



The Royal College of Psychiatrists London Division Newsletter

Editor:
Angela Hassiotis



Editorial

This is my second time as editor having previously edited the newsletter of the Faculty of the Psychiatry of Learning Disabilities for four years. I have generally enjoyed this role and its creative potential; one starts with a general idea of how the issue should look and there is a certain amount of adrenaline

rush when deadlines approach and articles commissioned or promised are not yet submitted...And finally, the finished product, out for consumption hopefully generating some interest or debate and maybe encouraging consultants and trainees to come forward with new material.

A newsletter is a printed report giving news or information of interest to a special group, which in this instance is the membership of the London Division. I must admit that I am not sure what most of you would like to see included in our newsletter or indeed whether you read it at all. However, all of us in the editorial team, take great care to ensure that a combination of commentary on recent policy, reporting on various educational initiatives, inclusion of artistic interpretations of mental health in its broadest sense and coverage of diverse issues that affect our practice provide stimulation and may even increase knowledge and indeed "grab" your attention.

Following the publication of Tony Blair's memoirs, "The Times" leader commented on it being a book that would appeal to anyone who is not only interested in history but also in the concept of modern leadership. Doctors generally have been slow in espousing managerial responsibilities and some years ago might have regarded such positions with scorn. However, these days a trainee or a consultant may complete a degree in medical management and take part in the NHS run leadership programmes. O Tempora! O Mores! The article by Kostas Agath tackles some of the issues related to medical



leadership and anchors his argument within the context of the new NHS white paper.

I have known Paul Bebbington for several years at UCL. He has an incredibly productive research career and as he is about to leave clinical and academic life, I thought it was apposite to ask him to talk about his views on psychiatry and perhaps offer a few tips to the new generation of psychiatrists. We debated what format of the interview should take, e.g. the Proust version of Vanity Fair or a more conventional form, e.g. used by the Psychiatrist for the e-interviews feature and finally adopting the latter.

At the end of June I and another colleague spent two weeks teaching psychiatry of learning disabilities and of addiction to medical students and trainees at the Medical School, University of Nairobi. Our coauthored piece (Kostas Agath, Caleb Othieno, Angela Hassiotis) tries to capture our personal experience as well as the implications of such work for the long term advancement of psychiatry in low income countries.

There are three different takes on the interplay between art, psychiatry and social attitudes to mental illness. Thus, Surya Gaudaman takes as her starting point the empty forms of the asylums in an eloquent exploration of what meaning they have for us today; Gina Soden goes back to photograph remnants of one such place expalining her thinking behind the pictures and Stephen Ilyas reflects on Anish Kapoor's Ernst Jones lecture earlier this summer at the Institute of Psychoanalysis. Alexandra Pitman writes about being an MRC fellow and Alex Bailey and James Main report

on an innovative teaching project at Imperial Medical School and Central and North West London Foundation Trust.

Last but not least, our new chair, Oyepeju Raji, is setting his agenda for his term in his article. Furthermore, we congratulate Kevin Healey on his election to the Chair of the Psychotherapy Faculty (sorry to see him leaving the team) and welcome Andreas Papadopoulos as the incoming member of the editorial team.

I am grateful to all our contributors for giving time and thought to the newsletter and we hope that you will enjoy this

issue.

We would like to hear your suggestions, feedback and ideas for forthcoming issues.

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Incoming Chair *Oyepeju Raji*

I would like to start by paying tribute to the immediate past Chair, Dr Michael Maier who will be a hard act to follow. He held the position of Chair of London Division alongside that of Head of London School of Psychiatry, each one, being a big enough commitment. In the June 2010 newsletter Dr Maier referred to the issue of conflict. A lot has to be said for the skill with which he held both positions, forming a two-way bridge between the College and Deanery in delivering postgraduate training in psychiatry. As a member of the London Division Executive Committee and both the Board and Executive Committee of the London Deanery, I had the good fortune to observe him in both roles clearly demonstrating the advantage. The Head of School of psychiatry is now a co-opted member of the London Division Executive Committee. Balancing conflict is an inherent part of our training as doctors. Increasingly we are called upon to demonstrate our ability to manage potentially conflicting responsibilities such as being a clinician and a manager without 'selling out'. The importance of this is demonstrated in the emphasis on training future doctors to be better equipped to cope with and, indeed, lead healthcare change.

My first thought after becoming the Chair was 'what have I let myself in for'. I take on the role with a mixture of excitement and apprehension. The London Division has the largest membership. Engaging the membership has been a challenge for the Division

and the College as a whole. It would appear that a small number of (the same) people repeatedly put themselves forward for things. This may be because others consider that they do not have the time, skill or anything to offer. I consider the required ingredients are a healthy curiosity and interest in making things work. There is usually help along the way and it is quite rewarding.

I started on this journey through the encouragement of colleagues to become the Faculty Regional Representative (RR) for learning disabilities for South West London in 2005. Fortunately, the RR before me and other colleagues were very supportive. I learnt a lot and found it an interesting developmental experience, an eye-opener to College and Trust activities. I became the Deputy Regional Advisor for South West London in 2007 and one year later the Regional Advisor by virtue of which I became a member of the London Division Executive Committee. I was also Chair of the Specialty Training Committee for General Adult and Old Age Higher Specialist Training and all Core Training in South West London. This introduced me to the inner workings of the London Deanery as a member of the Board and Executive Committee of the School of Psychiatry. I have watched the Deanery emerge out of the shadow of MMC on its way to becoming a Commissioner of postgraduate training and splitting off provider functions.

The role of Chair of Division is to be a 2-way transmitter between the College and the membership. As we all know, the pace of change within the health service is unrelenting. Some would say it picks up ever increasing pace with no time to catch ones breath before the next change arrives. We are called upon to maintain and improve on quality outcomes at a time of financial pressure. Quoting the new College Registrar, Dr Laurence Mynors-Wallis, the role of the College is to help organisations by setting quality standards and advising how such standards might be met. The role of psychiatrists as leaders within their teams and organisations needs reinforcing. This does not involve railroading particular models of care on to patients and unwilling colleagues, but rather using our skills to ensure that patients receive high quality, personalised care.

