



The Royal College of Psychiatrists London Division Newsletter

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Editorial

This current newsletter comes to you with not only a re-vamped presentation, but a new editorial team comprising myself, Dr Anne Patterson and Dr Nick Dunn. Each newsletter will be headed by a different editor, with Dr Cyrus Abbasian remaining as co-editor.

We continue to benefit from the publishing expertise of Wiseworks Enterprises, without whom the current format would not be possible. Firstly, I would like to welcome Dr Michael Maier as new Chair of the Division and the Division would like to thank Dr George Ikkos who is credited with the legacy of starting the newsletter. We wish him well in his new position of Treasurer at the College.

In November, the Autumn Academic Meeting was held at the Institute of Psychiatry and attracted

a diverse audience, but reflected less than 10% of the current membership of the Division. We would encourage more members to consider making it to such events, which are highly valued by those who attend. I have provided a snapshot of this event in the newsletter. Future academic events are being planned and will appear shortly on the Division Website.

The content of this newsletter is, I hope, varied enough to draw the attention and hold the concentration of readers. There is certainly something for everyone, including trainees. So, please read on.....

The Financial Burden of Mental Health Trusts in London

In spite of the recent unprecedented investment in the NHS there is a clear sense that our service is neither healthy and at some risk of not being entirely national for much longer. Nowhere is this being felt more than in London. To make things worse mental health services, long seen as Cinderella specialities, are carrying more than their fair share of the burden.

On page 2 we are publishing a letter written on behalf of the Chief Executives of the ten Mental Health Trusts in London highlighting the current problems which centre around financial savings. The letter demonstrates how mental health services are being penalised to support the overspending in acute services.

The message from this letter is clear in its objection to what appears to be an inequitable situation in resource allocation.

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8 August 2006

Dr George Greener

Chairman

London Strategic Health Authority

David Nicholson CBE

Chief Executive

London Strategic Health Authority

1 Berkeley Street

London

W1J 8DJ

Dear George and David,

Re: London Financial Plan

We write following receipt of David's letter to the five Managing Directors in London dated 27 July regarding the financial position in London.

David's letter sets out that there is still a significant problem in delivering the agreed bottom lines in the 2006/07 Financial Plan for London, resulting in at least £70 million at risk.

The letter then goes on to set out the proposals to rectify this position.

Our purpose in writing to you is to register that we are extremely concerned over these proposals and wish to request a meeting with you both as a matter of the utmost urgency,

Rather than go into great detail in this letter we thought it might be helpful to set out our overarching concerns.

We do not believe that the proposals can be practically achieved to the timescale required. All the mental health Trusts involved agreed in April to plans to sustain the overall London position. These already require significant savings to be made, in some cases in direct response to PCT disinvestment consequent upon the 3% topslice. Those savings already involve service closures, and the timescales for that are governed by formal consultation requirements. We signed up to those plans in April because we accepted we would need to deliver them. Our Trusts are only in financial balance because we have tackled the need to improve efficiency and to make service changes; to require substantially greater savings at a point four months later in the year is not realistic.

We appreciate that this requirement has emerged because there is concern that London Trusts in deficit are unlikely to return to balance as planned, but we can see no value in substituting that with a plan which has even less likelihood of success. To realise these additional targets will result in further closure of services and staff redundancies. This will take many months to realise given that we will have to go through a period of consultation with our staff, their trade unions, the Overview and Scrutiny Committees and local PPI Forums. The impracticality of this approach is exacerbated by the other risks in the system at the moment – for example the uncertain status of funding for MPET and other national levies – and the fact that reductions in PCT allocations are often in practice passed straight onto Trusts, and those unprotected by PbR (as in mental health) are most exposed to that.

We believe that this approach is inequitable. Of the 37 non-Foundation NHS Trusts in London, 16 have been singled out to contribute towards the £70 million debt and of those 16 Trusts 8 are mental health Trusts. As a proportion of the total expenditure in all London mental health NHS

Trusts, that amounts to a further 1.6% reduction. As a proportion of the total acute expenditure the seven acute Trusts affected are being asked to find 0.5%. Whilst we would acknowledge that the requirement falls particularly on a small number of acute providers, that is only because so many acute Trusts are not in financial balance, so in terms of actual spend the inequity may be even worse.

The effect is that the saving required overall is more than three times greater from London's mental health services (and incidentally from the London Ambulance Service), than it is from acute services. This appears to be a clear case of mental health services being penalised to support overspending in acute services. We are concerned about the impact of this in both the immediate and the long term.

We believe the effect will be a perverse incentive to improving financial management in the NHS in London. It flies in the face of the Secretary of State's and Health Minister's statements that poor performing PCTs and Trusts will not be bailed out by those who are managing within their financial limits. More specifically the fact that last year's underspend is now a factor in the calculation of the savings target is a particular perversity, as Trusts were urged last financial year to underspend in order to support the overall London position. Having done as asked they now find that this tells against them when further savings are required this year. This is unlikely to encourage further willingness to assist in future.

As a group of Mental Health NHS Trusts we are astonished that 8 of the 10 Mental Health Trusts in London are being asked to contribute to this yet none of these Trusts are responsible for the £70 million shortfall. As we stated at the commencement of this letter we request an urgent meeting with you and the Mental Health Trusts will arrange for three Chairmen and three Chief Executives to be our representatives at that meeting.

As Chairman of the London Mental Health CEO Group, I am sending this letter on behalf of the Chairmen and Chief Executives of the 10 Mental Health Trusts in London.

