

# Newsletter

Faculty of General and Community Psychiatry  
Royal College of Psychiatrists

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**Editor:** Rajesh Mohan  
**Editorial Board:** Mark Agius  
Mark Salter

**This is a publication of the Faculty of General and Community Psychiatry. The views expressed here are not necessarily those of the Royal College of Psychiatrists.**

## From the editor

**Faculty conferences:** Our faculty conference in Liverpool was well attended with 185 delegates. The conferences offer a good opportunity to meet our colleagues and to share views and discuss important issues concerning the psychiatrists who work with adults of working age. We hope those of you who attended found the conference stimulating, with useful discussions and workshops. Please send us your thoughts on the themes you would like to be addressed in the future faculty conferences.

**Your contributions to the newsletter:** We continue to need your contributions to the newsletter and suggestions for improvement of its contents and design. Please do send in your contributions and comments on the articles in the newsletter either by email or post.

**Roles and responsibilities document:** Our work on the document on 'Roles and responsibilities of a consultant psychiatrist' is now complete and available on the faculty web page. This document should provide the foundation on which we can further develop as a specialty and continue to provide seamless and efficacious service across the UK, despite ongoing problems of recruitment and retention of psychiatrists in our specialty. In view of the impending changes in the curriculum and training for psychiatry, we are anxiously waiting to find out more about the proposed changes and how these will impact on the services as well as on training.

**Faculty prizes:** Lastly, we have an important role in encouraging medical students and psychiatry trainees to identify Adult Psychiatry as a future career. The difference from other specialties is, perhaps, the range of disorders that we deal with and the number of other disciplines that we liaise with, and the challenges of working in a variety of different settings. The prizes instituted by our faculty have led to considerable interest among trainees and medical students and in the past two years we have had entries of a very high standard. Please do continue to encourage your trainees and medical students to participate in these competitions and thereby promote our specialty as a future career.

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## From the chair

Jed Boardman

As I write this the Labour Party conference is in full swing and the journalists assure us that the politicians won't be revealing answers to the things that matter. I wonder if it is the same for Adult Psychiatrists. What actually matters at the moment? I suspect the answer is a perennial one: the quality of our working lives and the quality of the services we provide to users. From the perspective of the user we seem to be doing something well.

A recent patient survey published by the Healthcare Commission (see [www.healthcarecommission.org](http://www.healthcarecommission.org)) reported that 77% of respondents rated their overall care as excellent, very good or good, with fewer than one in ten rating their care as poor or very poor. Most (90%) had trust and confidence in their psychiatrist and their community psychiatric nurse (93%); 80% said that they were treated with respect and dignity. This final gauge may be the most important indicator of quality and you can see how your Trust did by looking on the website. I wonder how we compare in quality to acute services, and remain concerned that for many indices of this we lag behind that of Acute Trusts.

But how would we respond if asked about the quality of our jobs? The range of answers, I believe, would be considerable. What of the current national matters are of relevance to this? The reform of the Mental Health Act must be one, and it is disappointing that the Government accepted so few of the Scrutiny Committee's recommendations, despite the excellent representations by the Mental Health Alliance. The Act remains illiberal and it is difficult to see how it can be implemented. PMETB goes live in September and the nature of training is being revised. Should we have two CCTs or many? What aspects of adult psychiatry should be represented in the competences? What will be the impact of the Foundation year? The *New Ways of Working for Psychiatrists* Report will be launched this year at two meetings on 1<sup>st</sup> November (Newcastle upon Tyne) and 3<sup>rd</sup> November (Slough). You may wish to attend and, if you do, remember the subtitle of the document is "... but not the end of the story". The issues raised by all these developments are of concern to all of us, but remember - amidst these promises of increasing complexity, someone is planning to create more of us!

## Faculty of General and Community Psychiatry Strategy day on 8<sup>th</sup> June 2005

For the past three years we have held a day-long meeting of the faculty executive and regional representatives to discuss key matters for the faculty and to plan our actions for the year ahead. This year's Strategy Day was held at Belgrave Square on June 8. We were assisted by an excellent facilitator in Alan Berresford.

### **We examined the achievements of the faculty over the past few years, which included:**

- Completion of the update of the Roles and Responsibilities of Adult Psychiatrists document.
- Improvement in the quality and attendance at the annual residential meeting.
- Development of a clearer sense of the role of consultant psychiatrists in adult services and the interfaces between adult psychiatrists sub-specialties
- Establishment of the Faculty Newsletter and Website
- Finance – well in the black
- Producing strong responses to the Mental Health Bill, the Capacity Bill and the Disability Discrimination Bill.
- Development of Medical Student Essay Prize and Trainees Prize
- Regional representatives established in almost all regions

### **However, there remain challenges, including:**

- Improving communication between Faculty Executive and Faculty members
- Establishing our boundaries and status as a specialism
- Evolution of new community teams and in-patient
- Recruitment
- Working with other organisations
- Involving users and carers
- New NHS developments e.g. payment by results

### **Taking the 5-year review of the NSF, we had intensive discussions over several clinical areas, which had been identified as a priority. These included:**

- In-patient services

- Social inclusion and whole community approach
- Primary care
- Dual diagnosis
- NICE implementation

**We identified other key areas for discussion, including:**

- User involvement - invited a representative of MIND to advise us on a strategy
- Regional network
- Training
- Communications

**The action plan from the meeting was to focus on the following:**

- Develop a plan for user involvement with MIND
- Regional representatives to identify roles, local consultant groups and relevant meeting/structures
- Establish a link with Divisional Chairs to inform about regional representatives
- Use the Roles and Responsibilities document to drive curriculum.
- Use the Roles and Responsibilities document to drive CPD on-line.
- Develop standards for in-patient services
- Establish a Communications Taskforce
- Establish a one-day seminar with GPs
- Develop Prison Mental Health Document recommendations
- Establish an interface group with Addictions Faculty
- Establish an interface group on Social Inclusion with Rehabilitation and Social Faculty
- Use business meeting in 2005 Residential meeting (Liverpool) to feedback on the Strategy Day
- Create an initial paper on a marketing strategy for medical students.