In July, the health white paper, Equity and Excellence: Liberating the NHS was launched. What will GP Commissioning mean for mental health service provision and for psychiatry? Different from GP fundholding of the 1990s and its successor, Practice Based Commissioning (PBC), GPs will look after individual patient needs as well as have responsibility for wider population health and funding through their commissioning strategies. This creates a range of new opportunities and challenges. GPs will need to engage specialist colleagues, patients and the public to deliver the health outcomes of local populations. The College has a joint working group with RCGP on mental health in primary care which can influence national policy and strategy. On a local level, NHS London is setting up a 'Clinical Senate' in conjunction with the Kings Fund comprising all disciplines and organisational forms to support the London GP Council in coordinating the commissioning of London's health services into the future. Clinicians have a role in shaping health outcomes locally and for this to happen effectively, need to have management and leadership skills. The first cohort of 'Darzi Fellows' set up by NHS London and London Deanery for post-membership specialty trainees have completed their 1 year experience of management and leadership. This experience should not be for the few so that trainees no longer spend their entire budget on one expensive course in the last few months of higher specialist training, but have the opportunity of in-house programmes that include a range of management and leadership learning opportunities throughout their training in preparation for clinical leadership in the NHS.

Continuing with training, the Royal College of Psychiatrists has launched Portfolio Online, an e-portfolio built on the existing Assessments Online platform with additional features. It has been difficult to link learning and progression in psychiatry to the curriculum. This e-portfolio provides evidence to support the attainment of competencies, allowing progress to be monitored. For the career grade psychiatrists, there have been some changes to Continuing Professional Development (CPD). The number of hours required to ensure compliance will remain at 50, however, the External/Internal classification has been replaced by a more practical distinction between Clinical, Academic and Professional activities. This change makes it much less restrictive on how the annual requirement is achieved. CPD online continues to grow with an ever increasing number and variety of modules. Updated information is available in the recently published 2nd Edition of Good Psychiatric Practice: Continuing Professional Development (CR151). Plans for Revalidation are being reviewed in line with feedback from pilots to ensure that it is streamlined, simple and proportionate. To avoid bureaucracy, being workable and cost effective in the pressured and busy environments in which most doctors work and contributing to the quality of patient care. It is now planned for 2011. The new College Report 'Revalidation and Guidance for Psychiatrists' (CR161) has more information.

I congratulate Dr Helen Miller and the Conference Committee on the success of the 2010 International Congress in Edinburgh. I found it more streamlined and 'user friendly'. It was easier to follow the programme and choose what to attend. The difficulty was that there were many more things of interest than was possible to attend. The next one is planned for 28 June to 1 July 2011 in Brighton. The conference theme is 'Evidence and Implementation'.

Plus ca change, plus c'est la meme chose. The more things change, the more they remain the same. I would welcome ideas on improving the engagement of members. I am looking forward to the next 4 years.

Dr Oyepaju Raji
Consultant Psychiatrist
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e-interview: Professor Paul Bebbington



Paul Ernest Bebbington was head of the Research Department of Mental Health Sciences from 2004 to 2009, and has spent the last few months luxuriously, tidying up and writing papers. He is honorary consultant at HMP Holloway, where he has worked for six years.

He did his preclinical training at Jesus College, Cambridge (where I got an athletics blue), and clinical training at Bart's. After obtaining the MRCP, he joined the Maudsley Hospital registrar training scheme in October 1972. He received his MRCPsych in 1974, and then worked as a senior registrar at Cane Hill Hospital from 1975.

In 1977, he obtained a lecturer post at the Social Psychiatry Unit in the Institute of Psychiatry under the direction and tutelage of John Wing. He stayed in that unit and its successor until he became Professor of Social and Community Psychiatry at UCL in February 1996.

He says "I am a butterfly in a way that would not be approved now". His many research interests have included social psychiatry, epidemiological surveys, instrument development, the social causes and concomitants of depression and schizophrenia, psychological mechanisms in schizophrenia, cognitive behaviour therapy, and health service research.

In the last few years, his main research activity, with colleagues, has been in epidemiological and mental health service research, and in using psychological treatments to test psychological theories of psychosis. He had the great good fortune to be involved from the beginning in the National Surveys of Psychiatric Morbidity, the most recent of which was carried out in 2007. These have been enormously productive, and the "writing group" has been particularly creative in its interrogation of the data. He has used the data to examine the nature and correlates of psychotic disorders and experiences.

The mental health service research that he has been involved in has included evaluations of recent policy initiatives, with RCTs of Crisis Resolution Teams and Assertive Outreach Teams. Most recently, he has been taking part in a cluster randomised trial to evaluate two different ways of delivering a new Early Intervention Service in Camden and Islington Foundation Trust.

However what has most stimulated him over the last twenty years has been his involvement in CBT for psychosis. The treatment is theory-based and the evaluation of it was designed not only to establish its effectiveness, but to test the theoretical ideas it was based on. As a result there

is much to be learnt about the psychological processes involved in the generation of psychotic experience. The Prevention of Relapse in Psychosis programme (funded by Wellcome 2001-2007) was a collaboration with KCL, UEA and the University of Manchester. All in all it has led to around 70 papers related to methodology, process and outcome. As a sideline he has been involved in a collaboration with Professor Mel Slater at UCL - a programme using virtual reality in experiments designed to identify psychological processes relating to paranoid ideation in both patients and the normal population.

Since 1993 he has been the Chief Editor of Social Psychiatry and Psychiatric Epidemiology

1. What attracted you to Psychiatry?

My father was a doctor, and it was clear that he would be greatly disappointed if I did not follow in his footsteps. I did not want to disappoint him, but neither did I want to do exactly the things that he had done (he was a Medical Officer of Health: oddly we both ended up doing a form of social medicine). So doing psychiatry was a way of doing medicine without quite doing medicine. Moreover, at university one of my options was to study psychology in the third year of the Natural Science Tripos. To my horror, it took me a while to work out what psychology was about, and this

led me into considerations of what might constitute a good theory in the psychological sciences. (I managed to work this out just before my final exams). I almost ended up doing a PhD in psychology, but people suggested that there were advantages (financial, actually) to moving into abnormal human psychology by doing psychiatry. So by the time I'd finished my clinical training I had already decided on my specialty. As a psychiatrist, I have always spent my time looking over the fence at the flowers in the garden of psychology, and many of my research colleagues are psychologists.

2. What do you think are the challenges for Psychiatrists today?

I think the main challenge is to keep going in the face of the distractions brought about by the changes in the systems that affect us: the organisation of psychiatry and the organisation of psychiatric training. I have seen great improvements in the psychiatric services during my 40 years doing clinical work. I think the development of community psychiatry has been a major improvement. However we have now reached a position where we have effective systems for delivering treatment, but our ability to provide the treatments is limited. This will be a training issue, both for psychiatrists and for their colleagues from other disciplines in the mental health services, but considerable work is needed to develop psychological interventions suitable for deployment in CMHT's, given that care coordinators are not all equally skilled.