Yours sincerely,



Dr Peter Carter

Executive

London Division Autumn Academic Meeting Institute of Psychiatry, 14th November 2006



by TonyRao

Secretary, London Division

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Amid the squally autumnal climate of south east London, conference attendees witnessed a bustling Wolfson lecture theatre, with a packed day of high quality presentations from experts in the field of affective neuroscience. The day was first put in context by **Dr George**

Ikkos, who gave splendid pictorial representations and historical quotations associated with mind and mood.

The topic of the morning session was 'neurocognitive function', with the first question to be answered: *what do we mean*

by normal affect? **Dr Anthony Cleare** (Institute of Psychiatry), the first speaker of the day, highlighted the relevance of depression as a chronic and disabling disorder, both in clinical and public health terms. The critical role of cortisol in the pathogenesis of depression was

discussed, followed by the role of key brain areas in people with depression. The 'added value' of cognitive behavioural therapy was also shown to be of importance. The speaker concluded by postulating the role of factors such as cortisol resistance, thyroid dysfunction, kindling and cerebrovascular disease in treatment resistant depression.

Is it all in our genes? **Professor Peter McGuffin** (Institute of Psychiatry), the second speaker, engaged the audience with a detailed and comprehensive review of current knowledge in this area. The heritability of affective disorders was elegantly displayed by comparing unipolar and bipolar disorder, with the former 'breeding true' and the latter producing an increasing risk of both sub-types of affective disorder. Professor McGuffin then moved on to discuss putative genes and locations on specific chromosomes (so called 'functional candidates'). The implications of such discoveries appeared to have implications for the more clinical aspects of care, such as diagnosis, treatment, public perception/stigma and the relationship between genes and the environment.

How do our emotions relate to false beliefs? **Dr Turnbull** (University of Wales) was able to elucidate this question. He listed the four common emotions of happiness, sadness, anger and fear and pointed out the misfortune for mankind that three of these were negative emotions! Each of these emotions determined our decision-making choices, which are refined according to experience ('trial action')

and 'intuition'. The latter phenomenon was shown to be important in focal brain lesions and in schizophrenia. The audience was left to ponder upon the reason for the high preponderance of positive confabulation in low mood states.....

Is it something about chemical imbalance? **Professor Phil Cowen** (University of Oxford) enlightened the audience in this respect, first showing us that lay views of mood disorder were surprisingly judgmental, with only 10% of lay people attributing mood disorder to changes in brain activity. He then focussed on 5HT and the role of tryptophan in maintaining euthymia. This neurochemical focus was then tied in with emotional processing circuitry in the ventral and dorsal prefrontal cortex, as well as the amygdala and thalamus.

Watered and fed, attendees returned for the afternoon session, entitled 'assessment and treatment'. The audience was introduced to the question of how cognitive function is affected by bipolar disorder. **Dr Sophia Frangou** (Institute of Psychiatry), used data from the Maudsley Bipolar Disorder Project to provide some answers.

Using a large sample of patients, a range of neuro- psychological domains were examined and complemented by brain imaging. In patients with chronic disorders characterised by multiple episodes, moderate impairment was present in the form of changes in working memory and executive function. This was also accompanied by changes in the size of ventral/dorsal pre-frontal cortices and

amygdalae. A key finding was the loss of the crucial role played by the ventral pre-frontal cortex in regulating its dorsal counterpart.

How much is known about the neuro-imaging of affective disorder? **Dr Paul Grasby** (Imperial College, London) provided a plethora of information about this topic. He drew our attention to the methodological shortcomings of imaging studies, but added that data from higher levels of evidence applied to structural brain imaging, has shown changes in the volumes of limbic and striatal structures in affective disorders. These findings are complemented by functional imaging, which highlights some reversibility in blood flow to certain areas after remission. Lastly, the use of Positron Emission Tomography has concentrated on the role of 5HT_{1A} receptors as a state marker for depression/anxiety.

Professor Anne Farmer (Institute of Psychiatry), delivered the penultimate lecture on medical illness and metabolic syndrome, with panache. She drew our attention to the considerable attention paid to schizophrenia in the context of medical problems; this was often at the expense of affective disorders. In fact, the prevalence of obesity in the Depression Case Control Study (DeCC) was twice that of controls. Cases also had an increased prevalence of most physical health problems (including the metabolic syndrome) compared with controls. This may, in part, be mediated by the HPA axis and it was postulated that a common aetiology might perhaps underlie both depression and obesity.

The blue sky of future research beckoned, with the delivery of the final presentation by **Professor Nicol Ferrier** (University of Newcastle). Professor Ferrier helped us to look at the current research evidence on Bipolar Disorder, starting with the benefits of psychoeducation in the prevention of relapse, by identifying 'relapse signatures' and suggested incorporating these into clinical care pathways. The conclusions of best evidence findings were

that atypical antipsychotics, lithium and valproate still offer proven benefit in the treatment of bipolar disorder. A veritable pharmacopoeia of other drugs of equivocal benefit was also detailed, most of which are currently used in the treatment of epilepsy, but remain unlicensed in Bipolar Disorder.

The day was an overall resounding success and **Dr Mike Maier**, the newly incumbent

Chair of the London Division, thanked all speakers for making the day a success. He also proposed a vote of thanks for the contribution made by **Dr George Ikkos** to the London Division over the past 5 years. Although difficult shoes to fill, there is every hope and expectation that Dr Maier will continue to lead the Division into pastures new and that future academic events will continue to draw an ever growing numbers of attendees.



