



Summer 2006

BULLETIN
OF
TRANSCULTURAL SPECIAL INTEREST
GROUP (TSIG)

of

Royal College of Psychiatrists

Editors: Dr Deenesh Khoosal
Dr Derek Summerfield

www.rcpsych.ac.uk/college/sig/trans.htm

Foreword by: Prof. Kam Bhui, Chair TSIG

This edition of the Bulletin follows the July 2006 Annual General Meeting of the Royal College of Psychiatrists held in Glasgow. TSIG hosted and contributed four sessions. These addressed the research evidence for social influences in psychoses, the impact of the mental health act on ethnic groups in the UK, an update on the Delivering Race Equality programme in England and a session on equalities including race, gender and sexual orientation. These sessions were well attended and generated a well received, lucid and considered debate on issues of importance to practitioners.

We are also committed to the development of appropriate curricula to meet the needs of future psychiatrists and mental health professionals in line with Modernising Medical Careers (MMC) and the Post Graduate Medical Education Training Board (PMET-B). These measures will bring the training of psychiatrists in the UK in line with the training in Europe and the rest of the world. This presents challenges as well as opportunities in how to address the cultural capability needs of psychiatrists. In the UK we do not have a Cultural Psychiatry Faculty or Section within the Royal College of Psychiatrists, unlike national psychiatric organisations in Canada and US. The Royal Society of Medicine (UK) has a separate Black and Minority Health Section. TSIG is however affiliated to the World Association of Cultural Psychiatry (WACP) and has long been active in the Transcultural Psychiatry section of The World Psychiatric Association and will be working closely with the newly formed Cultural Psychiatry section of the Association of European Psychiatrists.

We understand that the specific remit of SCEI (Special Committee on Ethnic Issues) is scheduled to end within the next year or two. Discussions are currently taking place at the College to consider how the work of SCEI can be sustained.

The TSIG website is fully operational. We aim to improve communications with our membership. We invite all those receiving this bulletin to use the college website to update membership details as the email database of TSIG members is incomplete. We also need your permission to retain your details for the sole use of the TSIG. Consultation on appropriate services and practices for asylum seekers and refugees is well underway. If you have any thoughts on this matter, or wish to send in a written submission, please contact Dr Kwame McKenzie, secretary to the TSIG.

I was delighted to become the President of the Psychiatry Section of the Royal Society of Medicine (Psychiatry) during the academic year October 2007 to May 2008. I am proposing to hold a series of meetings on Cultural and International Psychiatry, co-hosted with other sections of RSM, TSIG and stakeholders, such as NGOs. If you have proposals or ideas for speakers and sessions, please contact me asap as the programme will be produced by December 2006.

The WACP meeting in Beijing is being held between 23-25th September. TSIG, the College, and the UK are well represented in this exciting programme. Details are available on the TSIG or WACP website. The annual conference of TSIG takes place on 11th October 2006 on Depression and Common Mental Disorders at the Royal College. We look forward to seeing you there.

Forthcoming Events

1. WACP Meeting, Beijing, 23 – 25 Sept 2006. Further details from TSIG or WACP website or Prof. Kam Bhui.
2. Annual Conference TSIG – 11th Oct 2006 at the College on Depression and Common Mental Disorders. Details from Dr Kwame McKenzie.

DEPRESSION AS A REIFIED PANDEMIC

**By: Prof. David Pilgrim, Clinical Dean
Teaching PCT for East Lancashire, Blackburn**

This article provides a critique of the diagnosis of depression, which is situated in wider epistemological debates about the legitimacy of psychiatric categories. Depression is the commonest diagnosis of mental illness, although in Western Europe and North America it is mainly now assigned in primary care, where common distress is labelled without referral on to psychiatric services. Thirty years ago, before secondary services predominantly had become a psychosis and risk management system, and when it was not unusual for psychiatrists to be consulted about refractory cases, Seligman (1975) described depression as the 'common cold of psychiatry, at once familiar and mysterious'.

Despite the prevalence of the diagnosis, lay people tend not to see it as a major mental disorder but they do use the term regularly- even alluding to notions such as 'clinical depression', to distinguish it from merely being depressed (Kleinman, 1988; Rogers and Pilgrim, 1997). Lay people typically connect depression with everyday life and its vicissitudes rather than the alien world of madness (Jones and Cochrane, 1981). However, the original psychiatric view of depression clearly reflected insanity. It arose from Victorian descriptions of asylum-based 'melancholia' in middle class inmates and 'mopishness' in poorer lunatics.

The term 'depression' was used for the first time professionally at the turn of the 20th century, and increasingly after the shellshock problem of the First World War. Thereafter the diagnosis appeared in two separate forms. One continued to link it to a form of madness ('manic-depression', now generally dubbed as 'bipolar disorder'), whereas the other extended the shellshock discourse depicting depressive reactions to stress and loss (Stone, 1985; Kraepelin, 1921; Leonhard, 1959). A division was thus set up between endogenous and exogenous depression. The super-ordinate construct of depression could then accommodate *both* its putative link to biologically driven madness *and* to intelligible adaptations to life crises, such as the loss of people or control. Confirming this expansion of psychiatric interest, post-structuralist accounts note that, after the 'Great War' of 1914-18, the ambit of the profession enlarged from repressive power to include productive power. During the 20th century, the profession offered help that was increasingly 'anxiously sought and gratefully received' (Foucault, 1988; Miller and Rose, 1988). It was no longer simply about the coercive control of insanity. If bio-determinism and a coercive function still predominated in the psychiatric profession during the 20th century (Moncrieff and Crawford, 2001), psychotherapeutic models and voluntarism were also evident in its activities. Misery could then be legitimately responded to by psychiatry as either madness or as a reaction to life events.