What are your views on the course of academic psychiatry in the next 5 to 10 years?

I think academic psychiatry is facing a rather difficult future at the moment. There will always be funding issues of course. Nevertheless, there is plenty to do. My own area of interest, that is, in the social and psychological attributes of psychiatric disorder, will I think continue to be researched. It is even possible that the current imbalance between social and psychological psychiatry and neuroscience may be redressed somewhat. This seems appropriate in terms of the practical applications of the different disciplines. So far neuroscience and molecular psychiatry have not really fulfilled their promise in psychiatry.

3. Who mostly influenced you in your career and why?

One of my early influences working at the Maudsley hospital in the 1970s was Isaac Marks, and I developed an interest in behaviour therapy. I spent six months working on the behaviour therapy ward in 1974, also with Jack Rachman. However I ended up broadening my interests, and when I was working in the Social Psychiatry Unit as a lecturer from 1977, I was exposed to the influences of two very different characters. One of these was John Wing, the other, George Brown. John Wing died in April of this year, but George Brown is still going strong. Between them, they gave me an appreciation of the theoretical basis of psychopathology and classification and of the

social influences on psychiatric disorders. I'm still strongly aware of the ways in which they influenced me, and this remains of practical application in my own work.

4. How would you describe your work with prison inmates?

I work with prisoners inside HMP Holloway as a sort of community psychiatrist. I am not forensically trained, and my work is very different from what forensic psychiatrists do. This is reflected in the name of the team I work with (the Community Mental Health Inreach Team). This operates essentially like an ordinary CMHT. In other words we try to arrange appropriate treatments for inmates and to link them in with supportive external agencies and psychiatric services as appropriate. Apart from a leadership function, my main role is to see women whose psychiatric status is unclear. Doing this provides an unusual slant on nature of psychiatric disorder. Many of the women are survivors of abuse, and there is some trick of the light in the prison that makes me reluctant to use the categories of personality disorder to describe the consequences of disrupted lives. The work in the prison links into some of my current research interests. Thus many of our clients have been abused in childhood, particularly sexually, and they very commonly also have psychotic symptoms, in particular auditory hallucinosis of a classic schizophrenic type, but paranoid symptoms as well. Their self-esteem is, not surprisingly, uniformly in their boots. Because they

have blatantly troubled lives, there is a great reluctance on the part of community mental health teams outside the prison to diagnose these experiences as psychosis. They will insist that the symptoms are drug induced even though they clearly persist long after access to drugs has been blocked or even though the symptoms precede drug use. Or they will make a diagnosis of personality disorder, and downplay or ignore the psychotic symptoms. Sometimes they will use the term pseudohallucinations (a term that leads me to reach for my gun), although the phenomenology is indistinguishable from the experiences of people they would be ready to diagnose as having schizophrenia. These symptoms do in fact seem to respond to antipsychotic medication. It is possible that my most important role is in taking my clients' experiences and symptoms seriously by enquiring about them in a respectful way, and one of my more abiding "delusions" is that being respectful in this manner actually make things better for them.

It is difficult to get junior doctors to work in the prison because they think the experiences in some way idiosyncratic. Sadly, they are probably right to be wary. It is almost certainly true that people shortlisting for training places discount prison experience. This is wrong. Working in a prison involves intensive exposure to psychopathology, and to the social context of mental illness. It provides experience in liaison with other agencies under difficult circumstances in a way that would be of huge

assistance to anyone taking up a post in an ordinary CMHT. Unfortunately these views seem unlikely to change, and problems of recruitment will persist in prison mental health services. This is an issue both for health services and for the criminal justice system.

5. What is the least enjoyable part of your work?

I am not a natural committee person, and I am perhaps a bit intolerant of meetings that don't have a clear purpose. However, oddly, the thing I find most difficult about my job is going to the prison. Although I think working there is an extremely valid activity and I am very committed to it, the place is dispiriting (as perhaps it is meant to be), and I always get a sense of lightening when I walk out through the gates in a way that is not open to my clients.

6. What are your views on professionalism and conflict of interest?

My main worries about conflicts of interest related to the involvement of the pharmaceutical industry in psychiatric education, broadly conceived. There was a time when I thought that it was reasonable that psychiatric education should be subsidised by pharmaceutical companies. This was partly because psychiatric education has historically been underfunded, and the subsidy was in a sense to the NHS. I used to accept payment from drug companies for giving lectures, although the topics I lectured on were very rarely of any relevance to drug

issues (I am so fastidious). For several years I have not done this, as I think it constitutes a real conflict of interest. Pharmaceutical companies clearly have a valid imperative to operate in profit, and this involves effective marketing. We benefit from this in the development of new treatments. However, as is well known, there have been a number of instances when companies have overstepped the mark, both in their use of evidence and in their provision of services to the medical profession. When I go to conferences, I now usually pay for myself, partly because I can, and partly because I think that limited university funds should be used to support juniors.

7. What changes would you like to see in Psychiatric practice including legislation in the future?

One of the beauties of retirement is that I no longer have to think about this (particularly the legislation).

8. What advice would you give to a psychiatric trainee?

Carry on, enjoy the subject, treat your clients with the utmost respect, be open to all the ideas that are around, and think hard and creatively about your subject and about your clients.

Teaching and training in Kenya: a tale of two countries



The Royal College of Psychiatrists has an ongoing interest in international educational developments in mental health, particularly to low and middle income countries which is best exemplified by the International Affairs Unit. Several initiatives are in operation within the unit including a volunteer programme, international divisions and links. About 120 fellow psychiatrists have submitted their details to the volunteer programme and several thousands of pounds have been raised by college members in order to provide some recompense for those who are involved in this work.

My own interest in teaching and training colleagues abroad has arisen out of being a member of the International links committee, RCPsych, which focuses on the promotion of education and training in intellectual disabilities in low and middle income countries. Several committee members give their time to countries with insufficient mental health resources for curriculum development, clinical and research skills training, and even for mental health consultations. Furthermore, I have taken part in similar activities with a broader community education focus through the IASSID Academy.

