

Social and Rehabilitation Psychiatry Section Newsletter



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A word from the editors

As CHI has recently reminded us, addressing the mental health needs of all the people from the diverse communities living in England, at least, has not, so far, been a brilliant success. We hope this issue, focusing on **diversity**, will provide a few ideas as to how we may progress the issues locally - ideas being a key ingredient of social and rehabilitation psychiatry. Our key article, in what we hope, with your help, will become a series is Shakil Malik's paper on Islam. Elizabeth Bayliss from Social Action for Health spoke to LP about how we can find out about what people would find helpful from our services and Tim Jerram gets us thinking about NIMHE's 'Values in practice' agenda.

How often do our patients remind us of the importance of faith in recovery? Larry Culliford's Book Tips on that subject (and psychotherapy for psychosis) are highly recommended for 'CPD' reading time - NB don't forget to count it, however entertained you are! The ethical pitfalls teams may face in attempts to address peoples' spiritual needs are brilliantly described in Caroline Cupitt

and Paul Wolfson's story of a team's response to a request for baptism.

Our seriously committed chair describes the Exec's progress in forging partnerships with Rethink, the College of OTs and NIMHE's Social Inclusion Unit, urging us (in England) to make contact with our local NIMHE Regional Development Centre. Social inclusion is what Rehab is about, after all!

Tom Harrison gives us the benefit of his wisdom about copying letters to patients - timely, given the approaching deadline for implementation; and Tony Zigmond keeps us up to date with the draft (England & Wales) new Mental Health Bill. The energetic rehab people in Scotland are working well to address a different agenda . . . See Debbie Mountain's report.

Please keep the top tips coming . . . They can't be any more daft than the ones we think up! Hope you all survive until the daffodils appear.

Louise Petterson and Theresa Tattan

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Newsletter of Section of Social & Rehabilitation Psychiatry.
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Chair's report

Good wishes to all Section members for 2004; I hope that we can make a productive and creative contribution to 'modernising' rehabilitation during the coming year, without losing the lessons of our history. Our Rehabilitation and Recovery Position Statement is regularly aired at E&F to keep it in the College mind, alongside the request for faculty status.

We certainly achieved a great deal during 2003.

Perhaps the most important innovation was the invitation to user and carer representatives from RETHINK to join our executive meetings, our academic sub-group and our very successful joint residential conference (with the Faculty of General and Community Psychiatry). The contributions made by Jenny Fisher, Dennis Preece, Graham Estop and Keith Hall were outstanding in all these forums. It was such a good way to begin to develop partnership working and we look forward to more next year.

We have also made some progress with partnership working with NIMHE.

I met David Morris (National Director of NIMHE Social Inclusion Unit) and Jed Boardman (Chair of G&C Faculty) during November. We agreed to host a partnership seminar at No 15, Belgrave Square, for both executive committees and all the regional representatives of both our Section and the Faculty, together with NIMHE representatives from the Social Inclusion Unit. We also thought to involve the College of Occupational Therapists, too, to promote partnership working between our professional organisations.

The aim of the seminar will be to raise awareness of the importance of addressing the barriers to social inclusion for the users of our services. We hope to come away with some clearer ideas about how to make meaningful improvements to their social capital. The seminar is timed to coincide with the launch of the Social Exclusion Unit's Implementation Guidance from the Deputy Prime Minister's Office in March 2004. Hope this comes out on time!

A useful outcome of this national seminar could be to roll out more local events, based around each Regional Development Centre.

In the North West, the rehabilitation psychiatrists have agreed to meet with the Social Inclusion and service user representatives from NIMHE NW in the spring of 2004. The aim here is to investigate partnership working to promote social inclusion and to improve the quality of rehabilitation services locally. Do you think there is energy to initiate this through the other seven Regional Development Centres, with rehabilitation regional representatives taking a lead?

David Hughes is the NW regional representative, and the new Chair of the regional representatives group. He may be able to provide some pointers as to how to get going.

Please contact me on the usual email address (Sarahdvnpt@aol.com) if you have ideas about how to take this initiative forward.

Very best wishes for 2004

Sarah Davenport

Chair of Social and Rehabilitation Psychiatry
Section

What psychiatrists should know about Islam

I am no scholar of religion. However, as a Muslim psychiatrist, I will try to highlight some basic tenets of Islam, which should facilitate greater understanding of the Muslim patient. This short paper is not meant to explore in any depth the relationship between faith/religion and managing psychiatric disorders; such work would require several volumes.

Our world is coming ever closer in this global village where time and distances continue to shrink and financial realities frequently require people to travel and emigrate to alien cultures. Technological advances are taking place at a pace never before witnessed in history and contemporary societies are rapidly moving to multi-ethnic, multi-racial, and multi-religious communities. Globalisation and its psychosocial and economic consequences are increasingly becoming apparent in the presentations of our patients.