The shifting and contradictory codifications of depression have been explored critically by a number of reviewers (e.g. Pilgrim and Bentall, 1998; Dowrick, 2004). Here are some summary points about difficulties with the concept:

- Psychiatry has not developed a stable position about depression.. By the 1960s the view prevailed that two distinct forms existed, one endogenous and the other reactive (Carney *et al.*, 1965). However, others began to argue for a uni-modal distribution of cases (Kendell, 1968). The bimodal distribution model then returned to fashion (Parker, 2000). Moreover, as McPherson and Armstrong (2006) note, during these broad trends over time, types of depression have varied in professional popularity and a plethora of sub-types have waxed and waned. These shifting fads for sub-types of the diagnosis have only partially followed the strictures of DSM revisions; in clinical practice ‘unofficial’ labels from the past can still be found. ‘Clinical freedom’ has ensured a more variegated discourse than that prescribed by the APA DSM committee (American Psychiatric Association, 1994).
- Depression has not been readily distinguished from other diagnoses, especially anxiety states, psychosis and adjustment disorder (Casey *et al.*, 2001). Chronic depression has also been re-framed as a form of personality disorder (‘dysthymic’).
- Psychiatric texts on depression have emphasised different core features. Some have claimed that it is primarily an abnormality of mood (Becker, 1977), others that it is largely a cognitive dysfunction, which triggers affective changes (Beck *et al.*, 1979).
- Experts texts have varied in the number and type of symptoms required to warrant the diagnosis (Mendels, 1970). Some of these have even permitted the diagnosis when core symptoms, such as low mood, are absent (Willner, 1985). A related confusion is that the term ‘depression’ is used as a diagnostic category, a syndrome and a symptom. Some codifications which reflect aetiology in their title (such as ‘endogenous’ or ‘reactive’) are still used in the clinical discourse, even though DSM has been neutral about aetiology since 1980.
- Depression is a putative global pandemic (Murray and Lopez, 1995). However, some cultures have no emotional description of depression, rendering its international meaning highly problematic (Weirzbicka, 1999). To insist on this global status is thus a form of cultural imperialism. Western medicine has pre-emptively assumed that some physical symptoms in minority ethnic patients are ‘masked depression’, without countenancing alternative ways of accounting for these presentations (Fenton and Sadiq-Sangster, 1996).
- In primary care some have argued that anxiety and depression overlap so much that the diagnoses should be abandoned in favour of a single one of ‘neurotic distress’ (Shorter and Tyrer, 2003). However, this might simply replace two dustbin categories with one.

The disputes over aetiology mean that we find elaborate psychosocial explanations alongside bio-reductionist assumptions about CNS dysfunction. Those favouring psychosocial accounts point to the conceptual difficulty in

situating depression as a skin-encapsulated disorder. The latter is considered to be inseparable from the past and present social context that gives rise to personal expressions of misery. By contrast a confluence of the interests of drug companies and biological psychiatry have co-constructed a circular bio-deterministic discourse. Depression is deemed to be a brain disorder requiring anti-depressant medication. When mood lifts following drug administration, a biological aetiology of serotonin depletion is proven (Zoloff, 2002). This is analogous to arguing that a headache is caused by a relative absence of analgesics in the brain. Moreover, the placebo effect in drug treatment for depression is now so evident that it undermines the pharmacological rationale being claimed (Moncrieff and Kirsch 2005). The brain disease logic is also advocated by lobbies dominated by the relatives of psychiatric patients, such as the National Alliance for the Mentally Ill in the USA (NAMI, 2002).

In summary, depression is scientifically dubious but a working consensus seems to exist, across research, clinical and lay communities, that it is a legitimate concept, at least in the bulk of the Western world for now. McPherson and Armstrong (2006) draw attention to the maintenance of the concept in Western psychiatry over the past century, reflecting a resolution within the profession of the struggle for hegemony between bio-determinists and psychoanalytical therapists. The not-so-hidden-hand of the pharmaceutical industry has also played a role in maintaining the legitimacy of the diagnosis (Antonuccio, Burns and Danton, 2002; Koerner, 2002). The UK 'Beat Depression Campaign' of the Royal College of Psychiatrists and similar ones from and other members of the World Psychiatric Association were sponsored by the pharmaceutical industry (Pilgrim and Rogers, 2005).

Logical and sociological aspects of the diagnosis

Depression, like all other functional diagnoses, is flawed by tautology (Pilgrim, 2005). Any functional mental disorder is defined by symptoms, but the latter are then explained by the existence of the disorder, as indicated in the following logic. Q. How do we know this patient suffers from major depression? A. Because they report low mood, loss of libido, nihilistic thinking and they manifest psychomotor retardation Q. Why do they present in such a miserable way? A. Because they suffer from major depression. Tautology is not an explanation but simply an indicative truth convenient to those with the power to invoke it. For example, a triangle is a three-sided single plane figure; true but so what? In this case a focus on a single category (depression) to capture the complexity and mystery of human misery leads to reification. The diagnosis adds little to, and could even detract from, ordinary language accounts of misery coming in all shapes and sizes in a variety of contexts.

Conceptually, mental disorders, like that of depression overlap with one another, or with normality, so much, that their measurement is imprecise and so arguably worthless (Wakefield, 1999). However, this scientific weakness has not led to most in the mental health research community abandoning these categories in favour of more persuasive ones. Nor has it created a major shift from a nomothetic to an idiographic approach to madness and misery in services, even if a minority of clinicians might favour this reform.

Psychiatric knowledge based upon neo-Kraepelinian categories has predominated, leaving dimensional or continua models in a marginal role in the profession, as is evident in the nosological systems of ICD and DSM (World Health Organization, 1992; American Psychiatric Association, 1994). Though vulnerable to internal and external critiques, this de-contextualised categorical approach has been a creaking wall that remains standing. Its survival itself requires some sort of socio-historical explanation. Below three explanatory factors are suggested.

1. Critics divided

A variety of positions have been taken up across the rough divide between social constructivism and critical realism in response to psychiatric positivism. The latter phrase describes the tendency of medicine to confuse the map with the territory- the 'epistemic fallacy' (Bhaskar, 1989). Psychiatric positivism assumes that to name is to reveal reality; that labels non-problematically capture pre-existing embodied disorders, awaiting discovery by diagnosticians.

Szasz (1961) pointed out that minds, like economies, can only be sick in a metaphorical sense. Consequently, according to Szasz the beneficiaries of socially constructed mental illnesses like depression are his own profession, whose role as a proper medical speciality is maintained, and those who are sane by common consent. But, in this emphasis, Szasz preserves the legitimacy of 'true' illnesses. Medical sociologists were later to extend constructivist critiques to physical pathology, though they encountered some resistance in their ranks from philosophical realists (Bury, 1986). These unresolved debates also pushed medical sociologists into resolving whether the symptoms of mental disorder were social constructs or social products (or both) (Busfield, 1988)

A different conclusion from Szasz is drawn by Horwitz (2002), who argues that the 'major mental disorders' are true illnesses but all other categories should be treated as socially created forms of deviance. By contrast, some sociologists exploring the origins of depression (Brown and Harris, 1978) do not challenge the diagnosis in principle. Thus critics vary in how problematic they consider psychiatric diagnosis to be and they vary in their positions about particular causes and constructs. Within these debates, much hinges on the salience attributed to the presence of signs (observable and measurable bodily events) rather than symptoms (what patients say and do) and whether those signs have clear and demonstrable antecedents (aetiological specificity).

