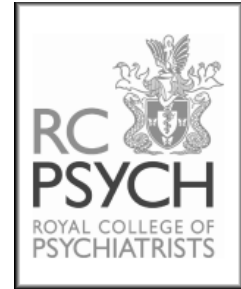


# Root and Branch

*The Newsletter of the Faculty of  
General and Community Psychiatry*

*Royal College of Psychiatrists*



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## Editorial:

### **Of Schizophrenia, Bipolar Disorder and Society**

*Mark Agius*

2008 has been a remarkable year for Psychiatry in Europe. For the first time in its history, the European Union has issued two research calls, each worth 12 million Euros, for research in Schizophrenia. One call is entitled 'Gene – environment interactions and Schizophrenia'; the other is 'Optimising current treatment approaches to Schizophrenia'. What is particularly interesting about the latter is its specification of 'pre-clinical studies', in particular neuroimaging, which are to precede clinical trials. It appears that the EU has faith in the idea that high-tech biological approaches will eventually improve treatments and outcomes in this illness.

What is not mentioned is the optimisation of treatment by 'low tech' methods such as assertive community treatment, psycho-education, family interventions, and relapse prevention. That would not be such a problem for European Psychiatry except for the fact that in large parts of Europe the psychiatrist still sees the patient alone, in outpatient clinics, without the benefit of a community team. The current system of psychiatry in the UK appears to have a great deal to recommend it. Because our treatments should be enhanced by effective team-oriented community treatments, we should therefore expect better outcomes than in many parts



of Europe, which leads us to the cogent argument, made by Professor Goodwin recently in our annual conference, for seeing Bipolar Disorder as the 'heartland' of Psychiatry. The treatment of Bipolar Disorder, indeed of the whole of the bipolar spectrum of disorders, is essential to the proper management of psychiatric services. On the other hand, one of the merits of National Service Framework is its focus on the treatment of Schizophrenia, which had long been neglected. Ultimately, there is a need to focus on a 'balanced ticket' in the longer term, embracing the idea that the whole gamut of psychotic illness, from the 'schizophrenia spectrum' to the 'bipolar spectrum', comprises the true 'heartland' of psychiatry. Our community services must be able to deal with all these conditions.

Meanwhile, 'high tech' interventions such as fMRI will continue to yield new insights into the pathophysiology of psychotic illness. We are now better placed to both understand and treat the pathology of psychotic illness. But whatever our progress, any recovery based approach to mental illness will need to confront the societal stigmatization of these conditions, so as to achieve much needed social inclusion for our patients. It remains for society to accept our patients as human and to ensure they all receive the care that they require and thereby recover and re-integrate into society.

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Goodwin, G.M., Geddes, J.R. (2007). What is the heartland of psychiatry? *British Journal of Psychiatry*, 191, 189-191.

### From the Chair

*Michele Hampson*

*Chair, General and Community Faculty*

I am delighted that so many of you attended our most successful annual conference and that the feedback was so positive. We used the event to launch the first two clinical networks for primary care liaison and CRHT. Already, there has been considerable activity on the CRHT discussion forum on a variety of issues, and information has been distributed to the primary care liaison group. The aim of networking members doing similar roles with

each other and with the Executive Committee is clearly helpful. We are now trying to establish a similar network for SpRs, as our trainees represent our future and we want to be sure that they can play an active part in the Faculty and, in turn, feel supported by it. If you want to join an existing group, simply send your email address, stating which network you wish to be linked with, to: [gandcfaculty@rcpsych.ac.uk](mailto:gandcfaculty@rcpsych.ac.uk). Electronic

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communication will be vital in the future and you may be surprised to know that we can only use the College mailing list a few times a year. So, if you want to be better connected, simply give us permission to contact you as a Faculty Executive by contacting [gandcfaculty@rcpsych.ac.uk](mailto:gandcfaculty@rcpsych.ac.uk). We are only a click away!

At the Conference we heard about the New Ways of Working Review Group established by the College and with multi-professional involvement. I am a member of that group and we hope, in the near future, to obtain members' views as part of that review process. We know that experiences are mixed from consultant posts being axed in some areas to those who feel their expertise is now better utilised and who have greater job satisfaction. What accounts for that variation? This issue links to professionalism and the role of the psychiatrist and we are in the process of reviewing our roles and responsibilities document, so that is for a future newsletter.

We now need to turn our attention to the Quality Agenda set out in Lord Darzi's final report, '*High Quality Care for All*'. The emphasis on local teams developing quality indicators and outcome measures is welcomed and should help to ensure local ownership and innovation, but some coordination is required nationally to support bench-marking. That will be a key role for all the Royal Colleges, both directly and through representation on

NICE, as their role will change to support this agenda too. All acute trusts will be required to produce quality accounts alongside their financial accounts, but there we have the fly in the ointment. As happened with PbR, mental health trusts will not be required to produce these accounts in 2010, unlike the acute trusts. Given that there will be a quality tariff in the future this delay could represent a funding threat. It is hard not to see this as discriminatory practice and you can rest assured that this point will be vigorously made.

It is encouraging that so many applied to join the Executive and you will be receiving election papers shortly. We now have an additional vacancy following the resignation of our secretary, Leon Rozewicz, which will be advertised shortly. The job is effectively that of Vice Chair and, in our Faculty, they tend to take responsibility for administering the ACCEA process. They take on other roles related to their areas of interest and act on behalf of the Chair as required. Who do YOU think would do that role well? Speaking from experience, unless someone nudges them, they may not apply and that will be a loss, not only to the Executive, but to members as a whole as our task is to represent you to the best of our abilities. So we need your help.

By the way, what networks would you like us to develop? If prison inreach, do get in touch as soon as possible.