Islam is a global religion which transcends borders and boundaries, colour and creed, providing common ground in fundamental beliefs and giving a moral and legal code for successful individual and collective life.

There are over a billion Muslims in the world, of whom over ten million live in the West and are shared about equally between the USA and Europe. Although Arab culture has influenced the life of Muslims worldwide, Islam does not essentially propagate any one culture. Today Arabs constitute only 20% of the total and there are about fifty Muslim nations, each with its own unique cultural heritage displaying diversity in language, social customs and traditions, but coloured and bound together by their faith. Islam preaches love, compassion, kindness and tolerance and provides a prescription for the intellectual, spiritual, moral, psychological and physical development of individuals and through them of the communities they live in.

Literally, the word Islam means 'submission' and expects one to believe in the oneness, omnipotence and divinity of God 'tawhiid'.

Tawhiid is the affirmation that there is only One Creator who deserves our praise and gratitude and whose guidance needs to be followed for our own good and benefit. This affirmation thus establishes a direct link between God and man and liberates man from the powers of priests and other intermediaries. It liberates the human mind from superstition, the grip of horoscopes and fortune-tellers and from the sinister grip of occult practices. It also liberates a person from self-conceit, false pride and arrogance of self-sufficiency. Tawhiid thus creates a unique blend of submission to God and individual freedom and dignity.

Muslims believe that there is a destined time of death, which cannot be changed, that the life of this world is transitory and that there will be an afterlife. The Quran teaches that during this life, at one time or the other, we are bound to be tested with adversity, separation from loved ones and financial difficulties; however, no individual is burdened more than he can sustain. Illness, bereavement and other adversities should thus be taken as a challenge and endured with steadfastness. There is, however, an obligation on every Muslim to seek expert advice of a physician should the need arise, irrespective of the physician's religion or ethnic background. As such, physicians are held in a sort of reverence that facilitates development of therapeutic alliance and compliance with treatment plans.

In practice, of course, many Muslims when distressed, just like people of other faiths, consult healers of various kinds; spiritual healers and clergy are often the first ports of call. Such healers command enormous respect and influence because of their perceived understanding of religion and are well placed to offer social acceptability, meaning and authoritative suggestion/advice. By and large they tend to provide empathetic hearing and emotional support as well as interpret and reformulate the presenting problems of the sufferer in a format which makes some sense to him. Depending on the

psychological sophistication of the healer, the presenting problem can be attributed to such phenomena as due to evil eye, sinful life, possession or due to medical/psychological illness.

The phenomenon of possession is particularly intriguing and challenging to understand and manage. Possession states are usually dramatic presentations invariably motivated by secondary gain and social control, and are a feature of the local customs, traditions and educational status of a particular section of society rather than part of Islam. These are culture-bound disassociative phenomena but can be easily misdiagnosed as psychotic conditions when presenting with symptoms of neologism, abnormal behaviour, psychomotor activity and high arousal. The vast majority of these present to faith and other traditional healers, who use diverse indigenous remedies to treat them, ranging from fascinating ingenious psychosocial interventions to humiliating and horrifying rituals. Such healers play an important role in the careers of patients and in the future pathways of their care.

Islam involves living in harmony with nature. It can be rightly considered a behavioural science as it inculcates values, attitudes and habits that are for individual and collective benefit. It provides a clear code of conduct and helps develop a mind-set where an individual thinks and behaves in a manner which should benefit his body, spirit and the environment in this world and the hereafter. Muslims believe that human beings were not created in vain; instead, God placed a trust on each person. This trust requires one to respect and fulfil the needs of body, mind and soul as well as the needs and rights of other creations - human beings, animals and the environment as a whole.

Preservation of life is considered paramount and Muslims are prohibited from committing suicide, using intoxicating drugs and alcohol, gambling, indulging in sex outside wedlock and from eating carnivorous animals. It is emphasised that he who saves the life of one individual saves entire humanity. Maintaining personal and environmental cleanliness is

considered an essential element of faith and is repeatedly reinforced. Ablution is a prerequisite for prayer, where the body is washed in a prescribed manner at least five times a day, emphasising the need for and ensuring personal hygiene.

Irrespective of ethnic and social background or where one lives, all Muslims are expected to subscribe to five principles or fundamentals, namely: Kalima Tayaba (oath of allegiance to God); Salaat (prayer five times a day); Sawm (fasting in the month of Ramadan); Zikaat (to pay 2.5% of personal savings to the poor); and Hajj (pilgrimage to Mecca at least once in a lifetime if one can afford it). The prescribed code of conduct for a Muslim is based on central principles of balance ('adl') and compassion ('ihsan') in all walks of life and is eloquently described in the Quran (Holy Book), elaborately seen in practice in the Sunnah (the life of Prophet Mohammad) and supported by Shariah (the social and legal system born out of the Quran and Sunnah).

