

WOMEN IN PSYCHIATRY SPECIAL INTEREST GROUP

Note from the Editor

Welcome to the Autumn WIPSIG Newsletter. It is dominated by issues concerning training, following the huge problems created by MTAS/MMC throughout this year. The problems are far from over, and have impacted both on individual trainees and their families, and on services in general. We need to be very aware of the particular impact on women trainees, many of whom will want to pursue training pathways that do not run directly from ST1 to Consultant. The risk to flexible training is clear.

Like any organisation, WIPSIG relies on the active participation of its members. Helen Crimlisk writes here of a new way for members to reach both the Executive Committee and each other via a JISCMail service – please do join. The Executive Committee would also like to extend a warm invitation to join us at the WIPSIG AGM every year at the College's AGM. The meeting is open to all, and although the details are hidden away in the College Conference brochure (we are trying to change that!), we shall be there next year and hope you will come along.

This Newsletter is one of the ways the Executive Committee seeks to reach members, and also a good way for members to share ideas and thoughts. Please do put pen to paper (fingers to keyboard these days?) should you feel you have something to say on matters affecting women, either as service users or as service providers.

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Report from Fiona Mason, Chair of WIPSIG

I have recently taken over the role of Chair from Dr Ros Ramsay, a hard act to follow. Ros led WIPSIG through a period of significant change and restructuring, and in doing so injected new energy and purpose into our work. I was a committee member throughout the time that Dr Ramsay was Chair and would like to thank her for her energy, drive and vision.

Special Interest Groups were established to facilitate the exchange of information, to promote discussion and to generate interest in a particular field of psychiatry. WIPSIG has always sought to consider both the interests of women psychiatrists and those of women service users. Our strategy document, circulated to all members recently, outlined how we intend to meet these aims.

In addition to the two specified work streams there are always a number of important initiatives and policies requiring a rapid but thoughtful response. We do our best as a committee to provide thorough consideration as and when possible. However, we are aware that with such a large membership, it has been difficult to ensure that we accurately represent the views of that membership. To this end, Dr Helen Crimlisk has been instrumental in setting up a JISCMail group as described later in this newsletter. We are hopeful that members will sign up to this group, thus increasing involvement and facilitating debate, discussion and dissemination. I have personal experience of similar mail groups' effectiveness, as I participate in the very lively group linked into the Quality Network for Forensic Mental Health Services, and an equally informative and interesting group relating to the work of the UK Trauma Group. I would therefore like to encourage members to sign up, as increased participation will serve to enliven this forum and inform the committee of your views.

A number of key issues challenge the medical profession at this time. Dr Elaine Arnold is leading on our involvement in matters relating to the careers of women doctors, whilst Dr Olivia Protti is leading the group addressing the physical healthcare needs of women service users. We would welcome



involvement from the wider membership and are always keen to recruit to the committee individuals who feel passionately about these areas and who are prepared to make a commitment to undertaking committee work and attending meetings. We are also pleased to have recruited a number of new members over the past year and I would like to welcome them to the committee.

Tony Blair's resignation and Gordon Brown's appointment has led to some interesting changes in government. Harriet Harman, the Minister for Women recently invited a consultation on her priorities. Baroness Corston's work relating to women offenders, Baroness Scotland's appointment as Attorney General and Vera Baird's as Solicitor General all have implications for matters that affect women's lives, particularly in their contact with the criminal justice system, both as offenders and victims of crime. As chair of WIPSIG I now have involvement with the Programme Board for the National Programme for Gender Equality in Women's Mental Health, and in addition have met with a number of government ministers interested in reviewing the laws relating to rape. I will keep you updated on the work being undertaken.

There have been two successful conferences involving WIPSIG since the last newsletter. The first (Mind the Gap, Women's Mental Health and the Law) is described later however, I am pleased to report that it was oversubscribed and generally feedback was extremely positive. WIPSIG also presented at the RCPsych Annual Meeting in Edinburgh, and again attendance was excellent and informal feedback indicated that those who came to the WIPSIG presentation gained from the material presented. The session, entitled Integrating the Physical and Mental Healthcare of Women, had excellent talks from Dr Shubulade Smith, Dr Liz McDonald, Ms Mary Hepburn and Dr Louise Howard. Issues relating to health promotion, substance misuse, pregnancy, needs assessment and ethical dilemmas in prescribing were addressed. Unfortunately, the AGM was less well attended, although in fairness, the timing of the AGM, location and advertising within the programme documentation were all felt to have contributed to the low numbers. We are keen as a committee to include membership views in the work that we do and are therefore keen to avoid such low attendance in the future. I will therefore be addressing these issues with the College.