Many of our newsletters will now only be available in electronic format. Please ensure that your e-mail details are up to date in order to receive them. Please visit: [www.rcpsych.ac.uk/member/securemembersarea.aspx](http://www.rcpsych.ac.uk/member/securemembersarea.aspx) to check your details

We welcome your letters and would also like to hear from people who would be interested in writing articles for the next edition. Please e-mail us at: [gandcfaculty@rcpsych.ac.uk](mailto:gandcfaculty@rcpsych.ac.uk) or write to us at the correspondence address on page 2 of this newsletter. If you have any updates for the website or any other comments please let us know.



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### **Reflections on a Balint Group in the current climate of change**

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*Dr Susanne Wille, SpR Psychiatry*  
*Dr Claire Archdall, ST3 Psychiatry*

*Dr Mohammed Khan, ST1 Psychiatry*  
*Dr Ragini Heeramun, ST2 Psychiatry*

We would like to use this contribution to this newsletter to reflect upon our experience of a fortnightly Balint Group. We have noticed that the recent climate of change and uncertainty may have influenced our experiences. These include the pressure for trainees to undertake workplace based assessments and increasing job uncertainty.

Attendance at Balint Groups is mandatory (Royal College of Psychiatrists, 2007) for psychiatric trainees, but there are scarce guidelines as to precisely how these should be run. College guidelines have suggested that Balint groups can make up part of the basic psychotherapy training for all psychiatrists by providing protected time for case discussion groups for difficult patients. They state the groups should be led by a consultant psychotherapist or a senior member of the Psychotherapy Department (Royal College of Psychiatrists, 2003).

Our group consisted of six junior doctors (one F2, one ST1, two ST2 and two ST3 doctors) and was run by an SpR in psychotherapy. One of the ST3 doctors was also in the psychotherapy department and two others were undertaking long term psychodynamic cases. This meant there was already a certain level of psychotherapeutic understanding. When discussing clinical cases we introduced a model regularly used in the Psychotherapy Department at Blackberry Hill Hospital, Bristol. This consisted of a boundaried approach in which 3 ten minute slots were given to each case presentation. The first ten minutes involved a trainee presenting a case with no interruptions allowed. In the second ten minutes the rest of the group reflected on what they had just heard, without the presenter being allowed to intervene. The final ten minutes was a discussion involving

all people present. For most people this was a new approach. Having periods of not being able to intervene facilitated deeper reflection for both the presenter and the rest of the group. The approach was also a stark contrast to normal everyday clinical communication which is more time limited.

#### **Advantages and Disadvantages**

We were not prescriptive about who and what was presented. For example, we discussed the effects of MTAS on junior doctors and how this may have affected patient care. Our group was made up of varying ethnic origins and transcultural issues, such as being a foreign doctor in the UK and the effects this could have on psychodynamic thinking, were considered. Two of the trainees were working in the forensic department and brought some complex forensic cases for discussion. These cases added to the diversity and showed the benefit of having trainees from different specialties.

We felt that our group was probably too small in size. This was particularly noticeable when there were annual leave and study leave commitments. In addition, the time sometimes clashed with clinical learning opportunities, such as going to court. We wondered whether increasing our numbers by including staff grade doctors would be an option to overcome this. However, it was felt that a smaller, more committed group fostered a more comfortable and trusting atmosphere. One trainee mentioned she felt observing her colleagues' personal presentation styles helped her to bond with them.

Some members felt intimidated that most of the group consisted of more advanced psychiatric trainees. They reported finding it hard to think about cases away from the



medical model and were therefore afraid to contribute. They felt an introduction into the potential benefits of Balint groups with links to basic psychodynamic theories and a reading list could be useful.

Our group was run by an SpR. People felt overall that they could talk more freely without a consultant present. The SpR received regular supervision from a consultant psychotherapist which meant that there was still useful consultant input.

### **Changing role of Balint Group?**

The training culture has been changing over the past few years and is becoming increasingly driven by summative assessments and obtaining portfolios of evidence. This could conflict with the overall ethos of a Balint Group. Several trainees felt under pressure to complete these assessments, so we experimented by completing two case based discussions during a Balint group session. This had a pragmatic advantage of meeting an assessment target, but we felt it changed the dynamics of the group. In order to complete the assessments, the presentation had to be more structured and this left less time for personal reflection. We wondered whether this should be avoided in future as it went against some of the principles underlying a Balint Group, such as free association.

F2 doctors may feel particularly out of their depth in Balint Groups. Most of them will have a limited experience of psychiatry and may have no inclination to pursue it as a career. However, F2s can potentially bring a non psychiatric perspective and it may be the only opportunity for them in their career to reflect in more depth on patient interactions. With increasing numbers of F2 doctors rotating four monthly through psychiatry, the challenge is to integrate these doctors into Balint groups.

### **Conclusions**

Overall, we felt that a Balint Group was a helpful contrast to everyday clinical demands and controls. It helped us to think about cases psychodynamically and, for some, it dispelled the myth that they were unable to think in a psychological way. The experiences gained could be taken into everyday psychiatric practice. It was hard, at times, to find the right balance between experiential learning, such as reflecting on difficult feelings, alongside the need for key psychodynamic concepts to be understood. This dilemma has also been commented on previously (Mitchison, 2007)

The changing climate has led us to re-consider whether the fundamental roles of a Balint Group are able to remain the same. We question whether it is appropriate to include workplace based assessments during a Balint group and whether more focus is required to integrate frequently rotating junior doctors. The new College guidelines may help to clarify some of these uncertainties.

We look forward to any comments or ideas on the above.

