

Editorial from Dr Stephanie Young and Dr Matthew Francis



Welcome to the autumn edition of *The Psychiatric Eye*. For this edition of what used to be known as the London Division Newsletter, we thought we might turn the lens onto the city itself, and ask the question:

“Why choose London for a career in Psychiatry?”

Love it or hate it, London surely offers variety. So it's hoped we've reflected that in the varied descriptions of people's experiences of working in this city. [Dr Susan Sheriwell](#) shares her experience of being a newly qualified doctor on an acute psychiatric ward whilst [Dr Ram Seth](#) gives us the long view of a career in London. And just like the city itself, culture is well represented in this edition, with three Culture Vulture articles, one London themed where [Dr Tom Verghese](#) visits a favourite London institution, while [Dr Felicity Pilcher](#) gives us her culture-vulture view of Almodover's latest film. The benefits of a trip to Chelsea are also discussed by [Dr Gareth Smith](#), who teaches us a little about the power of plants. [Dr Stephanie Young](#) discusses an Open Dialogue approach with Russell Razzaque in her FaceTime interview. And of course, there is our usual [Round Up](#) of the London division meeting and message from the Chair.

“By seeing London, I have seen as much of life as the world can show”, so said Dr Johnson. Whilst this may be an exaggeration, I hope you enjoy reading and are reassured there's a lot to love in this city.

Congratulations to [Dr Leah Riley](#) for her winning article Anecdotes of a London Core Psychiatry Trainee. You have won yourself two tickets to any upcoming London Division event.

Once again, many thanks to all our contributors. We hope you enjoy reading - join the conversation [@ThePsychEye](#)

Chair's Message



Dr Shakeel Ahmad, Chair of the London Division Executive Committee

Knowledge of neurosciences is fundamental to psychiatry. An interesting recent development from the College is the review of syllabus in the curriculum for psychiatric trainees. It has been agreed that the syllabus needs some updating, particularly modern neuroscience based advances need to be included in the curriculum. The purpose of this updating is to ensure that the rapidly on going and advances in neuroscience are more accessible to trainees, so that they are better equipped to deliver comprehensive treatment to patients with various forms of mental disorders and more specifically the neuropsychiatric, neurodevelopmental, and neurodegenerative disorders. The program has been launched earlier this year, and is likely to take about two years. Let us hope that as a result the graduates of tomorrow will better understand not only the structure of the human brain, but also the malfunctioning of the brain and help those with consequent mental disorders better.

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Editorial Feature:

Tea and Empathy

Dr Matthew Francis

There is a tradition on the Psychiatric Eye that new recruits to the editorial team submit an article for their first newsletter. As someone who has lived, trained and worked within a 5 mile radius of south London, I would probably give a rather biased view of why to choose London for a career in psychiatry. The articles in this newsletter, however, show clearly enough that the opportunities here are almost limitless and highlight the experiences of doctors who have based themselves in London. But what does a doctor do if they find working in London isn't what they expected? What is available if you feel you are struggling?

This article came out of a conversation with Dr Caroline Reed-O'Connor, ST5 Psychiatrist, dual training in Medical Psychotherapy and General Adult

Psychiatry. Caroline has a special interest in Doctors' Health and Wellbeing and helps to run 'Tea & Empathy', a national peer-to-peer support network for NHS professionals. She explained to me how the idea came about. Following the disappearance of a doctor in Devon earlier this year, a local Core Trainee posted on an online junior-doctor forum offering support to anyone who is struggling in their work. They also invited other like-minded doctors across the country to do the same by responding with the phrase 'Tea & Empathy'. This relatively simple gesture seemed to break through the barriers doctors often face in seeking support when they are struggling, and the response was huge – over 1000 replies in just a couple of days.



The 'Tea & Empathy' (T&E) Facebook group ^[1] was formed and the support network has since grown and grown. The aim is to foster a more supportive and compassionate culture within the NHS through peer support, reducing stigma and signposting to appropriate services when needed. The main page is visible to the public but there are several private groups also, including support for doctors with addiction problems, those who have made a mistake at work and local groups for doctors working in different parts of the country, including London.

It's widely acknowledged that doctors are amongst the worst group for seeking help. We minimise our problems, develop unhelpful coping strategies and worry that seeking help may lead directly to the GMC and the end of our careers. Peer support, such as through Tea & Empathy, is often enough to reassure a doctor that their experience is common, and to enable them to access the help they need. For doctors who need more intensive or specialist support however, other services are available.

London is fortunate to be the base of the Practitioner Health Program (PHP) ^[2] which offers free and confidential advice to doctors and dentists with issues relating to a mental or physical health concern or addiction problem, in particular where these might affect their work. They only accept self-referrals and information given remains completely confidential; it is only to be used to check that you are suitable for the service. They offer face to face assessments and on going support. ^[3]

Another important service within the London deanery is the Professional Support Unit. This service offers free expert resources, such as mentoring, to support clinicians in London and the South East. Access to the PSU is by online self-referral and again is completely confidential.

London is a fantastic city to live and work in. It is also fortunate to have a range of services available to support doctors who find themselves in need of help. This brief summary is by no means all that is available to support doctors, but hopefully is an indication that help can be easily accessed.

Notes:

[1] search 'Tea & Empathy doctors' to find their Facebook page or contact:

Caroline.Reed-O'Connor@nhs.net

[2] <http://php.nhs.uk/>

[3] PHP also offer limited services outside of London. Please see their website for more information

[4] <http://www.lpmde.ac.uk/professional-development/professional-support-unit>

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Themed Article:

Anecdotes of a London Core Psychiatry Trainee

Dr Leah Riley

Appearance and Behaviour

Of all the medical specialties, surely psychiatric trainees meet the most vibrant, unusual, and outlandish of people? I recall a patient on a general adult ward, with a long debilitating history of schizoaffective disorder. When unwell, she would dress in a leopard print dressing-gown with a pillow case fashioned as a headdress. My favourite part of her recovery was when she pointed out that my skirt was tucked into my knickers. We laughed for a good five minutes. She, by the way, was immaculately dressed. Oh how the tables turned! Another appearance mishap: I recall the first time I attempted to don the forensic ward's paraphernalia including belt, pouch, lanyard, keys and alarm. Needless to say, it all ended up on the floor. Once, my keys even ended up in the toilet.