Modernising Medical Careers- Points of view

Vinodini Vasudevan
Senior House Officer

South London and Maudsley NHS Foundation Trust

I am sure no junior doctor is viewing the MMC with actual distrust or dislike, the main factor is probably the uncertainty associated with it, especially if they have put in a lot of hard work to get to where they are and lose it all due to some changes; that too at short notice. Recently I came across an acronym for the MMC (Medical Musical Chairs). This probably reflects how junior doctors feel when they are insecure of the future and new rules keep coming up. In the same vein, I would like to start with some examples I read in an article written by an SHO. He wrote 'Having being appointed for a 2 year rotation in February 2006, I was surprised to learn that my trust was terminating my contract 6 months earlier; this was apparently due to the fact that the trust was not to recruit beyond August 2007'. It was described that his fear was missing out on a crucial stage of his medical training because of the speed of the changes.

Reading such articles (of which I am sure there are many more available), does not really help in building confidence, and I hope that people can see this is why most of us are worried. Most of us are not very clear about of what is really happening. We are aware of "watchdogs" warning that the MMC will drive the doctors out of the NHS unless the changes are put on hold. As far as we known, the number of posts

that will be available is less than the number of doctors who are currently employed.

If the warnings are correct, then we would lose a lot of good doctors and that would be a waste of talent!

We know that by this time next year, SHOs will be heading for extinction as the grade is abolished under the second phase of MMC. What we don't know is the likely impact of the proposals on postgraduate education and how many training posts will be on offer? This could, in the long run, probably cause irreparable damage to the high quality of postgraduate medical training. It would have consequences not only for the individual doctors, but also the general public.

With the ongoing and as yet uncertain changes that the MMC will bring, I think many doctors would feel persecuted and unsupported (especially non-EU doctors). Patients and relatives have an extensive number of fora in which to express their concerns. Most of us are not aware if there is a forum to which we can comfortably air our grievances to, other than the BMA.

To be fair, there are things in favour of the MMC, e.g. the advent of the 2 year foundation programme under the MMC has changed the face of medical training in the UK by making it

more standardised and structured. Realistically, the impact will probably not be so bad, and we are being biased, uncomfortable with change and catastrophic about the whole situation. The MMC web site is actually quite useful and tries to describe, with interactive models, what the system is likely to change to, and this is definitely useful.

Lucy Russell
Senior House Officer
Central and North West London

Modernising Medical Careers is set to be fully implemented in August 2007. As from 31st December 2006, it will not be possible to achieve a National Training Number and enter the SpR grade. This leaves all current SHOs at all levels, anyone currently in research or clinical fellow posts, in all four countries of the United Kingdom, to apply for run-through training in January 2007.

There has been very little detailed communication with trainees even at this late stage. No-one, including MMC committee members or the Dean of the Royal College of Psychiatrists knows the break down of numbers of posts across the years and across the country. The most up to date news suggests that it will be possible to apply for one specialty and four "units of application" or four specialties and one "unit of application" or two specialties and two "units of application".

A unit of application is the geographical area within which the candidate can be placed. At the moment, the whole of London and Kent, Sussex and Surrey will be one Unit of Application.

The MMC website states, "It may be possible to state a preference for North or South". As someone from Scotland, I am particularly concerned that the widest geographical area that any unit of application covers is the entire country of Scotland. This means that a candidate,

once they have accepted the offer of a run through post in Scotland, will be withdrawn from their other choices. They may then be told they are posted to the Outer Hebrides. The candidate will then have just 48 hours to accept or decline the offer of a post. Just 48 hours to make a life changing decision to uproot their life, and the lives of their family, to decide if their children should leave their schools, to think about mortgages and moving companies. In the old system, any candidate would have chosen to apply to that geographical area.

It is a fact that many thousands of current SHOs, research or clinical fellows will not get a post on a run through training grade. Some of them may be able to get a post in a "FTSTA". This is a Fixed Term Specialist Training Appointment, which is for a maximum of two years to allow "competencies" to be achieved before the candidate can reapply for run through training. Of course they can only get a post in run through training if one is available. The entire premise of the run through training is that there is a post in the next year for everyone in the year below. Therefore only if one of the people at your exact level drops out of run through training will you be able to slot in after their FTSTA.

There will therefore be an unspecified number of SHOs who do not have a training job in August 2007. Of course, there are many people ambitious enough to move across the country at short notice - just 5 weeks between the results of the second round of interviews and the start of the new system! However, there are also many people with ties of family, friends and social networks in their area who will not be willing or able to move to the opposite end of the country to advance their career.

In terms of service provision, just how will the NHS cope when all the SHOs are attending interviews, possibly many miles away, and many consultants are involved with interviews, all at the same time?

BMA Junior Doctors Committee



by Omer Moghraby
Specialist Registrar
Child and Adolescent Psychiatry

Have you ever been caught up in a pay dispute or wondered about your on call arrangements? I'm sure many of you have been, and I'm sure for some of you, with good negotiating skills, these issues have been resolved quickly. For everyone else, there is the British Medical Association! The BMA is the union for UK doctors and has the sole negotiating rights with the NHS employers

(NHSE). For example in the case of junior doctors, they have negotiated the New Deal, produced guidance on its implementation (for doctors as well as employing trusts) and shaped a range of policies, from accommodation to pay protection and even appointment to posts. Some readers may be thinking about their own 'horror story' about when they contacted the BMA who was "not interested". Getting involved and making your voice heard is important and this can be done through your local representative. Are you unsure about who your rep is, or how to go on about starting the ball rolling, or even how the BMA works for junior doctors? Well I hope to enlighten you a little with this article.