Islam provides a clear social framework subscribing to family values and ties, and clearly describes roles, responsibilities and obligations to family members and to the wider community, leaving no room for experiment and consequent confusion and conflict. The cohesive social structure thus established encourages reaching out to others in both giving and receiving of emotional and instrumental help, which can serve to modulate and modify the effects of psychiatric and physical illnesses. However, at times strict adherence to such clearly defined roles and obligations can be difficult, particularly in countries where Muslims are in minority. Failure to adhere to these by a believer can lead to feelings of guilt and despondency.

My interest in the interface of religion and mental health goes back some years when I developed a model of community care for mental health in Pakistan, using the infrastructure of the mosque. The institution of the mosque plays a pivotal role as a community resource centre in Islam and can be effectively adapted to serve the mentally

ill. An alliance between the mosque and mental health services can be usefully employed to de-stigmatise mental illness, create awareness and run meaningful preventive programmes, as well as provide emotional and practical support at times of distress. This is particularly so in the developing world where the population invariably has access to inadequate or virtually no mental health services. Such an alliance can perhaps be more beneficially employed in the Western world to establish a referral system, and to manage/monitor treatment compliance as well as prevent marginalisation and social drift of psychiatric patients.

As in all good psychiatric practice, an understanding of patients' beliefs and culture is essential to the understanding of the aetiology and presentation of the condition

and formulation of a meaningful management plan. The dynamics of religion/spirituality can be highly complex, at times serving as a source of strength providing meaning and hope, while at others as a source of conflict, distress or an excuse for treatment avoidance. Becoming aware of the religion/spirituality aspects of our patients and the potential value or harm of their practices/beliefs is important to fully understand 'the whole person'.

I hope this brief introduction to the subject gives an overview of the Muslim patient, his religious and social obligations and the supports of the social structure that could be used to good effect in his management.

Dr Shakil Malik

Consultant psychiatrist, East Sussex

Top tips

1. People who have experienced chronic psychotic symptoms are more likely than the rest of us to know what helps. Do check out www.voicesforum.org.uk/zspeech.htm The classic strategy that Zyra used to handle the feeling that people were looking at him was to dress in a way that ensured that they did. Great street theatre, adding to the life experience of us all, I thought!

See also www.zyra.org.uk and www.voicesforum.org.uk (Ed)

2. There is no such thing in law or statute or DoH rules as RMO responsibility, apart from for inpatients detained under the Mental Health Act . . . Professor Louis Appleby at a recent BMA/DoH/RCPsych./GMC conference on roles and responsibilities of consultant psychiatrists . . . The College and others are taking it forward.

The Douglas Bennett Prize

Awarded annually for the best paper on rehabilitation psychiatry presented by a psychiatrist*
(maximum length 2000 words)

For further information contact:
Sonia Walter, Conference Office,
Royal College of Psychiatrists
e-mail: swalter@rcpsych.ac.uk

Closing date for applications:
1st September 2004
Please send 3 copies per submission

* To include consultants within two years of appointment, basic and higher trainees and non-career grade psychiatrists.

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Consent to baptism and the multi-disciplinary team

At a recent CPA review, a resident of a local hostel mentioned that she would like to be baptised. She was not a regular churchgoer but had been brought up in the Christian faith. Her parents had arranged for her brother and sister to be baptised, but she had missed out 'because of the war'. The request was passed on to the hospital chaplain. A few weeks later the chaplain left a message for the multi-disciplinary team. Did they agree?

At the next team meeting, the consultant was asked for his opinion as her consultant. The consultant had just had a bruising encounter about informed consent with a young man with a psychotic illness who had applied for a divorce. The Official Solicitor had raised the question of his capacity as a vulnerable adult, and requested a report from the consultant, which raised serious concerns. The divorce would have had adverse financial consequences and the young man kept changing his mind about it from day to day, depending on the strength of his delusional beliefs. When the applicant read the consultant's report he was furious. Divorce involves money and property but it is a very personal matter. Nevertheless the consultant felt sure of his ground, and had the support of the multi-disciplinary team.

The chaplain's request about baptism split the team down the middle. Grumbling about the growing medicalisation of everyday life, the consultant expressed the view that the team had no right to interfere in matters of faith. Our role was limited to whether she was fit to attend the ceremony, which she obviously was. Her mental state was stable, although she was guarded. After that, it was a matter between her, the chaplain and God. As a non-practising Jew with atheistic tendencies, should the consultant be allowed to be the judge of whether her delusion was rational?

The psychologist did not believe in God either, but felt the question of capacity to make an informed decision about baptism was just as important as consent to treatment or ability to manage your affairs. Even more important, in fact, as the Buddhist position would be that the decision would affect her spiritual life in subsequent rebirths. The nurse was an atheist and believed that everyone had a right to be baptised, subject to the chaplain's agreement. When it came to the afterlife, if there was a Christian God they were covered, and if there was not a God, what possible harm could it do? The social worker thought the important thing was whether the patient was behaving out of character. Had they previously been, for instance, a devout Muslim and suddenly wanted to become a Christian, we should probably become involved. Even though this did not apply here, the chaplain's request was perfectly reasonable.