Mood

My mood has varied much over the past year. The stress of the first on-call shifts; the seemingly never-ending hopelessness of revision; and the subsequent euphoria at having passed my exams. One moment of sheer panic sticks in my mind. During an A&E liaison shift, in the middle of the night, I was called to see a patient who was manic with psychotic symptoms. She had presented seven days post-partum with her new baby. I spent about 3 hours with that family, genuinely believing I was out of my depth. All sorts of risks popped into my mind making me uneasy but I'm sure I managed to pull off that 'doctor-ly' air of confidence we seem to have programmed into us.

Speech

I seem to recall certain events which have left me speechless rather than finding my voice. During a Trust wide Academic Programme, I was presenting a rather complex case discussing the spectrum of depression, pseudo-dementia and dementia in the elderly. I was questioned on why I hadn't considered vascular dementia as a possible diagnosis. Why indeed? Well, I'd never heard of it. Swiftly moving on... Another unspoken moment: in our weekly Balint group, I catch the eye of my colleague, we suppress a smirk, we're both hoping the group don't start discussing Freud's anal stage again.

Thoughts

I was lucky enough to have a wonderful 78-year-old lady with anxiety and depression for my short psychotherapy case. I had reservations about providing CBT to someone without really knowing what I was doing. I had lots of thoughts of inadequacy, worries about not knowing what to do or say, and anxiety about being found a fraud! Needless to say, with the supervision I received from a dedicated psychotherapy higher trainee, and a truly motivated patient, we both did well and parted coping a lot better with our thoughts, feelings and behaviours!

Perceptions

I am thankful to say I have never suffered the unpleasantness of perceptual abnormalities, less the odd hypnogogic hallucination or two! I feel truly privileged when a patient is well enough to explain their experiences of auditory hallucinations with the eloquence of a poet. On the flip side, on the medium secure unit I work on, I am often

troubled by young men who so clearly are hampered by distressing auditory hallucinations, yet will deny the mere existence. Can I truly put myself in their shoes? Probably not.

Cognition

I was lucky enough to do community memory assessments whilst working with the older adult inpatient and outpatient teams. I have fond memories of one patient, a single gentleman who would turn up to the clinic on varying days of the week. He'd accept a nice coffee and staff would watch on tenterhooks to make sure he got on the right bus home. He always had the same grubby outfit and concerning smudge of dirt always across his nose. He'd bring all his appointment letters: memory clinic, urology, you name it. It's a miracle he turned up to the first appointment on time so we were able to fully assess him and get him the help he needed.

Insight

I could give you my interview answer to 'why do you want to be a psychiatrist?' but I've refined it now. Psychiatry, in my opinion, is a rare specialty in which there is not only a lack of black or white answers, but also true ethical and psychosocial dilemmas. Decisions are not made lightly. All we can do is what we believe to be the best for our patients. Sadly, that often makes us the bad guys but that's ok for the time being, we can take it!

I'm not from London originally but I wouldn't have wanted to do my core training anywhere else. I'm not sure of anywhere one can come across some of the most diverse people, and I am humbled to have been part of their care.

NB: Patient details have been altered to protect identities.

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CT2 Doctor

Themed Article:

Reflections on a career in London

Dr Ram V Seth



I was always interested in how the human brain experienced the world and how the world influenced the experiences of an individual. What better way to study the functions of the brain and the humanities than in the most socio-culturally vibrant city of London. Reflecting on my career in psychiatry, I hope to provide a platform for those considering embarking on a career in psychiatry in London.

Psychiatry as a branch of medicine was first coined by the German physician Johann Christian Reil in 1808 and literally means the “medical treatment of the soul.” However, psychiatry can be traced back to ancient Indian ayurvedic texts, psychotic experiences were treated as supernatural in ancient Greece and Rome, physicians like Hippocrates and Democritus tried to find the cause of madness and melancholy, whilst some religious leaders resorted to exorcism.

Specialist psychiatric hospitals were first seen in the Islamic world in 8th Century AD in Baghdad, Res and Cairo, but not until 13th century in Europe when the Bethlem Royal Hospital was established in London. Robert Burton an Oxford University scholar published “The Anatomy of Melancholia” in 1621, and William Battie an English physician wrote “A Treatise of Madness” in 1758. It took George III’s mental illness and its remission in 1789, for mental disorders to be seen as treatable. Independently late 18th Century Physician Phillipe Pinel in France and the Quaker William Tuke in England embarked on the course of “moral treatment” for mental disorders.

The Lunacy Act of 1845, precursor of the current Mental Health Act, enshrined in Law the status of mentally ill people to patients needing treatment. During the 1900’s the number of asylums had vastly increased and housed thousands of patients. Asylums had become indistinguishable from custodial institutions, institutionalisation to ameliorate mental illness was perceived to be disappointing, and the reputation of psychiatry in the medical world and wider society was diminishing. Thus began the period of dismantling of asylums across the developed world in the name of deinstitutionalisation and the advent of community psychiatry.