Your first port of call should be your hospital representative – in theory there should be an 'accredited trade union (i.e. BMA) representative' for each grade and at every hospital. This person would be able to involve the BMA at a more local level, via the Local Negotiating Committee (LNC) for trust specific issues. It also entitles them to LNC and negotiation skills training which is run by the BMA. For each region in the country there is a regional junior doctors committee (RJDC), which roughly follows deanery lines; so

in London there is a North and a South Thames committee. Any junior doctor may attend, but you will need to be a BMA member to be elected as an officer. The RJDC meets around 4-5 times a year and annually (early September time) elects officers tasked with taking forward its objectives and representing the region on the National JDC committee.

This year has seen a surge of interest at RJDC meetings – probably because of Modernising Medical Careers related fears. If you are not happy about what the BMA, JDC, RJDC or your local representative is up to, then get in touch and get involved. JDC also has its annual conference held in London around May time. Here, JDC policy is made and so a strong London representation can have a significant impact on national JDC policy and priority areas.

How to get in touch

National JDC: info.jdc@bma.org.uk

South: rjdc.souththames@bma.org.uk

North: rjdc.norththames@bma.org.uk

General matters: AskBMA (0870 60 60 828)

Professional Articles

National Programme for Information Technology (NPFIT):

What are the implications for Mental Health Trusts in London?

by Martin Baggaley

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- 1) 'Connecting for Health' is responsible for delivering NPFIT across the NHS in England. It is a very complex and ambitious programme designed to bring the standard of IT in the NHS up to 21st Century standards. There are a number of strands to the programme including the 'spine' (a

National database including demographic details), a Care Records Service (CRS) which is the local electronic patient record, N3 (the broad band network), Choose and Book, and Electronic Transfer of Prescriptions (ETP). England has been divided into five clusters, of which London is one. British

Telecom (BT) is the local service provider (LSP) for the London Cluster responsible for delivering the CRS to London, including the 10 London Mental Health Trusts. Mental Health has been relatively well organised as prior to the National Programme work was started on the so called IMHER (integrated mental health electronic record). The original contract was signed in December 2003 with IDX, an American software company, as the main sub contractor, who were to supply one system across acute, mental health, community and primary care. The IDX system was shared with the Southern Cluster (which spans from Cornwall to Kent and up to Oxfordshire). Unfortunately development of IDX 'Carecast' was slow and in the spring of 2005, the Southern Cluster dropped IDX and chose Cerner 'Millenium' instead.

IDX was taken over by General Electric (GE) and it had been hoped that this would speed up delivery of systems.

In the meantime, the CSE Servelec "RiO" product was selected as an interim solution for Mental Health and Community Services in London. In July 2006, BT requested permission to proceed with negotiations to replace GE Healthcare (IDX) with Cerner. At the same time, BT put forward a revised strategic proposal for London which identified three main suppliers/products for each of the sectors:

- a. Cerner "Millennium" – Acute Services
- b. CSE Servelec "RiO" – Community/Mental Health Services
- c. InPractice "INPS Vision 4" - GP Practice Integration. This proposal represented a significant move away from the original vision of a single instance/single solution across all care settings. To address this, BT proposed an "integration layer" to allow information from the three "products" to be shared within and across the care settings. This will rely on messaging to push/pull information across the various care settings. Access to these systems will require Smart cards and passwords.

- 2) Other Clusters. In the Southern Cluster, it is proposed to provide Mental Health functionality through developing Cerner. There will therefore be a different system in place in the Southern Cluster in comparison to London. The other boundary is with the Eastern Cluster who is using iSoft Lorenzo, which is unlikely to be available until 2009/2010.
- 3) Progress so far: In London, RiO V4 has gone live now in three Trusts (Oxleas, SW London & St Georges & West London). Initially these Trusts have deployed to a single borough and then are rolling it out sequentially. EL & CMHT and NELMT are the next Trusts in line. SLAM and CNWL are likely to remain on their existing systems (ePJ and Jade respectively) for the time being.
- 4) Mental Health Programme Board. The delivery of RiO in London is overseen by the Mental Health Programme Board, chaired by John Newbury Helps, Chief Executive of Barnet, Enfield and Haringey Mental Health Trust (John.Newbury-Helps@beh-mht.nhs.uk) Dr Ben Lucas (ben.lucas@thh.nhs.uk) and Dr Hashim Reza (Hashim.Reza@Oxleas.nhs.uk) are the clinical leads for Mental Health. There is a RiO user group chaired by Dr Hashim Reza.
- 5) Conclusions. The first stage in the deployment of NPFIT systems to mental health trusts in London is making good progress with the likelihood that within 18 months the majority of Trusts will have started to deploy on RiO. There will be considerable advantages in having a common system in Mental Health across London. Work is underway to provide integration, in particular to social service systems. There is also work to look at interfaces with private/voluntary organisations, children's services and the prison services. The extent to which integration across settings can be achieved will be crucial in determining the success of the programme for Mental Health.



The Silent Drinkers

by Tony Rao

South London and Maudsley NHS Foundation Trust

Rarely is there a news item about an older person being arrested for a public order offence or for any form of bodily harm against an innocent bystander outside his 'local' on a Friday night.

Equally rare is the scenario of an older person being involved in a serious road traffic accident as a consequence of being 'several times over the limit'.