For example, let us compare and contrast depression and dementia with reference to the Szaszian critique. In the latter, dementia is not a mental illness but a neurological illness. However, the Szaszian dichotomization soon falters with closer scrutiny. Often neurological signs, such as Parkinsonism, are not evident in patients with diagnosis of dementia and neuropathology can only be proved definitively post-mortem. It is still the psycho-social dysfunction that accrues from memory loss and confusion that warrants the diagnosis of dementia and guides patient management. Also, many transient physical states,

from hypoglycaemia and fever to drug intoxication and concussion, can lead to acute psychological dysfunction, suggesting that Szasz is just as much a hostage to Western Cartesian dualism as those he attacks in his profession.

The neat boundary that Szasz wishes to retain between true and mythological illness is not readily available. One reaction from political science to this disputed dichotomisation has been to frame all illness as deviancy (Sedgwick, 1982). From bio-medicine we find a completely different reaction: dogmatic hoped-for-reductionism. All mental illnesses are simply deemed to be brain diseases (Guze, 1989; Baker and Menken, 2001).

The error of isolating psychiatric labels, like depression, for unique critical scrutiny is highlighted by inflammatory conditions, such as rheumatoid arthritis, psoriasis, irritable bowel syndrome and asthma. Like mental illnesses, they too 'run in families' but do not follow neat genetic patterns. They also have weak aetiological specificity and poor treatment specificity. For example, analgesics, steroids, immuno-suppressants and chemotherapies, developed for cancer, can be applied across a range of inflammatory conditions. Szasz would not dismiss inflammatory conditions as mythological because of the somatic *signs* that appear to warrant their ontology.

Thus doubts about the scientific status of psychiatric categories are expressed in various ways and critics are not of one voice. This lack of unity helps the preservation of psychiatric confidence- the orthodox view is then rendered as legitimate as any other view about mental health problems. However, what both constructivist and realist critics concur on is that psychiatric diagnoses should not be accepted at face value and that the labels reflect a range of interests. The most obvious interest group in relation to psychiatric diagnosis is, well, psychiatry. The application of a categorical, rather than a dimensional or situated, framework to madness and distress has clear advantages for a profession which has been and remains a relatively insecure medical specialty.

2. Professional interests- more than psychiatry

Although psychiatry is the main professional beneficiary of the retention of categories like depression, it is not alone. For example, clinical psychology (the author's profession) has been less than robust in consistently opposing diagnosis and advocating situated psycho-social formulations instead.

Clinical psychology certainly contains those (like the author) attacking a categorical approach but it also has established researchers who are content to hang on to the diagnostic coat tails of psychiatry. There are some socio-cognitive forces that can be identified to account for this mixed picture.

- Because psychology itself is a contested and wide ranging discipline, touching physiology and neurology at one end of the range and sociology at the other, it contains bio-determinists, who readily see eye to eye with bio-medical practitioners.

- Those clinical psychologists who seek research grants for their interventions operate in a context in which medical authority allocates resources according to the gold-standard methodology of randomised controlled trials in clinical populations. The latter must be carved at the conceptual joints of DRGs (diagnostic related groups) to warrant grant allocations. Hence we find RCTs investigating CBT for depression (or schizophrenia or anxiety disorders).
- The main therapeutic rationales deployed and investigated by clinical psychologists are derived from forms of *psychiatric* treatment. The commonest example in current times is 'cognitive therapy'. Despite its name, the latter did not emerge from cognitivism within the academic discipline of psychology but from the work of clinical psychiatrists (Beck *et al.*, 1979; Ellis, 1994). It is the case that some clinical psychologists have argued strongly that formulation should be privileged over diagnosis (e.g. Bruch and Bond, 1998) but the fact that this minority need to special plead for their position indicates a comfort with DRGs in the mainstream of the profession.

These epistemological trends and financial incentives together divert clinical psychologists from a consistent position, about privileging unique formulation over diagnosis.

3. *The pharmaceutical industry*

An interest group that partially drives and sustains particular diagnoses like depression is the pharmaceutical industry. Since the putative 'pharmacological revolution' of the 1950s, the drug companies have invested in research into the treatment of diagnostic categories, thus shoring up or amplifying their legitimacy. In the first part of the 20th century, drugs were used only as adjuncts to psychiatric treatment. But the last fifty years has witnessed an important shift of emphasis. Since the 1950s, we now have 'anti-depressants' and 'anti-psychotics', their titles suggesting that they are magic curative bullets, no longer simply adjuncts (Moncrieff, 2002).

Despite the undoubted role and relevance of the pharmaceutical industry in sustaining diagnostic reifications, the continuation of scientifically dubious categories is only partially attributable to its interest work. The strongest evidence for this claim is that categorical reasoning was evident and powerful within psychiatry, even when few commercially important agents were utilised (such as the use of bromides and paraldehyde) and their role was secondary within the medical management of cases.

Conclusion

Psychiatric diagnoses do not stand or fall on their scientific merits. Arguably, all functional psychiatric diagnoses have little or no scientific worth but they survive. And contestation about psychiatric diagnosis cannot be reduced to inter-professional disputes alone. Not only have these diagnoses at times been

problematized by psychiatrists themselves, nearby professionals making bids for legitimacy, like clinical psychologists, do not offer a consistent alternative to, and may even be content to utilize, psychiatric categories. However, the intra-professional dispute between biological and psychodynamic psychiatrists has played an important part in shaping shifts and compromises in DSM (Bayer and Spitzer, 1985).

Modern professional and industrial interests shape and sustain categories like depression but they do not totally determine its existence. In non- and pre-psychiatric cultures, psychological difference was still codified, stigma was still attached and social exclusion and control was still apparent (Jodelet, 1991; Westermeyer and Kroll, 1978). 'Mental illness' or 'mental disorder' may be a by-product of modern Western psychiatry but madness and misery have always been with us globally, as have been the societal reactions of fearful distrust, derision, rejection and social control. The drug companies certainly benefit from reifications like depression to sell their products, but categorical medical reasoning about madness and misery preceded the 'pharmacological revolution'.

The lay plausibility of psychiatric diagnosis is variegated. For example, psychiatric labels may be willingly accepted or cynically dismissed by different social groups in different socio-historical contexts and acceptability even varies from one diagnosis to another. In recent times, a strong relatives' lobby has existed to defend the diagnosis of depression and to define its bio-deterministic status. By contrast the label of schizophrenia is less willingly embraced by its recipients (Rogers, Pilgrim and Lacey, 1993). The general population in developed societies is so 'protoprofessionalised' (de Swaan, 1991) about the term 'depression' that it has now entered the vernacular. Despite criticisms rehearsed above about the coherence of the diagnosis, it seems to have a strong lay, not just professional credibility, at least in Eurocentric cultures for now.