Late last year, Professor Rachel Jenkins, who has been running a long term mental health research project in primary care mental health in Kenya, asked whether I was interested in providing teaching and consultations in intellectual disabilities to staff at the University of Nairobi Medical School. Another colleague from the Addictions speciality offered to

do the same for substance misuse. Dr Caleb Othieno, Chair of the Department of Psychiatry, University of Nairobi Medical School, has helped to organize our activities and introduce us to colleagues.

Kenya is a low income country with a life expectancy of 54 years, significant HIV/AIDS problems and has suffered recent political upheaval (http://www.afro.who.int/index.php?option=com_content&view=article&id=1036&Itemid=1889).

Local training in psychiatry was started at the University of Nairobi in the early 1980s by pioneer psychiatrists who had trained in the UK. The post graduate programme was modeled on the MRCPsych curriculum but has not changed much since then. There are no sub-specialist departments and no formal links with other academic institutions.

As further specialization is unavailable newly qualified psychiatrists may spend time in South Africa, the UK or the USA in order to gain additional skills, mainly in addictions and child psychiatry.

However, Kenya provides psychiatric training to most sub-Saharan countries. Since the world has become a global village it is important that students and trainees become exposed to what is practiced in other parts of the world. Through this volunteer programme we hoped to have senior mental health professionals visit the department and share their experiences with the staff and the students. We further hoped that these interactions would lead to professional networks and exchange programmes for students as well as staff. For example trainees who wish to spend an elective term at either institution could do so. In addition joint research projects in areas of interest could be developed. Lastly we hoped that the medical students who interact with the visiting faculty could be made aware of the opportunities offered in psychiatry and hence be attracted to making it a career.

The educational activities we offered place over a two week period:

Lectures to 3rd and 5th year medical students

Attendance at outpatient clinics in Child Psychiatry

and General Adult Psychiatry

Plenary lectures to nursing and medical professionals
Clinical and research tutorials with psychiatric trainees

Visits to services and other local facilities (e.g. a private school for children and adolescents with developmental disabilities)

During the visit we also had the opportunity to meet the Head of Department, Professor David Ndetei, who runs an extensive programme of research and heads a charitable Foundation and Dr David Kiima, who is the Mental Health Director in the Ministry of Health.

Several of the lectures took place at Mathare Hospital, which is a national referral hospital with 800 inpatient beds including a drug rehabilitation unit and a forensic inpatient service. We were interested in being informed that this was the hospital where JC Carothers, an influential early 20th century “ethnopsychiatrist”, was superintendent (<http://www.bmj.com/cgi/content/long/312/7039/1167>).

We were generally impressed by the breadth and detail of the undergraduate curriculum and pleased to find colleagues who had spent time studying or practicing in the UK!

Needless to say that intellectual disabilities does not feature particularly in the trainees’ clinical and research experience and is mostly discussed in the context of childhood disorders. Although there are various NGOs and even state facilities that provide care, for those individuals, their activities are not joined up. A recent WHO report (Atlas-ID, 2007), confirms that *“there is a paucity of information and few databases at a national level for intellectual disabilities. ... However, (we) lack the resources, especially funding and technical assistance”*.

We found differences in practice between Kenya and the UK, e.g. our understanding is that ECT is used a lot more frequently and for a wider range of mental disorders; there is considerable lack of other professionals such as occupational therapists and psychologists, therefore, family carers undertake a lot more responsibilities in the management of the service user than expected in the UK.

Comments

1. We found the experience constructive and absorbing. We were impressed by the way in which staff and patients were able to cope with lack of resources. The members of the department that we

met were welcoming and supportive.

2. The lack of screening and diagnostic instruments is considerable as many of those widely used in Western countries are not translated for and standardised for the Kenyan population

3. Although all the trainees have to complete a research project by the end of their training, most of this work is rarely published and thus research capacity building might be a future area of development that could contribute to epidemiological and other evidence based mental health interventions for the local population.

4. Both Dr Agath and I carried out a simple evaluation of our teaching and training; the feedback was very positive indicating that we had provided new information and ideas that the audience had found clinically relevant.

However, an issue that needs addressing is how to sustain any gains made during volunteer visits in the future. For example, we thought that there were possible research opportunities in our respective specialities but in order for these ideas to take flight, there is a need for ongoing contact and mentoring. Therefore, longer term outcomes may only be achievable through setting of common goals that can be realised through email, teleconferencing and joint supervision of projects. It has been suggested that there could be important rewards for both local and international centres of excellence to collaborate on delivering relevant research that can alleviate the stigma and improve quality of life for service users with a wide variety of mental disorders (Njenga, 2009). However, at least in intellectual disabilities, such expectations may be premature in the light of other local competing priorities.

Finally, one of the challenges identified as possibly hampering the volunteer programme might be the cost of such visits which is entirely borne by the volunteer. Most of the expenditure is accommodation and we doubt that host departments in low income countries can find the funds to support the visits financially.

For any colleague interested in this work, it is worth reading the accounts by Professors Philip and Nori Graham and Dr Munro who visited in 2007 and 2009 respectively (<http://www.rcpsych.ac.uk/members/internationalaffairsunit/volunteersprogramme.aspx>).

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Monuments for Society's Misfits



"But there is something at Hanwell more precious than any of these. As a traveller by the Great Western Railway dashes through it, his attention is arrested for a moment by a large building on the southern side of the railway, a plain but handsome structure, which stands cheerfully in an open country, and discloses even to the hasty glimpse of the traveller, as he hurries past, evident indications of careful and attentive management. It is the LUNATIC ASYLUM for the county of Middlesex, one of the most interesting buildings in the kingdom ; a temple sacred to benevolence, a monument and memorial of the philanthropy of our times. " —by [Sylvanus Urban](#), [The Gentleman's Magazine](#) (July- December 1858). John Bower Nichols & Son, London. Vol 34; page 294, 2nd col.

A vast majority of people draw their understanding of psychiatry through the media. The portrayal of the environment or the backdrop of this subject, mainly the old asylums are notably dark and eerie in both written and visual material that is aimed to evoke fear and intrigue about the subject. Even a bland environment such as a hospital hall is provided a sense of drama through the massiveness of the walls, the length of corridors and the play of light and shadows through large windows. If one watched a movie about a disturbed person set against a backdrop of a beautiful bright field or the sanitized settings of *Scrubs*, the TV show, the impact I suspect would not be quite the same. One of the reasons why I might have subconsciously been drawn towards this field would have been this very intrigue. I was one whose attention was drawn towards large ruins of grand design and was keen to understand the purpose and their histories. Archaeology or architecture as a profession would have suited me quite well however a keen interest in psychiatric buildings would be quite a different sort

of interest. These buildings communicate to us the quiet suffering of the inmates who once lived there and remind us about our own vulnerability.