If we are to understand the very real public health problem facing our society, we need to look for a very 'silent' problem that may not be immediately apparent. In our casualty departments, where up to 50 per cent of older people with alcohol misuse present with falls; on medical wards, where alcohol-related problems may be masked by depression, dementia and chronic physical problems, and on housing estates, where non-payment of rent, self-neglect and squalor may be indicative of alcohol misuse or dependence. The sad fact of the matter is that the true extent of alcohol problems in later life is likely to remain undetected unless a concerted effort is made to raise awareness. Personally, I have tried to do this through the traditional vehicle of the medical press, but also on a local level, where I now manage and deliver (as care coordinator) specialised care to older people with a dual diagnosis within an inner-city community mental health team. The scope for harm reduction through the multiplicity of medical and psychosocial interventions is limitless and has considerably reduced both health and social problems related to alcohol misuse in my own catchment area.

So what do we know of drinking in later life? We know that the number of people aged 65 and over in the UK who drink above sensible limits has increased by 100% for women and over a 33% for men over the past 20 years. Given that the absolute number of over 65s in the UK is expected to rise by 50% (from 8 million to 12 million) from 2001 to 2031, we are at risk of neglecting a problem that is waiting to erupt

unless we tackle it head on.

If we are to make any headway, professionals within the alcohol field will require specialist training in the very different health and social problems facing older people with alcohol misuse. This also applies to those working with older people, who will require training in the detection and treatment of alcohol misuse disorders.

In older people, there are some parallels with younger people in terms of risk factors for alcohol misuse. These include homelessness, a past history of hazardous/harmful drinking and depression. However, other risk factors come into play in older people, namely bereavement, social isolation, immobility and retirement.

There are many barriers to the detection of alcohol misuse in older people. Ageism may operate here and comments from relatives that 'they have always been a poor sleeper' can detract from the main problem. In fact, elderly care physicians are much less likely than general physicians to screen for alcohol misuse in older people who are in hospital. Under-reporting through fear of stigma and stereotyping of 'drinkers' as being male and of a certain socio-economic status, also comes in the way of detection. In medical settings, physical symptoms such as poor appetite, low mood and memory problems may hide hazardous or harmful drinking. There may also be a co-existing problem with misuse of benzodiazepines.

If used in a timely and appropriate manner, the use of rating scales for the detection of alcohol misuse in older people is invaluable. These include the commonly used Alcohol Use Disorder Identification Test (AUDIT), as well as the Michigan Alcohol Screening (Geriatric Version) Test or MAST-G. There is some evidence from research that treatments such as brief intervention and Motivational Enhancement Therapy are clinically effective in reducing alcohol misuse and admissions to hospital, but there still a great deal that is not known.

To borrow a term from across the Atlantic, research in this area still remains very much 'blue sky' territory.

Even within the population of older people, there are undoubtedly population sub-groups that remain at increased risk.

One example is the problem of alcohol misuse in older Irish men in inner-city areas. Any interventions to address this will also require culturally appropriate services, some of which already exist in areas such as North Southwark and Camden.

We owe it to ourselves to be advocates for a group

of largely forgotten elders whose needs compete with those of younger people, where the focus of interventions and funding is on crime and public order. Hopefully, government initiatives such as the Choosing Health paper and Models of Care for Alcohol Misuse from the National Treatment Agency will give further impetus for the funding of research and service development aimed at providing help for a problem that will continue to weigh heavily on society. Until the profile of older people with alcohol misuse deserves the attention that it warrants, we are sitting on a problem that is, from a public health and mental health perspective, silent but deadly.



Coombe Wood Perinatal Mental Health Service

by Jona Lewin and Meena Patel

Central and North West London Mental Health NHS Trust.

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The management of mentally ill mothers with very young children is complex and challenging, but also provides an excellent opportunity for a proactive and early intervention. In Britain, joint mother & baby admissions to psychiatric hospitals were pioneered nearly 60 years ago. At that time the importance of avoiding mother-infant separation became increasingly clear and was informed by the innovative research of John Bowlby and others. Joint admissions are valuable for many reasons that benefit not only the mentally ill mother, but also the infant and often the whole family.

A mother & baby unit can provide a variety of crucial assessments and treatments within a structured and safe environment with the help of specialist staff. The milieu of a mother & baby unit supports

the mother to maintain or form an attachment with her infant, while she receives treatment for her illness. It allows the mother to remain in touch with her maternal role, prevents atrophy of her parenting skills and fosters the development of self-confidence and independence.

For first time mothers it promotes the acquisition of parenting skills from other experienced mothers and staff. It also is an ideal setting for focusing on any disordered mother-infant relationship, where the difficulties can be directly observed and treated. In mothers suffering from chronic psychoses or severe depression the capacity to care for the child may be impaired. A psychiatric mother & baby unit can provide the expertise to assess maternal attitude and competence.

Dr Tom Main, based at the

Cassell hospital, was the first psychiatrist to admit a mentally ill mother with her child to a psychiatric hospital. The psychiatric practice at the Cassell hospital was mainly concerned with neurosis and treatment was by psychotherapy over prolonged periods of time. In the mid 1950s Baker and his colleagues at Barnstead hospital in Surrey began studying the interactions between "schizophrenic mothers" and infants and, in 1959, opened a unit for eight mothers and their babies.

The origins of Coombe Wood Perinatal Mental Health Services began with the work of Dr Barton, who admitted a mother and her baby to Shenley hospital in Hertfordshire in 1956.

This was quickly followed by the opening of an 8-bedded unit with purpose-built

facilities, which included a playroom, a nursery, communal living areas and single rooms for mothers and babies. From early on, the unit admitted mothers with a wide range of psychiatric disorders including post-partum illnesses, neuroses, schizophrenia and personality disorders.

