

Welcome to the second edition of this year's newsletter! The theme for this issue was:

“Culpability for current shortcomings in mental health services: the human resource charged with delivering and managing the service v austerity measures & welfare reform”.

The theme focuses on the failings recently highlighted in the report of the ‘NHS England Mental health Taskforce’ on current services entitled ‘Mental Health Five Year Forward’. The taskforce highlighted rising suicides, long waiting lists, problems accessing acute beds, staff shortages and a lack of perinatal services.

The title caused somewhat of a stir with our readers, with the critique that we were being too negative. Our readers preferred a theme focusing on solutions rather than who to blame. Our contributors voiced that the solution lay in strengthening our professionalism and leadership.

[Dr Robertson](#) argues that we need to get our “house” in order and that extending the service as it stands is not an option.

Controversy aside, in our [Facetime](#) feature, Dr Sheehan, one of our editors, interviewed Professor Stuart Carney, a psychiatrist and a formidable influence in the world of Medical Education. [Dr Fehler](#) describes the evolution of the [London Psychiatry Club](#) and his delight at hosting the inaugural meeting at the College funded by the London Division.

[James Main](#) attended a conference considering the impact of the United Nations Convention on the Rights of Persons with Disabilities on people with mental illness. The convention diverges from the current mental health and capacity acts where rights are concerned and challenges the criteria for their application.

[Dr Crichton](#) shares his passion for Venetian portrait artist Giorgone, describing his flair for capturing human emotion whilst [Miles Clapham](#) praises Charlie Kaufman’s animated exploration of human connections, introducing the philosophical theory of solipsism in his film review of Anomalisa.

There are also a number of firsts in this issue:



We are awarding our first prize for best article of the issue to [Dr Robertson](#) for her timely article making the case against 24 hour services. Congratulations!

You have won yourself two tickets to an upcoming London Division event.

We also add two new features this issue:

Firstly [AUDIT](#) – to showcase some of the hard work undertaken by trainees in their efforts to improve quality. We kick off with Dr Russell's audit looking at the important issue of cardiometabolic risk in patients taking clozapine. Guidelines for submissions are now on our website.

The other new feature is the [Service User and Carers \(SUC\) Corner](#). We welcome

carer, Sara Muzira, who will be writing a regular piece to summarise the discussions in the colleges SU and Carers fora. We hope other service users and carers will also contribute articles.

We should also point out, as you will have noticed already, that our format is changing in line with the other college e-newsletters. You can still scroll down and look over all articles but there is an easy access list too. We hope that this will make the newsletter more user-friendly.

We would also like to remind you that we have a twitter account now and are keen to hear from you the account is: [@ThePsychEye](#)

Chair's Message

Dr Shakeel Ahmad , Chair of the London Division Executive Committee

The impact of mental disorder does not only remain up to the affected person, but, in most cases, affects the whole microcosm around the person. Affected person's family, friends, work environment and possibly the neighbourhood is also affected. The impact can even extend to further afar e.g. society as a whole. This widening of impact in mental disorders is much more common and pronounced compared to the impact of physical disorders.

This width of the impact further increases the importance of early and effective intervention in cases of mental disorders. This requires adequate resources at various levels: early detection at primary care level, smoother referral systems to secondary care, quick assessments and reliable diagnostic formulations at secondary care level, and well-functioning multidisciplinary teams to offer effective interventions that can then facilitate recovery in these cases.

How many of us can boast that we have consistently adequate and effective resources at the levels described above? Part of the reason for this lack of resources is in lack of medical leadership within mental health providing organisations. Over the last few decades, the leadership in health organisations in UK has gradually moved on to either the non-technical hands or at least in non-medical hands. The trend may have provided some financial or operational benefits to the organisations, and that too as a short term fix, whilst at the same time, the longer term impact on clinical practice in psychiatry has been somewhat negative.

Lately there has been a realisation of this negative impact of the reducing medical leadership, and we have seen an attempt to bring medical leadership back into effect. Leadership and Management Committee at the RCPsych looks at these and other

relevant issues. London Division is represented in this committee like all other Divisions. A well planned strategy will need to be implemented over the coming years to restore more effective clinical practice in psychiatry and to gradually undo the above mentioned negative impact on the science and clinical practice of psychiatry.

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Themed Article:

The Future of the Professions, Professionals, Professionalism and Practice

Drs Ram & Ramona Seth

The earliest medieval universities such as Oxbridge fostered the development of professionals and the classic professions of Medicine (Physic), Law and Divinity. A professional was engaged in the practice of a profession, both for livelihood and as a vocation. Professionalism described the values, beliefs and behaviours expected of professionals. Professional practice required authority and trust to be bestowed upon professionals. Professionals had a liberal university education, whilst traders and artisans acquired their practical skills and knowledge through apprenticeships.

The 18th Century saw an increase in sub-divisions of the classic professions. Joseph Addison, son of the Dean of Lichfield wrote in *The Spectator*, (1711); “the three great professions of divinity, law and physic” were “overburdened with practitioners.” He argued despite honours and authority bestowed on professionals, many failed to deliver e.g. attend to their parishes, public duties or patients respectively. The 19th and 20th centuries witnessed industrialisation and a rise in the number of professions e.g. nursing, social work, dentistry, pharmacy, librarianship, education, occupational therapy and many more.

General Medical Council

Regulating doctors

Ensuring good medical practice

British Doctors were recognised in law in 1858 with the first Medical Act. This provided privileges and control over, entry to the profession, their education and work, and an enhanced social status and income. Professional self-regulation, autonomy, and the General Medical Council were established. Professionals, professionalism and practice developed in harmony between 1858 to the 1980's.