Professionals highlight that the general public are often ignorant or confused about psychiatric diagnoses (Jorm *et al*, 1997). But given that the latter are contested and vulnerable to so many pre-empirical and empirical criticisms, they have no inherent right to be privileged. Professional and lay discourses about mental disorder overlap but they cannot be conflated, and it is open to dispute which one is superior and when.

Although functional psychiatric diagnoses like depression are scientifically dubious, their legitimacy for now largely remains. Moreover, grounds for querying the scientific merits of the diagnosis of mental disorder can be applied reasonably in parts of physical medicine. Many diagnoses of physical pathology are vulnerable to similar criticisms, such as a lack of aetiological and treatment specificity. However, it may be that psychiatric diagnoses are distrusted more because of the skewed balance of symptoms to signs. Their role in the deprivation of liberty without trial and the peculiar shame and stigma they invoke in recipients and others does put them in an unusual socio-political position in society.

The professional response to this contention (evident in the constant revision of the DSM system) has been to seek greater consistency in psychiatry's knowledge claims. However, the problem for DSM is that consistency may improve reliability but it does not prove validity. Also, by insisting on aetiological neutrality, DSM further undermines confidence in its own categories as aetiological specificity is an important defining feature of validity. If psychiatry wants to retain scientific and social plausibility in its claim to expertise about human misery then it must enter rather than evade the contention explored in this paper. ICD and DSM committees to date have not dealt seriously with this contention.

References

- American Psychiatric Association (1994) *Diagnostic and Statistical Manual of Mental Disorders* Washington DC: APA.
- Antonuccio, D.O., Burns, D.D. and Danton, W.G. (2002) Anti-depressants: a triumph of marketing over science. *Prevention and Treatment* 5, 1, 25.
- Baker, M. and Menken, M. (2001) Time to abandon mental illness. *British Medical Journal* 322:937.
- Bayer, R. and Spitzer, R.L. (1985) Neurosis, psychodynamics and DSM-III. A history of the controversy. *Archives of General Psychiatry* 42, 187-196.
- Beck, A.T., Rush, A.J., Shaw, B.F. & Emery, G. (1979) *Cognitive Therapy of Depression*. New York: Guilford Press.
- Becker, J. (1977) *Affective Disorders*. New Jersey: General Learning Press.
- Bhaskar, R. (1989) *Reclaiming Reality*. London: Verso.
- Bruch, M. and Bond, F.W. (1998) *Beyond Diagnosis: Case Formulation Approaches in CBT*. London: Wiley.
- Brown, G. and Harris, T. (1978) *Social Origins of Depression* London: Tavistock.
- Bury, M. (1986) Social constructionism and the development of medical sociology. *Sociology of Health and Illness* 8, 137-69.
- Busfield, J. (1988) Mental illness as social product or social construct: a contradiction in feminists' arguments? *Sociology of Health and Illness* 10, 4, 523-542.
- Carney, M.W.P., Roth, M. and Garside, R.F. (1965) The diagnosis of depressive syndromes and the prediction of ECT response. *British Journal of Psychiatry* 111, 659-74.
- Casey, P., Dowrick, C. and Wilkinson, G. (2001) Adjustment disorders: fault line in the psychiatric glossary. *British Journal of Psychiatry* 179, 479-80.
- Davidson, J. and Meltzer-Brody, S. (1999). The underrecognition and undertreatment of depression: what is the breadth and depth of the problem? *Journal of Clinical Psychiatry*, 60s7, 4-9.
- de Swaan, A. (1991) *The Management of Normality*. London: Routledge.
- Dowrick, C. (2004) *Beyond Depression: A New Approach to Understanding and Management*. Oxford: Oxford University Press.
- Ellis, A. (1994) *Reason and Emotion in Psychotherapy* New York: Birch Lane Press.
- Fenton, S. and Sadiq-Sangster, A. (1996) Culture, relativism and mental distress. *Sociology of Health and Illness* 18, 1, 66-85.
- Foucault, M. (1988) Technologies of the self. In L.Martin (ed) *Technologies of the Self* London: Tavistock.
- Guze, S. (1989) Biological psychiatry: is there any other kind? *Psychological Medicine* 19:315-23.
- Hoggett, B. (1990) *Mental Health Law* London: Sweet and Maxwell.
- Horwitz, A.V. (2002). *Creating Mental Illness*. Chicago: University of Chicago Press.
- Jodelet, D. (1991) *Madness and Social Representations* London: Harvester Wheatsheaf.
- Jones, L. and Cochrane, R. (1981) Stereotypes of mental illness: a test of the labelling hypothesis. *International Journal of Social Psychiatry* 27, 99-107.
- Jorm, A.F., Korten, A.E., Jacomb, P.A., Christensen, H., Rodgers, B. and Pollitt, P. (1997) 'Mental health literacy': a survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment. *Medical Journal of Australia* 66, 182-87.