Further consultation occurred, firstly with a Christian consultant who said that in many religions, people with a mental illness are regarded as particularly close to God, and it was not the business of the team to start ruling on religious matters. The consultation extended beyond mental health services to a theologian who told the story of how, in ancient times, an actor had been baptised on-stage during the performance of a play. When the actor subsequently wanted to convert to Christianity, there was an interesting debate over whether his stage baptism had any validity. A person whose mental illness interfered with their thinking to such a degree that they were unable to participate fully in their baptism might raise similar issues. Indeed, he had heard of cases where someone had requested a re-baptism because a previous attempt was felt to have been invalid due to ill-health.

You might begin to wonder whether the capacity to consent to baptism is something else to check when determining the conditions of Section 17 leave for detained patients who want to go to church. Freud appeared to believe that all religious belief was delusional. DSM III-R (1987) contains many examples of psychotic symptoms involving religion, most of which were removed after criticism by DSM IV. The issue remains unsolved.

The Assessment of Capacity Guidance for Doctors and Lawyers published by the BMA is a very useful guide, but contains no mention of baptism or capacity to participate in ceremonies other than marriage.

In the end, the consultant spoke to the chaplain, which is where he should have started. It was quite a subtle thing, but he picked up just a hint of urgency about the woman's desire to be baptised that he could not quite account for. Could she be thinking of ending her life? He always worked closely with the multi-disciplinary team. In fact, it was part of his contract with the hospital to consult the team on just such issues.

Caroline Cupitt, Clinical psychologist
Paul Wolfson, Consultant psychiatrist

Book tips

Spirituality and Mental Health Care - Rediscovering a forgotten dimension

John Swinton. Pub. Jessica Kingsley 2001 ISBN 1 85302 804 5, 221pp.

Spirituality is less divisive than 'religion' and pertains to everyone. The relevance of spiritual life, a sense of belonging, of meaning and purpose, is increasingly evident to those engaged in the long-term care of people with mental illness. This book gives a comprehensive and accessible introduction to the topic and is highly recommended.

God, Faith and Health - Exploring the spirituality - healing connection

Jeff Levin. Pub. John Wiley & Sons 2001. ISBN 0 471 21893 6, 256pp. £11.50

Jeff Levin, an epidemiologist, has the facts at his fingertips and reports a wide range of data from many peer-reviewed papers, demonstrating that religion/spirituality is good for physical and mental health, whatever your faith tradition or spiritual practice may be. He speculates intelligently and persuasively about how this works, and has developed seven so-called 'theo-somatic' principles by way of explanation. Each principle gets a chapter, and each chapter begins with an illustrative human story. Highly readable.

Weathering the Storms - Psychotherapy for psychosis

Murray Jackson. Pub. Karnac Books 2001. ISBN 1 85575 267 0, 374pp.

Glenn Roberts, reviewing this book in the B.J.Psych. (Feb. 2003) called it 'timely, impressive and provocative'. Comprising an introduction, 15 case histories, 15 vignettes and closing chapters entitled 'mainly theory', 'mainly practice' and 'conclusions', this book is about the people we, as rehabilitation psychiatrists, meet every day. You don't have to be interested in doing psychotherapy to gain from the valuable insights presented. Some may find this a difficult read initially, but it repays perseverance, and I have found myself revisiting it as individual patients so often remind me of the experiences of one or other of the people Jackson describes.

Watch out for:

Breakthrough - Spirituality and mental health

Ed. Phil Barker, due out Nov. 2003. Pub. Whurr Publications

Larry Culliford

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On getting people to tell you what they need and helping them to get it

Those of us who have been involved in 'implementation teams', had to read the weighty tomes produced in the development of 'HIMPs', or who tried to get things improved within the statutory services may think, as I do, that the 'system' is often impenetrable. The only 'unmet needs' we know about are the ones that get 'expressed' to statutory services and even if these are 'counted', it can be a bit like holes in the road in Hackney - a circle is drawn around the spot and that's the end of it. We are aware, when our guard is low, that the complex health problems experienced by the people we see often have their origin in long-standing deprivation and social disadvantage. We may feel impotent in the knowledge that access to our services is not equal for all people and the response we are able to give is often inappropriate or inadequate.