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## A Traffic Light system for zoning clinical risk in Early Intervention Team

*Mohammed Ashir & Karl Marlowe*

Risk assessment and management is a duty of all mental health clinicians and part of clinical governance. There is an onus on mental health services to develop decision-making processes with regard to levels of risks in a way that stands up to scrutiny (Morgan, 2007). Crude predictions of suicide or violence are rarely useful. Similarly, complicated risk assessment tools that are used, either in research or in specialist settings like forensic services e.g. HCR-20 (Webster, 1997), are labour intensive and not suitable for daily use by community multidisciplinary teams (MDT). The Care Programme Approach (CPA) was introduced as a safety net of care for patients with mental illness and, even though the CPA as a tool to manage risk is stressed, there are many questions of its ability to diminish risk (Kingdom & Amanullah, 2005). In fact, CPA is not dynamically responsive to changes in risk e.g. CPA assessments are 3 or 6 monthly at best while risks change on a daily basis. What has been borne out consistently in suicide and homicide inquiries is the lack of a system for communicating risk and action plans when a risk has been identified (Appleby, 2006). A simple and clear risk management system that could be used in an everyday setting is needed.

### **Traffic lights system**

The symbolism of the three primary colours used in traffic lights has been adapted in other contexts to manage risk. One example is in food package labelling where green indicates recommended low levels of fat, salt and other nutrients, red indicates high levels and an unhealthy choice to be avoided, while amber indicates neither high or low but not recommended in the long-term. The use of "Zoning" has been described for managing resources in Community Mental Health Teams (Ryrie et al, 1997). We describe here a Traffic Light system for risk management based on Zoning. Table 1 illustrates how this

system of could work in an Early Intervention service. Each patient is placed at any time within one of the three categories of the Traffic Lights. A defined set of clinical and operational characteristics determine the colour of light, and change is dependent on the ongoing risks. The criteria and action plan for each category are known to all members of the team, including administrative staff, utilizing a whole team approach. For example, all patients who are within the first two weeks of being an in-patient are within the Red category. If a community patient is non-compliant with the care plan, or any concerns are raised by any team member or family, the patient will be moved to a greater risk category. A patient in Red would have up to weekly MDT and medical review, three times per week contact with the key worker, be discussed daily, and only exit this category after a clinical assessment with a modified care plan.

### **Strengths & weaknesses**

Traffic Lights aim for an intervention at an acute stage, whilst also allowing for a care plan to be formulated in a chronic but stable phase. Responsiveness is ensured via a decision matrix that changes rapidly (within minutes) with little recourse to paperwork. Also it provides a fulcrum for a full team discussion and for the allocation of clinical responsibility when individual members are unavailable. However, this system is more specific to risk management in community teams. The drawbacks are that it could be prescriptive and inflexible, e.g. exit from a high risk category is achieved only after medical review or via MDT review. Also a practical problem for large teams trying to adopt this system could be too many high risk patients for a daily or weekly MDT review. The principle could still be adopted if sub-teams are used, with each group having less than 200 patients on their caseload.



<b>RED</b>	<ul style="list-style-type: none"> <li>• Within 2 weeks of inpatient care</li> <li>• Increasing risk to self/others</li> <li>• Non-compliance with care plan</li> <li>• More than three non-attendances</li> <li>• 6 weeks post natal</li> <li>• Early warning signs apparent</li> <li>• Increased substance use</li> <li>• Concerns from key worker/ carer/ family/ health professional</li> </ul>	<ul style="list-style-type: none"> <li>• Medical review every one to two weeks</li> <li>• Care coordinator review two – three times per week (face: face at least once per week)</li> <li>• Team review 1 once per week</li> <li>• Discussed daily in handover</li> </ul> <p style="text-align: center;"><b>EXIT ONLY AFTER MEDICAL REVIEW</b></p>
<b>AMBER</b>	<ul style="list-style-type: none"> <li>• Within 12 weeks of initial contact</li> <li>• During medication change or discontinuation</li> <li>• Two non-attendances</li> <li>• Within 4 weeks of DSH</li> <li>• During pregnancy</li> <li>• Accommodation change</li> <li>• High expressed emotion</li> <li>• During Discharge Planning phase</li> </ul>	<ul style="list-style-type: none"> <li>• Medical review 4 – 6 weeks</li> <li>• Care coordinator review 1 – 2 weeks</li> <li>• Team review 12 – 14 weeks</li> </ul> <p style="text-align: center;"><b>EXIT ONLY AFTER MDT REVIEW</b></p>
<b>GREEN</b>	<ul style="list-style-type: none"> <li>• Engaged and compliant</li> <li>• In Remission</li> <li>• Chronic residual symptoms</li> <li>• “Watch &amp; Wait”</li> </ul>	<ul style="list-style-type: none"> <li>• Medical review 8 – 12 weeks</li> <li>• Care coordinator review 2 – 4 weeks</li> <li>• Team review 24 – 26 weeks</li> </ul>

**Table 1: Criteria and clinical expectation within the Traffic light system adopted by Tower Hamlets Early Psychosis Service**

**The way forward**

This system is not intended as an actuarial risk evaluation or prediction tool, but more as a pragmatic method to ensure that risk is recognised, acted upon and reduced. Within a clinical governance framework and allocation of responsibility structure, there is an argument for alignment of care planning with risk, a suggestion made by the National Confidential Enquiry into Suicide and Homicide (Appleby et al, 2006). The whole team approach of the traffic light system should fit well with the development of “New Ways of Working for Everyone” and “Creating Capable Teams Approach” (Department of Health, 2007).