Most grand and beautiful buildings are generally associated with a positive purpose like the seat of a governing body, a lovely home of a rich merchant, a place of worship or a place of entertainment. Oddly enough many of the old psychiatric buildings are also surprisingly very rich in their architectural style. Their architects produced grand palaces of healing, expressing in brick and stone the enlightened therapeutic ideals of their age.

These structures were built with a purity in their purpose. They were massive, but allowing patients to view the natural world outside. The light, air, decent accommodations, useful work, and kindly staff were supposed to help patients recover or remain in compassionate care (Psychiatric News, September 2, 2005). The asylums that were built in the nineteenth and the turn of the twentieth centuries were in fact

built to reflect society's real progress. In them were created music halls, ballrooms, and amenities such as post offices, shops, laundry, parks, farms and even railway lines. Asylums formed the backdrop for administering Moral Treatment for the insane.

Our practices changed after the discovery of many important psychiatric drugs. There was a drive to

integrate patients back into society and the numbers of those staying at long stay hospitals reduced leading to the shutting down of many of these once busy complexes. They were now considered obsolete, a waste of resource and representing the dark ages. In 1961, Enoch Powell, Minister of Health announced that these hospitals must be scaled down or closed in his famous water tower speech.

"There they stand, isolated, majestic, imperious, brooded over by the gigantic water-tower and chimney combined, rising unmistakable and daunting out of the countryside - the asylums which our forefathers built with such immense solidity -to express the notions of their day. Do not for a moment underestimate their powers of resistance to our assault. Let me describe some of the defenses which we have to storm.

First there is the actual physical solidity of the buildings themselves: the very idea of these monuments derelict or demolished arouses an instinctive resistance in the mind. At least, we find ourselves thinking, "Can't we use them for something else if they cannot be retained for the mentally ill?" "Why not at least put the subnormals into them? Wouldn't this one make a splendid geriatric unit, or that one a convalescent home." "What a pity to waste all this accommodation!" Well, let me here declare that if we err, it is our duty to err on the side of ruthlessness. For the great majority of these establishments there is no appropriate future use, and I for my own part will resist any attempt to foist another use upon them unless it can be proved to me in each case that, such, or almost such, a building would have had to be erected in that, or some similar, place to serve the other purpose, if the mental hospital had never existed."- THE RT. HON. J. ENOCH POWELL, Minister of Health; Address to the National Association of Mental Health Annual Conference, 9 March



Many of these facilities were suddenly abandoned in a short span of time and have been at risk under the attack of vandals, arsonists and squatters. Security to such premises has been problematic due to their sheer size. However these buildings have now spurred new interest among a certain type of adventurers. These buildings are now being recorded in photography and video as never before. There are whole websites and video arcades dedicated to abandoned asylums. This is where we talk about the hobby of Urbex or Urban Exploration.

Tales of marvels, wonders, or mysterious phenomena have excited human curiosity and inspired travel for centuries. Old asylums are hotspots for urban explorers who are equally enthralled by necropolises of subterranean catacombs and sewer systems. I am fascinated by the dedication and wonderment of such explorers who visit these sites. Many paint a picture of horror and torture which is far removed from the

original intention of these facilities.

Now being no more a stranger to this environment when I look at these buildings from an insider's point of view I see how misrepresented our institutions are. They were at the time meant to provide the best care that was known to be of any benefit to the mentally ill.

Liz Rochester rightly showed her shock and dismay at the Science Museum for the morbid representation of psychiatry. What we all are pointing at is probably the one thing that we have not truly addressed despite advances in our field-lack of understanding and stigma.

Understandably old asylum buildings are recalled by some patients in fear as it is closely associated with their illness experiences. I recall how a patient described to me her first illness episode while she was a young woman. Although she was well into her fifties, she vividly recalled the corridors



in the asylum that she was in and the rambling grounds which she many a times had tried to run across in the attempt to escape her prison as a young girl of nineteen. In her delusional mind her carers were torturers no doubt and her personal experience would not have been very different if she had been placed in an art deco block next to the cancer treatment centre.

Showcasing our history, including the history of asylums and treatments that were in fashion through the centuries to the public is necessary to dispel the myths and mystery that shroud our practices. A good example of this is the Old Operating Theatre, in St Thomas' Street. There was a time, not in the distant past when anatomists and body snatchers made strange bedfellows. A trip to this museum is a very educational one where the original environment is recreated to provoke thought and discussion about the science

and its practices. This is aided by special lectures provided by knowledgeable curators. By displaying their milestones, other sciences have been able to embrace their pasts and move forward. Why are we not showcasing our history with the same candour and bringing to people's attention about our modern practices and working with the media to achieve a realistic picture of psychiatry? In London hospitals such as the Bethlem Royal has made such attempts. We have many such historical gems in and around London that have stories to tell.

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Images Captured in an Abandoned Asylum, by Gina Soden

"A way of recording the mysterious, unknown to the masses, ruin, dereliction. An adrenaline pumping, interesting, sometimes risky way of photographing history and preserving memories."



Out of Sight, Out of her Mind? "The shoot was inspired by a solo visit. I have since visited the place 18 times. I'm pretty obsessed by it! I am fascinated by the history, the layout, their practices, what the patients did, their stories. I find beauty in the decay of dereliction; so while some may see the picture as contrasting, it's in fact two completely different kinds of beauty complimenting one another. It should be left open for interpretation and make people think. The asylum is worn away, forgotten. Left to its own devices. The patients who once were cared for in there are probably in the same situation due to the 'care in the community' policy set out by the government back then."



GINA SODEN 2010

Bath Time: "These baths were temperature controlled and height adjustable so patients would be comfortable. Not only mental illnesses, but all sorts of people got put in these asylums: epileptics, people who couldn't look after themselves, the elderly and the depressed. And those who were in the final stage of General Paresis, also known as general paralysis of the insane or paralytic dementia, this a neuropsychiatric disorder affecting the brain and central nervous system, caused by syphilis infection"



GINA SODEN 2010

Amoxicillin: "Antibiotic used in asylums to treat common infections including laryngitis, bronchitis, pneumonia, and urinary tract infections."