In 1993, with the closure of Shenley hospital, Coombe Wood was transferred to Park Royal Centre for Mental Health next to Central Middlesex Hospital. The unit is specifically designed for the purpose and can admit up to 10 mothers and 11 babies up to the age of 18 months. The unit accepts referrals from the whole of London and the surrounding counties. In 1997 a Perinatal Community Service was established for Brent and Harrow Health Authority area. This Outreach Service works in close collaboration with the in-patient unit, community professionals and various statutory and voluntary agencies. This team is staffed by an associate specialist, an SHO, a community psychiatric nurse and a family therapist. Referrals are accepted from primary care, maternity services and community mental health teams.

Four years ago, Coombe Wood established a parenting assessment service. Mothers and sometimes couples are admitted for a specific period, usually 6 weeks, for these assessments. Such assessments are instructed by social services or courts when there is concern about the parents' ability to safely parent an infant and/or meet his/her physical and emotional needs. The parenting assessment team consists of a consultant child psychiatrist,

consultant adult psychiatrist, consultant psychologist, child/infant psychotherapist and occupational therapist. A senior psychiatric nurse is the assessment coordinator.

There are significant differences in the admissions of mothers for treatment or for parenting assessment. Prior to admission for a parenting assessment the parent(s) need(s) to be treated to obtain her/his optimum level of functioning, as otherwise, the assessment loses validity. For parents admitted for assessment staff take on a less interventional role and more of an observational role.

Mothers who are admitted for treatment, as well as their partners, are strongly supported in their parenting role. In addition to appropriate medical treatment, the milieu and therapeutic programme is geared towards helping mothers to bond with their infants. The unit offers mother-infant and baby massage groups run by the child psychotherapist and nursery nurse. Other groups and individual sessions are provided by an occupational therapist, a psychologist and an art psychotherapist. A family therapist offers individual, couple and family therapy sessions on a weekly basis.

In the last year, Coombe Wood has developed a day programme. This is attended by patients who have been discharged from inpatient care and are likely to benefit further from continuing a course of therapy, or by patients referred from the perinatal community service for specific therapeutic interventions.

The development of services at Coombe Wood has been

informed by various guidelines and recommendations; in particular the report of The Royal College of Psychiatrists: "Perinatal mental health services. Recommendations for Provision of Services for Childbearing Women" (CR88, 2001), and more recently by the draft NICE guidelines on perinatal psychiatry (2006). The service provides training to specialist registrars, SHOs, medical students, student nurses and trainee psychologists and psychotherapists. Formal training is also offered to local midwives and health visitors.

The aim of the unit is to provide a comprehensive care package for the patient and her family.

The unit has a strong multidisciplinary work ethos and works on the understanding that a close collaboration with families, professional disciplines and various agencies is necessary to deal with the complex issues that often arise in the lives of new mothers with mental health issues and their families.

We welcome visitors to our unit, but you can also visit us on: www.cnwl.org/coombewoodpmhs.html

The Association for
Psychoanalytic Psychotherapy
in the NHS

is holding a conference:

***"Adults and Children: Mental
Health Services Working
Together"***

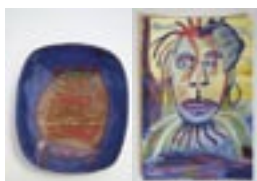
Date: 2.2.07

Place: Regents Park
Conference Centre

**Visit 'Conferences and
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website:

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Therapeutic factors in the rehabilitation of prisoners and mentally-disordered offenders: the work of the Koestler Trust

by Dr Alexandra Pitman
SHO

Central and North West London Mental Health NHS Trust.

Prisoners represent the last major group in society for whom certain forms of abuse are acceptable; on the basis that it is deserved or that it might be beneficial.

By design or inequity, prison environments can be humiliating, terrifying, or merely understimulating. The aim of the prison service is public protection by preventing re-offending, yet UK figures show that 60% of released prisoners are re-convicted within two years. The evidence seems to suggest that traditional prison regimes do not make society safer.

If exacting revenge on the most despised and rejected members of society cannot change behaviour, then other approaches need consideration. The fields of rehabilitation psychiatry and psychotherapy have much to offer, and this article describes an example linking these ideas.

The Koestler Trust is a prison arts charity which promotes creativity in UK prisons, young offender institutions, high-security psychiatric hospitals and secure units. Organisations involved include Broadmoor and Ashworth Hospitals, and Feltham Young Offenders Institute. It was founded in 1962 by the writer Arthur Koestler following his own dehumanising inmate experiences. Now partly funded by the Home Office, local projects allow detained individuals to engage in education in a more positive manner, learn new skills, and to channel their innate creativity in

a way that might restore a sense of humanity and empowerment. The projects are designed as a pathway towards rehabilitation and employability, and the self-confidence gained prepares them for wider opportunities following release or discharge.

The annual Koestler Awards Scheme recognises achievements with a public exhibition, reminding society that those locked away are still a productive part of the community. In 2006, nearly 5,000 entries were received, a third of which were from secure psychiatric units, and the winners were shown at a two-week exhibition in Kensington. The volume and eclecticism of entries reflected the enthusiasm of those involved and the comments of participants indicated that this was the first time many of them had received any recognition for a personal achievement.

What came through in this exhibition was that empathy, genuineness, respect, warmth and unconditional positive regard seemed to be incorporated into the approach. As core components of counselling one wondered whether they might be highly significant factors in these inmates' and patients' rehabilitation.