In closing, I would like to thank the committee for their support and hope that I will be able to meet their expectations during my tenure. I believe that WIPSIG will benefit from the re-organisation undertaken and look forward to hearing your views.

Dr Fiona Mason
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Living with MTAS, and The Way Forward

Around 120 junior doctors attended a meeting 'Living with MTAS' at the Royal Society of Medicine on Saturday 7th July 2007, organised by the Medical Women's Federation and the Royal Society of Medicine, and chaired by Baroness Ilora Finlay, President of the RSM. Also participating were Professor Sir John Tooke, Chair of the MMC Independent Inquiry, Professor Martin Marshall, Deputy Chief Medical Officer, Dr Hamish Meldrum, new BMA Chair, a BMA Junior Doctors Representative and presidents and representatives of several of the Royal Colleges, including Professor Sheila Hollins, plus Dr Neil Bacon of Doctors.net.uk and founder members of Remedy UK and Rob Finch, editor of Hospital Doctor.

Of the junior doctors attending, only one had a post they were happy with. Others either had no job in August, or had compromised, and accepted a non-training post, or a post far away from family and friends.

The meeting provided an opportunity for the junior doctors to express their unhappiness and frustration with the whole MTAS process, and to convey their feelings to those who might be able to change the system in the future.

The main concerns expressed were:

- mismanagement of manpower planning
- major lack of information available
- lack of a transparent and fair application process
- deafening silence from the Deaneries – no answering of emails or telephone enquiries

- no information on flexible training
- lack of flexibility in MMC, in relation to changing specialities or Deaneries
- ghetto-isation of Trust jobs

25% of the juniors expressed an interest in job swaps. 75% knew of colleagues going abroad. Most felt let down by the Royal Colleges and the BMA. Sir John Tooke urged all junior doctors to complete an online questionnaire (closing date 31 July) on www.mmcinquiry.org.uk to outline their experiences. These will all be taken into consideration for the Independent Review. Juniors were very concerned that the findings of the review would be too late to salvage their careers.

In her presentation, **RCPsych President Professor Sheila Hollins** reported psychiatry was a shortage specialty with 10% of training posts being in psychiatry, but only 4% of medical school graduates chose psychiatry. As a result there had been recruitment of doctors from overseas, where there was a dearth of training and so creating an international Royal College with a quarter of its members working outside the UK. She had had a meeting with the Department of Health on 6th July 2007. The fill rate in psychiatry was around 75%. 280 posts would be available in round 2 but there was a problem at ST4 level; most of the posts were for ST1 doctors. In psychiatry a number of staff grade doctors had been successful in getting a training post and there had been the Scottish factor (Scotland made offers earlier and most of the jobs went to doctors from England who may have put Scotland as their 4th choice). Professor Hollins also supported uncoupling, commenting that ST1 was too soon to be committing to psychiatry; trainees needed maturity and a chance to try other specialities. She supported the concept of common core specialties suggesting links with public health and acute medicine among others. 60% of new RCPsych members are women, and we need a system built around the expectation that trainees would want flexible careers. She encouraged any doctor without a job to consider a post in psychiatry. She described how she had first trained as a GP, and then taken a post in psychiatry and afterwards stayed on to train in the specialty.

Dealing with adversity and threats to one's psychological equilibrium

Dr Tony Garelick, Associate Dean, London Deanery and Head of MedNet Services for Doctors, addressed the human or psychological aspects of MTAS. He reminded us of the high level of significant psychological distress in the medical profession (30% compared with 18% outside the health profession). Doctors tended to have compulsive personalities with a demanding superego, which led them to be high achievers, but there was a personal cost and they were harsh taskmasters on themselves. He listed the stressors we faced working in an environment that was high demand and low control, with recurrent organisational change and demands, and with a culture of perfection. There were also the stresses of doctoring and coping with disease, ageing, dying and fear of insanity; and doctors had difficult tasks, talking to distressed relatives, facing treatment failure etc.