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## The rise and fall of risk

*The following article was first prepared by Mark Salter on behalf to the Executive of the General and Community Faculty as part of a briefing for Baroness Helena Kennedy, who chaired a College scoping committee on risk between late 07 and early 08. The final report (CR150) "Rethinking Risk to Others" was published in June 2008 and is available via the College website.*

### Introduction

For reasons that are as interesting as they are diverse, our civilisation has seen a major shift from the collective ideas of personhood towards the wants and rights of the individual. Modern ideas of 'self', 'identity' and 'rights' have arguably replaced notions of faith, patriotism or community as the concepts we now value most highly. This change is reflected in our increasing preoccupation with endangerment of the self. Areas that have always provoked uncertainty (God, Nature, Illness, Death, Madness) have now become foci of concern, out of which, 'risk' has evolved from a statistical notion into a highly emotive issue. Irrational hopes of risk assessment, management and elimination (which are usually confused) have spawned a veritable industry. Nowhere is this better illustrated than in regard to what is unhelpfully called 'mental illness'.

The irrational nature of our current response to the tiny proportion of mentally ill people who pose a risk can be seen in our laws, in the ways that we design and allocate resources to our services and in the images and stories that we make available to ourselves at all levels of discourse, from table talk through to the media.

### Law

Mental illness features infrequently on the lawmaker's agenda, except when the issue is brought into the public gaze, usually in response to emotive events. A rash of such stories came thick and fast between 1987 (e.g. Spokes report) and 1996 (e.g. Clunis report). These events have virtually defined the Government's response to the present, from

Mrs Bottomley's 'ten point plan' to include supervision registers, and the issue of HSG (94) 27 which guaranteed a risk-driven inquiry after every case of psychiatric homicide, through to the chaotic genesis of the new Mental Health Act.

After the Government's dismissal of the patient-oriented expert report on the review of the 1983 Mental Health Act (Richardson 1999), the new mental health bill (for England and Wales, the Scots having long taken a more pragmatic approach) bounced between committees, expert groups and Parliament for eight years. It is clear that, as it finally stands, the bill is driven by a public protection agenda. Much of the debate over the bill was taken up by themes of compulsion and the clinically vague concept of Severe and Dangerous Personality Disorder (DSPD). Compulsory treatment and pre-emptive detention are the two themes at the heart of the bill; the risk-driven stance of the Government is starkly revealed in the strap line of its proposal for a 'safe, sound and supportive' new act. The only word with any therapeutic connotation comes third.

### Structure and resourcing of services: the growth of forensic psychiatry

Forensic psychiatry has grown remarkably over the past thirty years into a specialism ostensibly based upon its ability to assess and manage people who pose a risk by virtue of mental illness. A steadily growing body of evidence supports the notion that they are unable to deliver on this claim (Turner and Salter, 2008), and that, away from expensive locked units – where any risk is theoretically containable – ordinary, well funded generic



adult general mental health services can do just as good a job.

There is an extraordinary overlap between forensic and adult general clinical populations, in terms of demographics, diagnosis, history, outcomes and treatments used (Dowsett, 2006; Coid, 2007). In fact, it is probably impossible to define what constitutes a 'forensic' patient, other than the fact that they have committed an emotive deed, at some point, usually in their remote and distant past. This does not stop us from diverting a disproportionate amount of our resources to a tiny fraction of the clinical population. In one external review of an inner city mental health trust, the Sainsbury Foundation (2002 – *see Guardian, Social Supplement 16.10.02*) found that almost one quarter of its annual £35 million budget was spent on its forensic unit that then comprised 85 beds. The remaining 75% of the budget was allocated to a population of approximately 2,000 patients. Ironically, it is from the latter population, as yet unknown to the forensic services, that future serious incidents are most likely to derive.

The rate of offending by the mentally ill shows a stability that, in the current risk-obsessed climate, seems counterintuitive. Despite the substantial increase in homicides committed in the UK since 1955, those attributable to the mentally ill have remained stable (Taylor and Gunn 1997). This has occurred in spite of extensive psychiatric bed closure. In England and Wales in 1955, the psychiatric in-patient population stood at around 155,000, but by 1998 this had fallen to around 48,000. A reasonable conclusion from this would be that homicides by the mentally ill are very rare events, the frequency of which does not relate in a readily understandable way to environmental factors, contact with psychiatric services included. Such a view seems consistent with the finding of the National Confidential Inquiry into Suicide and Homicide (Appleby et al 2006). This is also a

view that has yet to filter into public discourse on the matter.

A hallmark of forensic psychiatry's claim to specialist status is its apparent expertise in the assessment of risk, in particular the use of specialised risk assessment tools. The debate about their usefulness is ongoing (Maden, 2005; Undrill, 2007), but the limitations of applying population-based, actuarial methods of risk assessment to real-world clinical practice are clear (Szmukler, 2001). Risk assessment tools are an ineffective way to allocate resources (Munro and Rumgay, 2000), and the notion of risk assessment and management as the specialist domain serves to deskill generic mental health teams, drawing risk away from where it truly belongs, woven into the warp and weft of all clinical practice (Turner and Salter, 2008).

The current perception of mental illness as dangerous seems set to guarantee the predominance of risk as theme in mental health care some time to come. A major reinforcement of this misperception is to be found in the images made available to us in the media.

### **Images of mental illness**

The media remain the primary source of information by which we form our beliefs about mental illness (DoH, 2007). Public understanding of psychiatric issues is also quite sophisticated. Crisp (2000), for example, found that people could easily distinguish between at least six different types of illness when exploring their prejudices about these conditions. This sophistication, however, is displaced in situations that provoke fear or uncertainty. There is compelling evidence that heightened arousal encourages an innate tendency to rapid judgment based on stereotype (see Mackie and Hamilton, 1993). Human cognitive styles have probably been subject to the same evolutionary pressures as the rest of our brain and body functions; it is therefore likely that this capacity for rapid



evaluation has served us well for hundreds of thousands of years. Only over the last 5,000 years or so have we usefully been able to exert sufficient control over our environment for hazards to be manageable by less automatic, more rational methods. It is possible, therefore, that our preoccupation with risk is a by-product of our tendency to civilise.