- Kendell, R.E. (1968) *The Classification of Depressive Illness* Maudsley Monograph Number 18. London: Oxford University Press.
- Kleinman, A. (1988) *Rethinking Psychiatry*. New York: Free Press
- Koerner, I.M. (2002). First you market the disease... then you push the pills to treat it. *Guardian*, 30 July, G2, 8-9.
- Kraepelin, E. (1921) *Manic-Depressive Insanity and Paranoia* (trans. M. Barclay) Edinburgh: Livingstone.
- Leonhard, K. (1959) *Die Aufteilung der endogenen Psychoses* Berlin: Akademie Verlag.
- McPherson, S. and Armstrong, D. (2006) Social determinants of diagnostic labels in depression. *Social Science and Medicine* 62, 1, 50-58.
- Miller, P. and Rose, N. (1988) The Tavistock programme: the government of subjectivity and social life. *Sociology* 22, 2, 171-92.
- Moncrieff, J. (2002) Drug treatment in modern psychiatry: the history of a delusion. Paper presented at the Critical Psychiatry Network Conference, Birmingham England.
- Moncrieff, J. and Kirsch, I. (2005) Efficacy of antidepressants in adults. *British Medical Journal* 331, 155-157, 16th July.
- Moncrieff, J. and Crawford, M. (2001) British psychiatry in the 20th century- observations from a psychiatric journal. *Social Science and Medicine* 53, 3, 349-56.
- Murray, C.J.L. and Lopez, A.D. (eds) (1995) *The Global Burden of Disease*. Cambridge MA: Harvard University Press.
- National Alliance for the Mentally Ill (2002) *Understanding Major Depression. What you need to know about this medical illness* Arlington, VA
- Parker, G. (2000) Diagnosis, classification and differential diagnosis of the mood disorders. In M.G. Gelder *et al.* (eds) *The New Oxford Textbook of Psychiatry* Oxford: Oxford University Press.
- Pilgrim, D. (2005) Defining mental disorder: tautology in the service of sanity in British mental health legislation. *Journal of Mental Health* 14, 5, 435-44
- Pilgrim, D. and Rogers, A. (2005) Psychiatrists as social engineers: a study of an anti-stigma campaign. *Social Science and Medicine* 61, 12, 2546-56.
- Pilgrim, D. and Bentall, R.P. (1998) The medicalisation of misery: a critical realist analysis of the concept of depression. *Journal of Mental Health* 8, 3, 261—74.
- Rogers, A., Pilgrim, D. and Lacey, R. (1993) *Experiencing Psychiatry: Users' Views of Services* Basingstoke: Macmillan.
- Sedgwick, P. (1982) *PsychoPolitics* London: Pluto Press.
- Seligman, M.E.P. (1975) *Helplessness: On Depression, Development and Death*. San Francisco: Freeman.
- Shorter, E. and Tyrer, P. (2003). Separation of anxiety and depressive disorders: blind alley in psychopharmacology and classification of disease. *British Medical Journal*, 327,158-160.
- Stone, M. (1985) Shellshock and the psychologists. In W.F. Bynum, R.Porter and M. Shepherd (eds) *The Anatomy of Madness* London: Tavistock.
- Szasz, T.S. (1961) The use of naming and the origin of the myth of mental illness. *American Psychologist* 16, 59-65.
- Wakefield, J.C. (1999) The measurement of mental disorder. In A.V. Horwitz and T.L. Schied (eds) *A Handbook for the Study of Mental Health* Cambridge: Cambridge University Press.
- Westermeyer, J. and Kroll, J. (1978) Violence and mental illness in a peasant society: characteristics of violent behaviours and the 'folk' use of restraints. *British Journal of Psychiatry* 113, 529-41.
- Wierzbicka A. (1999). *Emotions across Languages and Cultures: Diversity and Universals*. Cambridge: Cambridge University Press
- Willner, P. (1985) *Depression: A Psychobiological Synthesis*. New York: Wiley.
- World Health Organization (1992) *The ICD-10 Classification of Mental and Behavioural Disorders* Geneva: WHO.
- Zoloff (2002) Website www.zoloff.com?index.asp?pageid

CRISIS FOR INTERNATIONAL MEDICAL GRADUATES (IMG's)

**By: Dr Roopa Singh
SHO in Psychiatry, Leicester**

On 7 March 2006 the Home Office announced that it would be making changes to the UK's immigration rules to effect a points-based system of managed migration. Implementation of the new regulations would be staged over a period of time, but some regulations affecting postgraduate doctors would come into effect from 3 April 2006. There was no consultation on this and the implementation with immediate effect meant that doctors already in the UK had no time to adjust or make alternative arrangements

From 3 April 2006, non-EEA or non-resident doctors (IMG'S) will no longer be covered by the previous "postgraduate doctor and dentist category", also known as 'permit-free' training status. Instead, Trusts will need to apply for a work permit before employing candidates not covered by any other leave to remain in the UK and to demonstrate, via the resident labour market test, that there are no suitable EEA nationals to take up the post. The only exemptions to this are non-EEA doctors who have graduated from UK universities, who will be eligible for the postgraduate doctor and dentist category in order to complete the foundation programme and be eligible for full registration with the GMC. The new immigration rules, which were introduced on 3 April, bar NHS hospitals from recruiting junior doctors from outside the EU unless they can demonstrate that no UK doctor is available to fill the post.

There is clearly a need for a new system where the number of doctors coming to the country is based on the needs of the NHS, but what the government is doing is unfair on the doctors who are already here. It seems that whilst the government was considering and finalizing the introduction of these, the PLAB test was continued in earnest. Indeed, from the beginning of 2005 the places for PLAB part 2 were increased to 10000 per year from around 2000 per year, a substantial increase which clearly was completely unnecessary given the imminent changes in visa rules. There was no legitimate discussion between the relevant stakeholders including the GMC as PLAB test would have been an important aspect to consider as part of the overall manpower planning.

The government has rushed through new visa restrictions for overseas doctors without regard for their welfare. This has caused a huge amount of confusion and anxiety among overseas doctors. New doctors, who have invested time and money to come to UK, find that their careers are being ruined as training opportunities disappear. For those already here, they will have to stop their training and go back or try for non-training posts, with no career progression. This is unfair to the doctors who are already here. Many are going to have to uproot themselves, their families, remove children from schools, sell homes, and make arrangements to leave, all at very short notice. But, beyond the human tragedy for these doctors, the new rules could also damage service provision more widely. Specialties, such as psychiatry, geriatrics, O&G and A&E, have for many years depended on the commitment and skills of overseas

doctors. The implementation of new immigration rules leads to discrimination against doctors who have been the backbone of the NHS since its inception. These doctors have devoted a huge amount of talent, time, and energy to the NHS. The UK's reputation in international medicine is being harmed and compromised.

Health minister Lord Warner says the change was necessary, as competition for jobs has increased. "What we have done is make sure that we are becoming more self-sufficient in training our own doctors," he said. "There has been a 70% increase in the number of medical school intakes over the last seven or eight years and we have to find and ensure that there are postgraduate specialist training posts."

The British Association of Physicians of Indian Origin (BAPIO) estimates that 15,000 doctors may have to leave the UK heavily in debt and without having completed training or obtaining qualifications, despite having been encouraged to come to the UK. The British Medical Association accused the government of changing the rules without regard for welfare. It estimates that 9,000 doctors in short-term junior and senior house officer grades would be affected.

The BMA and BAPIO are calling for:

- Overseas junior doctors who are currently working in the UK to be allowed to complete their training without a permit.
- Overseas doctors who are living in the UK, but are not currently employed, to be given a period of grace of up to two years for training.
- Doctors who come from overseas, but who graduated from a UK medical school, to be allowed to complete all their training in the NHS, not just the two years stipulated by the new rules.

Your help and support for IMG's is essential on a variety of levels. Our President has spoken out about this injustice and has written to Lord Warner as have several of the Presidents of the other Royal Colleges. Don't let us down. Please support our campaign against this injustice.

DEPRESSION: EPIDEMIC OR PSEUDO-EPIDEMIC?