In a recent letter to the BMJ, RCPsych Dean, Professor Dinesh Bhugra and colleagues reported that 21% of trainees in a survey had 'more thoughts of ending my life than usual' which represented an increased level of suicidal risk in an already vulnerable professional group, while 94% had a higher than usual level of stress in the last six months. In psychodynamic terms secure attachment was the basis for emotional security; where was our secure attachment in the current uncertain climate? We could replace the word patients with trainees in Good Medical Practice to help us reflect on the way we were treating our trainees. Dr Garelick summarised the sources of support for trainees: mentoring, informal peer groups, and accessing the agencies that could help, the Deaneries, Colleges and BMA.

Ros Ramsay

Feedback from PMETB/MMC Working Group

Lead Elaine Arnold, Anne Aboaja, Hema Ananth, Lucy Watkin and Jane Mounty

A workshop session was held on 20th June 2007 as part of the College's Annual General Meeting in Edinburgh. It was titled 'Assessing the Impact of MMC and PMETB on Non-Traditional Career Grades' and the presenters were Professor Dinesh Bhugra, giving the view from the College; Dr Elaine Arnold, presenting the views of Programme

Directors and Deaneries; Dr Nick Rose, representing the College on the problems facing overseas doctors; and Dr Jane Marshall representing the College on flexible training.

Some positive aspects of MMC and PMETB were highlighted, such as the aim of moving to competency based training with smoother transition through the "run-through" grades and less chance hopefully of a "lost tribe" developing as with the SHO grade. Also the alternative route offered by PMETB under Article 14 to achieve CESR (Certificate Confirming Eligibility for Specialist

Registration) was welcomed as enabling people who have worked successfully as locum consultants/associate specialists to demonstrate their competencies.

However, there were enormous concerns and frank dismay at the way that so many changes had been implemented all at once and the detrimental impact on some groups such as overseas doctors and flexible trainees. The failures of the centralised computer recruitment (MTAS) had only compounded the problems. The presenters had no easy answers to the problems posed by trainees in the audience, but were aware that a key role in the next few months of College and Deanery representatives was to support distressed trainees and offer appropriate career counselling.

Applications for CESR (Article 14)

Since the workshop, the PMETB/MMC working group have been liaising with the College to monitor applications for CESR (Article 14) and to develop a useful questionnaire to all applicants, which will enable us to monitor the chances of a successful application for different groups. Currently the information we have for February 2006 – March 2007 only gives gender, date of birth, region and current grade of working. We would like information on ethnicity, medical school, MRCPsych status and duration of current job to make more meaningful comparisons.

Of the 87 applications processed during the above period, 75.9 % (66) are male and 24.1 % (21) are female. It is difficult to be sure if this is an under-representation of female applicants due to the relatively high average age of applicants (males 50.6 years, females 47.2 years). It may simply reflect the gender distribution of this age cohort. The overall success rate of applicants was 43.7 % successful, 24.1 % rejected and 32.2 % still pending. We do not have information to predict the likely success rate of the pending applicants but the final overall success rate will obviously be higher and may approach 60 % if the same proportion of

successful to unsuccessful applications holds. The success rates analysed by gender were similar (successful males 43.9 %, females 42.9 %; unsuccessful males 22.7 %, females 28.6 %; pending males 33.3 %, females 28.6 %).

There was no clear pattern relating age to success of the application. Successful male applicants were slightly younger than unsuccessful ones (mean age for successful males 49.8 years, mean age for unsuccessful males 52.3 years) but successful female applicants were older (mean age for successful females 51.3 years, mean age for unsuccessful females 43 years). The applicants ranged in age from 31 years to 72 years. The youngest successful applicant was 36 years old (male) and the oldest successful applicant was 65 years old (female).

The group will be attempting ongoing monitoring of these statistics and hope to have more useful data in the future. This cohort of applicants may represent a backlog of very experienced long term locum consultants and we would expect the age profile to change.

As we write, the August changeover is taking place, and there is enormous change and confusion due to Junior doctors still getting offers of posts, and locum posts being created to cover gaps and offer placements for doctors still without jobs. It is not clear how many people will ultimately be without permanent jobs but it is clear that some overseas doctors who did not get HSMP status before 5th February have been very harshly treated and in some cases, job offers have been rescinded at a late stage. Doctors also face moves to distant areas with little prospect of any “swaps” or interdeanery transfers being agreed. We would like to have any feedback/queries from newsletter readers of issues/problems encountered at this time.