The organisation cites one of its aims as addressing low self-esteem, destructive emotions and fear of failure using the forum of arts classes in which individuals are recognised and rewarded for work produced and skills

learned. The therapeutic alliance between those facilitating arts classes and those participating seemed likely to be of real value, particularly in the context of evidence of its predictive value for positive outcomes across the range of therapeutic modalities. Other features of group therapy are also recognisable, particularly supportive therapeutic factors such as acceptance, instillation of hope, cohesion, universality and altruism. Although such approaches are well established in institutions like Grendon Underwood, the Koestler Trust appears to have introduced them more informally. If projects like these are able to incorporate features engendering therapeutic alliance, namely unconditional positive regard, supportive contact and a validatory environment, there may be real potential to effect positive change. The approach is rooted in psychodynamic theory, borne out by achievements in the field of rehabilitation psychiatry, and has a clear potential application in the forensic population. Observational studies similar to those performed at Grendon Underwood are needed to investigate whether arts-based interventions are associated with reduced re-offending rates, and wider targets like employment rates and psychiatric morbidity. In an increasingly over-crowded system any scheme that can cost-effectively rehabilitate offenders, and has high participant acceptability, is well worth society's investment.

The Teaching of Edward

By *George Ikkos*
Current Treasurer,
Royal College of Psychiatrists
Chair, London Division (2001-2006)



Is there no end to Professor Peter Tyrer's talents? Well known as a clinician, clinical service developer, researcher, international academic and editor (and even poet to some), he has now turned his hand to musical theatre!

His operetta, "The Teaching of Edward" was performed in a charity event at Leighton House, South Kensington, on 28 July 2006. The musical director was Anna Maratos, Head of Creative Therapies, Central North West London Mental Health NHS Trust. Your reporter was truly surprised to find his daughter, Ana, singing the part of Maria Acland. In the operetta, Maria Acland is one of the patients in Worcester County Asylum, where the famous-composer-to-be Edward Elgar was appointed Bandmaster of the Attendants' Orchestra in 1879. Born on 2nd June 1857 in a small cottage in the village of Lower Broadheath, near Worcester, Elgar was a local lad. He was the fourth of seven children born to William Elgar, a piano tuner and music dealer, and his wife Ann.

He went on, eventually, to compose many brilliant musical works, including "The Enigma Variations", which consist of musical portraits of his wife and friends and "Pomp and Circumstance" which invariably concludes proceedings at the BBC Proms every year.

"The Teaching of Edward" story-line is one of pompous and narrow minded asylum staff, especially doctors, having their minds opened by the arrival of Elgar and the "discovery" of "music therapy" by the patients and the composer. It was performed with great humour and enthusiasm by mental health services users, medical students and mental health services staff (and their relatives!). Professor Tyrer appeared to enjoy himself enormously in the role of Daniel Hack Tuke the hospital superintendent.

In the programme notes Professor Tyrer informs us that the work was dedicated to David "a man who had been in the Paterson Centre in Paddington for over eight years. He was continuously frightened and puzzled by the strange people in the ward and could not understand what was going on. He often reacted to his fears by violence and this led to long periods of detention in the intensive care unit. He was then introduced to music therapy with Anna Maratos...

his behaviour was transformed...and before long was engaging with gusto in complex duets with Anna on the piano. He became cooperative and pleasant, and within a year he was discharged from hospital to supported accommodation where he remains with no further spells in hospital in the past five years, and now has a girlfriend."

The proceedings from the event will be given to a prominent playwright in Lithuania, in order to write a play (based on the trial of Socrates) portraying the stigmatisation of the mentally ill in that country. It will be part of a wider initiative to combat stigma and improve mental health services in Lithuania.

This light hearted and entirely friendly event is important in combating stigma and social inclusion in our country as well as Lithuania.

Through engaging jointly with service users, mental health staff and medical students, Professor Tyrer gave us a great example of what a truly patient centred and socially inclusive psychiatry might look like, at least in part. In writing about the nature of society and citizenship the Italian historian and philosopher Nicolo Machiavelli has observed that an essential part of affirmation of society and citizenship is the staging of public festivals. In its modest but important way this event was an act of citizenship for all participants, including service users. One of the most gratifying aspects of the event was the participation of medical students with no specific intention to go into psychiatry.

I look forward to the next production by Professor Tyrer and his colleagues. In the meantime they have given us an evidence base for music therapy with encouraging data from a randomised controlled trial (Talwar et al, 2006), which is one of the first studies from the British Journal of Psychiatry to be the subject of a podcast with Dr Raj Persaud on the Royal College of Psychiatrists website. Please have a listen.

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London, literature and psychiatry 4

by Anne Patterson

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As doctors, we are necessarily trained to seek out pathology, always suspecting the worst. When writing an earlier account of London's "psychogeography," I concentrated, accordingly, upon stories of resonating malevolent forces. It never occurred to me to investigate any benign counter currents.

The Peace Trail described by Valerie Flessati (1998) might redress this bias.

It is a walk through London, honouring sites of peace and peacekeepers.

Interestingly, for doctors, Tavistock Square is at the beginning of the Trail. How many visitors to BMA House notice the statue of Mahatma Ghandi, the monument to conscientious objectors or the cherry tree commemorating the Hiroshima dead?

Continuing, one arrives in Red Lion Square where many humanists and ethicists have lectured in Conway Hall. There is also a bust of the philosopher Bertrand Russell who issued a manifesto with Einstein in 1955 warning of the dangers of nuclear war.

Einstein's deep concern over the destructive use of his momentous discoveries is well known. In 1932 he wrote to Freud asking whether his work might illuminate: "...the dark places of human will and feeling." He asks: "is there any way of delivering mankind from the menace of war?"