**By: Dr Derek Summerfield, Institute of Psychiatry, King's College,
London**

There are a number of under-examined fault lines running through the medical literature on depression, and current clinical practice in UK. There is too often a narrow, reductionist reliance on biological and cognitivist formulations, neglecting the social and cultural construction of the human mind. For a start, the term "depression" tends to be used without qualification in the medical and mental health literature, as if it was settled that we were always referring to a

timeless, free standing, internally coherent, universally valid, biologically based disorder with a life of its own 'out there'. Yet in everyday usage, as much by doctors as by the general public, "depression" can mean something figurative or literal, can denote a normal or abnormal state, and if abnormal either a individual symptom or a full-blown disorder. And though depression -as-disease may have acquired the status of a natural science category, this was an achievement rather than a discovery: the history of the concept demonstrates the gradual incorporation of a Western cultural vocabulary of guilt, energy, fatigue and stress. (1)

Even the authors of international classification systems like ICD and DSM publish a disclaimer to the effect that their categories are not facts of nature (as, say, a tree is) but phenomenological groupings emerging as committee decisions. Indeed it was not inevitable that depressed mood should be seen as the cardinal symptom, and furnish the name of the clinical syndrome. Other symptoms could have sufficed: "sleep disorder syndrome" or "concentration and drive disorder syndrome". (2)

Orthodox teaching has been that a 'functional shift', the presence of so-called biological features, points to medically significant depression (and responsiveness to anti-depressants). But bar a small subset of severe cases, I would contend that there is no reliable demarcation of depression from ordinary unhappiness or misery on this basis. Poor sleep and concentration, weight loss, reduced motivation and drive, anhedonia etc (as well as suicidal ideas) not uncommonly accompany ordinary misery as well. The line between depression and unhappiness has been drawn by man, not by nature.

A repeatedly recycled assertion is that 1 in 6 of the population will have major depressive disorder during their lifetime, and that up to 75% of these will not be known to health services. This is a modern myth: in a WHO study in 15 cities around the world, recognition of "depression" by doctors made no difference. Indeed those not recognised did slightly better than those who were! (3) This surely suggests presentations of circumstance-related distress, not of depression as psychiatric disorder. Moreover, I would suggest that if a psychiatric model claims to capture no less than 16% of the hugely heterogeneous subjects who comprise a whole society, there is something wrong with the model. Quantitative screening instruments for depression, with their demand characteristics and narrow focus on "symptoms", generate inflated prevalence estimates because of their structural inability to assess the whole person-in-life context.

In 1996, just before the Royal Colleges of Psychiatrist and General Practitioners began a "Defeat Depression" campaign, they surveyed lay people's attitudes to depression and its treatment. (4) The views they elicited tended to portray depression in terms of emotional problems, like unhappiness, caused primarily by social and situational factors, and not something to take to GPs. 78% of the 2003 people polled saw anti-depressants as addictive, and liable to dull symptoms rather than solve the problem. The Royal Colleges seem to have been undeterred by these findings, which were rather at odds with their view of "depression" as straightforwardly connoting a psychiatric disorder. Indeed the

Royal Colleges initiated the “Defeat Depression” campaign because they believed that 50% of people with depression did not consult their GPs. They wanted to increase this figure. But was the lay view wrong? We can see here how professional pronouncements can contribute to a blurring between unpleasant but commonplace mental states, part of life, and those associated with objective dysfunction and breakdown, meriting medical attention.

The other explicitly stated reason for the campaign was the belief that GPs often missed depression anyway. Since then the notion that there were large numbers of undiagnosed cases has been remarkably tenacious. Why? There is in fact no sound evidence for an epidemic of depression (as psychiatric disorder) in the UK. On the other hand the case for an epidemic of antidepressant prescribing is now cast iron. In Britain prescriptions rose from 9 million to 21 million during the 1990's, and in the USA have doubled in only 5 years - mirroring the production and marketing of SSRI antidepressants. 1 in 8 of the US adult population has been prescribed an SSRI in the past year. I wonder whether the Royal College of Psychiatrists is gratified by these trends.

What remains striking is how unrobust the evidence base for antidepressants still is, particularly for the mild/moderate cases that account for the majority of all prescriptions. (5) Part of the reason is surely that antidepressants will not cure human misery, whether presenting in primary care or in psychiatric clinics. Indeed many of those difficult cases described in psychiatric journals as having “treatment resistant depression” may be “resistant” precisely for this reason. GPs often tell a mixed bag of patients gathered under the rubric of “depression” that they need anti-depressants to correct a “chemical imbalance”. (6) So too with patients offered counselling for “depression”: they get better at the same rate as those who continue to see their GPs only. (7)

It is possible that this repeatedly aired assumption about under-recognition at primary care level has itself led GPs to prescribe more readily. Further, some GPs prescribe for low mood per se, even if other features of the syndrome are absent, and the simpler dose regimens of SSRIs by comparison with tricyclics have encouraged this. Patient feedback is influenced by placebo effects, and by factors like non-specific sedation that have nothing to do with “anti-depression”. People whose record indicates prior prescription of anti-depressants are more likely to be prescribed them again at a later time by other doctors. It remains to be seen if NICE guidelines, which do not recommend anti-depressants as the primary intervention in ‘mild/moderate’ cases, make a difference to these trends. (8)

Pharmaceutical promotion of SSRIs made much of the claim to have fewer side effects than the tricyclics, and this contributed to the confidence with which GPs recommended them to patients. In view of the public concern about addictive effects evident in the survey described above, it is ironic that discontinuation reactions are now emerging as a distinct clinical problem (extending to litigation against doctors in USA), both in SSRIs and in other new anti-depressants like Venlafaxine.

The weak construct validity of psychiatric categories, and the dominance of empiricism over theoretical development, are overarching issues for the psychiatric profession. (9). Both are apparent in the discourse about depression. So too is a lack of explicit reflection on the ideological and societally framed nature of medical practice, which would need to take account of cultural shifts in attitudes to adversity and the emergence of an expressive, less stoical individualism. (6) The surge in anti-depressant prescribing is as much a cultural trend as a medical one, reflecting the rise of a medicalisation and professionalisation of everyday life and its problems across Western societies. (10)

There is also an important international dimension. “Depression” is said to contribute 12% of the total burden of nonfatal global disease. (11) The World Health Organisation describes it as an epidemic that within two decades will be second only to cardiovascular disease in terms of global disease burden. But “depression” has no exact equivalent in non-Western cultures, not least because these do not share a Western ethnopsychology that defines “emotion” as internal, often biological, unintentioned, distinct from cognition, and a feature of individuals rather than situations. (12) Non-Western peoples would tend to see the problem in situational and moral terms (as some Western citizens still do, as evidenced by the survey described above), though when they migrate to the West they become more likely to ascribe to a depression-as-disease model. (13) This is to highlight the work of culture and its opinion formers- including the medical profession- in shaping a particular interpretation of the world.