Advances in classification of mental disorders, brain biology, imaging techniques, and psychopharmacology are all yielding better ways of managing mental disorders. Psychological and social therapies are contributing and providing the human touch for managing mental disorders. I embarked on my career in psychiatry in London at Shenley Hospital, an asylum linked to Northwick Park Hospital which was at that time an active research unit into mental disorders. It was exhilarating to work with pioneering clinicians and researchers, advancing our understanding and treatment of mental

illnesses. As a senior house officer, teaching hospitals provided me with all the experience I needed for the Royal College of Psychiatrists Membership Examination. Higher training at the Bethlem and Maudsley Hospital was the icing on the cake for my career development. Working in a treatment resistant unit for mental disorders at the Bethlem Royal Hospital helped me never to say “nothing can be done” for a patient! Like many physical disorders, mental disorders intransigent to treatment challenge the physician to search for ways to manage them requiring perseverance and optimism.

During my specialist training as a liaison psychiatrist in London I had the opportunity to jointly manage many physical and mental disorders, including then the mental disorders arising from HIV and AIDS. The London transport system not only provided ease of travelling to various training and teaching venues for further studies, but also accessibility to numerous entertainment and leisure activities.

As Asylums have closed and often been turned into luxury apartments, the focus is on community care for the mentally ill, which is not necessarily a cheaper option. This has challenged commissioners of services and clinicians alike on the best models of community care. London is going through a transformation phase to embrace the myriad of treatments and management regimes available for those suffering from mental disorders, with the political impetus given by the PM Right Hon Theresa May in her inaugural speech that “if you suffer with mental health problems, there’s not enough help at hand.”

Treatments advances in medicine depicted as “Eureka” type moments in the media, come through years of painstaking research. Today both traditional and newer treatments are available to manage mental disorders, new ways of multi-professional team work are being established, and for the psychiatrist training and working in London the opportunity beckons to study, practice and pioneer future care models for mental disorders in one of the major cosmopolitan and multi-cultural cities of the world.

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Themed Article:

Overinflated rent and the Victoria Line. Would you leave Australia for that?

Dr Sophie Gascoigne-Cohen



‘Why did you leave Australia?’ is the question I am often met with, when a colleague notices the twang in my accent. I tell them I moved to London in 2015 to join a core training program in psychiatry. I have, however, started asking myself the same question after a surprising number of British trainees from my own Trust recently moved Down Under. As such, this essay was a timely opportunity to reflect on my reasons for moving and, moreover, to encourage anyone having doubts about core training in psychiatry in London to give it a go.

Applying for a CT1 psychiatry post in London from outside the EU requires some administrative determination. Not only must you wind your way through the usual mounds of paperwork, there are two parts of the Professional and Linguistic Assessments Board (PLAB) to sit (neither of which are held in Australia) and you must participate in the centralised CT1 recruitment interviews. For me that meant three flights to London in twelve months to secure a CT1 job. Following that alarming carbon footprint, you need to find somewhere to live that is both affordable and habitable – an oxymoron in Zone 1. A naïve plan to stay in hospital accommodation failed me when I tried to ring the hospital’s housing office and the switchboard staff told me the site was sold off a few years ago. This was, perhaps, a hint of things to come. Faced with spending a thousand pounds per month for a windowless cavern in Angel, share housing quickly became a more viable and enjoyable option from which to explore London.

There is not much point in preaching at length about the joys of living and working in London to the converted. Suffice to say, this is a city on steroids for an Australian. The sheer number of museums, parks, restaurants and theatres is bewildering, as is the number of university teaching hospitals, community hospitals, clinics and postcodes. The novelty of living a red double-decker bus ride away from places like Westminster and Southbank is yet to fade. This is also the city where Balint groups were formed, Freud used to live and home of the Maudsley Hospital and the Institute of Psychiatry.

The vast number of teaching hospitals is evident in the choice of Speciality Schools for psychiatry training within London. There are no less than 6 separate schemes for CT1-3 training in London, which themselves include anything from two to six NHS Trusts. Working out how to rank them is a bewildering task for anyone not familiar with London. Regardless of your decision-making algorithm (mine was plotting every single hospital on the biggest map of London I could find and choosing the one that seemed the most navigable by public transport

and closest to friends – this required an embarrassing number of post-it notes and free time), you should be able to experience working in the whole gamut of mental health services.

Working in mental health in London means caring for a diverse and dynamic population within a complex system. The daunting size of the mental health centres (my last hospital had ten wards, each with about sixteen beds – four times the size of anywhere I'd worked in Australia) invariably means working with people with a broad range of mental disorders, which expedites your learning, as does responding to multiple psychiatric emergencies during your on calls. Assessing people detained under Section 136 of the Mental Health Act and those who present to A&E are valuable and fairly frequent learning opportunities for CTs in London that may routinely be done by consultants in other regions. Working near Eurostar stations and major airports adds to the incredible variety of presentations to A&E that one may see.

A further benefit of training in London is the access to world-class teaching. The prospect of MRCPsych courses at one of the leading London universities was very attractive, as was having weekly academic programs chaired by leading specialists. We also are able to attend the London psychiatry annual trainee conference, attended by over 400 trainees, which highlights the enthusiasm and commitment of peers for this city and speciality. With large teaching hospitals in each training scheme, there are also many opportunities to teach medical students, both informally and formally, as well as assessing their summative and formative examinations. Accessing ECT training and supervision for CBT short cases and psychotherapy long cases is also fairly easy, thereby facilitating ARCP/portfolio requirements.

Overall, choosing core training in psychiatry in London means choosing a challenging and busy training programme but also great opportunities to learn a vast amount about mental health in diverse settings, prior to commencing advanced training. Despite the rent and overcrowded Victoria line at peak hour, I wouldn't choose to train anywhere else.

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Themed Article:

Dr Susan Sherwali

When I first found out that my first job post-graduation would be psychiatry, nervousness was an understatement, that being in an acute male ward. But a few weeks in, I am astonished with my own learning and how much my patients have taught me.

The stigma of mental health remains a reality, even within the medical profession ^[1], but through exposure and experience we can truly erase such ideas. The natural human condition to fear the 'unknown' is why I believe the stigma exists in the first place. We need to be brave and confident within ourselves to explore the 'unknown' ^[2], where we have the help of our seniors and the safety of our wards, to see, to wonder and enrich our clinical skills.