Social Action for Health (SafH) is a voluntary organisation set up in 1985 with a brief to address health inequalities across London. Elizabeth Bayliss, SafH's executive director, recently helped me understand how it can be done. (She has a habit of doing that!) Working from the basis that local people know what they need and can be assisted to improve the management of their own health and wellbeing, even in areas with compound deprivations and inequalities, SafH uses community development principles to get needs addressed. These include finding out about and working with groups that already exist and focusing on *their* concerns and within their terms of reference, rather than setting the agenda ourselves. Instead of trying to find 'stakeholders' within communities to comment on 'our' plans, by facilitating the development of peoples' abilities to influence political and administrative systems of decision-making (i.e. through empowerment), we can all work to address the *real* problems. The process of participation becomes an instrument of change, increasing self-

determination with the benefits that the local community owns developments.

(A more coherent explanation of the above, with a brilliant set of how to do it guides, is available in SafH's publication 'Community Development and Regeneration, Theory and Practical Action'.)

Recent and current SafH projects include Community Development Projects working with local people in Inner London to identify health concerns and encourage community-led initiatives to address these; Cross-cultural Jargon Busters (great!); the Cross-cultural Communications Project (to improve communication between services and Islamic users); Tobacco Cessation Projects for several different ethnic groups in which tobacco usage – smoking and chewing – is dangerously high; projects on diabetes, incontinence, safe circumcision, self-management of chronic illness, working with homeless/vulnerable families to promote self-help and improve service responsiveness; and the STAR project (Southwark Training Area Representation) which helps people from the community learn how to work the system, negotiate, manage conflicts and get their views heard. SafH has facilitated the development of a network of out-of-hours activities and groups for mental health users and provides technical and organisational support to grass roots organisations. (For a full description of the 19 projects, see their annual report.) They are able to get community groups' agendas included in the HIMPS.

Elizabeth has a depth of knowledge about mental health, having set up multiple innovative services from the CPRU in Hackney some years ago. I asked her about her thoughts on facilitating MH user representation:

- Power is a major issue.
- As with other groups, leaders emerge and formal mandating/election is not necessary initially, as long as the person has some way of checking back with the group they represent.
- It is preferable to facilitate the development of a local group rather than ‘cherry pick’ particular people.
- If arranging a first open meeting for local MH groups and users over lunch, provide proper food, not sandwiches.
- Users working with statutory services need to be part of a team of user workers to make the work sustainable.
- The development of trust is essential, takes time and requires delivery.
- There are experienced national bodies that can help large statutory organisations kick start the process of user involvement. The Mental Health Foundation, which hosts a network of user workers, Sainsburys Mental Health Centre and Rethink all have a good track record in facilitating user involvement.
- The local employment service has a ‘permitted employment’ officer who can advise on how to pay users up to £60/week through payroll without affecting benefits for a few months. The employer needs to be registered. (The going rate in inner London is £10/hour.)
- Local ‘Friends of the Hospital’ groups, as charities, can access funds that we cannot and widen the constituency base.

I left enthused!

Louise Petterson

For further details please contact:

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**Section of Social and Rehabilitation Psychiatry
Residential Meeting**

Monkbar Hotel, York

11 – 12 November 2004

Contact College Conference Office

Tel: 0207 235 2351 x 145

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Copying letters to patients - tips and pitfalls???

By 4 April 2004 patients will be entitled to receive all written communications between clinicians that refer to them. This presents a huge challenge for most clinical staff. From September 2002 to February 2003 the old South Birmingham Mental Health Trust was one of 12 pilot sites participating in the Department of Health initial research. In November 2003 four clinical teams will start to implement the process in order to try to explore the pitfalls that may present themselves.

As an initial part of the process we surveyed people using the services and clinicians as to their views. Of the 57 people using services who responded, 79% wanted to know about their diagnosis; 74% wanted to know about the treatment they would receive; 84% were interested in indications of their progress; 72% wanted to know about alternative treatments; and 65% wanted a record of the discussion with their doctor. With regard to where they preferred the letter to go, 85% wanted it sent to their home; 9% wanted it posted to their GP to be collected; 1% wanted to be able to collect it from hospital; and 5% wanted to collect it at their next appointment. A small group of service users from an Asian background were asked about which language they would prefer it in and, interestingly, 50% of them were happy to have it in English, with 25% of them wanting it in Urdu and 12% either in Gujarati or in Indian Punjabi script. The explanation was that if it came in English, they would find members of the family to translate it for them. Also, 346 questionnaires were sent out to clinicians, of which 68% were returned. Of this, 105 psychiatrists were contacted, of whom 75 responded; two-thirds of 120 CPNs also responded. Of a small number of questionnaires sent out to GPs (17), only 8 returned them. When asked how much will clinicians need to modify their practice, over 60% of medics felt they would have to

modify to some degree; half the CPNs felt there would not be much change; and nearly two-thirds of 32 psychologists felt there would need to be change.

The main areas of concern about information that would be passed were: 50% of the clinicians felt that diagnosis was a problem; three-quarters of them felt that risk information would be difficult; 13% felt side effects of drugs and half felt the patient's history would be problematic; only 25% felt the care plan would be difficult to communicate with individuals; and 83% felt that there would be difficulties with third-party information.