Thus the use of Western-derived quantitative instruments to estimate population prevalence’s worldwide is likely to commit a category fallacy, which is the assumption that mental and bodily state phenomena mean the same thing in whatever setting they are detected. There is no such thing as depression, if by this we mean (as the WHO appear to mean) a unitary, universally valid, pathological entity requiring medical intervention. Such claims seem a serious distortion, one serving to deflect attention away from what millions of people might cite as the basis of their misery, like poverty and lack of rights. The one clear-cut beneficiary would be the pharmaceutical industry, with its vested interest in the biologisation of the human predicament.

To conclude, sociological, anthropological, philosophical, and indeed political frameworks are needed to understand human pain and distress in all its nuances and ambiguities, shaped by context and culture, and above all centred on meaning (no psychiatric model captures meaning). The depression-as-disease model does have some purchase (a seriously ill subset) but as a general formulation it says rather more about the contemporary dominance of medicalised ways of seeing than it does about the world ‘out there’. (2)

(this is an expanded version of a paper with the same title in Journal of Royal Society of Medicine 2006; 99:161-2)

References

1. Jadhav S. Cultural origins of Western depression. *International Journal of Social Psychiatry* 1996; 42: 269-86.
2. Summerfield D. What exactly is “depression”? *BMJ* 2006;332:1154.
3. Goldberg D, Privett M, Ustun B, et al. The effects of detection and treatment on the outcome of major depression in primary care: a naturalistic study in 15 cities. *Brit J Gen Pract* 1998; 48: 1840-44.
4. Priest R, Vize C, Roberts A, Roberts M, Tylee A. Lay people's attitudes to treatment of depression: results of opinion poll for defeat depression campaign just before its launch *BMJ* 1996;313:858-9.
5. Moncrieff J. The anti-depressant debate. *British Journal of Psychiatry* 2002;180: 193-4.
Summerfield D. Recent developments and controversies in depression. *Lancet* 2006;367:1235.
Friedli K, King M, Lloyd M, et al. Randomised-controlled assessment non-directive psychotherapy versus routine general-practitioner care. *Lancet* 350; 1662-65.
8. National Institute for Clinical Excellence. Depression: management of depression in primary and secondary care. London: NICE, 2004.
9. Pilgrim D, Rogers A. Social psychiatry and sociology. *Journal of Mental Health* 2005;14:317-20.
10. Summerfield D. Cross-cultural Perspectives on the Medicalisation of Human Suffering. In *Posttraumatic Stress Disorder. Issues and Controversies* (ed G.Rosen) 233-45. Chichester: John Wiley, 2004.
11. Ustun T, Ayuso-Mateos J, Chatterji S, Mathers C, Murray C. Global burden of depressive disorders in the year 2000. *Brit J of Psychiatry* 2004;184:386-92.
12. Lutz C. Depression and the translation of emotional worlds. In *Culture and depression. Studies in the anthropology and cross-cultural psychiatry of affect and disorder* (eds A. Kleinman, B.Good) 63-100. Berkeley: University of California Press, 1985.
13. Karasz A. Cultural differences in conceptual models of depression. *Social Science & Medicine* 2005; 60: 1625-35.

TSIG AT AGM OF ROYAL COLLEGE OF PSYCHIATRISTS – Glasgow July 2005
--

By: Dr Kwame McKenzie, Secretary TSIG

The TSIG organised three sessions at the above meeting.

The first session on 11th July was entitled “Social influences on Psychosis”. Increasingly, social factors are seen as being important in increasing the risk of developing a psychotic illness. The symposium heard of cutting edge research about this. Dr McKenzie reviewed this field: how citations for social causes have increased, how social causation is conceptualised and about new ideas in this field. The research data centred on childhood trauma, abuse and neglect, the work on racism, social capital, inequality and cannabis. Dr Morgan then presented data from the AESOP (Aetiology in Ethnic groups of Schizophrenia and Other Psychoses). His group reported their findings about the increased risk of developing psychotic disorders where childhood separation due to family break-up had occurred. It is possible that for African and Caribbean people the higher rates of psychosis may be related to childhood separation. Dr James Kirkbride reported that the AESOP study did not find a significant effect of social capital at a ward level. He found that the proportion of people from different ethnic groups on a ward was inversely proportional to the incidence of non-affective psychotic disorder in black and minority ethnic groups.

On the same afternoon, TSIG reviewed the proposed amendments to the Mental Health Act. The government still needed to explain why it had decided on these particular amendments. Dr McKenzie believed that changes were driven by political and financial concerns. The second question raised was whether the amendments helped the Government to fulfil its duty under the Race Relations Amendment Act-viz. to promote racial harmony and to produce equity. Dr McKenzie concluded that this was unlikely to reduce detention in BME groups. The last question was centred on the disparity between BME and white groups. Dr McKenzie suspected that three of the amendments could increase section rates on BME groups: 1) supervised community treatment, 2) the change from a need for symptoms to be treatable to the test being whether appropriate treatment was available and 3) the move towards a single definition of mental disorder. Professor Singh presented a review of the rates of usage of sections of the Mental Health Act. He reviewed the literature and the reasons offered by authors for this disparity in rates. Dr Suman Fernando gave an insightful presentation about the proposed amendments and how each could be modified to make them less discriminatory. Dr Tony Zigmund offered to incorporate Dr Fernando's amendments within the College's strategy to influence the parliamentary process.

The 3rd session on 12th July reviewed Delivering Race Equality, the Department of Health's blue-print for improving the service that BME patients receive from mental health services. Professor David Sallah outlined what had been achieved in the year, the strategy, the infrastructure for change that was in place and targets. Dr McKenzie presented Professor Heginbotham's report on the 2005 census. There were higher admission rates and rates of section among Black Caribbean, Black African and Black Other patients. Pathways to care were different in BME groups. BME people used their GP less and were more likely to be admitted through the criminal justice system. Dr Killaspy presented the findings of one of DRE schemes on community engagement. There was some evidence that the needs assessments undertaken by this pilot project was more comprehensive than standard assessments.

Altogether it was a very successful series of presentations. The numbers of people attending the TSIG presentations clearly thought so as was evidenced by attendance and discussions.

AUDIT: SINGLE POINT OF ACCESS (SPA) FOR THE CITY EAST CMHT

By: Dr Dina Munim, SHO in Psychiatry, Leicester

Background

The single point of access (SPA) protocol for psychiatric referral is a recent one and was initiated as a part of the waiting time initiative in the NHS. It was fully adopted by the Leicestershire Partnership Trust.