Whatever our progress, the capacity of mental illness to elicit fear and uncertainty has lost none of its potency, a fact that is not lost on journalists and broadcasters. Studies that identify the predominant themes of media content consistently reveal that themes of dangerousness, harm and unpredictability remain overwhelming (Nairn, Philo, HEA). A similar predominance is found in the academic literature on the stigmatisation of mental illness (Hayward and Bright, 1997). A variety of strategies have been suggested that may mitigate against this influence (Salter, 2005; Thornicroft, 2006).

### Conclusions

Mental health professionals should consider how they may bring a more balanced quality to the debate about risk as it pertains to all aspects of mental illness. The central target of this effort must be acceptance of the fact that risk management will never equal risk elimination, regardless of resources. Notions of 'positive risk' management have yet to enter the mainstream of debate, let alone our statutes. Psychiatrists, with their spread across the land, and proximity to individuals so affected, are uniquely well placed to take a lead in this regard, but to do so will require us to adopt methods that may seem to come more from the toolkit of a PR agency than a mental health trust. We could begin by being explicit about the fact that reinstitutionalisation is already well underway in response to risk rather than mental illness. Imaginative presentation of images of mental distress that expand on stereotypes, rather than confronting them, should, if psychological theory is

correct, avoid falling foul of processes that have influenced human behaviour for millennia. The steadily growing voice of the 'user movement' – which has worked effectively alongside psychiatry during the revision of the new Mental Health Act – may be our most potent ally in what needs to become 'a campaign' against our obsession with risk.

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## Psychoeducation clinic for patients with schizophrenia

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### **Introduction**

Schizophrenia is one of the top ten causes of disability in the world (WHO) with dramatic impact on individuals, families, communities and economies.

The WHO Mental Health Gap Action Programme 2002 recommended offering family and psychosocial interventions alongside antipsychotic treatments in schizophrenia and other psychoses. This is reflected in the NICE guidelines. Advances in medical and psychosocial treatments mean that most individuals and families can be helped (New understanding/New hope, WHO 2001).

In the United States a patient “has the right to and is encouraged to obtain from physicians and other direct caregivers relevant, current, and understandable information concerning diagnosis, treatment, and prognosis” (AHA, 1973/1992). And it is proven that client’s treatment adherence is increased when health education is an integral part of the client’s care (ANA, 1982).

In the United Kingdom the approach is not dissimilar. Both the Royal College of Psychiatrists and the General Medical Council have emphasized that patients be given access to information to develop their understanding of their condition and treatment plans (Good Psychiatric Practice Report, April 2004) in a way they can understand (GMC, Good Medical Practice, 2006).

### **The Evidence**

The Cochrane review of ‘Psychoeducation for schizophrenia’ (Pekala & Merinder) provides the evidence that psychoeducation is effective in reducing relapse or readmission rates at 9 to 18 months follow-up compared with standard

care. The authors describe psychoeducation as a process to increase the patient’s understanding of their illness and treatment and found that it can improve compliance, reduce expressed emotion, improve psychosocial functioning and have an overall positive effect on a person’s wellbeing.

### **Aims of the clinic**

The North East CMHT in Barnet has been running a pilot psychoeducation clinic for patients diagnosed with schizophrenia between January 2008 and July 2008. The objective was to provide an innovative service to this client group.

### **Methods**

Staff members were informed of this new service provision and asked to identify and invite patients who might benefit.

The programme was structured around a range of topics: understanding the illness, the models of illness, relapse prevention, medication concordance, family intervention, problem solving skills, 5 areas model of CBT (Wright, et al), stigma (Crisp & Gelder), drug and alcohol misuse (DoH), lifestyle balance, family intervention, and any other topic of individual interest to the patient (excluding psychosis and pregnancy).

A one hour weekly individual session for a total of eight sessions was offered to the patients. The session was collaborative and interactive between the patient and the facilitator. The patients were encouraged to underline aspects of the programme of individual significance and supported to cultivate self efficacy and to identify their strengths on this journey (NIMHE, Roberts & Wolfson).



At the beginning of each session the client was invited to review the previous session, to ascertain his understanding and/or disagreements, to give verbal feedback and to clarify the agenda.

The direct access to Internet sites during the sessions (e.g. Royal College of Psychiatrists, Rethink and MIND) greatly increased the pool of resources immediately available to the patient and the facilitator.

A repertoire of non-exclusive and non-exhaustive skills was found to be useful to

direct the sessions, namely CBT (NICE; Fowler et al), Motivational Interviewing (Miller & Rollnick), Solution Focused Brief Therapy and Transactional Analysis. These skills were drawn from the facilitator's previous training.

### Results

The clinic started at the end of January 2008. The intervention was initially offered to seven patients from a list of sixteen. Four patients completed the intervention. Of the three dropouts, one felt that it was not suitable to her needs, another did not attend and a third

### Advance Notice: October 15 & 16, 2009

#### Faculty Annual Meeting – to be held in the Hilton Hotel, Cardiff

**Theme** “*Evolving services, evolving treatments*”

Following on from the highly successful 2008 annual meeting in Manchester – here are some typical quotes:

“*Best Royal College meeting I have attended*” Prof Peter Jones, Cambridge.

“*Very good conference. Themes covered and speakers were excellent and even felt more in touch with day to day experience compared to Royal College annual meeting.*” (Anon)

- and appreciated by over 300 delegates per day, the Faculty Executive conference committee are pleased to announce that the 2009 programme will be just as varied and topical.