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Report from the Association of European Psychiatry Congress 17 – 21 March 2007, Madrid

This was the first time that I had attended this congress and found myself gravitating towards the symposium: ‘Women’s Careers’ in Psychiatry – developments and data’. Firstly Dr MA Kastrup (Denmark) presented her work on the need for female leadership in international professional organisations. She described psychiatry as being an open medical specialty, demonstrating that the proportion of women entering the field was increasing and that the proportion of those in clinical leadership positions was also gradually increasing. This was in contrast to women in leadership roles within large international organisations. Her main point was that women should actively mentor their junior colleagues or colleagues working in professional isolation, to provide much-needed support and guidance. She spoke about the need to develop strategies to overcome the inner and outer obstacles preventing women from due representation in these organisations.

Leading on from that, Prof. A Riecher-Rossler (Germany) then presented her work on the indication for,

and impact of mentoring models. She explained that it was vital to mentor in all disciplines as a way of advancing the careers of young professionals. She specifically used her work with supporting young female psychiatrists. Different models were presented including her own 'Basel' method and she reported that it was a positive influence on professional medical careers, and especially helpful for young women to promote their research careers. She also felt that special mentoring programmes, considering gender specific needs, should be implemented in psychiatry.

Dr B Schrank (Germany), then discussed her research showing that there were more men than women as first authors in research papers, but that the difference in numbers had declined greatly from 1994 – 2004 but nevertheless remained significant. She demonstrated her systematic gender-specific analysis of publication trends and found that the trends reflected the status of women at the leading edge of psychiatric research. She stated that this served to highlight the impact of recent policies supporting women's careers in research and would act as a baseline for her future work in gender specific monitoring.

There then followed a discussion on Prof M Amering's (Sweden) work on the fact that it seems business scores for promoting women correlate positively with profitability. She described how she was aiming to gain gender-specific data to assess the role of women in psychiatry, and their impact on the development of the field. She also stated that she was finding it very difficult as most people were not accustomed to monitoring gender-specific data. This then sparked a very interesting discussion on women generally in psychiatry, and revealed to me a surprising issue, that it seems outside the UK and Scandinavia women are still facing discrimination. In countries such as France, that I thought were quite egalitarian, it seems that some women psychiatrists (who were present) have been actively discriminated against, and the fact that Latin countries were still seen as being male-dominated and difficult situations to work in. It made me think that despite all the problems that the NHS is in, the fiasco of the new MTAS and confusion over the MMC process, it seems one thing we should be proud of is the fact that most young women in medicine in the UK, and most definitely in psychiatry, have had a straightforward, uncomplicated climb up the ladder with regards to discrimination, and haven't had to face the discrimination that some of our counterparts in Europe and around the world unfortunately have. This in itself left me feeling somewhat positive, in a way I never thought I would, prior to attending the AEP congress.

Dr Shamila Moodley

SPR General Adult Psychiatry, Royal Free/UCL Training Rotation

WIPSIG Conference

'Mind the Gap - Women, Mental Health and the Law'
Friday 11th May 2007 - St Andrew's Healthcare, Northampton

This conference, hosted by St Andrews, sought to highlight the difficulties faced by women in their contact with the criminal justice system, current policy developments and therapeutic initiatives. Fiona Mason did a fantastic job organising this and we are extremely grateful to St Andrew's for their generous hosting. The conference was sold out and had consistently high quality speakers. For those of you who do not know, St Andrews is a charitable organisation. Its buildings were originally built when one made psychiatric hospitals look like stately homes, so the surroundings were very pleasant indeed.



What was interesting was that there were multi-faceted speakers; not everyone was in accordance with each other. Vera Baird Q.C. M.P. argued that imposing a custodial sentence for most female offenders is inappropriate. 4018 women are in custody, of these, two thirds are drug dependent and half are subject to domestic violence. The average custodial sentence is 39 days which is expensive to the taxpayer, unhelpful and disruptive to women's lives. Most of these sentences are due to petty crime, ie shop lifting. Tragically, a third of sentences are for the theft of an item worth less than £25. Even worse, more than 40% women then lose their home when in prison.

