the two tiers of services in terms of accessing the health service by the patient and as soon as a patient destabilises in the primary care, a direct access back to the Tier 2 or Tier 3 services needs to be in place. GP Shared Care models in Wales are operating with wide variation ranging from a structured; step down approach to specialist services doing satellite clinics with minimal input from primary care. More standardisation across the country can only be a useful system to develop.

The creation of 'value' for the patient is heavily dependent on the secondary activities of the value chain, which include the *clinical governance systems*, and the human resources deployed to deliver the services. Discussions in SWAG along with a meeting of the Royal College of Psychiatrists in Wales with Health Inspectorate Wales highlighted the lack of standardised procedures and lack of a standardised Clinical Governance framework within the various non-statutory and some non-NHS services delivering substance misuse interventions in Wales. These concerns extend to the commissioning processes as well. Even though the WAG Guidance (WAG, 2009) suggests this, there is a patchy representation by the Consultant Psychiatrists in Addictions across Wales in the Area Planning Boards now. Bringing in robust clinical governance systems in Addiction Psychiatry and standardisation of procedures and practices, including the way services are commissioned, is a huge but fundamentally a key priority area from SWAG's point of view.

In the current financial climate, recruitment and retention of *human resources* remains a major challenge for Addiction Psychiatry in Wales. There has been one initiative for recruiting Advanced Nurse Practitioners in the Substance Misuse field. Recruiting Advanced Nurse Practitioners in specialist fields such as Addiction Psychiatry comes with its drawbacks and some of them include the issues of accountability, responsibility and the issue of down skilling the Advanced Nurse Practitioners due to the limitations of their practice in substance misuse. Therefore, such decisions need to take the crucial balance of patient safety, efficient use of human resources and financial pressures seriously before embarking on changing the workforce of Addiction Services in Wales.

Finally, Addictions Psychiatry has broadened its remit from dealing with Substance Misuse to Behavioural Addictions such as Gambling. A similar neurobiology to chemical addictions has been found so far (van den Brink, 2011). Wales has to be prepared to tackle this new tide.

Cntd....

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Dr Raman Sakhuja

June 2011



Mental Health Research Network Cymru

From Strength to Strength

We are pleased to announce, following a period of change, that the Mental Health Research Network Cymru is now at full strength. We would like to introduce our network management team: Prof Peter Huxley (Network Lead), Alison Lewis (Network coordinator), Dr Seren Roberts and Jo White (Research Portfolio Development Fellows), Michelle Grey (Research Officer), Karen Evans (Administrative Officer). Our team ensures that mental health service users, researchers and clinicians across Wales get the most of their Network to support, facilitate and develop mental health research across Wales to improve the health of the people of Wales.

The Network has been hugely successful over the past 6 years with a membership list of almost 50 stakeholders across Wales who help to attract research funding to Wales to the tune of £13,858,370. We currently have 45 studies on our portfolio, many which are eligible for network support in the form of clinical studies officers, research nurses and research office input. The network currently funds 9 Research Development Groups ranging in topic from addictions to neuroimaging to suicide and self harm. These groups aim to build research ideas in to large scale funded research projects in Wales and wider afield, and contribute to the academic field through 85 new publications this period in peer reviewed journals. We would be delighted to hear from you if you have a research project which you would like us to assist with, if you have a research idea which you would like to develop, or if you have an interest in research and wish to identify possible collaborators.

Our annual scientific conference 'New Models of Care' will be held on the 22nd September 2011 at the Millennium Centre in Cardiff Bay, with Key note address from Sir David Goldberg and response to Key note address by Prof Nick Craddock. Further information about our conference can be found on our website (www.mhrnc.org) and we look forward to seeing you there. Service Users can register free of charge, and for the first time we will be holding an Art competition as part of the Annual Conference, as a novel way to engage Service Users and Carers in the event.

We are also in the process of re-launching the MHRN-C website to a more modern format. It will be a portal, containing up to date information about the work of the network, the portfolio and upcoming news and events. More information available soon.

Please get in touch at info@mhrnc.org or visit our website www.mhrnc.org.



**The Bipolar Disorder Research Network (BDRN)
'The Largest study of bipolar disorder in the world'**

Investigating the Genetic and Environmental Causes of Bipolar Disorder

(funded by research charities The Wellcome Trust and The Stanley Medical Research Institute)

Over 4500 individuals have now taken part in BDRN, bringing us closer to our target of 6000 participants. Many mental health teams across England and Wales have been invaluable in facilitating participant recruitment to the study and we are very grateful to everyone who has helped with this. We are continuing to look for individuals with bipolar disorder who would like to participate in the study. Participants are visited in their own home for a research interview lasting about an hour, are left with a pack of questionnaires to complete and also give a blood sample. Participants then receive feedback about the research via our annual newsletter.