#### Highlights will include:

- National and international speaker plenaries, with built in debating time
- “*How to do it..*” workshops on writing expert court reports; applying to ACCEA; assess & deal with domestic violence
- “*Masterclass*” workshops by recognised national experts in managing bipolar disorder; treatment resistant depression; and many more
- Crisis Resolution & Home Treatment network stream
- Early Intervention Network stream
- Primary Care interface network stream
- Sessions planned on the MHA & CTOs; ADHD; outcomes in mental health; spirituality

Also, trainees and new consultants will be encouraged to submit poster abstracts (deadline August 2009) with the best research being invited to oral presentations, and **a significant and prestigious prize for the winner.**

Finally, ample personal networking opportunities will be available.

**All of this at a reasonable price, with discounts for trainees!**



one who presented with early relapse signs needed a medication review with close monitoring in the community.

Those who completed the intervention reported a high level of satisfaction. One patient has recommended it to the Barnet Service Users Group. The parents of another patient have written an enthusiastic letter to the Chief Executive requesting that this programme be offered to other clients. The patients unanimously felt that they were given an unexpected opportunity to discuss, in individualised ways, their experiences and understanding and they also reported gaining a greater awareness of their strengths and relapse signature.

#### Discussion

The WHO Mental Health Gap Programme identified four core strategies for mental health: information, service development, use of evidence-based intervention and research. With the exception of the latter, the pilot clinic has addressed three of these four core strategies.

The main limitation is the small sample size to assess the validity and effectiveness of this intervention. The other limitation is a selection bias. Patients who attended were usually mentally stable and motivated.

If the programme were to be rolled out in the

future there will be need for clearer selection criteria and to standardise the intervention.

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#### **Do you work as an adult psychiatrist in a prison inreach team?**

There is considerable interest currently in court diversion and developing mental health services within prisons and the Bradley Review is due to report in the Spring. To enable us to guide developments, to provide an informed response to consultations and to support staff working in these areas, we intend, if there is sufficient interest, to set up a Prison Inreach Network.

To join, please contact: [gandcfaculty@rcpsych.ac.uk](mailto:gandcfaculty@rcpsych.ac.uk)



**Winner of this year's trainees' and new consultants' poster and oral presentation prize:  
Suicides in Nottingham: A Descriptive Study of Psychiatric Mortality**

*Dr. Adarsh Shetty, Specialist Registrar in General Adult Psychiatry, Nottingham*

*Dr. Gillian Doody, Clinical Associate Professor in General Adult Psychiatry, Nottingham  
(Supervisor)*

### **Aims**

1. To examine all deaths in patients aged 16 – 65 years in Nottingham who were known to secondary psychiatric care services between 1998 – 2003.
2. To compare the numbers of suicides with numbers in the general population.
3. To identify the predictors of suicide.

### **Methods**

Ethical approval was granted by the local research ethics committee. Patients who died between 1998 and 2003 were identified from our electronic database. AS reviewed case notes and filled out data on a template.

The Office for National Statistics (ONS) provided the causes of death and coroners' verdicts, and the total numbers of suicides in the general population. All data was coded, entered onto a spreadsheet and analyzed using SPSS, version 15.0.

Analysis was conducted using T-tests and chi-squared analyses to differentiate between groups. Logistic regression was performed to identify predictors of suicide.

### **Results**

A total of 307 patients comprised the study group.

Using a logistic regression model, the variables that predicted suicide were age ( $p < 0.001$ ), diagnosis of affective disorder ( $p < 0.001$ ), previous self-harm ( $p < 0.001$ ) and being admitted to a psychiatric unit in the last year ( $p = 0.028$ ). For each increasing year of age up to 65 years, the odds of dying by suicide decreased by 11%.

In total, 275 people aged 16-65 committed

suicide in the study period. Of these, 71 were open to psychiatric services at the time of death.

### **Conclusions**

The majority of patients committing suicide are not known to psychiatric services. Therefore, there is a need for better resource provision for psychiatric services and better links with primary care to improve identification of people at risk of suicide. There is a real need for psychiatry to be provided with the resources it needs to achieve government targets.

### **Learning points for me as a trainee doing research**

Using my research day to do this study has proved an invaluable experience for me. It has helped me get a better understanding of research methodology, statistical tests and the practical difficulties of doing research.

In addition, it has helped me reflect on the clinical practice of psychiatry. Most of us will at some point face the tragic event of a patient of ours committing suicide. If and when this happens to me, I think the results of my study will help me step back and look at 'the bigger picture.' There are people out there committing suicide who are not known to our services. Hopefully, for our patients, we do whatever is humanly possible.

Winning the General and Community Faculty Oral & Poster prize has been an exciting experience. This external validation and encouragement from the Faculty is a real morale booster. It makes it all worthwhile – even those days spent amongst dusty case notes in a dark, dingy room!



## Crisis Resolution and Home Treatment Network

*Dr Mary-Jane Tacchi*

The Faculty of General and Community Psychiatry decided to set up a number of networks, of which we are one of the first. The purpose of the network is to make sure that the faculty executive committee has access to up-to-date, realistic and informed views on issues. This means that the Faculty can contribute to the development of the clinical speciality, ensure high standards of clinical care and service delivery and offer support to psychiatrists working in the field.

I am delighted to take the role of Clinical Lead of the CRHT network and am extremely lucky to have Maria Atkins, Consultant in CRHT in Cardiff, working with me! As many of you know, I was involved in the setting up of a crisis and home based treatment service in Newcastle in 2000. It's a great job but not without problems. I am very keen for us to share our experiences and expertise so that we can all benefit from each other. I am aware that we are at different stages with regard to the development of services and what is apparent is that no two CRHT teams are alike. It would be fabulous if we could incorporate all the good bits of the services that exist as a model for the future.