The SPA was well advertised before its implementation in September 2004 when copies of the protocol were distributed to all primary Health care centres and referring agencies. Though there had never been a waiting list as such in the City East Catchments area of Leicester, the opportunity was taken to streamline the referral system. The SPA was anticipated to be simpler, more convenient and faster when accessing services.

Standard

All referrals should follow the single point of access. This is through the team secretary of the CMHT.

Aim

To audit whether all referrals have followed the single point of access protocol.

Materials & Methods

Audit Forms were given to the team secretaries and the medical secretaries. These were to be completed for every referral received during the 1st stage audit period of February and March 2005 and then for the re-audit period of August and September 2005.

Results

25 referrals were received during the period of the 1st stage audit whilst 52 were received during the re-audit period. All were completed and analysed. Only 4 referrals (16%) followed the SPA protocol whilst 21 (84%) did not in the 1st stage audit in comparison to 9 (17.3%) and 43 (82.7%) respectively in the re-audit stage. The later were received by the consultant.

Out of those 18(72%) referrals were forwarded to the CMHT in the 1st stage in comparison to 36 (69.2%) in the re-audit stage. 3(12%) referrals were sent a psychiatric outpatient appointment arranged by the consultants in the 1st stage in comparison to 17(32%) in the re-audit. Only 1(4%) of the above mentioned three was considered to clinically urgent whilst 4(7.6%) were considered to be so of the 17 during the re-audit. The other 2 (8%) in the 1st stage and 1(1.9%) in the 2nd stage were not sent to CMHT because the consultant considered that the referral were clinically appropriate for psychiatric outpatient appointment. No referral was sent to other psychiatric services by the consultant in the 1st stage audit but 2 (3.8%) were during the re-audit.

Number of inappropriate referrals received by the consultant was 11(44%) but none by the CMHT during the 1st stage audit in comparison to 14 (27%) and 4 (7.6%) respectively during the 2nd stage audit.

Outcome of referrals sent by consultant to CMHT in the 1st stage audit was: 11(44%) considered to be inappropriate to CMHT whilst 4(16%) were taken by CMHT in comparison to 14(27%) and 5(9.6%) respectively from the re-audit.

Who received the referral first?

	1 st Stage Audit (%)	Re-audit (%)
CMHT	4(16)	9(17.3)
Consultant	21(84)	43(82.7)
Total no.	25(100)	52(100)

Referrals not following the SPA

	1 st Stage Audit (%)	Re-audit (%)
No. received by consultant	21(84)	43(82.7)
No. sent by consultant to CMHT	18(72)	36(69.2)
No. not sent by consultant to CMHT	3(12)	7(13.5)

Outcome of referrals sent by consultant to CMHT

	1 st stage Audit (%)	Re-audit (%)
Inappropriate	11(44)	14(27)
Taken by CMHT	4(16)	5(9.6)
OPC appointment	3(12)	17(32)

Referrals following the protocol

	1 st stage (%)	Re-audit (%)
No. seen by CMHT	2(8)	3(5.8)
No. seen by consultant	2(8)	1(1.9)
No. of inappropriate referral	0(0)	5(9.6)
Total No. received by CMHT	4(16)	9(17.3)

What were the reasons for not sending to the CMHT

	1 st Audit (%)	Re-audit (%)
Urgency of the referral	1(4)	4(7.6)
Sent to other psychiatric services	0(0)	2(3.8)
More appropriate to OPC	2(8)	1(1.9)

Conclusions

Five months after the SPA protocol began, the majority of GPs were not following the new referral process. For the re-audit we found that slightly more GPs were following SPA protocol

Possible reasons for GPs not following the protocol

- Being unaware of the new protocol
- Familiarity with a referral process that they had long used previously
- Urgency of referrals
- Reluctance to use a new protocol whose outcome they were not confident about
- Their previous long established relationships with the Consultants
- Team leader not personally contacting GPs
- Secretaries were not sending reminder letters and or copies of the new protocol.
- Other unknown reason.

Recommendations

1. Reminder letters and a copy of the SPA protocol to be sent by the medical secretary to all referrers who have not been using the SPA protocol.
2. All referrals received elsewhere should be forwarded to the CMHT in keeping with the SPA protocol.
3. The team leader should personally contact referrers not following the SPA protocol.
4. Audit the role and effectiveness of the team leader and the secretaries in the SPA protocol in 6 months time

TSIG INITIATIVE: REFUGEE AND ASYLUM SEEKERS

By: Dr Kwame McKenzie

TSIG has been asked by the Executive and Finance Committee of the Royal College of Psychiatrists to produce a consensus statement on the subject of refugee and asylum seekers. The first consensus statement deals with the configuration of services for refugee and asylum seekers, the second concerns refugee doctors and the third good practice in psychiatric report writing. Each will be run as a separate project.

Work on the first consensus statement has commenced. The team consists of Dr Kwame McKenzie, Professor Kam Bhui and Dr Helen McColl. A draft consensus statement is being produced which will be discussed at an initial meeting of stakeholders. A further meeting will then be convened to agree the consensus.

The list of participants was agreed between the stakeholders and the executive of TSIG. It includes academics, people in the voluntary and statutory sector who had developed services for refugee and asylum seekers, specialist interest groups such as The Refugee Council, College officers and the Chairs of Faculties. A lively debate took place at the initial meeting in June. The team is now producing a consensus statement.

NOTES

Secretary of the Transcultural Interest Group

Nominations are requested for the post of Secretary of the Transcultural Special Interest Group. This is an honorary position with membership of the Executive Committee. Please contact Dr McKenzie by email for details.

GOOD PRACTICE IN TRANSCULTURAL PSYCHIATRY

The Transcultural Special Interest Group is developing a database of good practice in cultural psychiatry. We want to hear what you are doing. For example about good liaison and engagement with communities or innovative service designs. Do not feel constrained by examples - whatever you are doing that is new or that you are doing well, tell us about it. The aim is to be able to document good practice. The database will act as a fount of knowledge and help us network and share expertise.

Send us a short paragraph about what you are doing by e-mail. Please provide your contact details so that we can get in touch with you for additional information. Let us have the name of the Trust or Hospital where you work, your e-mail and telephone number, which BME or cultural populations have access to the service or good practice, the size of population served, and why you think this is good practice

Please send to:

k.mckenzie@medsch.ucl.ac.uk

This is a publication of the Transcultural Special Interest Group. The views expressed here are not necessarily those of TSIG or the Royal College of Psychiatrists.	If you would like to contribute to the newsletter, please contact Dr D Khoosal, Brandon Unit, Gwendolen Road, Leicester, LE5 4PW.
--	---