It is clear from this feedback that there was a lot of hard work to do to change clinicians' attitudes and to overcome their worries. In particular, this was going to provide some interesting challenges for medical colleagues. Also, as a rehab psychiatrist, I have found a number of people arriving at our service who do not even know their diagnosis and certainly have had no detailed explanation of their difficulties.

A number of particular issues arise:

1 Confidentiality

An obvious exclusion from letters going to patients would be third-party information that the third party has explicitly requested should not be communicated to the person receiving services. It is also clear that re information that the patient thought was given in confidence, or may feel they did not want communicated to the GP or the recipient of the letter, they will now know what has been stated.

2 Ensuring that the letter goes to the right address

One of the most difficult, logistical exercises will be to ensure that:

- (a) the person actually wants to receive the letters;
- (b) that we are clear about which address they prefer letters to be sent to;
- (c) that we actually have the correct address.

Who will be responsible for making sure of this? It is difficult when the person comes to an out-patient clinic. However, when we are making a referral during the ward round, where should the letter be sent? The logistics behind having absolute certainty that the letters are not being sent to an incorrect address are proving quite daunting, especially in an environment where admin. staff change regularly.

3 What pieces of information should be sent?

What about those communications where no interview with the patient has taken place in recent time, eg blood result which you wish to send on to the GP after the person has been discharged from hospital. Do you send a copy of the form or perhaps, more properly, should you inform them that a result has gone back to the GP and please would they contact the GP to have a discussion about this?

4 Misunderstandings, common mistakes and misinformation

It is very likely that medical secretaries will be inundated by calls from patients not understanding what has been stated in the letter, or correcting wrong information. Unfortunately, although this is likely to be common, this is the least of the problems. We are all aware of doctors, and other clinicians, whose command of the English language may lead them to write information that may be incorrect, rude or difficult to understand. It is likely that this will lead to many complaints and even litigation.

5 Sub judice information

What about that information about diagnosis or behaviours that you do not want the patient to know you are passing on to the GP? There is a clause in the GMC's Good Practice Guidelines which allows for this ('in some cases involving particularly sensitive areas ... it may not be appropriate to copy a letter to the patient') but how does one handle this in practice?

Many of these difficulties arise particularly when you are writing letters after you have seen the patient and are no longer in contact with them. A major issue is going to be discharge letters from hospital in-patients care.

Over the past twenty-odd years, I have found that dictating letters in front of patients overcomes a lot of the problems. You are forced to write in a language that the person understands, you can discuss what information to pass on so that the issues of confidentiality are overcome, you can correct misinformation at the time and you can ensure that you check information about who should have the letter and to whom it is sent.

Over and above this, this technique allows for increased development of trust between staff and the person receiving care and gives the patient a record of all the interviews they may have had. It ensures that the person knows their diagnosis and clarifies what educational input there needs to be if they do not. Once you are familiar with the technique, actually dictating a letter at the end of the consultation, even assessments, becomes a fairly quick and simple process, which helps to round off the interview and ensures that outstanding issues are dealt with.

With regard to the diagnosis, particularly if people have what are called personality disorders, it often means that, rather than using the specific terminology, one can give a description of the behaviour. Unfortunately, in many cases, using diagnostic terminology

means that the GP or clinician is more likely to discriminate against that person, whereas a description allows them to get alongside.

As for information that you do not want the patient to receive, over a period of twenty years I have probably had about ten to twenty cases where I have added a paragraph or two as a postscript to the GP, which is not communicated to the patient. During that time I have worked in assertive outreach,

rehabilitation, acute psychiatry and home treatment and I have found that this necessity is rare in all situations. There are usually ways of making statements that are not condemnatory to the patient but do give a clear explanation to the GP of what needs to be communicated.

Tom Harrison

Values in practice

The College Ethics Committee has been discussing this draft document, produced by NIMHE (National Institute for Mental Health England) for some time. As you may recall NIMHE was established in July 2001 and one of its tasks was 'to develop a national framework of values and a process for implementation, built through a dialogue with all stakeholders, in order that the role of values informs every aspect of mental health care..ie policy, planning, research and service delivery'.

The consultation document appeared last summer and identifies three principles:

1. **Recognition** – that values have a role alongside evidence.
2. **Raising awareness** – NIMHE is committed to this in all contexts.
3. **Respect** – NIMHE respects a diversity of values, so that ultimately the values of each service user are the starting point for all actions taken by professionals.

NIMHE plans to encourage education and research that makes workers better able to deliver a value-based service. The new paradigm of ethics varies from the more traditional quasi-legal approach, putting the patient's/carer's values on an equal basis to the professional's facts and evidence base.