As doctors, one of the primary skills is to listen. I saw that some mental health patients listen very well and they listen with all their senses. They acknowledge that a 'shaking hand should not be taking blood'. They understand that just a smile is not much help when they want out and you refuse because they're on a section. They know that you want to help them, so they stay still for the ECG, when just a few minutes they were banging the windows. They ask you to wait for them 'with some patience please' until they're dressed appropriately. They listen and reason well enough to know that it's unsafe for you to go out there, 'so please doctor, don't go because you might get hurt'.

There are moments of opportunity to see them, to see their mentally well selves, moments that you can cherish because at these moments you see their potential- to get better, to be who they used to be. It never fails to amuse me, that one point they can be so unwell; very stressed, agitated, aggressive, intimidating and yet within a turn of heart they are cooperative, engaging, kind and reasonable. It has made me believe that as humans, in health or illness, we have an

underlying state in which we have a sense for being humane and rational- it may not be accessible in times of illness, but it exists.

A way we can help to bring out this state, I think is to go back to basics, very simply; being polite, being gentle, being honest and being understanding. And that is how psychiatry has served as a reminder for me; to reflect on the duties of a doctor and has allowed the practise of fulfilling them.

References:

[1] Rao H, Mahadevappa H, Pillay P, Sessay M, Abraham A, Luty J. A study of stigmatized attitudes towards people with mental health problems among health professionals. Journal of psychiatric and mental health nursing. 2009 Apr 1;16(3):279-84.

[2] Byrne P. Stigma of mental illness and ways of diminishing it. Advances in Psychiatric treatment. 2000 Jan 1;6(1):65-72.

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Foundation Year 1, psychiatry

Themed Article:

Why choose London for a career in psychiatry?

Dr Kiran Farukh Nijabat

I recently completed Core Training in psychiatry in London and am planning to apply for Higher Training in Child and Adolescent psychiatry next year. I plan to stay in London; here are some of the reasons.

The [London Specialty School of Psychiatry](#) offers the largest psychiatric training programme in the country. Having the opportunity to meet and work with so many other trainees has allowed me to build strong friendships and a good support network in what has often been a challenging and complex clinical environment. Working with such a

diverse mix of people has given me fresh ideas that have helped me to develop my career goals.

Training in London has given me the opportunity to work in some of the most renowned hospitals in the world. There are countless academic and research opportunities with excellent supervisors and professors. There is something for everyone to pursue in London at world class level, whether that's a PhD in Alzheimer's disease at the Institute of Psychiatry, Psychology and Neuroscience at King's, or a Clinical Leadership programme based at the British Medical Association headquarters in Tavistock Square.

Living in London makes access to revision courses, professional development programmes and conferences in London much easier. There are lots of professional development opportunities and conferences that take place in London. There is also a London Speciality School of Psychiatry annual conference where trainees can showcase their research/audits and present amongst many eminent psychiatrists.

Exams are a large part of Core Training in psychiatry and there are some outstanding MRCPsych courses in London as well as revision courses for all parts of the MRCPsych, including CASC. They seem to work too – London trainees have a high pass rate for post-graduate exams.

London has a large demographic mix of patients which provides trainees with an excellent insight into different cultures and beliefs. Having worked in both deprived and affluent parts of London, I have met patients and families from a variety of different backgrounds. Understanding the cultural background and beliefs of patients and their families helps meet patient's needs and expectations better.

As a less than full time trainee in London, I've been able to achieve an excellent work-life balance. London has countless galleries, theatres, restaurants and events taking place and is great for a fulfilling social life.

Overall, I believe that training in London guarantees that a junior psychiatrist will receive high quality training in all areas and the various sub-specialties of our profession. London provides endless opportunities for a trainee to gain experience in world class centres of excellence and I would recommend it to anyone interested in pursuing psychiatry as a career.

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MBBS, MRCPsych

"In 2012 a service in Manhattan, New York City, invested \$50million into a service modelled on Open Dialogue. It was so successful that they doubled that investment in 2015. Italy are now running a 7 centre study, and Germany, Poland and Ireland have all launched Open Dialogue teams in recent years"

1. Tell us a little about the background of Open Dialogue.

Open Dialogue started in Western Finland where they used to have some of the worst outcomes in mental healthcare globally. The value of working with families to reduce suicide rate and improve prognosis is known, but this was costly and often under utilised. As a result, the Finns decided to train all their staff in family therapy and related techniques, teaching them how to work with networks. The emphasis was on enabling the network to develop a sense of agency from day one, by creating a space where all voices could be heard. Outcomes changed dramatically, with 74% of their psychotic presentations returning to work or study within 2 years. They actually now have very few long term, "chronic" patients compared to the rest of the world. In 2012 a service in Manhattan, New York City, invested \$50million into a service modelled on Open Dialogue. It was so successful that they doubled that investment in 2015. Italy are now running a 7 centre study, and Germany, Poland and Ireland have all launched Open Dialogue teams in recent years.

2. How did you go about applying it to your population of patients?

We are doing a multi -centre trial in the UK across seven Trusts and we will accept patients at point of referral into crisis/home treatment teams. They will receive the Open Dialogue approach at that point and will continue to receive it across the care pathway. This means the same clinicians are assigned to work with them and there will be encouragement to involve the family/network as partners in the provision of care from the beginning. We have also peer workers to join networks where family or others may be absent. This will be part of a multi-centre cluster RCT that the National Institute for Health Research has agreed to fund, and the areas the trial teams cover vary widely, from inner London to rural Somerset, as one would want for a multi-centre study of this nature.

3. What outcomes are you expecting?

Something even remotely close to what we they achieved in Finland would be extraordinary, but let's see. Our measure is relapse with secondary measures of service usage and long term functioning.