GINA SODEN 2010

The Day Ward - Cure me of my disease "This was shot on one of the female wards. The green curtains were left behind, it was creepy at first, but I eventually could imagine people in these environments"

For more information and photographs please go to:
www.facebook.com/ginasodenphoto
www.ginasoden.com

Anish Kapoor at the Institute of Psychoanalysis

The Institute of Psychoanalysis Ernest Jones Lecture 2010 was given by the Artist Anish Kapoor. He was also presented with an Honorary Fellowship by the President of the British Psychoanalytical Society, Michael Brearley, who acknowledged his exploration of themes common to psychoanalysis in his work.

Anish Kapoor was born in Mumbai in 1954 and studied at the Hornsey College of Art and Chelsea School of Art Design in the 1970's. He represented Britain in the Venice Biennale in 1990 winning the Premio Duemila Prize and was awarded the Turner prize in 1991. He has exhibited extensively all over the world and had a large solo exhibition at the Royal Academy of Arts last year. He has also won a commission to build a 120m tall tower in the Olympic park.

In his lecture he gave an engaging account of his work, discussing how themes evolved through different phases in his career. He started by emphasising that the creative process starts with the action of producing work and the meaning becomes apparent afterwards, in this sense the work speaks for itself. He stressed the need to play freely with material and allow work to develop which is something that he achieves in his studio, which sounded rather like an oasis for him. With this freedom of play he can be different roles, for example being male, female or child. This comes across in his work and it was pointed out that much of his work is feminine in its concave forms. With fame and recognition he has tried to retain his 'inner space' in his studio to allow this creative process to continue. The audience also brought out similarities between this and analytic interpretation which can give rise to new and unpredictable areas of exploration in the consulting room.

His early work involved objects coated in rich powder pigment in a way that changed the nature of the objects in how they are perceived. He stated that he was not so much interested in the material itself but rather how it is perceived instantaneously by the viewer, in this way he plays



with our perceptual preconceptions of the world in his work. For example large stones seem to shed their weight and become light when covered in blue pigment in his Angels sculpture. He thought these sculptors were illusory in nature and it was this illusion that led to a deeper truth. This effect was enhanced by the fact that the artist's hand in creating these objects is not detectable and in this sense they become 'autogenerated'.

From this work he became interested in utopian themes, the other-worldly nature of his work allowed them to act as transitional objects carrying the viewer closer to utopia. From these objects he moved onto transitional spaces and showed examples of his work containing voids such as the sculpture Adam. The distortion of space that occurs can appear infinitely deep, so taking the viewer to a more fundamental place, losing oneself in the void. He has created many

sculptures varying this theme of void spaces, on many different scales and with many different materials, evolving also in the use of mirrored surfaces in his work.

In more recent years he has gone back to the colour red with wax as the material, as he says the darkness of red has a deeper quality than for other colours. He states that the darkness of red is something we all have an understanding of with our experience of our bodies and emphasised the fundamental nature this has for us. These works were the highlight of his recent exhibition at the Royal Academy and marked a change to more primitive, bodily motives, such as the moulding of a huge block of red wax as it was squeezed through the passages of the RA in the piece entitled Svayambh (autogenerated). The piece 'Shooting in the Corner' was mentioned several times in the evening, which was a canon firing large lumps of molten red wax through a doorway onto the white walls of the RA, a piece with many different interpretations which caught viewers imaginations. As well as an ejaculation aimed at the establishment it had notions of war

and decomposing flesh, but as someone pointed out, it was a source of sheer delight to children in anticipation of the canon firing.

This highlighted how his work is both serious and playful, the meaning which occurs depends on what takes place between the work and the viewer. From his talk I could see how his work can allow us to explore notions of our existence and how we relate to the world which is something in common with psychoanalysis. The audience was thrilled to hear him speak and were keen to share their views on his work. They were certainly glad to have him as an Honorary Fellow.

Examples of his work, including many of the images he used in this talk can be seen on his website: www.anish Kapoor.com

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The new NHS White Paper : *Implications for Medical Leadership*



Medical doctors intuitively grasp *leadership* as a manifestation of their *personality, behaviour and skills*. Thus, performing one's duties in under-resourced environments could be perceived as evidence of medical leadership. However, the '*triumph in the face of adversity*' paradigm, reflects a narrow perception of leadership that has three shortcomings.

First, it cannot account for the links between *medical leadership* and the *leadership by other NHS stakeholders*, including: multi-disciplinary team members; managers of health organisations; commissioners of local services; regulatory bodies.

Second, it cannot explain why psychiatrists are more likely to embrace some leadership initiatives than others: why for example the 'New Ways of Working' enjoyed a mixed reception whilst the 'Fair Deal Campaign' and the 'Professionalism' were widely accepted.

Third, this particular concept of leadership is underpowered to deal with medical leadership conflicts, such as the one between policy and research evidence. The circumstances last year leading to the dismissal of the ACMD (Advisory Council on the Misuse of Drugs) Chair by the Home Secretary is a case in point.

The need for a broader leadership paradigm could be satisfied with the WHO (1993) definition of *managerial leadership*:

"The capacity to secure the willing support of people in the achievement of the organization's worthwhile goals"

This 20 year old definition has lost nothing of its relevance offering numerous advantages when used in the modern NHS.

For example, it makes the leadership subject to the *worthwhile* nature of the goal of an organisation. The WHO publication did not expand on how to ascertain the 'worthwhile' quality of a goal. However, subsequent work suggested that a goal set by an organisation is 'worthwhile' if, at a bare minimum, is supported by *facts* and is endorsed by sociocultural *norms*. For example, an efficient and effective treatment delivered with humanity and equity by properly trained staff following a population needs assessment.

It allows *multiple types* of leadership to co-exist, provided that they all serve worthwhile goal(s) of an organisation. This is an important characteristic of the modern NHS within which we seek the endorsement of leadership by a variety of professions including medical doctors, pharmacists, psychologists, nurses and NHS managers. The co-existence of multiple leaderships does not undermine the importance of medical leadership in the same way that the co-existence of Premiership football teams does not undermine the importance of the champion. Furthermore, the *active pairing* of a medical and a managerial lead within the *Service Line Management* framework appears to be an evolutionary step in serving common worthwhile goals of an organisation.

Finally, it allows the mapping of *conflict* in leadership. Leadership conflicts manifest themselves amongst leaders and/or amongst professional bodies. Most, if not all, conflicts arise from disagreements on what is a *worthwhile* goal to pursue.