Freud's (1932) reply was pessimistic.

He invoked his dual instinct theory, hypothesising that the phenomena of human life result from an interaction between the mutually opposing currents of the "Life" and "Death" instincts. As it was impossible to rid mankind of instincts, the "Death" drive might be only be tempered by encouraging the "Life" instinct, fostering emotional ties and common interests among men.

Further, the process of civilisation depended upon the restriction of instincts and therefore worked against war.

The Trail proceeds south to Trafalgar Square past

St Martins-in-the-Fields Church where a refuge for soldiers and the homeless was established during the First World War by the Reverend Dick Sheppard. Crossing the river, the path ends at the Peace Pagoda in Battersea Park via the Imperial War Museum. In an eerie psychogeographical resonance, the Museum's building, dating from 1815, was formerly the Bethlem Hospital.

WG Sebald, in "Austerlitz," points out, however, that the original priory of St Mary Bethlem stood on the present day site of Liverpool Street Station. His eponymous protagonist arrives at the station as a five-year-old boy, a refugee on the Kinder transport and is adopted by parents who rewrite entirely his personal history. The novel shows how this devastating obliteration is constitutive of Austerlitz' personality. He is haunted by the clues to his earlier life, forever drawn back to Liverpool Street Station where his repudiated memories begin to return and propel him into a search for his origins.

In spare yet eloquent prose, Sebald evokes Austerlitz' inner life. Coolly dispassionate, yet rich in erudite detail and surprising observations on a multiplicity of subjects, he captures precisely Austerlitz's emotional dislocation and his attempt to find refuge in a keen intellect. Relationships tragically elude him.

The vicissitudes of individual memory in response to trauma are central preoccupations of psychoanalysts, writers and neuroscientists. I am writing this on Remembrance Day and wonder about our collective capacity for honouring memory as wars continue throughout the world, in Iraq, Chechnya, Sri Lanka ...

Alan Bennett's smart but provocative tutor in *The History Boys* (2004), walking round a War Memorial while he disposes of "war poetry" declaims: "the best way of forgetting something is to commemorate it." Perhaps it is important how the ritual is used. Another response to my question might be in the often-quoted words from TS Eliot's *Burnt Norton*:

"...human kind...Cannot bear very much reality..."



SOUTHWARK IRISH PENSIONER'S PROJECT

Southwark Irish Pensioners Project (SIPP) was set up in 1994 as a lunch club for isolated elderly Irish people who were found not to be accessing statutory services. It has grown to meet the needs of its client group and now provides services to over 400 elderly Irish people living in the Borough of Southwark and surrounding areas. 314 are aged 70 and over, 306 live alone and 90% live in rented accommodation, 39% suffer Mental Health problems due to isolation. Southwark rates 5th in the London Index of Deprivation.

SIPP is a registered Charity and Company Limited by Guarantee. The Trustees of the Charity are Directors of the Company and they are the Management Committee. They are also users of the project. We currently employ 12 staff and receive financial support from the Irish Government (50%) Southwark Social Services (30%). The remaining 20% is made up from funding from various trusts and charities and our own fund-raising.

This year we received over 100 referrals, the majority due to isolation. 252 clients accessed our lunch and drop-in centre that opens 4 days a week and provides a variety of cultural, therapeutic and social activities. The remainder accessed our Community Support Team's services.

Our Community Support Team outreach an average of 200 Elderly Irish People every year, many of whom have mental health issues including: depression, anxiety, various stages of dementia/alzheimer's, schizophrenia and bi-polar disorder.

We provide support, covering a wide range of issues such as housing, benefits, advocacy, substance misuse and emotional support in a culturally specific manner. Many clients are known to mental health teams but are difficult to engage, due to a deep mistrust of statutory services.

Our Community Support Services provide ongoing emotional support whilst endeavouring to persuade our clients to engage with social services, GPs and mental health teams. We do not have a cut-off date, and continue to support our clients for as long as they wish us to do so.

Below is a brief summary of some of the clients we deal with and what support we give them. Due to

reasons of confidentiality, names have been changed.

Pat and Bridie are in their seventies, married but have no children. Pat suffers from schizophrenia, and has done for many years. Bridie has taken on a lot of his irrational fears and delusions as her own.

Though they are known to the mental health team and to social services, they refuse any help that these services offer. They refuse to maximise their benefits, seeing this as 'charity' and have a very low income.

Early last December, their electric cooker stopped working. They refused meals on wheels and refused to let the CPN fill out a community care grant form for a new cooker and were living on sandwiches and orange juice. After 3 months of persuasion, Pat and Bridie accepted a two ring electric hob from us and have since agreed to us sorting out a council tax rebate.

All of this takes time, time that statutory services do not have.

Sean is 83 years of age, has been widowed for 15 years, has no children, lives alone and suffers from anxiety and depression. Since his discharge from a mental health ward last January he has become more confused and delusional. He is still depressed and anxious and has left his home just 5 times since his discharge.

Though the mental health team are still involved they have had to pull back most of their services since 6 weeks after his discharge. Born and reared in Dublin, Sean enjoys a tremendous rapport with our workers who visit 2 or 3 times a week plus phone calls.

As with most elderly Irish people, Sean is a proud man, reluctant to ask for help, and pretends that he can cope far better than he actually can. Without our presence at case conferences, Sean would not receive the services he currently receives. Social services recognise that we know him well and he trusts us and they now act upon issues or concerns that we highlight.

**Rita Andrews
Manager**

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