We launched the network at the General and Community Faculty Meeting in Manchester in October and there was tremendous enthusiasm. There is no set agenda for the network and the idea is that the members shape this with Maria and I acting as co-ordinators. In the first instance I would like to make sure we have reached as many people as possible who may want to join the network. If you want to join or know anyone else who might, please e-mail me at: [mary-jane.tacchi@nmht.nhs.uk](mailto:mary-jane.tacchi@nmht.nhs.uk) or e-mail the Faculty at: [gandcfaculty@rpsych.ac.uk](mailto:gandcfaculty@rpsych.ac.uk)

At the first meeting we generated a list of current issues that I will post on the network. I

would be grateful to you for ideas about how to take these forward. What do you think about us organising a conference? We will have a dedicated session at the Faculty meeting next year and in the meantime I look forward to our discussions by email and any suggestions re the shape of the network.

I am extremely grateful to Elena Baker-Glenn, who is the SpR rep from the Faculty and who has set up a forum discussion group via email. She is amazing.

There are topics of ongoing discussion on the discussion thread – feel free to join and post comments about these issues. These are some of the issues raised at the inaugural meeting of the network at the Manchester meeting:

- Isolation.
- Applicability of urban research to rural areas.
- Models of service e.g. 'Norfolk model' with inpatients/CRHTT being managed together within acute care group.
- Tensions between new ways of working and teams being nurse dominated.
- Standard/benchmark lacking.
- Patient groups seen e.g. age ranges/ Learning disability.
- Gate keeping.
- Meaningful outcomes.
- Balances between home treatment/ assessment.
- Continuity concerns.
- Skill mix? How much medical input needed? Psychologists needed?
- Physical health assessments.
- Research forum.
- Role of the consultant/case load.
- Limiting the time CRHTT involved.
- Exclusions by diagnosis.
- Disincentive of some of targets already set.
- Interfaces.
- How to demonstrate added value.



**Are you a psychiatrist interested in the interface with primary care?  
Here is a network for you**

*Linda Gask*

There is considerable interest in finding ways of working collaboratively and more effectively across the interface between specialist mental health services and primary care. New 'primary care mental health services' are developing, and some PCTs and mental health trusts are looking at the development of medical posts including psychiatrists and GPs with a Special Interest in Mental Health to support these new services.

At the Annual General and Community Faculty Residential Conference in Manchester in October 2008, we launched a network for those interested in this area of working. You do not have to be working with primary care, simply interested in discussing and working with other colleagues in developing this area. This is an opportunity to:

- Share experiences and ideas about ways of improving the interface
- Access a bibliography of the evidence base that we have been developing over the last 6 months
- Share and/or comment on quality indicators for the delivery of new services and in particular the job descriptions for new consultant posts.

- Share your knowledge of developments in working with primary care, both in the UK but also in other countries across the world.
- Generally air your views!

The network is being chaired at present by Linda Gask from Manchester University and Salford PCT, with input from Safi Afghan from Walsall and Frances Burnett from Hertfordshire mental health trusts.

A new forum is also in development which will allow us to have better liaison at College level between the Colleges of Psychiatry and General Practice in order to develop joint statements and work on projects together more effectively. Given that that we have already set up our network, our Faculty is at the forefront of this development in the College, although there is also significant interest in closer working with primary care amongst our Old Age, Liaison and Child and Adolescent colleagues. More news on this will follow shortly.

If you are interested in joining the network, please contact us by e-mail via the faculty e-mail address: [gandcfaculty@rcpsych.ac.uk](mailto:gandcfaculty@rcpsych.ac.uk)

**In-patient accreditation goes from strength to strength**

*Mark Salter*

One of the less anticipated effects of the diversion of psychiatric care into the community has been its impact on the climate of the psychiatric admission wards. Several of the papers presented at the Adult General Faculty's successful AGM this Autumn described how in patient units are becoming 'hotbeds' for the most psychotic and

disorganised patients, now that individuals with lesser degrees of disorder are being successfully diverted away from wards.

As a result, vigilance to the standards of inpatient care is more important than ever, and the College Accreditation for Acute Inpatient Mental Health Service (AIMS) is tackling this



issue. It is, in effect, the psychiatric equivalent of the Egon Ronay guide – Trusts signing up to the service can expect to their wards to be visited by an AIMS team and subject to a rigorous inspection of virtually every aspect of inpatient care imaginable. Early results indicate that AIMS feedback is practical, sensible and effective.

Since its inception over two years ago, people from all of the mental health specialisms (including service users) have undertaken the AIMS inspection training. Their fascinating findings will be reported in future College publications, but early results hint at a marked regional variation in standards as well as between urban and rural locations. Of the total

of 131 visited so far, 45 have reached an acceptable standard of service, while 6 have achieved 'excellence'. Data on the remainder are still undergoing assessment.

The main difficulty facing the project's managers lies in retaining those who have undertaken the AIMS training. Although the project has now trained over 150 individuals, who are no doubt happy to enter this fact in their CVs, only a small number go on to complete more than a handful of visits. If you are concerned about the state of inpatient services and want to do something useful about it, you can contact Mark Beavon at the AIMS base on 0207 977 4994.

### Trainees' update

*Elena Baker-Glenn, SpR representative and PTC vice-chair*

It has been a busy few months for trainees, with developments in the assessment process, examinations criteria, national recruitment, the curriculum, new regulations regarding College registration, and work to improve undergraduate recruitment into psychiatry.

Workplace based assessments have been moved 'in house' and are now being completed through Assessments Online rather than HcAT. All trainees are required to have registered with the College by January 2009 and this registration will be essential to ensure ongoing access to Assessments Online. Several deaneries are piloting a new workplace based assessment tool for higher trainees, Direct Observation of non-Clinical Skills (DOCS), which includes assessments of tasks such as chairing ward rounds, supervising others and giving evidence.