Leadership conflicts could be *internal* to the medical leader when the disagreement arises from simultaneous membership to more than one organisation/professional body (such as a Foundation Trust, GMC, Royal College, and Board of Directors). Other leadership conflicts could be *external* arising from disagreement amongst different leaders.

The new White Paper for the NHS brings *external* medical leadership conflicts in the foreground while it permits the *internal* medical leadership conflicts to develop.

A prime example of the former is the introduction of the commissioning of secondary care services

including psychiatric services, by primary care. Within that framework it is predictable that there will be disagreements between *medical specialists* and *general practitioners* in the pecking order of worthwhile goals for commissioning. To make matters more complex a third category of stakeholders, *public health doctors*, will also contribute to the external leadership conflict.

A less visible, but equally important conflict is *internal*. The new White Paper invites joint enterprises between private, third sector and NHS providers. This not only brings together an *external* leadership conflict of differential medical payment depending on who is your employer in the partnership, but most importantly the internal conflict for NHS doctors who also work in the private sector.

It is not the first time that joint commissioning and joint enterprises have been announced in the NHS. What is different now is that the changes are taking place within a medical leadership framework that was virtually unknown in the 1990's. Within those variables, it is imperative that the profession systematically re-examines medical leadership as a *heterogeneous* entity fraught with *conflict*, juxtaposed to the leadership of other stakeholders and shaped by differing view points of structurally defined categories of medical doctors.

Far from being divisive for the medical body, such a piece of work will not only be true to the nature of medical leadership, but it will also be the cornerstone of what the role of the psychiatrist should be in the new era.

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The Autism Act 2009: Will the government act in 2010?



Autistic spectrum disorder (ASD) is a range of complex developmental disorders, characterized by impairment in social functioning, communication difficulties, and restricted, repetitive, and stereotyped patterns of behaviour. Autistic disorder, sometimes called autism, is the most severe form of ASD, while other conditions along the spectrum include a milder form known as Asperger syndrome, Rett syndrome, and childhood disintegrative disorder and pervasive developmental disorder not otherwise specified. Autism is much more common than many people think. The prevalence of ASD in the UK is about 1%. It has been estimated that there are over half a million people in the UK with ASD.

The range of ability and disability in autism means that individuals and their families have diverse needs and require different levels of support. There has been legal framework in the UK to promote the equality of people with autism. Autism is a disability under the Disability Discrimination Act.

A new legislation has been recently introduced to offer further support to the people with autism and their carers. The Autism Act 2009 which received Royal Assent in November 2009 is the first ever disability-specific law in England. The Autism Act started out as a Private Members Bill, drafted by The National Autistic Society (NAS) and taken forward by Conservative MP Cheryl Gillan. The Bill was backed by a coalition of 16 autism organisations.

The government's vision is that 'all adults with autism are able to live fulfilling and rewarding lives

within a society that accepts and understands them.' The Secretary of State has developed a strategy for meeting the needs of adults in England with autistic spectrum conditions. Adult autism strategy "Fulfilling and rewarding lives: the strategy for adults with autism in England", is the Government's first ever strategy for adults with autism in England and was published on 3rd March 2010.

In addition to adult autism strategy, the Autism Act 2009 has made another key provision. The Act puts a duty on the Secretary of State for Health to introduce statutory guidance for local authorities and local health bodies on supporting the needs of adults with autism by 31st December 2010. The Government has launched a 12-week consultation process on the statutory guidance which runs until 22 October 2010. This is to seek views from those with autism, their families, carers, representative organisations and all sectors of society on a number of important issues like diagnosis of autism and provision of training and specialist training for frontline staff.

It appears that shadow of spending cuts hangs over the autism consultation. The coalition government has already warned that the new draft guidance for social care and health services should be seen in the "context" of cuts to public spending. The Department of Health has said that it would examine the "relative costs and benefits" of any measures that "may require additional investment or redistribution of funding". In March 2010, the Autistic Rights

Movement UK (ARM UK) heavily criticised the autism strategy for its failure to demand real change from councils and health trusts, its "weak" language and "derisory" funding of £500,000.

There is no doubt that more needs to be done for the people with autism and their carers. It will be interesting to see how the cuts to the public spending will affect the government's statutory guidance which is due to be released later this year. It will have significant effect on people with autism and their carers and the way services will be delivered to them in the future.

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Research training fellowships in psychiatry:

what they are, where they lead on to, and how to apply.

The average job application usually takes a day; a whole weekend if the job is particularly coveted. Yet most applications for a research training fellowship (RTF) take a couple of years. What takes so long is that as well as having to convince the shortlisters that the usual essential and desirable criteria are met, the onus is on the applicant to design their own job description, carefully timetabling a period of 3 to 4 years.

The application usually is made to one of three major funding bodies (the Medical Research Council, the Wellcome Trust, or the National Institute of Health Research) to pay a salary for this period whilst engaged in the research project of one's choice. The project must be of clinical importance, cost-effective, feasible in design, acceptable, ethical, and achievable within three years. Not only this but the project must be seen to deliver a valuable academic training for the applicant, preparing them for a career in academic medicine. A Masters course or shorter course may be proposed as part of the application and the fees for this will be paid on top of salary. To design a project that satisfies all these criteria is one challenge. The other two hurdles are for the applicant to prove that they are the right person in whom to invest these funds, and that their chosen university department can offer the required standard of supervision and educational support. It is for all these reasons that the form, which can be up to 63 pages long, becomes a full-time occupation.

A few years ago the preparation work would have to have been accommodated around clinical work, whilst using the now defunct SpR Research Day. The introduction of competitive Academic Clinical Fellowship (ACF) posts in 2006 allocated 25% of time to academic work in a post lasting 2 to 3 years. Rather than conducting research *per se*, the aim was to use the post to construct a RTF application, perhaps using a pilot study to demonstrate feasibility. The choice of clinical topic is a function of the applicant's own interests and experience, their supervisor's

expertise, and the resources within that university department. Recent RTF applications from UCL have addressed areas such as MRI imaging to determine dementia aetiology, cognitive testing to investigate theory of mind deficits in dementia, clozapine prescribing in ethnic minorities compared to other groups, and the impact of suicide bereavement on psychosocial functioning. Usually the ACF's supervisor is proposed as the supervisor for the RTF but other academics can be invited as secondary supervisors, or as collaborators, depending on the topic.