So far the research has already highlighted a number of genes that are associated with bipolar disorder (ANK3, CACNA1A and ZNF804A), although it is now well established that there are many more unidentified genes that influence susceptibility to bipolar disorder. In order to identify these genes, large numbers of individuals are needed to participate in the research.

Pregnancy and Childbirth in Women with Bipolar Disorder

As part of BDRN we are conducting a new study looking at pregnancy and childbirth in women with bipolar disorder. Again, participants are visited in their own home for a research interview lasting about one hour and give a small blood sample. Participants also then complete a telephone interview 3 months after childbirth. We hope this research will help us understand more about why some women become severely ill following childbirth and lead to better treatments for these episodes.

If you would like further information or would like to help with the research please contact:

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www.bdrn.org



Approved Clinician Induction & Refresher/ Section 12(2) Induction & Refresher Training for Wales

Induction Course –14th & 15th September 2011 **Refresher Course – 15th September 2011**

Venue – The Catrin Finch Centre, Glyndwr University, Mold Road, Wrexham, LL11 2AW

This training is eligible for 1 CPD point per hour subject to peer group approval(Psychiatrists only)

Betsi Cadwaladr University Health Board is pleased to announce this initial training course for prospective approved clinicians and Section 12(2) doctors within Wales. Completion of this course will be accepted by Betsi Cadwaladr University Health Board as evidence of initial training for the purposes of approval as an Approved Clinician in accordance with the Mental Health Act 1983 Approved Clinician (Wales) Directions 2008 and also as evidence of Induction/Refresher Training for Section 12(2) Approved Doctors. Betsi Cadwaladr University Health Board do not currently accept any other courses running in England or Wales for the purposes of approval.

This course will provide delegates with an understanding of the powers, functions and duties of approved clinicians and others under the Mental Health Act 1983. The training will be set within the context of the wider legal, policy and guidance framework which govern and affect situations requiring the presence or intervention of an approved clinician.

Trainers

This course is organised by Betsi Cadwaladr University Health Board and will be run by Edge Training.

Booking arrangements

Please complete the booking form available to download at: <http://www.rcpsych.ac.uk/members/divisions/rcpsychinwales/externaleventsinwales.aspx>

and send to Heulwen Hughes, Betsi Cadwaladr University Health Board, Technology Park, Rhyd Broughton Lane, Wrexham LL13 7YP. This form can also be faxed to 01978 346501 – please note telephone bookings are not accepted. **Please return no later than Friday 26th August 2011.**

Course fees and cancellations

The course fee is £425 for the full two days tuition/£225 for refresher training, and includes a handout book of presentations, lunch and refreshments on both days. Delegates are responsible for booking and paying for their own accommodation and travel. Cancellations received at least two weeks before the course will receive a refund minus £125 administration charge. There will be no refund for cancellations made less than 14 days before the course.

Please note that delegates attending induction training are required to complete both days of the training course in full.

Further information

For further information regarding the course arrangements or the process of seeking approval as an Approved Clinician or Section 12(2) Approved Doctor in Wales please contact Heulwen Hughes, Betsi Cadwaladr University Health Board on 01978 346522.

A copy of the Directions may be found at www.wales.nhs.uk/mentalhealthact1983 and follow the links for 'secondary legislation'.



Betsi Cadwaladr University Health Board, in conjunction with the Royal College of Psychiatrists, ran two Approved Clinician Conferences during March 2011 in both North and South Wales. The following topics were covered:-

Recovery	Ron Coleman and Eleanor Longdon
CTOs	Eve Pifaretti, Professor Richard Jones and Giles Harborne
Deprivation of Liberty Safeguards Case Law Eligibility Assessments Guardianship	Neil Allen
Treatment without consent and ECT	Peter Edwards and Professor Phil Fennel

Feedback from both events was excellent.

Plans are underway to hold conferences again in 2012 and suggestions on the topics to be presented are welcome. Please contact Heulwen Hughes with your suggestions, telephone 01978 346522 or email heulwen.hughes2@wales.nhs.uk



National Centre for Mental Health

In March 2011, the National Institute for Social Care and Health Research (NISCHR) made a major research award to Cardiff University to support research into mental illness. The funding will establish a National Centre for Mental Health based in Cardiff and directed by Professor Nick Craddock.

In partnership with all the Health Boards in Wales and a number of charities, the centre will provide an effective interface between the world-leading research of the psychiatry groups at Cardiff University and the NHS in Wales. The work will look at major psychiatric illnesses across the lifespan, including ADHD, autism, mood disorders, psychoses and dementias. It will enable the recruitment of large numbers of patients for research together with detailed clinical and supporting information as well a biological samples, like blood and saliva, and brain scans. These will be vital for research to better understanding the causes and triggers of illness and to use this knowledge to improve treatments and services.