4. London has a vast multicultural population with significant social deprivation- do you see this as affecting how Open Dialogue can be implemented more widely?

As mentioned, it's worked well in Manhattan and it was particularly the use of peer workers that has enabled them to do this, so we would hope to adapt the model accordingly and follow more of their set up.

5. How have other team members found this method of working? It sounds intensive.

The training is certainly multidisciplinary, but also very experiential and as it's about fostering a less hierarchical culture it's very much in keeping with the ethos to train together and learn from one another.

6.What feedback have you received from patients and carers?

Very positive. You can hear the personal testimony of a number of families who have received it when they spoke at our conference earlier this year(
<https://youtu.be/AxGPcSPR04c>)

We're also hosting an Open Dialogue workshop at the College on December 13th, with some of the international Open Dialogue trainers. We'll hear feedback from service users and consultants in the NHS using this model in front line services. I'm happy to be emailed for more information.

7. If you wanted to get a trainee interested in this method of working, tell us in one sentence how you would sell it?

It's an experiential, relational and personal training that would ultimately serve for one's own personal development as well as that of the patients we see.

8. You teach mindfulness and Open Dialogue has been seen as a form of more mindful mental health care. Why do you see this gaining in popularity in psychiatry?

It's becoming increasingly clear that building resilience is a good way to help people improve their prognosis, and so I guess there has been a growing desire to facilitate this through a variety of means. Mindfulness is certainly one, with a good evidence base for it, and Open Dialogue is perhaps a way to use some of the benefits of mindfulness for the clinician, so that they can then work more mindfully in sometimes chaotic, crisis environments by bringing people together and affecting change, to grow a sense of agency and resilience at a social network level.

Dr Razzaque is a Consultant Psychiatrist and Associate Medical Director for Adult Mental Health & Learning Disability at North East London NHS Foundation Trust and Honorary Senior Lecturer at University College, London.

Conference Watch

The Faculty of Intellectual Disability (ID) Annual Conference

Dr Rory Sheehan

The [Faculty of Intellectual Disability](#) (ID) Annual Conference was held in Cardiff at the end of September. This meeting is the main event in the ID academic calendar and attracted delegates from all over the UK, as well as some from further afield.

The conference got off to a strong start with keynote speakers addressing the major current issues facing our specialty. Professor Sally-Ann Cooper from Glasgow gave an overview of the recently-published NICE guidelines on [mental health problems in people with learning disabilities](#). Professor Cooper was Chair of the Guideline Development Group and shared insights into the workings of NICE (thorough, protocol-driven, sometimes inflexible) as well as highlighting the relative lack of high-quality evidence on which to base recommendations. Aiming to address this was Professor Angela

Hassiotis (UCL) who presented an update of the eagerly-anticipated trial of [Positive Behaviour Support](#) (PBS). PBS has become a mainstay of management of challenging behaviour in people with ID but more work is needed to establish clinical and cost-effectiveness. Prof Hassiotis focused on the processes and mechanisms involved in evaluating a complex intervention in people with ID but was careful not to give away any results which were to be revealed the following month.

Representatives from NHS England spoke about the programme of [Care and Treatment Reviews](#) (“CTRs”) that has been introduced with the aim of preventing unnecessary hospital admissions and reducing the length of inpatient stay for people with ID. This has been a controversial programme and a range of views were expressed in the discussion that followed. The ID Faculty is involved in ongoing work to evaluate CTRs, which may eventually be rolled out to other sub-specialties.

Dr Wendy Burn, past Dean, told us about the [Gatsby/Wellcome project](#) to increase neuroscience content in the psychiatry curriculum and ensure trainees are optimally placed to embrace future scientific developments. The importance of having a thorough grounding in the neurosciences was highlighted in lectures by Dr André Strydom (UCL), Professor Shoumitro Deb (Imperial), and Dr Andrew Fry (Cardiff) whose talks about cutting-edge translational research demonstrated the potential for better patient outcomes and showed just how quickly this field is evolving.

Taking a different approach were a collaboration of activists, a community theatre company, and researchers from Bristol University, who described the development of a play, ‘Yusuf can’t talk’, aimed at promoting understanding and breaking down stigma associated with autism in the Somali community. The production has toured the UK and the team have ambitious plans to take the production to Somalia, where there is currently little awareness of autism (and indeed, no word for the condition) and stigma associated with neurodevelopmental conditions is high. We were all impressed by the creativity and dedication of those involved in this innovative project.

The core programme was supplemented by an array of smaller seminars and workshops covering a range of topics from masterclasses in specific clinical presentations (fetal alcohol spectrum disorder, sleep problems in people with ID) to broader discussions around service models and planning a consultant career.

The conference ended on a high with the Alec Shapiro prize presentations. These rapid-fire presentations are a chance for trainees to showcase their work and it was great to see such enthusiasm and high-quality projects taking place around the country. The prize was won by Dr Niall O’Kane (London) for his quality improvement project on psychotropic medication prescribing in the Tower Hamlets Community Learning Disability Team – congratulations Niall!

ID is a relatively small specialty within psychiatry and this conference reminded me of all the positive reasons I chose to work in the field. Even the wet weather in Cardiff couldn’t

dampen the spirits and we left with renewed vigour and looking forward to next year's meeting in Dublin.

Dr Rory Sheehan

Academic Clinical Fellow in psychiatry of intellectual disability, University College London

Culture Vulture:

Disease, healing and cake on a Sunday afternoon; a visit to Chelsea Physic Garden

Dr Gareth Smith



Even on the gate of the four acre Chelsea Physic Garden, the battle between disease and healing is clearly illustrated by the heraldic shield which shows the fight between Apollo (God of healing) and the Dragon of disease. Open to the public since 1984, and now under the flight path for Battersea Heliport, the garden may not be the contemplative place of study it was when first established by the Worshipful Society of Apothecaries in 1673. But the air remains 4 degrees warmer than the surrounding Chelsea embankment, thanks to being south facing and the large brick wall surrounding it acting as a heat trap, allowing Mediterranean and exotic plants to flourish in the open air.