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## **New Ways of Working – Our Experiences in Stoke on Trent**

**Lisetta Lovett**

I have little idea how consultant colleagues are progressing with the implementation of *New Ways of Working* up and down the country, if at all. I thought it would be helpful to share experiences, which is why I decided to write this article to open a dialogue, though our service is a long way from actual implementation.

### **Background**

Like most consultants, we are all over-stretched. There are 7½ funded consultant posts to service the catchment area of Stoke-on-Trent, which has a total population of about 280,000. We are split between three Community Centres across the city. Two other Centres exist which cover north of the county of Staffordshire. As an inner city, with a concentration of hostels, supported housing, housing associations, students and asylum seekers, the patient population often presents with very complex health and social needs. Substance misuse and forensic problems are more common than not. Matters are not helped by the lack of medical input in the functional teams – Assertive Outreach, Crisis Intervention and Home Treatment, Early Intervention – which are all nurse-led and have no medical staffing.

Another problem, reflected in the large caseloads of consultants, is the tradition of assigning a consultant's name to any patient who walks through the door of our

service, even though the consultant has never and probably will never see that patient. Not only is our name put next to the patient, but we are always referred to as the patient's Responsible Medical Officer, a term which is in fact only applicable for detained patients. Psychologically, if not in practice, there is an embedded view among the rest of the team that consultants are responsible for everyone! Further, our service takes on a Primary Care role for so many of our patients. Once someone has had contact with the service there seems to be an expectation from Primary Care that we will continue to monitor that patient's mental health needs in perpetuity and, indeed, some of their physical health needs.

### **Early struggles**

My first mistake was to produce an Operational Policy for our Centre which suggested that other team members undertake new patient mental health assessments (with training) and with clearly stated lines of clinical responsibility. This policy was based on the experiences of Child and Adolescent Mental Health Services, which have been practising this model for years. The policy was politely acknowledged and allowed to gather dust. However, two or three senior team members did start to take on new assessments. One attended a year-long degree module, which I

organised at Staffordshire University, covering *inter alia* assessment, use of the mental state examination and diagnosis. Unfortunately, like so many of the more senior staff, she was lured away by the pay and glamour of the new functional teams.

#### **Local and national driver for change**

Locally, there has recently been a drive to split mental health services provided by our Trust into those servicing the City of Stoke and those servicing North Staffordshire County. This split mirrors the configuration of local PCTs and Social Services' arrangements. Further, consultants in Stoke who had regularly met colleagues from the County became aware of how different the clinical priorities were between the two catchment areas, which are, on the whole, quite different socio-economically. Then *Modernising Medical Careers*, *Agenda for Change* and *New Ways of Working* all started to infiltrate our general consciousness. Perhaps, after all, there was another way of working which not only suited our wish not to burn out but which might lead to a more efficient service delivery.

#### **What we have done**

During spring, the Stoke consultants set up their own regular group which we called the Stoke Psychiatrists Advisory Group (SPAG), of which I am chairperson. Our main objective is to implement *New Ways of Working*. However, we also want to change the relationship between General Psychiatry and sub-specialties and to create more permeable boundaries, where priority is given to the needs of the patient. Our sub-specialty colleagues therefore receive our minutes and are welcome to attend our meetings. We hope that this will help overcome General Psychiatrists' perceptions that they are dumped on by gate-keeping sub-specialties.

So far, SPAG has met about four times but meetings are now regularly timetabled to occur on a monthly basis. Our first priority has been to encourage team members in our respective mental health Centres to take on an extended role, which means not only undertaking assessments of new cases but becoming case managers of such, with supervision from their line managers and the option of consultation with consultants. To develop a dialogue on this, our Centre used the forum of an Away Day, when it was agreed that a training day on assessment and diagnosis would occur in June.

The format of this day consisted of a mixture of small interactive groups, talks and role-playing, with actors playing patients. I have previously used these actors to teach medical and postgraduate nursing students psychiatric interviewing (please contact me if you want more details). It was a very well received day, and as a result we are repeating it in September and October. However, it is an intensive learning event where each group is facilitated all day by a consultant.

Consolidation of the experience then takes place with each staff member observing a new patient interview by a consultant and then doing a new patient interview themselves and presenting to a consultant. The intention is that these trained staff will then take on all new patient assessments and case management. Freed time from new patient assessments will allow consultants to be more readily available for consultation to case managers. Under *Agenda for Change*, those undertaking this role may expect to see a rise in their grading and salary.

There are further developments which SPAG is planning, with our ultimate aim to abolish or lose the majority of our current routine caseloads, therefore freeing up time to take on a much more consultative role. The follow-up clinics will be replaced by quick response consultation sessions which could lead to the consultant seeing the patient together with the case manager, and giving medical advice, but not taking on responsibility for the patient except for the advice given.

To facilitate the loss of a routine caseload, I started a Medication Monitoring Clinic in my centre, which is protocolised and run by junior doctors. (At present it has to be doctors because of the prescribing required but could be nurse prescribers in the future.) All patients needing medication monitoring are seen in this clinic, which also has a discharge policy to Primary Care after two years of a patient being stable. It is hoped to roll this out to the other Stoke mental health Centres. We are also examining our caseloads with other staff members, where they are involved with the patient, with the intention of discharge to Primary Care where there is no clear therapeutic benefit from repeated appointments.

SPAG has agreed that a large demand on consultant time is the in-patient commitment at the Acute Psychiatric Hospital, which could become far more onerous if the Mental Health Bill is passed. One Centre has been trialling a dedicated in-patient consultant. This is helping, but it has become abundantly clear that it is very important to develop an agreed policy which covers admissions, discharges, communication between ward and community consultant etc. One of our members is undertaking to write this, and from January 2006 we have agreed that one of the existing consultant community posts will become a full-time acute ward-based post.

Another demand on our time has been the constant request for advice or appointments by the functional nurse-led teams. SPAG has agreed that once dedicated consultant caseloads cease or reduce very substantially we will take turns, perhaps every three years, to provide four sessions/weeks of medical time to each team's Stoke patients. This system will also keep us fresh, since every three years we can switch our part-time roles. All the functional team leads seem pleased with

this proposal and are prepared to engage in developing protocols for how this could work in practice.

Discussions have taken place with users and carers about some of the above proposals and so far they seem to be very supportive.