This all felt quite depressing and reminded me of Victorian times when it was thought wholly appropriate to ship petty thieves to Australia. What is it about petty thieving that annoys the human condition so much?

Vera Baird is also seeking to change the law of murder from disproportionate force. The problem is that a woman, to defend herself from a persistent aggressor cannot use direct proportional force. Instead, in order to survive she might have to use disproportionate force on a passive aggressor. This makes her liable for murder as opposed to manslaughter.

Dr Annie Barlett, reader in forensic psychiatry and honorary consultant in forensic psychiatry shared her experiences of working in Holloway Prison. Again she highlighted the difficult psychosocial circumstances of most inmates and how the system doesn't really help them. She also acknowledged the difficulty of addressing challenging behaviour without staff developing a punitive work culture or getting burnt out. We were reminded that most female prisoners have a dependent child who must be greatly impacted on by maternal detention.

The conference perspective then moved from "on the ground" perspective to the strategic overview. Karen Newbigging, Joint National Programme Lead for Gender Equality and Women's Mental Health, NIMH and CSIP, highlighted all the policy provision and future developments for addressing inequalities in mental health. I was left with an image in my head of the NHS as one of those massive container ships that take about 5 miles to change direction, even the tiniest bit. It seems that so much planning, policies and papers are produced for such an enormous organisation, the NHS, to change. However, this is all good stuff, with gender equality being put firmly on the agenda.

Dr Caroline Logan, Consultant Specialist Clinical Psychologist, looked at risk assessment and management practice with women, the problem being that most of the research has been done on the more proliferatively violent male population. So it is unclear whether the skills acquired for assessing and managing male offenders translate accurately to the female population.

The day concluded with two further high quality speakers. Dr Stuart Turner, consultant psychiatrist at the Trauma Clinic, London, talked about "Traumatic memory and the law; inconsistencies in recall after adult trauma." An accurate recall of an event is extremely important in asylum and other legal cases. Yet the tragic fact is that the more horrific the event, the less likely it will be recalled accurately. This is not intentional but a byproduct of how the brain processes information when under extreme stress. Add to this the socio-cultural factors of shame, guilt, the risk of ostracisation and family exacting revenge, and asylum seekers are on an uphill battle to be believed. The most pertinent study was one where more than 500 fit young volunteers were abused in a US Military Survival School. (This is one of those studies that completely prove the point, but can't be done any more as they are so disgracefully unethical.) However, having lived in the wilderness to evade capture, if caught, they received a "harsh" interrogation. 24 hours afterwards, 66% could only identify their interrogator if they wore exactly the same clothing. A small proportion could not even remember the gender of the interrogator. Thus, inconsistent recall does not invalidate the memory.

Finally, onto Dr Fiona Mason, Consultant Forensic Psychiatrist and Lead Psychiatrist, Women's Service, St Andrew's Healthcare, and new Chair of WIPSIG. Her talk was on the rehabilitation using a structured pathway, how this works for patients and also works for staff. Despite the Unit at St Andrew's having an extremely difficult client group, their staff turnover is enviably low and success rate high. A large proportion of the patients have been in hospital a long time (average 10 years), a reflection of both the seriousness of the offences and treatment resistance. However, the team have developed an excellent phased approach and model of care that could be translated to other treatment resistant clients. The phases include establishing a diagnosis; symptom management to facilitate stabilization; prioritising problems presented; creating narratives, integrating personal schemas and identifying feelings by verbalizing somatic states. This then moves on to increasing capacity to think and empathise with others, realizing repetitive patterns and learning to re-establish secure interpersonal connections. Although intervention is not cure, it does seek to greatly improve insight, appropriate behaviour and seeking help.

And with that the day was done, the conference had been a great success. Make sure you come to the next one!

Lucy Watkin

SpR Royal Free and UCH, London

Medico-Legal News – Mentally Ill Mothers and The Law

On June 20 2001, Andrea Pia Yates (born [July 2, 1964](#)) of [Houston, Texas, United States](#), committed the [filicide](#) of her five young children by drowning them in the family bath. Despite it being clear that she was suffering from puerperal psychosis at the time, she was convicted of first degree murder in 2002 and sentenced to life in prison with parole only possible after forty years. In May 2006, I was invited

to endorse an Amicus brief requesting that before her retrial she must be examined by an expert witness experienced in treating postpartum disorder and who had full knowledge of the literature. The brief was also endorsed by Professor Jonathon Glover from the UK, Professors of Law from the US, North American Perinatal Psychiatrists and Psychologists who are experts in the field.