NIMHE has prepared a number of draft questions to help in its consultation exercise:

1. What does the framework mean to you? What is the message?
2. Does the framework 'ring bells' for you?
3. Would the framework be useful? If so, how?
4. What would change if you use the framework? What are the outcomes you would expect?
5. Are there other stakeholders that would need to sign up to the framework before you could use it effectively in your work?
6. Any other comments?

If you want any more information please contact me at jerram@doctors.org.uk. The NIMHE website can be found through google - www.nimhe.org.uk

Tim Jerram

Draft Mental Health Bill, letter from campaign headquarters, Number 4

Another year over, a new one just begun. At least in Parliamentary terms. A great deal has happened since my last newsletter.

The draft Mental Incapacity Bill. One of the procedural options open to a government is to put a draft Bill before a Joint Select Committee of both Houses of Parliament for what is called pre-legislative scrutiny. The Committee takes both written and oral evidence and then advises government on the provisions that should, or should not, be in the Bill (and hence Act). This procedure is used for complex issues when the policy objectives are clear and agreed. An example was the Adoption Bill. Difficult to get right but we are all agreed about what we are trying to achieve. The same applies to the draft Incapacity Bill (most of us would have liked – would still like – the Mental Health Bill to go through the same process. Of course our policy objectives and those of the Government may not be the same for this Bill).

The College gave both written and oral evidence to the Joint Committee. The College's slot for giving oral evidence was alongside the British Psychological Society. The BPS sent five psychologists, the College sent me (with Rob Jones and Greg O'Brien sitting behind me for passing notes and moral support). The BMA gave evidence earlier that afternoon. I found it a very anxiety-provoking experience although the Committee members were charming. It is fair to say that I was able to cope for two reasons. I should explain that approximately two days before appearing you are sent the list of questions which you will be asked (they then add supplementary questions). Having done my homework I realised that the Committee were unaware of most of the matters which concern us. Without boring you with details, they included such issues as the interface between this Bill and the Mental Health Bill, giving treatment for physical illness to incapacitated non-compliant patients, Bournemouth Gap scenarios and so on.

Fortuitously Agnes Wheatcroft (the College's parliamentary officer) had organised a dinner at the Labour Party Conference. Among the guests were two members of the Joint Committee. We explained our concerns. Following the dinner they had discussions with other members of the Committee. The list of questions we received addressed all the areas we wished to speak about.

The second reason was the support from colleagues. In particular I must mention; Roger Freeman, Rob Jones, Greg O'Brien and, as always, Mike Shooter,

The College's written evidence is available on the College web-site.

<http://www.rcpsych.ac.uk/new/index.htm>

A transcript (uncorrected) of the oral evidence is on Parliament's web-site at

<http://www.publications.parliament.uk/pa/it/jtdmi.htm>

It is worth noting that the Bill, which is welcomed by the vast majority of organisations involved with health and social care, is bitterly opposed by a group of organisations which perceive it as opening the door to euthanasia.

The Joint Committee is due to report by the end of November.

Before I move on to the draft Mental Health Bill I must mention the Party Conferences. Roger and Agnes attended the Liberal-Democrats (as last year I had to attend another conference at that time). They, the Lib-Dems, are with us.

The three of us went to Bournemouth for the Labour conference with the President joining us to host the dinner. Of course there is a new ministerial team at the DoH. The minister responsible for the Bill is Rosie Winterton. Prior to her current appointment she was the minister in the Lord Chancellor's Department

(now the Department of Constitutional Affairs, known as DeCAff) responsible for introducing the draft Incapacity Bill. I spoke on the same platform as the minister at a fringe meeting. We also had a private meeting with her. Contacts were made or renewed with other (we hope) significant people, both MPs and peers. I have no doubt that having made contacts last year was very helpful in increasing the value of this year's meetings.

The three of us then went on to Blackpool and the Conservatives. The weather was awful. Contact with the Shadow minister was helpful. Hearing the Party Chairman in her opening address to the conference talking about 'loonies' and 'nutters' (albeit in reference to Lib-Dem policies) was painful. Agnes and I left early to enable us to get to the Houses of Parliament for me to give my evidence, described previously. Roger was rewarded for manfully staying on – 'I will long remember the flocks of about-to-migrate starlings swooping around me on a windswept and nearly deserted Blackpool North Pier.'

The Tories have stated that if the Mental Health Bill is not in the Queen's Speech they will introduce their own Bill.

Where are we with the draft Mental Health Bill? I don't know. The minister has been accessible and is very well informed. She has established a further series of meetings at the DoH which she attends. They are covering such areas as patient safeguards, criteria for compulsion, ECT, community treatment orders, offenders and compulsion in prison.

The minister listens and asks questions. In a brief debate in the Commons on mental health services she stated. 'In my discussions with organisations from the Mental Health Alliance, we are reaching a consensus over some of the principles and we are discussing some of the practicalities of how the legislation will work.' At a subsequent private meeting Mike and I had with Rosie Winterton we asked what she meant by 'consensus'. I think the best way to describe her answer is to say that it was bland.