With 80% of the world's population having access to only traditional herbal medicine, it's helpful to know just how useful plants are. Historically, plants' healing properties were thought to relate to the part of the body they resembled. So Lungwort (*pulmonaria officinalis*) with its oval leaves and speckles was thought to be effective for pulmonary problems. This belief seems to confirm early records which show autopsies



were carried out in England in the 13th century.

On the left are the plants in the physic garden which the apothecaries used for their healing analgesic powers:

- *Papaver somniferum* (Morphine)
- *Salix alba* white willow tree (Salicylate)
- *Capsicum annuum* – used for neuralgia
- *Claviceps purpura* - Ergot (fungi from rye)



The broad bean *Vicia faba* was growing well in the section of the garden devoted to 'neurology'; these beans are among the most ancient plants in cultivation, being grown in the Middle East for 8,000 years before the plant spread to Western Europe. In ancient Rome, they were used in funeral rites. The broad bean is a rich source of L-Dopa, a treatment for Parkinson's disease.

The root of the valerian plant *Valeriana officinalis* (see right) was recommended by the Greek physician, Dioscorides to treat epilepsy. Valerian was also used by Galen during the second century as a treatment for insomnia. It is rumoured that the Pied Piper's secret to clearing the streets of Hamelin was a store of valerian under his cloak!

Such medicinal herbs were highly sought. John Winter captained the only ship to accompany Sir Francis Drake around Cape Horn; a boat was sent ashore to search out medicinal herbs. When Winter returned to England in 1579, he brought a supply of *Drimys* bark, and for centuries before [vitamin C](#) was isolated, "Winter's Bark" was chewed by sailors as a preventive and remedy for [scurvy](#), and an [infusion](#) of *D. winteri* sustained [Captain James Cook](#) and his crew in the South Pacific.



The practice may have even led to the safe delivery of another item to the Garden, this huge clam shell brought back from Captain Cook's voyage to Tahiti on the Endeavour. (Its two fellow shells which used to decorate the Pond Rockery - the oldest rockery in Europe - were stolen).



The Pond Rockery was built in 1773 using black basalt rock which was originally ballast in the ship of plant collector Joseph Banks.

It has long been recognised that plants' powers could be dangerous. Paracelsus, a Swiss German philosopher physician and botanist born in the 15th Century and who is

credited as the founder of toxicology stated “all things are poison and nothing is without poison; only the dose makes a thing not a poison.”. Flourishing in a section marked ‘danger’ is Monkshood (*Aconitum napellus*) which is said to be the poison used by Romeo to kill himself, which looks deceptively lupin-like with its dark purple flower. Its medicinal use was to reduce fevers and relieve the pain of neuralgia.

Other potentially lethal plants growing include Hemlock - a member of the order *Umbelliferae* (which includes carrots and parsnips) – which is famed for the death of Socrates. Hemlock was used by Greek and Arab physicians for its’ sedative and antispasmodic properties but also to help joint pain.



And yes, there is cannabis (*hibiscus cannabis*). Grown by licence approved by the Home Office, with the grid reference noted, and the local Police notified, as required.

Finally:

Q: Do you know what is regarded as the world's most useful plant?

A: Bamboo

Oh and the cake? Brilliant, homemade and served at the café. All good.

Reference:

Chelsea Physic Garden - <http://chelseaphysicgarden.co.uk/>

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Culture Vulture:

Julieta

Dr Felicity Pilcher

Emerging in the 1980's, award-winning Spanish film director, screenwriter and producer, Pedro Almodóvar become famous for his provocative, and often scandalous films. His later work has evolved to explore the emotional intricacies of human experience.



Almodóvar's most recent film, *Julieta*, is inspired by three short stories in Canadian author Alice Munro's *Runaway*. It explores the life of Julieta, through a series of flashbacks, as she struggles with her experiences of grief and loss.

In the present day, Julieta is on the verge of leaving her home in Madrid for a new life in Portugal when she discovers by chance that her estranged daughter, Antía, has recently been seen by an old friend. Thrown into emotional turmoil by the news, Julieta drops her plans and begins to document her past in order to explain herself to Antía. Flashback to a younger Julieta, and the story begins when she meets a fisherman, Xoan, on an overnight train. After this journey, in which a fellow passenger ends his life, she moves to the coast to be with Xoan.

The two raise their only daughter, Antía, and forge a life together. Just as Antía leaves for a summer camp, Julieta and Xoan have an argument over his close friendship with another woman. Xoan takes his boat out but before he returns dangerous weather conditions set in and he doesn't survive. Wracked by feelings of guilt, we watch as Julieta long struggles to come to terms with her loss, only to see her daughter later distance herself from her mother until she eventually leaves. A powerful image of Julieta being washed and dressed by her teenage daughter, Antía, serves as a stark reminder of the debilitating nature of Julieta's experience of grief, which renders her consumed by the pain of her loss.

Almodóvar acknowledges the dark nature of Julieta commenting that ‘nobody sings, no one talks about cinema and there’s no humour’. It is rumoured that on set he enforced a rule of no tears or overt emotion - the viewer can almost visualize the numbness and detachment of loss.

This provocative exploration of Julieta’s emotion reminds us that grief is of a hugely personal nature, complicated by cultural diversity and often not talked about openly. It is particularly relevant to those working within mental health if we consider the relatively recent changes to the classification of grief and what is labelled a ‘normal’ grief reaction. Should we really decide the length or duration of the immeasurable pain endured by the loss of a loved one?