Once shortlisted an applicant is called to a panel of interviewers to make a brief presentation showcasing the project, the applicant, and the research environment. Questions follow, intimidating at times, but also constructive in terms of project design. If successful the training programme director is informed and the trainee arranges to come out of programme for research (OOPR). Start dates are negotiable but usually within 6 months of notification. If the application included a Masters course the first year is spent as a student, usually with exams and a dissertation at the end. Some of the RTF may be recognised by the local Deanery and the Royal College of Psychiatrists to contribute to CCT, but the necessary paperwork may take some time. This is more likely if the topic involves contact with patients, or if other clinical work is accommodated into the timetable. Some bodies, such as the MRC, allow up to 6 hours of clinical work a week. An honorary contract is sought for this, much like arranging Special Interest sessions. Joining the local on-call rota on a locum basis may be possible as well as *ad hoc* Mental Health Act assessments.

Life as a research fellow involves being a full time member of a university department, and joining in with departmental meetings and seminars. There is flexibility to take on other projects, such as peer review and subsidiary research projects, but the priority is the research project. The nature of this project determines whether the majority of time is spent at one's desk or in the laboratory, on the

road, or on the wards. The first year involves planning and recruitment, with the inevitable glitch requiring a rethink of the sampling strategy. Years 2 and 3 will involve endless data cleaning and analysis, with the write-up accruing throughout. Key skills sought in applicants are writing, managing and completing a complex project, and coping with rejection. These are not only invaluable in the application process but in the project's execution. Disappointments will occur and can often be used to improve the project.

One disappointment has been glossed over so far – being rejected by a funding body. Where this happens feedback is supplied and can be extremely useful in pointing out which weaknesses to address before applying to the next round. Sometimes the shortlisters may suggest that the project is not worth pursuing, but this does not mean that the work has been a waste of time. From the embers of a failed application a systematic review can usually be salvaged for publication, and the experience itself is useful as an exercise in feasibility for the next attempt. If no funding has been gained by the end of an ACF post options do remain open. By returning to clinical training the Special Interest day can still be used to pursue the application.

Alternatively an ACF may reflect on their experiences in academic life and decide that it no longer appeals. Either way the post has served a valuable purpose.

The future of clinical and academic posts within the NHS is uncertain. By the end of a RTF most trainees are near the end of their higher training. The usual trajectory would be to apply for post-doctoral post in order to combine clinical and academic work, perhaps as a Clinical Lecturer. Alternatively one might complete CCT and apply for a Senior Lectureship. Whatever job prospects the NHS and universities hold, the RTF guarantees a rigorous training in research methods, exposes one to a wealth of academic opportunities, and liberates time to pursue interests not possible in the usual course of clinical training.

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Innovation in teaching: The Psych-e project



For several months now, psychiatrists and actors have been meeting at St Charles Hospital in front of video cameras in order to reproduce the experience of taking a psychiatric history.

This is part of an ongoing project to re-vamp 'Psych-e' - the e-learning resource available to Imperial Medical students on the university's Virtual Learning Environment. The bulk of teaching on mental illness and its management is in a seven week attachment that medical students undertake in their 5th year of study. This

involves spending time on wards attached to a clinical team, observing clinics, interviewing patients, formal teaching sessions and online learning.

'Psych-e' provides recordings of lectures, written materials, assessments and quizzes for students to access along with links to relevant external information. However the site is in its fourth year and during this time there have been significant changes to the curriculum and indeed the training of doctors nationwide. Most notable is the increased emphasis on attitudes and acquisition of skills rather

than simply imparting huge amounts of information about disease and treatment, privileging explicit knowledge acquisition. The original layout was organized by diagnoses with separate modules on schizophrenia, mood disorders, personality disorder and so on. There was a feeling within the Imperial educationists that Psych-e may similarly put too great an emphasis on *what* rather than *how*.

To address this key stake holders and Imperial learning technologists met to discuss potential innovations. The

most exciting proposal was for more 'symptom-based' content that dealt with how patients present rather than merely teaching about individual diagnoses. Particularly the idea of 'Simulated Patients' was discussed as a means of simulating the experience of assessing a patient, recognizing symptoms and thinking about risk and other issues.

A focus group was arranged with medical students who had completed or were at the time doing their psychiatry rotation to get a users' perspective. All agreed that Psych-e is a popular and well-used site which has been verified by usage data from Imperial College. Interestingly all were against having symptom driven modules at the expense of teaching on specific diagnoses. Students felt it would be difficult to integrate knowledge without a background understanding of the diagnostic categories a clinician is looking for when seeing patients. However they supported the addition of Simulated Patients and were particularly keen on video content where a senior psychiatry trainee presents a mental state examination to camera.

Other findings from the focus group included providing explanations for why an answer is right or wrong and replacing the opportunistically videoed lectures with purpose-built podcasts.

This then formed the basis for the redesign. It was decided to produce video modules of simulated patient interviews with psychiatrists focused on a

presentation. The aim would be to demonstrate what a psychiatric assessment *looks* like and to set students the task of compiling a mental state examination and produce a differential diagnosis. It is hoped this will both demonstrate how more complex psychopathology and symptoms can be elicited and how presentations can often be multifactorial and ambiguous. Modules were to be made up of three approximately ten minute clips of an interview with linking introductions and a final talking-head Mental State Exam presented to-camera. In between these clips there would be tailored questions with explanations to focus attention on particular issues.

To go about producing the large volume of material needed for the modules we recruited a team of trainee psychiatrists from across the CNWL trust. The project was met with great enthusiasm from trainees and from a range of grades. People were put into specialty trainee and core trainee pairings and assigned modules according to particular interests they had expressed. The plan was for the pairs to produce a scenario and brief for actors rather than a script. This was intended to give a more organic and true-to-life interaction on screen rather than something that was completely planned out.

At present the majority of the modules have been filmed and are being edited into an appropriate format for the Psych-e website. The redesign has had widespread buy-in from all stakeholders including the Director of Medical Education,

learning technologists at Imperial and other trainees. One of the most enjoyable and interesting parts of working on this new content so far has been the enthusiasm and input from all the trainees involved. Particularly seeing colleagues taking a history based on a scenario they have devised and really 'getting into it'. The actors used are all very experienced at simulating patient in exam settings and with some fantastic performances have managed to really transport the interviewing doctor into a clinical scenario. This has struck us as something that we rarely have an opportunity to see given the pressures of working in a busy trust where most of your work is one-to-one with patients. It has been a privilege to see some colleagues at work (albeit in front of a cameral lens) and we hope to provide the medical students at Imperial with the same valuable learning resource.

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