#### Challenges for New Ways of Working

1. Getting the multi-disciplinary team on board with *New Ways of Working*. What is in it for them?
2. Adequate training of senior members of the multi-disciplinary team in assessment, diagnosis, case management – how to do it?
3. Freeing up their time for case work – how?
4. Abolishing consultants' existing routine caseload – how?
5. Negotiating with Primary Care, discharges and monitoring of stable patients (new GP contract should help here).
6. Communicating service changes to users and carers and securing their support.

#### Some Solutions for reducing consultants' routine work

Acute Ward-based consultant

Medication Monitoring Clinics for patients on mood stabilisers, atypical and typical anti-psychotics, run by junior medical or nursing staff, based on protocols.

Active discharge of patients from case load where no therapeutic benefit present. Signposting to voluntary agencies or referring to time-limited evidence-based psychological therapies

A more flexible approach to providing medical input to functional psychiatric teams. Again, based on the principle of consultation.

Providing a responsive consultation service, which contains other MDT members' anxiety, allowing them to feel comfortable taking on more responsibility.

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## Safety for Psychiatrists Revision of College Report CR78

Leonard Fagin

Despite many investigations and inquiries into violent incidents in mental health settings - resulting in subsequent reports and guidelines - safety considerations for mental health staff continues to be an issue of serious concern. Violence reflects societal mores and problems, so it is not surprising that it also extends to the clinical context, and to psychiatry in particular, where the management of disturbed behaviour is an essential element of care.

Aggression and violence are often preventable. This relies heavily on the awareness and skills of mental health clinicians working in organisations that are supportive and that help professionals to develop practical skills in a safe physical environment. Having said that, the latest National Audit of Violence (Royal College of Psychiatrists Research Unit, 2004) still indicates serious gaps, pointing to flaws in the design of in-patient units, inadequate staffing and an over-reliance on agency staff, poor leadership, changes in client mix, with overcrowding and higher proportion of dual-diagnosis patients, prevalence of substance misuse, and high levels of boredom and dissatisfaction with the appropriateness of training in the management of violence. The audit also reported high rates of staff stating that they have been assaulted, threatened or made to feel unsafe, ranging from 29% in Forensic Units, 43% in Acute Units through to 72% in Psychiatric Intensive Care Units.

In 1999, the Royal College of Psychiatrists produced a report, Safety for Trainees in Psychiatry (CR78), prepared by a College Trainees' Committee (CTC) Working Party and which in turn was an update of a previous CTC report in 1991 which put forward safety recommendations. In 2004, when this report was due for a review, the Public Policy Committee suggested that the scope of a report on safety should be broadened to include all practising psychiatrists. As an executive member of the faculty of General Psychiatry, I was asked to chair a working group with representation from the CTC, as well as representatives from the Faculties of General Psychiatry, Liaison Psychiatry and Addictions. We also benefited from advice from other Faculties within the College, receiving comments from Child and Adolescent, Learning Disability, Old Age and Psychotherapy, as well as the British Medical Association and the Police. The working group is currently reviewing the safety literature published since the last report, including recommendations made for all mental health professionals, along with Government initiatives to improve safety in the workplace. In arriving at its recommendations, the working group is consulting widely with other organisations that have produced similar reports, aimed at improving the safety for all mental health practitioners working in a variety of settings, as well as user and carer organisations. It also been helped by a survey it has commissioned to the Health Policy and Economic Research Unit of BMA, aimed at assessing current safety arrangements for

psychiatrists in training. Despite the low response rate, it is of concern that more than two-thirds of doctors could recall situations where they were put at risk, and that many had actually experienced verbal, and to a lesser extent, physical assaults, in hospital, out-patient and home settings. The A&E departments were particularly singled out as unsafe environments, and the lack of suitable interview rooms, personal alarms or chaperones was repeatedly mentioned. Some prison environments were deemed not appropriate or safe for assessments, and many reported the shortage of experienced nursing staff when risks were identified. The plight of pregnant trainees was highlighted as well. Finally, the need for adequate and regular induction schemes and training was requested, as well as protocols, guidelines and effective reporting systems.

The working group recognised that although different psychiatric disciplines are likely to be exposed to different degrees of threat to their safety, no particular branch of psychiatry is immune. In the same vein, the context in which psychiatric practice is delivered will also have a bearing on the likelihood of violence, be it in in-patient units, in out-patient settings, in accident and emergency departments, in prisons and other custodial institutions, or in patients' homes. In its report, brief vignettes will exemplify a number of situations which are likely to give rise to safety considerations in various settings, and will put forward advice on prevention and other recommendations to reduce escalation of risk.

In its conclusions, the working group will focus on those measures that psychiatrists should be aware of which can reduce the chances of assaults taking place, or of serious injury being sustained, should assaults occur.

Here is a preview of the summary and its likely recommendations:

1. While junior psychiatrists are now more likely to be receiving training in the recognition and prevention of violence, and in using de-escalation strategies and breakaway techniques, there is less evidence to suggest this is happening with senior psychiatrists. This should take place early on in the post, with regular refreshers.
2. Senior clinicians have a central role in preventing seriously aggressive behaviour in their patients. They not only provide the experience of assessing the risks posed by patients, but they can also advise their colleagues on how to manage such risks. Early detection of possible eruption of violence in an in-patient setting can be enhanced by a close working relationship with nurses, an ability to read and take action when difficult atmospheres exist, and a more active participation of psychiatrists in therapeutic activities.
3. Psychiatrists need to be aware of the potential for aggressive behaviour which might emanate as a direct result of their intervention, particularly where there exists an atmosphere of perceived confrontation, such as in Mental Health Act assessments, meetings with advocates, tribunal hearings, or where they are unrealistically expected to resolve problems outside their brief, skill or capacity.
4. Recognition of issues that require sensitive handling, in particular regarding racial or gender issues, and the careful usage of language in heated interchange, can help prevent violent outbursts.
5. In out-patient settings, A&E departments and prison environments robust safety measures need to be in place, such as adequate and well functioning alarm systems, clear exit facilities and support arrangements by other staff in cases of emergency. Recognition to patients of the anxiety experienced by them when coming to see a psychiatrist, or having to wait to be seen, can do much to reduce tension and enhance the quality of the interview.
6. For psychiatrists working in the community it is important to gather before visiting as much information as possible about the patient, the family and the environment where the visit will take place in order to take adequate preventative measures. In particular they should carry a means of communication and ensure that their team base is aware of the timing of the intervention, and what to do if there are any delays. It is recommended that psychiatrists should not visit private dwellings alone if they are not sure about the circumstances, and should never visit at night.
7. As far as Mental Health Act Assessments in the community are concerned, it is strongly recommended to have a pre-visit conference with all parties concerned, including the family, police and social workers, in order to plan the intervention and to take appropriate measures.
8. For those working with families and carers, in particular in old age and child and adolescent psychiatry, it is important to bear in mind that members of the family can also become highly agitated, aggressive and violent on behalf of their ill relative.
9. Psychiatrists should receive specific training on the assessment, management and risk assessments of patients with dual diagnoses.
10. The working group has endorsed the recommendations of the earlier College report on Safety for Trainees (CR78), many of them applying to all psychiatrists. In particular it wishes to highlight the importance of induction courses which take into account local safety considerations, matters of personal privacy, behaviour and appearance, and clear guidelines on what must be done following an incident of violence.