The examination criteria have been revised for 2009 and there will no longer be a requirement to complete six months in Learning Disability or Child and Adolescent psychiatry prior to being accepted as a

Member of the College, although trainees will still need to demonstrate that they meet the competencies for these specialties. For the CASC, ACEs in Psychotherapy and Child and Adolescent or Learning Disability psychiatry are required. The new curriculum will soon be available on the College website and there is a separate curriculum for General Adult psychiatry which higher trainees will need to follow in addition to the generic curriculum.

Trainees in England are preparing for national recruitment into CT1 posts and applications are due in by 16<sup>th</sup> January 2009, with interviews commencing on 9<sup>th</sup> March 2009. The aim is that national selection would become effective for all training grades from 2010.

The College is actively involved in improving recruitment into psychiatry and the Psychiatric Trainees' Committee will have an important role within this area. Many medical schools have already set up psychiatry societies and there is a Royal College Facebook account. Medical students can now become Student



Associate members of the College free of charge and will receive numerous benefits. The student area on the College website is also up and running, and a registration form to become a student associate can be found on the website.

In addition, the College is launching RCPsych Awards in 2009 and it is good to see that trainees have been included, with awards being offered for both a core and higher trainee. The closing date for nominations is 16<sup>th</sup> February 2009. Further information is available on the College website.

The General and Community Faculty have reduced their conference fees for all trainees and it was excellent to see so many trainees attend the conference in Manchester in

October.

The General and Community Faculty are keen to encourage further trainee involvement and we have now set up a group for higher trainees working in general adult psychiatry. We have our own e-mail address for this group: [gandcfacultyspr@rcpsych.ac.uk](mailto:gandcfacultyspr@rcpsych.ac.uk) and also have our own discussion forum. The first trainee meeting took place in Manchester and we hope that we can continue to arrange regular meetings. We also hope to hold a one day conference for higher trainees in 2009.

Please e-mail me at the above e-mail address if you would like to join the discussion forum or if you have any suggestions. Please also let me know if you have any queries or concerns related to training.

### Medical student essay prize in adult psychiatry 2008

*Laura May, University of Oxford*

#### ABSTRACT

Despite 120 years of research and a vast body of literature on the subject, our current state of knowledge concerning the aetiology of schizophrenia remains dishearteningly incomplete. We are unable to state with certainty any causal process underlying this complex mental disorder, and thus rely instead on a complex of risk factors in assessing who may be at most risk of developing symptoms. Contemporary opinions about schizophrenia demonstrate the full range of approaches to understanding mental disorders possible within psychiatry's 'biopsychosocial' model of causation, with currently accepted risk factors spanning all three domains: biological, psychological, and social.

With no coherent theory to link these seemingly disparate areas of investigation, recent research into the causes of schizophrenia may appear fragmented and lacking in overall direction. To some extent,

this is indeed a fair assessment. In order to understand why this is so, we must adopt a historically intelligent approach to the problem; this will complement the scientific judgement with which most researchers will be more familiar. Only by examining what has gone before can we truly evaluate our current state of knowledge, and assess where future research may take us.

This paper fulfils the need for an accessible historical sketch of how theories of causation have changed over the past 120 years. Beginning with Kraepelin and Bleuler, both biological and psychological theories are explored, with a particular emphasis on the three types of theory that have latterly been the focus of most research: genetic, neurochemical and neurodevelopmental.

#### References

For the full text and references, please see: [www.rcpsych.ac.uk/college/faculties/generalandcommunity/medicalstudentprizes.aspx](http://www.rcpsych.ac.uk/college/faculties/generalandcommunity/medicalstudentprizes.aspx)



## Correspondence

### Letter to the editor

#### 'Of CMHTs, GPs, and Mental Health Care'

Dear Dr Agius,

I read the editorial on the above subject with interest as we have created five such posts in Greenwich, London and it has worked quite well for about two years now. We created the posts as part of a change programme in which we centralised our access service to five CMHTs who now work to GP clusters. The clusters were originally defined on the basis of epidemiological data of illness but in the two years we have noticed that it does not ring true of the actual morbidity and are revising the clusters based on a series of data such as referral rates, standard CPA caseload and enhanced CPA case load. We have also used in patient and crisis data to redefine the clusters.

The gateway workers are nurse practitioners who are the first point of contact for GPs and

also liaison between primary and secondary care when we discharge or when GPs want a discharged person to return to see a mental health worker. GPs love it and so do psychiatrists and the real problem is that there should be more of them but we lack the funds to increase the numbers.

The working party is welcome to share our experience as the change has really altered the way we work. We have incorporated NWW by creating inpatient and community consultant posts.

I think it is interesting and probably the way of the future.

With best wishes,

Dr C I Okocha Ph.D; FRCPsych

The Psychiatrists' Support Service is a confidential telephone advice line for members, trainee members and associates of the Royal College of Psychiatrists who find themselves in difficult and/or distressing situations.

The calls we receive cover a wide variety of issues and we have published a series of information guides on some of the more frequent subjects that have arisen. These are available to download free of charge from the college website at:

[www.rcpsych.ac.uk/members/psychiatristssupportservice/informationguides.aspx](http://www.rcpsych.ac.uk/members/psychiatristssupportservice/informationguides.aspx) or by contacting the service directly.

For confidential advice or further information call: 020 7245 0412; e-mail [psychiatristssupportservice@rcpsych.ac.uk](mailto:psychiatristssupportservice@rcpsych.ac.uk)



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## FACULTY OF GENERAL AND COMMUNITY PSYCHIATRY: THE EXECUTIVE

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Dr Anne Bird (Acting Honorary Secretary)

### **Finance officer**

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