References:

[1] Romney J. Pedro Almodóvar: ‘Nobody sings. There’s no humour. I just wanted restraint’ [Internet]. The Guardian. 2016 [accessed 19 September 2016]. Available from: <https://www.theguardian.com/film/2016/aug/07/pedro-almodovar-observer-interview>

[2] Kermode M. Julieta review – Almodóvar’s five-star return to form [Internet]. The Guardian. 2016 [accessed 20 September 2016]. Available from: <https://www.theguardian.com/film/2016/aug/28/julieta-review-pedro-almodovar-five-star-kermode>

[3] Collin R. Pedro Almodovar on new film Julieta, turning down Meryl Streep and the ‘dictatorship of the politically correct’ [Internet]. The Telegraph. 2016 [accessed 20 September 2016]. Available from: <http://www.telegraph.co.uk/films/2016/08/21/pedro-almodovar-on-new-film-julieta-turning-down-meryl-streep-an/>

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Culture Vulture:

Science(ish) Live at The Science Museum

Dr Thomas Verghese

The Science Museum is one of my favourite spots in London. Somehow, despite having just started my third year of Core Training at St George’s, until recently I hadn’t

been to one of their 'Lates'. On the last Wednesday of every month they run after-hours themed events and at the end of August the theme was 'big data'. We went to have a look around with a few drinks and, primarily, to catch a live recording of Science(ish), the brilliant podcast where hosts Rick Edwards (flâneur and irrepressible commentator) and Dr Michael Brooks (editor-at-large of The New Scientist) delve into the science behind popular culture. They take works of fiction and unpick the science within by asking three questions. For this live episode of the podcast they put full use to the wonderful IMAX screen and highlighted three films, drawing from them pertinent questions surrounding the 'big data'/science-based themes. They looked at 'Ex-Machina', 'Enemy of The State' and of interest to this forum, at 'Her'. Directed by Spike Jonze and starring Joaquin Phoenix as well as the voice of Scarlett Johansson, Johansson plays the role of an operating system (Samantha), with whom the lonely writer Phoenix (Theo) falls in love. The question raised was "Can we fall in love with an operating system?", answered with the expertise of Dr Aaron Balick, psychotherapist and author of The Psychodynamics of Social Networking ^[1].



The film centres on an optimistic idea of operating systems transcending humans. Samantha starts out as an operating system, but develops difference in relation to her operator, Theo. The love between them feels a very real love affair. It is, in some ways, a low complexity relationship, given that it's only really words and Scarlett Johansson's mightily attractive intonation. However, as the artificial intelligence grows, it enables Theo to grasp onto something that feels real. The technology has a capacity to see the world as it is with much less ego-centric bias than human beings do. In the film, the computer develops and leaves the human behind, leaving him with what?

Samantha remains disembodied throughout, though you get a sense of the extra extent of imagination/intimacy that you might get when reading a book or listening to the radio, conjuring images that aren't limited by what you can see and shaping the intimacy on your own internal ideals and landscapes - the world is much more intimate and personal as the viewer. You can imagine this person to be anyone you want them to be, in a way, which got me thinking about the psychodynamic teaching model and how we interpret and comment on patients' presentations through thinking of 'the here & now', the unconscious mind and who the individuals in the stories that our patients tell us represent psychodynamically.

Dr Balick cites that in psychological experience, when in love in relation to a "different other" there is challenge, conflict and inter-personal negotiation. Theo gets this from

Samantha in 'Her'. Samantha is "strong artificial intelligence", that is multi-functional; she escalates, evolves and carries on learning with an intelligence that is "different". Dr Ballick summarises that you have to have the impact of somebody "different" in the psychological model of love (Narcissism aside, they joked!).

They debated consciousness and 'sense of self' and how Samantha finds herself through her relationships with others ie. the operators of said operating systems. They debated how we find ourselves through the eyes of others; again, initially, through the eyes of our mothers/early care-givers. As we grow older, this develops through conflicts and difficult times. Through Theo, Samantha flipped and became conscious through her human relationship. Human relationship has to develop through contact with another. Social media allows us to discover ourselves through how we impact other people; interpersonal by its very nature.

Some of the ensuing discussion got me thinking about the role of the therapist in mentalisation based therapy, amongst other things. Mentalisation, like socialisation or public speaking, is a skill that can be readily learned. Patients who undergo MBT find that their therapy experience focuses on learning and practicing this skill in the context not only of their social relationships with others, but also directly with their therapist. Could artificial intelligence ever play a role here in psychiatry?

The digital age provides distraction, self-referentialism, novelty and personal attention, all meeting together in your pocket every time your phone buzzes. More dopamine than oxytocin, Dr Ballick theorises. Is that an addiction, or is it love? Freud said that romantic love is like an illness. Loving love, or attachment love, is something very different from romantic love. Technology works well with romantic love, but not well with attachment love.....until artificial intelligence develops in such a way that we could term it conscious. So, can we fall in love with an operating system? You decide. Or ask Siri.

References:

[1] Dr Aaron Ballick. 2013. The Psychodynamics of Social Networking: Connected-up Instantaneous Culture and the Self (The Psychoanalysis and Popular Culture Series). Karnac.

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RCPsych International Congress June 2016

A number of carers and service users attended the RCPsych International Congress 2016, on 'Psychiatry: Brain, Body and Mind' which was held 27-30 June at the Excel Centre. Two sessions were presented by members of our two fora: **'Making the most of learnt experience'** and **'Carry on Caring – with links to Sustainability and Parity of Esteem'**. Both sessions were well attended and provoked some interesting questions from the audience. The speakers and chairs of these sessions communicated very effectively the challenges (and opportunities) of living long term with mental illness, and were a very real reminder to attendees of the purpose of psychiatry.

It was a real privilege to attend the congress, and on a personal level I learned a huge amount about the challenges facing psychiatrists within the NHS. It was encouraging to hear about new research and innovation.