11. A jointly agreed and understood protocol for the reporting of untoward incidents should be in place in each workplace. This will only work if the culture allows staff to feel comfortable about reporting incidents without prejudice. Reporting incidents should be linked to a structure that allows learning to take place, and the adaptation of practices as a result of incidents. Clinical governance principles should be followed, with regular audits on violent incidents, and effective measures introduced as a result from their recommendations.

12. In cases of serious assault, the matter should be reported to the police, who, jointly with the Trust, should consider pressing charges against the perpetrator. In less serious incidents, a judgement needs to be arrived at on clinical grounds whether this is the best form of action to prevent re-occurrences. This may need to be discussed with the legal advisor of the Trust, as well as the medical defence society.

*The final report is likely to be published by the College in 2006*

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## Reform of Incapacity Benefit

Jed Boardman

The Government is planning a major change to the benefits system and will publish a Green Paper on reform in October 2005. What is this about?

- The Labour Manifesto pledged a move to an employment rate of 80% of the working age population. This means that people who are usually outside the labour market (disabled, lone parents, elderly) will need to be moved into work.
- This is consistent with record levels of employment (75%), an aging population, the need for flexible labour markets, social inclusion policies, and a need to cut down on benefit claims.
- There is a need to reduce the number of people on incapacity benefit. The number of people on incapacity benefits rose from 700,000 in 1979 to 2.6 million in 1997. The numbers have peaked at about 2.7 million since 1997. About 800,000 claimants have a mental health problem.
- Once a person has been on benefit for 12 months, the average duration of their claim will be 8 years. After 2 years death or retirement is more likely than employment.
- Recent Pathways to Work Pilots have shown that using what are called *Condition management programmes* that people can be got off IB and back into work. Over 50 per cent of people involved in Pathways have mental health problems as their primary presentation, while many others with physical problems (e.g. back pain) have secondary depression and/or anxiety.

These matters are of considerable concern to those working in health services. GPs in particular, in their role as signatories of sick certificates, play a potentially huge role in helping people back to work. Mental health services are concerned because of the large numbers of people with common and severe mental disorders who are not employed and the evidence of the health gains of work. Vocational schemes are poorly distributed in the UK. A recent review of vocational schemes for those with common mental disorders

published through the British Occupational Health Research Foundation (BOHRF) shows some good evidence for the effectiveness of CBT-based interventions for getting people back to work, but the number of studies using employment outcomes are few. The Pathways to Work Pilots bring together important stakeholders in their schemes (health services, employers and Job Centre Plus) and have therapeutic activity at their centre. Evidence that Supported Employment schemes (particularly *Individual Placement and Support*) help people with severe mental disorders get back into open employment is good.

We are also aware that the possible loss of benefits is anxiety-provoking to many of our patients and while many may want to work, the uncertainty of loss of income is inhibiting. The proposals for the new incapacity benefits set out in the Department for Work and Pensions (DWP) five-year strategy suggested a two-tier benefit, a *Rehabilitation Support Allowance* paid at similar rate to IB but requiring people to engage in work-focused interviews, and actively preparing to return to work. The second tier is a *Disability and Sickness Allowance* for those with more severe problems who cannot work. It is not certain whether this system will be proposed in the forthcoming Green Paper and it is difficult to get the DWP to commit themselves on this. It does seem that whatever the benefit system, this should allow opportunity and choice to those who wish to move back into the labour market and security to those who cannot. A major factor that may be crucial to the former are the conditions applied to people to get them back into work; these will be particularly pertinent to those with mental health problems, especially those with fluctuating conditions.

The College will submit written evidence to the Select Committee to inquire into reform of incapacity benefits and Pathways to Work and hopes to be able to give oral evidence later. If anyone has thoughts on these matters please let us know.

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## Speeding on the mental health highway: Experiences of our intrepid reporter

Zsarina Sciocco

Following her last news scoop, Zsarina was overwrought. Her deficient output had been measured using the new and improved HoNOS scales: her back was in a dreadful state from carrying files to and fro in the community and candidly, her performance indicator was in the 'red zone'. She was urged by her homoeopathist to go to a health farm for rehabilitation and recovery. No further encouragement was needed but, as the interested reader can imagine, the mega-stressed psychiatrist-cum-reporter was too distressed to pay attention to the journey and it was some time before she noticed the flashing blue light in her rear mirror.

But the arresting officer had a kindly face and, having completed a quick risk assessment, inquired what the hell she thought she was doing travelling up the A1 in the wrong lane, at excessive speed and with such reckless abandon. Mortified (Zsarina always keeps the rules), she couldn't think what to say other than speculate that her medication had resulted in some brief confusion which accounted for her behaviour. Despite his kindness, the young policeman was astonished and declared that she should never have driven on medication and had she any idea how many points might accrue from that oversight alone? Had she notified the appropriate government agency, he wondered? The reader can only guess at the effect this line of inquiry exerted on our psychiatric reporter's equilibrium. A responsible clinician (possibly a devotee of this newsletter) would have gone straight past the CRHT, skipped AOT, notified the keeper of CPA register and demanded immediate access to a PICU.