I have no idea whether or not the proposals in the draft Mental Health Bill will be altered. We have been given no indication of any changes. I can say that we currently have a degree of dialogue with the DoH which was notably absent previously. Of course we don't know which department (Health or Home Office) is in the driving seat.

The Queen's Speech is on 26th November. By the time many of you read this we will know which, if either or both, of the Bills are listed. It is important to remember that absence from the speech does not mean a Bill will not be introduced. All three departments (Health and Home for the Mental Health Bill and DeCAff for the Incapacity Bill) have teams of civil servants working on their respective Bills.

I will keep you informed.

Tony Zigmund

Vice-president, Royal College of Psychiatrists
College lead on Mental Health Law reform
October 2003

Advance notice

Psychotherapy Faculty Annual Residential Meeting

22-24 April 2004

Ardoe House Hotel Aberdeen

Theme 'The life cycle'

The programme will include sections on psychotherapy of the elderly, mid-life, life transitions and child development.

We wish to encourage members of other faculties to attend. There will be a wide range of workshops available. The venue is a comfortable, well-equipped hotel with a purpose-built conference centre up to oil industry standards.

Full details will be posted on the psychotherapy faculty web pages on the College web site.

Newsletter of Section of Social & Rehabilitation Psychiatry.

If you would like to contribute to the newsletter, please e-mail us at rehabsocial@hotmail.com

News from the regions – Scotland

Actually news from Scotland [another country! – Ed]. Scotland is different – geographically larger with a relatively small population – circa 5 million. We do not know how the needs of people severely disabled by mental illness living in rural areas are met, but we hope to develop networks to find out.

The agenda addressed by the Scottish Division is huge and rehabilitation services have difficulty in finding their voice. The main issues facing rehabilitation in Scotland are not the same as in other parts of the UK: the hospital closure programme is not as ‘advanced’ as in England and community provision, so far, seems patchy. We are just coming to grips with ‘Joint Future’ – the pooling of social and health care budgets. The new Mental Health (Care and Treatment) (Scotland) Act 2003, although broadly welcomed, is likely to have significant resource implications in terms of consultant and multi-disciplinary team time and community support. In addition, Scots, under the new Act, will be able to appeal against the level of security under which they are detained. This will have significant implications for all services. If patients successfully appeal their level of security, rehabilitation services could find themselves overwhelmed with complex patients without adequate resources.

The new Adults with Incapacity (Scotland) Act 2000, again welcomed, has been introduced without adequate administrative infrastructure and has been implemented without adequate training. This will inevitably lead to its use being patchy across Scotland. ‘Delayed discharges’ are also a current issue of relevance as rehabilitation services develop to manage patients who live precariously in the community before becoming ‘delayed discharges’ in an acute ward.

Following the gradual demise of a large multi-disciplinary Scottish Psychiatry Rehabilitation Interest Group (SPRIG), the new rehabilitation sub-group of the Scottish Division is finding its feet. The mailing list of 32 consultants includes most psychiatrists working within rehabilitation psychiatry – many in part-time posts. After three meetings we now have plans for quarterly meetings, with case presentations, a debate agenda covering issues of relevance to Scottish rehabilitation services and time to explore service provision issues.

If you want to join the group/learn more please contact Dr Debbie Mountain –

debbie.mountain@lpct.scot.nhs.uk.

Dr Debbie Mountain

Regional Representative for Scotland

Mental Health and Safety in the Workplace

The Royal College of Psychiatrists’ Research Unit

10th March 2004

Held at: Royal College of Pathologists, London

Mental health is an inherently stressful profession: this conference aims to deliver the best of current research, opinion and informed comment to provide a platform for discussion.

The conference is aimed at psychiatrists (whether consultant, SpR, staff grade or SHO) plus any mental health professionals. Cost: Consultants £200; SpR, staff grade or SHO £150.

For more details contact Emma George on 0207 227 0825

Newsletter of Section of Social & Rehabilitation Psychiatry.

If you would like to contribute to the newsletter, please e-mail us at rehabsocial@hotmail.com

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Click on The College, then Click on College Structure, then click on Sections.

We warmly welcome contributions to the newsletter. These could include letters (up to 200 words), articles (300 – 700 words) short tips, cartoons etc.etc. Suggestions for articles include topical issues, recent developments, personal views, career experiences, articles from users and carers, book reviews or summaries of conference presentations.

If possible, please send contributions to the above e-mail address with the article as an attachment in a Word document. Alternatively, send a hard copy to us by post at the above address, preferably with a copy on disc as a Word document. Thanks.

This is a publication of the Section of Social and Rehabilitation Psychiatry. The views expressed here are not necessarily those of the Royal College of Psychiatrists.