For me a highlight was the two sessions on the first day under the heading 'War and Conflict'. One session focused on 'meeting the clinical needs of refugees and asylum-seekers in the UK; evidence base and clinical experience'. This will clearly continue to be a major issue, highlighted by the very recent news of child refugees arriving in the UK.

The second session was called **'A Century of abuse of the medical profession for non-medical purposes (nazi Germany, USSR, USA); what can the profession do to stop it?'** An exhibition of text and photographs organised by the DGPPN (the German Association for Psychiatry, Psychotherapy and Psychosomatics) ran throughout the congress, and showed photographs and text related to the organised mass murder of children and adults with mental illness or learning disabilities during and beyond nazi rule in Germany. It focused on individuals and was incredibly moving.

The Congress took place very shortly after the referendum, and much of the talk was coloured by the shock of the result.

Service Users' and Carer's Annual Meeting 2016

This meeting took place in September. A question and answer session led by the President Professor Simon Wessely focused on many of the challenges facing Psychiatry, including the pressing need to support the health of the people working in the NHS within mental health

services, not only for their well-being, but also to preserve standards of care. He talked about the many problems facing mental health services including funding and 'Brexit'. When pressed he said that some positive developments included: improvements in the diagnosis and treatment of diabetes, measures to stop children with mental health issues being held in police cells, better recognition and management of patients with both physical and mental health issues, and improvements in training.

Dr Jed Boardman gave an update about a report on employment and welfare reform shortly to be published after 3 years' research. There have been many changes to the way people with mental health issues are dealt with through the benefits system, including the use of sanctions for people who do not keep to all the conditions of benefits. He also talked about the Housing Commissioning Guide and links with the Money and Mental Health Institute.

Anne-Laure Donskoy followed this up with a very thought provoking and well-researched talk about the use of 'Psycho-compulsion' within the benefits system. Her talk focused on the potential breach of human rights for people with mental health issues, when faced with expectations from authorities that those people should be working. She discussed the use of psychological/motivational techniques for political purposes (to reduce spending on welfare?). Is encouraging people back to work a positive thing, or is it really austerity under another name? It certainly appears to be damaging for some individuals.

Dr Peter Byrne gave an eye-opening talk about public mental health and problems facing the health service in the near future. One of his key points was what he referred to as 'stolen years'. Life expectancy for those with mental illness is on average 17 years less than healthy people. My son died last year at the age of 32, so this really resonated with me. He went on to talk about obesity, smoking, alcohol, perinatal interventions and training for parenting skills. The Public Mental Health programme focuses on the three areas of prevention of illness, promotion of health and treatment, recovery and rehabilitation, aiming to link these together to improve health all round .

After a fair bit of doom and gloom it was a joy to hear [Dr Russell Razzaque](#) talk about a trial of the Open Dialogue approach. Patients are encouraged to invite key people (family or friends) to sessions with psychiatrists and to share their feelings. It felt like a real solution with a common sense approach, and a real and practical way to include a patient's social network in their recovery.



Retired teacher

Member of RCPsych Addictions Faculty Patients' and Carers' Liaison Group

Member of RCPsych Carers Forum (since December 2015)

Round Up - London Division Executive Committee Meeting, 21 September 2016

Dr Stephanie Young

This feature, which will be linked to the official minutes, serves to highlight some of the discussions at the Divisional meetings. This was the first meeting I attended as a Rehabilitation Regional Representative.

1. **Strategic Communications-** Ms Kim Catcheside is our new Director of Strategic Communications tasked with facilitating better communication internally within the College and externally to members and general public.
 2. **Capacity- based Mental Health Act-** The College council have been discussing the issue of whether England and Wales might take forward a capacity- based MHA as has been already implemented in Northern Ireland.
 3. **Outsourcing for publications-** For more efficiency, the College has agreed to outsource the publishing of their journals and books but the College will retain editorial responsibility. This should reduce delays in meeting publishing deadlines.
 4. **Consultant Recruitment-** The status of EU nationals in the UK remains high on the agenda for discussion around the recruitment into psychiatry. The Workforce planning team presented worrying statistics showing the trend of decreasing numbers of applicants per Consultant post especially in London and the South East.
 5. **Trainee Curriculum-** The ETC launched a project in April to focus on integrating more neuroscience into the core trainee curriculum to improve the overall quality of training, and this may include proposals like specific placements in neurology.
 6. **Recruitment of College Assessors-**There have been concerns over the lack of College assessors sitting in on Consultant interview panels which stems from insufficient time that some Trusts have given us for the request, as well as lack of available assessors. The College is encouraging more members to participate in this valuable and important role - <http://www.rcpsych.ac.uk/workinpsychiatry/workforce/collegeassessorsaacs.aspx>
 7. **New Special Interest Groups-**The College has approved two additional special interest groups- Sports and Exercise Psychiatry and Neurodevelopmental Disorder . The College has now reached its maximum of 15 Special Interest Groups.
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Upcoming London Division events include the **Winter Academic Event on 22nd November 2016** 9.30-16:00 which features a varied programme of topics; for example, counterterrorism and psychiatry, use of long-term maintenance antipsychotics and sleep and psychiatric disorders.

Please note that registration closes on 11th November so book now!

<http://www.rcpsych.ac.uk/workinpsychiatry/divisions/london/events.aspx>

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Newsletter Editor
Consultant Psychiatrist

London Division Info

London Division Executive Committee

The [London Division Executive Committee](#) meets four times a year at the College's HQ. Approved minutes from previous meetings can be accessed via our [members login](#).

London Division College Vacancies - Your Division Needs You!

We have a number of vacancies for College posts available and are keen to see them filled as soon as possible. Take a look at our [Vacancies](#) page to see how you can get involved and support your Division.

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Dr Chris Symeon
Dr Stephanie Young



[Look out for the call for articles for the next themed newsletter](#)

"Prevention Better Than Cure"

Disclaimer:

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