Zsarina, however, was quick-witted enough to explain that her therapist (recently relocated from California) had finally discovered what had been wrong with her all these years. You won't be surprised to learn that the psychotherapist declared that Zsarina had been mis-diagnosed by a succession of unreformed UK psychiatrists as a bit borderline, when in reality she clearly suffered from Acute Adult Attention Deficit Disorder for which urgent medical treatment was

required (*they certainly need to move with the times and change **their** working practices!*). Zsarina could only agree, as she was acutely aware that her main problem was her inability to concentrate on essential paperwork, and of course this wretched problem with the now smiling policeman was obviously a consequence of the hyperactivity element. She felt confident enough to explain to the officer that her medication, or even the diagnosis itself, was responsible for her conduct and that the doctor who prescribed it should face the full rigours of the law.

The young police recruit was impressed by the logic of this argument and thought it must be in the best interests of society to inquire further. He told the now relaxed Zsarina to stay put while he went back to the squad car to interrogate his NPFIS (National Programme For Intelligence Sharing) computer. This was a risk issue after all! It wasn't long before he returned with a grave, concerned look on his face. You wouldn't believe it - not only had he discovered from his NPFIS that Zsarina was on the mental health register but furthermore she wasn't prescribed psycho-stimulants at all: she was taking Fenelflaxine!! Lo and behold, there was no trace of a nice ECG result anywhere!! Shocked and lost for words, they both pondered the enormity of these developments. It was clear that our intrepid reporter was a victim of the system (was it her fair sex, or even some other innate quality she possessed, which explained this?). There was no choice; the officer immediately ordered her blue-lighted to A&E, knowing that the four-hour target would ensure an ECG was carried out promptly. The accumulated points for speeding would have to stay, but no mention would be made of his timely clinical discoveries.

As she continued her journey at a more leisurely pace, Zsarina could only marvel at the wholesome integration of the modern information age. She was left wondering how the world had ever coped without such a caring approach for the welfare of the upright citizen, who has nothing to fear from these most welcome reforms.

*Next issue: – Zsarina reports from the health farm on the benefits of some awesome new policy implementation guides (visit: [www.PIGSwillfly.com](http://www.PIGSwillfly.com))*

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## Happiness as an economic issue

Jed Boardman

Sometimes it is necessary for someone from outside a discipline to provide a ray of light to help those within the discipline to achieve some clarity of thought. Such is the case for psychiatry and Richard Layard, one time Professor of Economics at the LSE, now member of the House of Lords. In his book *Happiness* (Layard, 2005) he points out that despite economic and health advances in Western societies, we are no happier than we were fifty years ago. At a Government Strategy Unit seminar (Layard, 2004) and the first Sainsbury Centre Annual Lecture this year, he pointed to mental illness as being one of the biggest causes of misery in our society and the need to train about 10,000 new cognitive behavioural therapists. His main propositions are that:

- there is a mass of suffering that is untreated and which imposes severe burdens on the economy (some 2% of GDP)
- we have effective ways of treating this, which is already summarised and published in NICE guidelines, especially CBT.
- this need could be met over a 510 year period through training more therapists and providing this through a quality assured system
- this could be linked with the need to reduce those on Incapacity Benefit and the Pathways to Work programmes.

What are we to make of this? We could of course suggest that this is pie in the sky and that no one will listen to it. But he has the ear of Government and over the years has advised the Labour Government on employment matters. We also know from our daily work that CB therapists are difficult to find, and access to psychological therapies in the 21<sup>st</sup> century is akin to access to physical health care in the 19<sup>th</sup>. We may

suggest that no-one will fund this. But the subject of access to therapies is a priority of the NSF Review (DH, 2004), it is in line with the policy on patient choice, and the problem of mental health and the economy is a cross-government issue and a key area for the DWP. We may also ask where these therapists will come from. This may be a more difficult matter to address; some of these will come from the ranks of clinical psychologists, who may provide the necessary expertise and breadth to the system, others will be specifically trained and, of course, there are already a large number of counsellors, some of whom may readily accept training in this area. There are also people who may say that this is too simplistic - people have more complex problems and there are many other forms of therapy. That may be so, but it is illogical to turn down a scheme that proposes offering more of what is needed, for which we have evidence and which we and general practitioners face daily by what we see coming through our clinic doors. Of course we may just be pathologising ordinary life, but I think it may be difficult to sell that one to those many people who suffer from depressive and anxiety disorders. What do you think?

### References

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- Layard, R (2005) *Happiness. Lessons from a new science.* London: Allen Lane.
- Department of Health (2004) *The National Service Framework for Mental Health – Five years on.* London: Department of Health.

If you wish to make a comment or respond to this article email us at [adultpsychiatry@yahoo.co.uk](mailto:adultpsychiatry@yahoo.co.uk)

## Letters

### The stranglehold of 'criteria'

Kasha Wood

I feel strongly about the subject of this article and it is a relief in a way to see in print my own thoughts and observations.

I am a relatively new consultant, sector consultant. My caseload includes in-patients and out-patients. I took the

post just at the time when the new specialist teams were created within my sector and old-style CMHTs ceased to exist, as all their staff joined the new teams. IT was a reshuffle with some "new blood". It is now 1.5 years following the "transition" period and I often feel like a "captain without the crew". I need to negotiate with various teams to refer patients and often I hear "It does not meet our criteria". So I am stuck. Maybe I should be

many people in one (CPN, OT, psychologist etc, etc) and have a principle of "Do it yourself".

The services on the ground were definitely divided into separate teams and each of them only cared about their "operational policies and intake criteria". It is a pity that patients do not easily mould to those and I need to hold the gaps singlehanded; at times I feel quite demoralised when I hear "It does not meet our criteria".

The last point I want to make is that as a newcomer to the post I did not feel able to express my concerns as everybody was so enthusiastic about the changes, so politically correct. Alleluia.

**Updating job descriptions for consultants in adult psychiatry**

**Dr Craig Smith**

Dr Wood's workload figures were a most welcome inclusion in the newsletter of Spring 2005.

As a Community General Adult Psychiatrist I would like to elaborate on these with reference to the New Contract.

Dr Wood suggests figures for Out Patient and In Patient work using patient numbers per PA.

These figures are reasonable to my practice in terms of busy "Direct Contact Clinical" contact. However they fail to include the "Non Direct Clinically Related Administrative Time" these sessions generate (reviewing notes, liaising with other teams, preparing reports etc.).