At retrial on [July 26, 2006](#), a Texas jury ruled Yates to be [not guilty by reason of insanity](#) and she was consequently committed by the court to the [North Texas State Hospital](#), a high-security mental health facility where she is currently receiving medical treatment.

Also in 2006, the Law Commission reviewed the law on homicide and published a report in November on Murder, Manslaughter and Infanticide. I and other College members contributed to the review of Infanticide.

They recommended that the offence/defence of infanticide be retained without amendment (subject to 'murder' being replaced with 'first degree murder or second degree murder') and that in circumstances where infanticide is not raised as an issue at trial and the defendant (who must be the biological mother of a child aged 12 months or less)

is convicted by the jury of murder the trial judge should have the power to order a medical examination of the defendant with a view to establishing whether or not there is evidence that at the time of the killing the requisite elements of a charge of infanticide were present. If such evidence is produced and the defendant wishes to appeal, the judge should be able to refer the application to the Court of Appeal and to postpone sentence pending the determination of the application. This allows for the situation where a mother's denial of the killing is due to her mental state and psychiatric evidence to support a defence of infanticide cannot therefore be obtained and presented in court.

The full report is available at www.lawcom.gov.uk/docs/lc305.pdf

Carol Henshaw

WIPSIG E-mail Discussion Group

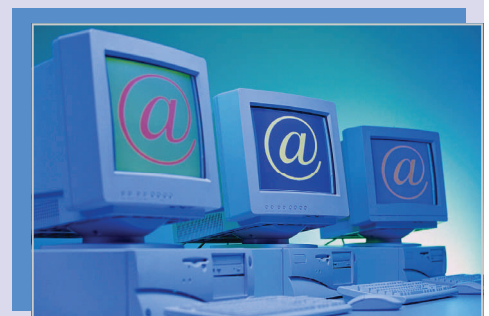
We have now set up a new email discussion group that will hopefully improve communication between the members of The Women in Psychiatry Special Interest Group (the last one, which we did with Yahoo groups, seemed to be blocked by some people's computer systems). The aim is that we can circulate one another with any issues of interest and alert one another to up and coming events / issues. We also hope it will be used by members to find out how local trusts / regions are addressing issues regarding women's services etc, so that individuals don't have to "reinvent the wheel" when asked to do a piece of work, if it's been done by someone else elsewhere. Some of the other Special Interest Groups are also using the group to share documents and PowerPoint presentations which others might want to use – this is something which we could perhaps discuss. Subscribing will only take 5 minutes or so to do and you can "unsubscribe" with one click.

What is an electronic discussion group?

Belonging to a list is rather like sitting in on a discussion - just by email. You can join in the talk, start a discussion, or simply listen. A list may be used to discuss work with other academics, share news, collaborate on projects and publications, announce conferences, arrange meetings or just to keep in touch with colleagues in your subject area.

How can I join?

- Go to the JISCMail website: <http://www.jiscmail.ac.uk/>
- Register a password with JISCMail - under Quick Links click on "Register a Password".
- Fill in the details and OK the confirmation message when it arrives in your email inbox.
- Go back to the home page and type in WIPSIG under "Find a list by name" on the right hand side.
- Click "Go"
- Click "join the list"
- Type in your email address and name
- Click "join WIPSIG"
- In order to confirm your identity an email will be sent to you (normally within a few minutes)
- Click on the site given to you in the email (this confirms you are who you say you are)
- Congratulations - you have now joined the WIPSIG discussion group!
- Don't worry if you don't have anything important to say at the moment - why not send us a message just to say you've joined??
- To send a message write an email and send it to: WIPSIG@jiscmail.ac.uk



What is "JISCMail" anyway?

JISCMail is the name for the National Academic Mailing List Service. It is one of a number of JANET services (www.ja.net <<http://www.ja.net>>) provided by UKERNA (www.ukerna.ac.uk <<http://www.ukerna.ac.uk>>) and funded by the JISC (www.jisc.ac.uk <<http://www.jisc.ac.uk>>) to benefit learning, teaching and research communities.

Do feel free to contact me at Helen.Crimlisk@sct.nhs.uk if you're having difficulties.