**Joint Meeting of the RCPsych
in Wales and The Welsh
Psychiatric Society
Friday 2 December
Wrexham Medical Institute
Wrexham
North Wales**



**Welsh
Psychiatric
Society**
Gymdeithas
Seiciatregol
Gymreig

DIARY DATE

Real Evidence – Real Practice

We are delighted to announce details of the above event.

The draft programme includes:

- Principals and Implementation on the Integrated Family Support Service in Wales
- Mental Health in Veterans
- Psychological Therapies within a Welsh UHB Setting
- Update on the Clinical Programme Board for Mental Health
- Dignity and Care in Vulnerable Adults
- Psychological Approaches to Dementia Care

Speakers to be confirmed

Poster Competition

Abstracts are being invited covering topics on any aspect of psychological medicine or mental health. Following feedback, successful authors will be invited to produce a poster for presentation at the conference. Prizes will be awarded for best in category. Submission guidelines and forms will be available shortly.

Dinner at the Ramada Hotel

We are holding a dinner for delegates and speakers at the Ramada Hotel, Wrexham on the evening of Thursday 1 December. Further details will be available shortly.

Who's Who in the new NHS Health Board Structures?

Clinical Programme Directors:

- Dr Tegwyn Williams, Clinical Director for Mental Health Services, Abertawe Bro Morgannwg University Health Board
- Dr Huw Griffiths, Clinical Director for Mental Health, Directorate Manager, Cwm Taf Health Board
- Dr Danny Antebi, Divisional Director for Mental Health and Learning Disabilities, Aneurin Bevan Health Board
- Dr Giles Harborne, Chief of Staff, Mental Health and Learning Disabilities, Betsi Cadwaladr University Health Board
- Dr Carl Hooper, Clinical Programme Lead for Mental Health and Learning Disabilities, Hywel Dda Health Board
- Dr John Lewis, Divisional Director, Mental Health Services, Cardiff and Vale University Health Board

Who's Who in RCPsych in Wales?

Executive Committee Members

- Dr Helen Matthews - Chair
- Dr Pravir Prasad - Vice Chair
- Dr Alka Ahuja - Financial Officer
- Dr Mick Dennis - Elected Member
- Dr Giles Harborne - Elected Member
- Dr Ray Jacques - Elected Member
- Professor Keith Lloyd - Elected Member
- Dr Clare Lamb - Chair, Faculty of Child and Adolescent Psychiatry
- Dr John Sandford - Chair, Faculty of Forensic Psychiatry
- Dr Carl Hooper - Chair, Faculty of Psychotherapy
- Dr Mark Winston - Chair, Faculty of General and Community Psychiatry
- Dr Glyn Jones - Chair, Faculty of Learning Disability Psychiatry
- Dr Rhoswen Hailwood - Chair, Faculty of Rehabilitation Psychiatry
- Professor Mick O'Donovan - Chair, Faculty of Academic Psychiatry
- Dr Raman Sakhuja - Chair, Faculty of Substance Misuse Psychiatry
- Dr Isabella Jurewicz - Chair, Eating Disorder SIG
- Dr Mark Janas - Regional Advisor, RCPsych in Wales
- Professor Richard Williams— Education, Training and Standards Committee Representative
- Dr Robert Colgate - Public Education Officer
- Dr Ian Jones - Chair, Perinatal SIG
- Professor Mike Kerr - Chair, Neuropsychiatry SIG
- Dr Sarah Watkins - Welsh Assembly Government Representative

All queries should be directed to:

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If you would like to submit an article for the next RCPsych in Wales newsletter which will be published in December 2011, please email the office with the relevant information by 30th November 2011.

ACCEA AWARD ROUND 2012

Members are reminded that the closing date for ACCEA applications is 5pm, Monday 25 July 2011. Application forms and guidance notes can be downloaded at:

<http://www.rcpsych.ac.uk/members/yourmembership/awards2012.aspx>

and applications should be sent to: sduncan@rcpsych.ac.uk

Sue Duncan, Awards Administrator, The Royal College of Psychiatrists, 17 Belgrave Square, London, SW1X 8PG.

Fellowship to the College

Members are reminded that the closing date for Fellowship nominations is 31st July 2011. Nominations forms and guidance can be found at: <http://www.rcpsych.ac.uk/rollofhonour/aboutmembership/collegefellowship.aspx>

And applications should be sent to: latkinson@rcpsych.ac.uk

Liz Atkinson, Membership Development Manager, The Royal College of Psychiatrists, 17 Belgrave Square, London, SW1X 8PG

The RCPsych in Wales wishes to thank all contributors to this issue of the newsletter