Consultants on a 10 PA New Contract should seek to negotiate 7.5 PAs categorised as clinical activity. These 7.5 Clinical PAs should include both "Direct Contact Clinical" time and "Non Direct Clinically Related Administrative Time" (including that related to all unpredictable emergency work both during the CMHT's working week and on call).

In my practice, one busy out patient clinic and one busy ward round (seeing the sort of numbers suggested by Dr Wood) both generate 1/2 PA of clinically related administration.

Using the language of the New Contract I would seek to have one busy ward round and one busy out patient clinic and the one PA of clinical administration generated by these recognised and categorised as 3 Clinical PAs in my job plan.

Where workload figures are published by the College it is crucial to identify, quantify and categorise the total work represented using the language of The New Contract in a non-ambiguous way.

**Sectorisation and choice?**

**Dr Rachael Cullivan-Elliott**

I read with interest your article including your comments on workload measures. As I work in a consultant team of two providing the general adult service to the county of Monaghan in Ireland, ensuring an equitable caseload can be problematic. At present we try to allocate new patients equally, but this does not always take into account the complexities of those who re-present, or are already being carried. We are anxious to remain "de-sectorised", allowing patients a choice of consultant regardless of geographical location. I would be interested to learn of the experiences of other consultant teams, as in the Irish Republic most services are based on the model of a single consultant leading a team in each sector, which is defined by population and geographical boundaries.

**Workload and resources**

**Masum Khwaja**

I would like to comment on Dr Graham Wood's article in the spring 2005 faculty newsletter. I am a general adult psychiatrist working in a community and in-patient team serving the West End of London. Although I support the notion of establishing "indicative workload figures" I was dismayed by the example figures suggested for out-patient clinics, CPA and ward round meetings. In my opinion, the figures given were not in keeping with modern psychiatric practice. Any figures established by the faculty should facilitate clinicians on the ground to acquire resources that will allow clinically effective and safe services to be provided. Although a safe, effective and user-friendly service is sometimes difficult to define and is dependent on the culture of teams, local resources and the particular attributes of the clinicians involved, most of us would agree that rushed clinics are soul-destroying for staff and disliked by users and carers. They are also a false economy, as, for example, they often do not allow sufficient time for a careful risk assessment or for clinicians to formulate a mutually agreed care plan that the user will adhere to. I also strongly believe that the views of our users should be sought and would suggest that in this regard there may well be a role for user-focused monitoring.

## Faculty of General and Community Psychiatry; Procedure for National ACCEA Awards 2006

Every year, the College makes a submission to ACCEA, nominating members for national clinical excellence awards. The College procedure and the functions of the College's Excellence Awards Committee (CEAC) are described in *Psychiatric Bulletin* (2004) 28: 306. The College submission is informed by submissions from Faculties, Section and Divisions of the College.

The Faculty Executive has recently reviewed its procedures with regard to the ACCEA process. The aim is to ensure a fair, equitable and timely procedure. This procedure is described below. However, before you read this you should familiarise yourself with the ACCEA Procedure and Guidance, which is available on [www.doh.gov/accea](http://www.doh.gov/accea). After that you should read what follows carefully, as the procedure is complex, with many pitfalls for the unwary. Experience has shown that deadlines (both College and national) are rigid.

Colleagues should note that in order to be considered by the CEAC, and thus potentially attract support of the College, the nomination must be:

- on the appropriate documentation: ACCEA form for the year of application
- submitted in time for the Faculty deadline
- with support from the applicant's Trust Chief Executive

Please be aware that this is often difficult to achieve and requires active chasing of the relevant Trust Officer (Chief Executive or Medical Director).

If you do not have the Trust's support or Citation in time for the Faculty deadline, please submit your CV anyway. However, please note that it is your responsibility to ensure that an updated CV with Trust support is submitted.

Nominations submitted to the CEAC by the Faculty will be supported by a citation from the Faculty.

It is extremely important that potential applicants recognize that the Faculty procedure does not replace the need to submit one's nomination directly to ACCEA in accordance with the appropriate deadline (usually in January). An application through the Faculty is in addition to, and not instead of, the ACCEA procedure.

### Timetable for 2006 round:

**1 November 2005:** Last date for submission of CVs to Faculty.

**7 November 2005:** Electronic CVs will be circulated to Decision Making Group (DMG) for consideration using agreed assessment process. Details of the Assessment process will be published on the website shortly.

**25 November 2005:** Final date for receipt of rankings DMG members.

**5 December 2005:** Meeting of Faculty DMG.

**12 December 2005:** Submission of ranked list to CEAC.

**17 January 2006:** CEAC meeting

**22 January 2006:** deadline for submissions to ACCEA

### Addresses for submissions

All submissions must be in electronic form.

Submissions for level 9: [suresh.joseph@nmht.nhs.uk](mailto:suresh.joseph@nmht.nhs.uk)

Submissions for level 10,11: [p.mcguffin@iop.kcl.ac.uk](mailto:p.mcguffin@iop.kcl.ac.uk)

## Procedure

1. The procedure will be overseen by the Chair of the Faculty, assisted by the Hon. Secretary.
2. The Decision Making Group (DMG) will comprise all elected members of the Faculty Executive.
3. All submissions must be electronic.
4. All submissions must be received by the appropriate officer according to level of award, by 1700 hours on the relevant date as set out in the Timetable.
5. Submissions will be despatched by these officers electronically to members of the DMG by 1700 hours on the appropriate date as per timetable.
6. DMG members will rank all submissions in accordance with ACCEA criteria, and using the agreed scale, to achieve an initial prioritisation of nominations. This procedure will be followed for each level of award.
7. DMG members will return ranked nominations to the appropriate officer for level of award by 1700 on the appropriate date as per timetable.
8. Appropriate officers will collate responses from DMG members and prepare a ranked list for each award level. This will be submitted as per timetable in preparation for the DMG meeting.
9. Ranked lists submitted by Appropriate Officers will be scrutinised by the Chair prior to the DMG meeting.
10. The DMG meeting will be chaired by the Faculty Chair and will produce a final ranked list, after consideration of ranked lists submitted, and taking into account the discussion at the meeting
11. It is recognised that the ranking system used is for the purpose of initial prioritisation, and that discussion at the DMG meeting may result in alterations to the rankings.
12. The number of nominations submitted to the CEAC will depend upon advice received by the Chair from the President, as to how many nominations would be accepted.
13. Final ranked lists will be submitted to the CEAC meeting in accordance with appropriate deadlines, and with a citation from the Faculty.
14. Decision as to who will prepare a citation will be made at the DMG meeting.
15. The Faculty will be represented at the CEAC meeting by the Chair or appropriate nominee.
16. Where a member of the DMG is a candidate for an award he/she will leave the meeting and abstain from discussion of nominations which may affect his/ her ranking (ie for the category of award for which he/she has applied). Where a member of the DMG submits a nomination, he/she should not rate the nomination on each of the 14 ACCEA criteria (see rating scale, below), but should include him/herself in the list of people whose nominations he/she has endorsed.
17. The committee is unlikely to give high priority to nominees who have been awarded a local bronze level award within the last two years or any national level clinical excellence award (or merit award under the old procedures) during the last five years.
18. It should be noted that nominations without Trust support by the time of the DMG meeting will inevitably be disadvantaged.