Helen Crimlisk

Hiding Your Light Under A Bushel?

We don't get a lot of correspondence but what does seem to exercise you is CEA Awards and the College Fellowship. I write as someone who has recently been awarded the Fellowship (I was so touched by colleagues' support) and 2 CEA points, having been a Consultant for twenty years, fifteen years of that part-time.

Notoriously, women don't do well with either of these. We're not good at telling the world how good we are. A woman Consultant writes 'It's not that in my head I don't value the work I do, but as soon as I start to compare with the others who are much better at not hiding their light under a bushel, I fade...I find the whole process humiliating and demeaning.'

Whilst Chair of our Consultants' Committee, I gathered support to open up the CEA process so that the results were made available to all consultants – before that, the whole thing had been secret and rife with rumour. Our Medical Director gives a seminar each year on How to Apply, and remarks that it takes a whole weekend to fill the CEA Application form in properly. The form is a National document with prescribed scoring methods, Trusts must stick with this, and successful candidates will be scoring well in most (though seldom all) domains, so that consultants who score very well in one or two domains only, may well be unsuccessful against candidates who score moderately well all round.

The BMA offer advice on completing the forms and say that people regularly don't put down everything they've done.

The Fellowship requires being sponsored by existing Fellows. The bashful may not like to put themselves forward, but if the local Fellows can be persuaded to consider the matter every year, candidates can be suggested to them, or may simply be obviously deserving, once you think about it. Not everyone wants it (it costs money!), but most are genuinely pleased and honoured.

Why do women so often struggle with this? I do not except myself. I guess we have to give up the notion that it's bad to put yourself forward, it's bad to be ambitious and it's bad to compete to win. Not quite sure what bushels are, but no more bushels!

Vivien Deacon, Newsletter Co-Editor

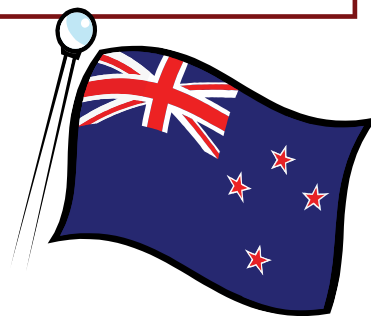
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An Update from New Zealand

Things are now moving over here regarding women's mental health. The 10 year Mental Health and Addictions Plan proposed by the Ministry of Health in 2004, made no specific mention of the needs of women. After much lobbying and actively raising the profile through talks and presentations and getting onto key working parties, and recruiting like-minded individuals, the final document Te Taahuhu – Improving Mental Health 2005-2015: The Second New Zealand Mental Health and Addiction Plan now has one line about women! The document lists 10 leading challenges for mental health care in NZ, one of which is Responsiveness. It states that there must be immediate improvement in responsiveness of services for Pacific peoples;

Asian and other ethnic communities; Refugee and migrant communities; people with specific disabilities; family and whanau, and Maori.

They have now added a sentence: "Women face particular cultural and gender issues when they access forensic and acute services." It might not sound much, but by making a specific reference to the needs of women in their own plan, the MOH has validated the specific inclusion of gender issues in all aspects of service planning and delivery. Implementation of the Plan across the 20 or so District Health Boards in NZ



is down to the individual Board. Capital and Coast District Health Board, who primarily cover Wellington, but with a wider coverage for regional services such as forensic, intellectual disability, rehabilitation and child and adolescent, have put together a five year implementation plan called The Journey Forward. It now makes reference to the particular needs of women mental health service users! The document is specifically aimed at acute and community services and does not include tertiary/regional services. There are a number of workstreams looking at various aspects of implementation and I am on the Acute Services workstream – not as a forensic psychiatrist, but to advise on gender issues for the new acute services that are being re-provided in the Wellington area. I was requested to provide a brief document for the architects, of design points to consider when building the new mixed gender acute unit and the two short-stay units (albeit that my view is that there needed to be a totally separate facility for women!). I am currently working with a service user member of the workstream, looking at gender-sensitive approaches to treatment in acute and community services, in conjunction with the psychology member of the workstream, who is looking at trauma-based approaches to treatment.