### Scale for initial prioritisation of applications:

The scale used has been piloted by several Divisional ACCEA committees. It should be noted that the higher of the two scores for domain 4a and 4b is taken into account. It is important that the instructions are closely followed.

### A Rational Means of Initial Prioritising of Contenders for NHS Clinical Excellence Awards 2004-2005

These guidelines should only be used as an initial means for sorting CVs. They cannot be applied rigidly but their use ensures that all the major categories of merit are weighed in the same manner. Hopefully, this will provide internal consistency and allow recognition of excellence in each individual domain.

**Please note that to be regarded as “definitely over and above contractual requirements” requires a range of achievements, persistent over the years.**

## Criteria used for grading

### **FIRST DOMAIN: Delivering a High Quality of Service**

- |                                 |   |
|---------------------------------|---|
| 0 Not eligible:                 | For a number of reasons ranging from doing the minimum required or questionable conduct as a clinician or a colleague to just doing the job.  |
| 2 Fulfils contract competently: | Performs competently in his /her job. There are no questionable issues regarding conduct as a clinician, colleague, researcher or teacher. Slightly more than the job with safety and quality assurance (e.g. operative morbidity and/or mortality documented). |

- 6 Definitely over and above contractual requirements: Exemplary standards in dealing with patients, relatives and all grades of medical and other staff, ideally include reference to validated patient or carers survey or feedback on the service (external or peer review reports) Demonstrated usage of evidence based practice. Excellence in leadership of the team, for example in the work of Chairman of a Division/Head of Department. Voluntarily contributes to recognised quality assurance schemes.
- 10 Outstanding: Innovative contribution to clinical governance and/or service delivery of proven worth (audited or published). Leadership role in relation to clinical governance.

### **SECOND DOMAIN: Developing a High Quality Service**

- 0 Not eligible: A number of reasons ranging from doing the minimum required to questionable conduct as a clinician or a colleague to no local input.
- 2 Fulfils contract competently: Contribution to relevant audit cycles and completing them with actions. Enhancement of quality and safety. Analysis of risk and managing it.
- 6 Definitely over and above contractual requirements: Use of multi-professional approaches to service delivery, improvement in service delivery. National appointments to Societies, for example NSF, HIMP, College, developing innovation in service delivery with evidence of improved outcomes (clinical governance).
- 10 Outstanding: A national leader/international profile/chairing national committees, for example NICE/Government Advisor/other. Demonstrable change in evidence based practice.

### **THIRD DOMAIN: Managing a High Quality Service**

- 0 Not eligible : Does not contribute to service management or involvement is contrary to clinical guidelines and/or trust policies: Just attending meetings.
- 2 Fulfils contract competently: Change management aimed at improving the effectiveness or efficacy of service, which an individual has led.
- 6 Definitely over and above contractual requirements: Chairing Trust/University committees, eg. Clinical Director. Conducting appraisal for peers/non-career grade doctors. Major reviews, enquiries or investigation, for example Medical Director. Actively contributes to College/ Specialty Advisory Committee (SAC member).
- 10 Outstanding: Professional practice, for example leading/chairing national committees or enquiries.

### **FOURTH DOMAIN: a) Research (see also Form D)**

**\* In the case of a DGH doctor, involvement in high quality research should attract a higher score than in the case of a University employee where there is contractual requirement to undertake or be involved in research.**

- 0 Not eligible: Does not undertake any research or has no citations in peer reviewed journals.
- 2 Fulfils contract competently: Citations in peer reviewed journals or more than 'case reports'. Office bearer/invited speaker.
- 6 Definitely over and above contractual requirements: Citations in significant impact journals or evidence of actually leading research projects not just lending support. Evidence of research grants secured, directing research departments, successful supervision of higher degrees.
- 10 Outstanding: Evidence of important research leading to altered national practice, editorial writing or significant editorial function in significant impact journals. Visiting Professorships

**FOURTH DOMAIN: b) Teaching and Training (see also Form E for level 12)**

0 Not eligible:	Refuses to train and be involved in teaching and education. Just students on ward rounds. Poor attention to trainees
2 Fulfils contract competently:	Above but "Obliges" with the odd lecture to undergraduates and/or postgraduates (medical and non-medical).
6 Definitely over and above contractual requirements:	Regular student contact, regular lectures to undergraduates or postgraduate organisations. Peer reviewed and other publications on educational matters. Positive student feedback. A major input: the above plus examiner for College and other health and social care professions. Institutional success in regulatory body and QA audits of teaching
10 Outstanding:	Leadership and innovation in teaching undergraduate and postgraduate courses organiser and regular contact and lectures plus examiners. Postgraduate teaching in other UK centres and abroad (presentations and invitations to lecture nationally and internationally). Office holder at College association level and involvement in setting educational trend.