From the forensic perspective, a National Working Party on Standards of Care for Women in Secure Mental Health Services was established in January 2007. The group, which I chair, consists of two representatives from each of the five regional forensic services across NZ. Our task is to examine and make recommendations to the NZ Forensic Advisory Group and the Ministry of Health regarding the minimum (as well as Gold Star!) standards of care, both from a treatment and environmental perspective, that any woman should expect to receive in any of our forensic services. We meet every six weeks and rotate the venue so that we can all see what each region currently provides (or not!). We have been to Wellington, Auckland and Christchurch. Our next meeting is in Hamilton. Just Dunedin left to go! We are making good progress and an auditable set of standards is beginning to emerge. I must acknowledge the invaluable support received from Les Petrie (Bristol) and the MDT Working Group for Women's Secure and Related Mental Health Services. From the searching we have done, UK is the most developed in this regard. We are also proposing some quite radical (for NZ!) changes in service delivery such that if a woman is approaching the end of her sentence and needs to go to hospital or if she is to be treated in the forensic service instead of going to prison, she should be admitted to her local (home) regional forensic service (if appropriate), to be closer to children, family and friends – for all the obvious reasons, rather than be admitted to the forensic service closest to the prison she is in, or the court where she was convicted.

We are hoping to complete the work by January 2008 and would be happy to share this.

From a more local perspective, the proposal for a regional single gender forensic service for women is going through its various stages as part of a draft 5 year development plan for the Central Regional Forensic Mental Health Services. The response to date has been very positive. In the meantime, we are looking at how best to manage women in our mixed gender secure unit, Rangipapa. I am now part of a MDT Working Party looking at philosophy, model of care and environmental issues for Rangipapa, with a particular focus on gender-sensitive approaches to treatment (a useful overlap with other roles!). We are also meeting 6 weekly. Katherine Schurer, a Canadian psychology colleague, and I, have run two evening workshops for the women inpatients, called "Have Your Say". We showed the DOH video "What Women Want" and with reference to the Implementation Guidance workshops, canvassed and included the views of current women service users in the working party deliberations. The men are going to have a separate consultation exercises! We are hoping to arrange for the Consumer Advocate to meet with the women, as other views may then emerge. It will be quite informative to compare the views of the Rangipapa women with those of the women on Awen at Llanarth Court, when we did this exercise about four years ago.

The only other new development I am aware of on this side of the globe, for 'forensic' women is in Melbourne, where there is a new unit attached to the Women's Prison, called the Dame Phylis Frost Centre. It is owned by the Dept. of Corrections but is being administered by health - Forensicare. It will also link with the women's MSU at the Thomas Embling Hosp.in Melbourne. They are recruiting psychology staff at present - Prof James Ogloff is organising this. I intend to do a recce! I've also been invited to Tasmania to see their new forensic services - watch this space....

From a training perspective, as a trainer for the RANZCP, the particular experience in women's secure mental health care that is now available to both junior and senior trainees on the wider Wellington training scheme, is now percolating through and we were in the very happy position on this occasion, to find that there were three general psychiatry trainees who wanted their next training placement to be at Rangipapa, especially as there are many more training slots available than there are trainees to fill them! We do not currently have any advanced trainees in forensic psychiatry in Wellington, although there is one in Auckland and two Christchurch. I was interested to see the PMETB forensic psychiatry training objectives and to read in the College's 2006 Annual Review about the proposed collaboration between the RCP and the RANZCP, particularly over training matters and the new curriculum (p7).

It will be good to see forensic higher trainees in Wellington, and for all higher training to include a specific component on women. Next mission! Some international dates for the diary: Book your flights now for the Annual Meeting of the Forensic Section of the RANZCP at the Millenium Hotel, Rotorua, NZ, from 11-13 October 2007. The meeting is entitled "Sex & Drugs & Rock 'n Roll" and is having part of its focus on women. Profs Pamela Taylor, Paul Mullen and James Ogloff are the keynote speakers and each is doing a day's workshop at the start of the Conference. Pamela and I are doing the workshop together, looking at

gender issues. We are aiming to be provocative! The venue is fabulous and the Polynesian Spa at Rotorua is rated as one of the world's top ten!

Further details available on: info@conorg.com
The 3rd World Congress on Women's Mental Health is being held in Melbourne from 16-20 March 2008. This is an absolute essential and the shopping in Melbourne is brilliant too! Further details available on www.iawmhcongress2008.co.au

Ka kite ano

Jackie Short