**List of Current Faculty Regional Representatives**

<b>Region</b>	<b>Representative</b>
East Anglia	Dr Mike Lowe
Ireland	Vacant
Mersey	Dr Norman Agnew
Northeast Thames (London, Northeast)	Dr Ian Collis
Northern	Dr Angela Walsh
Northern Ireland	Dr Paddy Moynihan
Northwest Thames (London, Northwest)	Dr Lester Sireling
North Western	Dr Ripudaman Singh Deo
Oxford	Dr Alexandra Day
Scotland: Edinburgh	Dr Pete Le Fevre
Scotland: Glasgow	Dr Mark Taylor
Scotland: Grampian (Aberdeen)	Dr A lastair Palin
Southeast Thames (London, Southeast)	Dr Ranga Rao
Southwest Thames (London, Southwest)	Vacant
South West	Dr Teg Freer
South-eastern – Kent, Sussex, Surrey	Dr John Vile
Trent	Dr Chris Wallbridge
Wales	Dr Stephen Hunter
Wessex	Dr Paul Courney
West Midlands	Dr Christopher Thomas
Yorkshire	Dr Dympna Ryan

## Dates for your diary!

### **Joint Residential Meeting of the Faculties of General and Community Psychiatry, CTC and Rehabilitation and Social Psychiatry, 2006**

**Leonard Fagin and Helen Killaspy**

*Conference Theme: Tailoring services to the needs of patients with long-term conditions*

**De Vere Grand Harbour Hotel, Southampton**

**19<sup>th</sup> - 20th October 2006**

We are now well advanced in the preparations for the above conference, which we think will be of great interest to the members of both our faculties. We have invited an array of national and international speakers, and there will be opportunities for focusing on subjects in symposia and entering into interactive dialogues in a large number of workshops.

In order to whet the appetites and start you running to your next year's diary, let us give you a flavour of what will be covered in the conference:

We will start on Thursday with Professor Rob Peveler giving an overview of current research and approaches to physical health in schizophrenia. Professor Zoltan Rihmer, from Hungary, a world expert on clinical and biological aspects of mood and anxiety disorders, will be talking on 'Mental states predisposing to suicidal behaviour'. We have also invited Professor Eduardo Vieta, from Barcelona, to speak on 'Psycho-educational approaches to schizophrenia and bipolar affective disorder'.

We have organised a symposium on Long-Term Conditions (LTC) inviting Professor Lynne Stokes from King's College, David Colin-Thome from the Department of Health and Helen Lester from Birmingham, in particular looking at shared care arrangements with primary care. Another symposium will focus on different aspects of physical care for patients, and we have invited David Osbourne from the Royal Free, as well as consultants in Cardiology and Endocrinology, to address medical consequences of mental illness. We also have a symposium on International Perspectives in Assertive Outreach, and have invited well-known speakers from Australia, Canada and the UK to address these issues.

Our workshops cover a wide variety of interests, such as improving standards in in-patient care, alternatives to hospital treatment, safety for psychiatrists, working in partnership with commissioners, management of mental disorders in prison settings, improvements in training in general psychiatry and rehabilitation, mindfulness approaches to long-term conditions and the therapeutic potential of creative writing.

On Friday, after repeating the workshops to give delegates an opportunity to attend at least two each, we will have symposia on out-of-area placements and re-institutionalisation (Professor Stefan Priebe, Dr Stefan Davies among others), epidemiological and psychological aspects of psychotic disorders (Professor Glyn Harrison, Dr David Kingdom and Gill Haddock), and preventative approaches in common mental disorders and timing of treatment (Professor Munk-Jørgensen from Denmark, Professor Graham Turpin from Manchester).

The meeting will round off with a plenary from Professor Norman Sartorius, Emeritus Professor of Psychiatry at the University of Geneva and ex-president of the World Psychiatric Association, speaking on European perspectives on Long-Term Conditions in Mental Health.

I hope that you will agree that next year's conference will be worth your while, and look forward to you joining us in what we hope will be a highly stimulating and enjoyable event.

## Faculty of General and Community Psychiatry: The Executive

<b>Chair</b>	
Dr Jed Boardman	(Elected: 2003)
<b>Honorary secretary</b>	
Dr Suresh Joseph	(Elected: 2003)
<b>Finance officer</b>	
Dr Michele Hampson	(Elected: 2005)
<b>Executive committee members</b>	
Dr Mark Agius	(Co-opted: 2005 – affiliate/SAS)
Dr Pradeep Arya	(Co-opted: 2003 - SpR rep)
Dr Maria Atkins	(Elected: 2005)
Dr Victor Aziz	(Co-opted: 2005 - alternate CTC rep)
Dr David Bickerton	(Co-opted: 2005 – alternte CTC rep)
Dr Anne Bird	(Elected 2005 - GOAPSAC)
Dr Frances Burnett	(Elected 2005)
Dr Alan Currie	(Elected: 2003)
Dr Lenny Fagin	(Elected 2005 - Academic secretary)
Dr Brian Ferguson	(Co-opted: 2003 - Psychotherapy link)
Dr Cliff Haley	(Co-opted: 2004 - Irish College of Psychiatrists)
Dr David Hall	(Co-opted: 2003 - CAP interface working group)
Dr Anna Higgitt	(Observer: Department of Health)
Dr Stephen Hunter	(Co-opted: 2003 - Welsh Division)
Dr Lisetta Lovett	(Elected 2005)
Dr Mike Lowe	(Co-opted: 2005 - Regional reps group chair)
Dr Hamish McAlister-Williams	(Co-opted 2005 – co-academic secretary)
Dr Rajesh Mohan	(Co-opted: 2002 - Communications)
Dr Paddy Moynihan	(Co-opted: 2003 - Northern Ireland Division)
Dr Geraldine O’Sullivan	(Co-opted 2005: GOAPSAC)
Dr Leon Rozewicz	(Elected 2005)
Dr Mark Salter	(Elected 2005)
Dr Mary Jane Tacchi	(Elected 2005)
Dr Mark Taylor	(Elected: 2003)
Dr Trevor Turner	(Elected: 2003)
Dr Graham Wood	(Elected: 2003)

### How to contact us



Faculty of General and Community Psychiatry  
Royal College of Psychiatrists  
17 Belgrave Square  
London SW1X 8PG



Phone: 020 7235 2351  
Fax: 020 7245 6074



Email: [adultpsychiatry@yahoo.co.uk](mailto:adultpsychiatry@yahoo.co.uk)  
Website: <http://www.rcpsych.ac.uk/college/faculty/gencom.htm>

Don't forget to mail or email us with your responses and articles for publication