The 1980's to date have witnessed a rise in the marketisation of the professions, information technology and global economic uncertainties and crisis. Performance management and targets drive professional work through efficiency and cost effectiveness (Relman, 2007; Friedson, 1985), changing the professional work place based culture. Policy constraints, diminishing finances and service cuts, and increasing regulations and contractual duties, has reduced professional autonomy in a climate of litigation. The GMC's emphasis has changed in becoming as much a public safety organisation dealing with complaints against doctors and fitness to practice, as well as accrediting doctors for licence to practice and to be on the specialist register.

Professionalism is not defined and I proffer the following definition; "Professionalism means belonging to a profession and possessing the necessary knowledge, skills and experience, demonstrated through competent practice and conduct by the professional; and that the competency and conduct lie within the expected standards of the profession and society." (Seth.R.V, 2012). Professionalism is acquired not just on propositional knowledge (episteme), but also on procedural knowledge and experiences (gnosis), (Davis, 2004; Playdon, 2011). Critically it is through gnosis and episteme that professionals inculcate the values of professionalism.



Susskind and Susskind in “The future of the professions”(2015) discuss the effect IT is having and will have on accessibility of information, and the digitization of professional work. Ultimately they envisage through evolving IT systems that traditional professions will be dismantled, leaving most (but not all) professionals to be replaced by less expert people and high performing IT systems. It is notable that already paramedics and paralegals are increasingly employed to undertake the professional work of doctors and lawyers. Recruitment and retention of doctors and many other professionals is increasingly difficult, whilst public and political expectations of professionals keep rising.

Rising complaints against professionals (e.g. doctors rose 54%, 2000-2014, GMC, 2015), litigation costs (NHS past five years £4.5 billion, Telegraph, 2016), and low moral and esteem of professionals (current strikes by doctors), highlights the transitional phase professions are going through. If Susskind and Susskind are correct that the question is not if but ultimately when the professions are dismantled, then transitional arrangements need to be considered for professionals, whose autonomy, authority and trust is diminishing and who are being treated as tradesman and artisans. A climate of realistic expectations of today’s professionals and services will assist in reducing professional failures, culpability and litigation.

The future of professionalism is at the heart of human competences and conduct as previously defined. Professionalism is the baby that will be thrown out with the changing bath water of the professions and professionals! Will future artificial intelligence systems or humans harbinger the traditional values of professionalism? Professor Terence Stephenson as Chair of the GMC in his newsletter 4th March, 2016 to doctors states that “at a time of such change, pressure and divergence, it has never been more important that the values that unite us—commitment, professionalism, compassion – continue to define medicine in the UK.”

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Themed Article: A 7 Day Mental Health Service

Dr Elizabeth Robertson

In recent months the Government discussion has been on a “7 day NHS”, a promise made in the Conservative Election manifesto¹. A 7 day NHS refers to full routine services in all specialties across the NHS, 7 days a week. What would this mean for Mental Health Services in general?

In September 2015, the Registrar of the Royal College of Psychiatrists released a statement to members on 7 day services². The statement highlighted the intrinsic nature of multi-disciplinary and cross-agency working in Mental Health Services; 7 day care is about more than Consultants and junior doctors. The Registrar stated that

expanding routine services should be done carefully, with an evidence-based, whole-system approach considering that 7 day services may cause detriment to other parts of the mental health system, especially in a time of Austerity.

A recent comment article in the Lancet Psychiatry 2016³ discussed these issues further. The authors observed that to make a significant difference to the running of Mental Health Services, the working week would need to be reclassified for all care providers. They noted that without this a change in the number of inpatient discharges, or meaningful outpatient clinics, at weekends, would be unforeseeable. They concluded that it was essential to address the deficiencies in our current service before attempting a reorganisation of our working week

And what about 7 day working in Mental Health Services when we are not achieving 7 day working in Urgent and Emergency Care?



The Five Year Forward View for Mental Health⁴, discusses “Good quality care for all 7 days a week”. It details the deficits present in our current urgent and emergency mental health care, and puts forward aims and recommendations. The report observes the intense pressure that Crisis Care in Mental Health Services is under: “Less than half of Crisis Resolution and Home Treatment Teams (CRHTTs) have sufficient staff to provide 24/7 intensive home treatment as an alternative to admission, putting extra pressure on hospital beds”. It also states that “Comprehensive Liaison Mental Health Services are currently available in only one in six (16%) of England’s 179 acute hospitals.” The report aims that by 2020/21 there will be 24/7 NHS urgent and emergency Mental Health Crisis Care and treatment, as exists in Acute Trusts. It recommends that by 2020/21, adequate resources will have been invested in CRHTTs to enable their expansion and allowing community-based intensive home treatment to be offered across England.

Therefore living under Austerity, it would appear logical to focus on the existing issues in urgent and emergency care, as illustrated by The Five Year Forward View for Mental Health, before moving on to a reorganisation of routine services throughout the 7 days of the week.



Mental Health Services rely on a network of multiple agencies and professionals. These include Local Authorities, the Voluntary Sector and Housing Associations. A true 7 day Mental Health Service would require input from these services 7 days of the week. What evidence is there that this could be provided? Has the complexity of Mental Health Services been considered within the proposal of a 7 day service?

The staff providing care within Mental Health Services will require rest days at some point in the week. If this is not to be at the weekend, this could leave gaps Monday – Friday. Staff with children will be adversely affected, with childcare being more expensive at the weekend. How would a move towards a more shift pattern of working affect continuity of care in Mental Health Services? And how will this affect recruitment to training in Psychiatry, a speciality often chosen by those who want to build an understanding of their patients, and to follow through with their assessment and treatment?

A pledge in an Election Manifesto has crystallised into a concrete discussion. Was patient care really at the centre of this idea and will it improve with the proposed changes? How will our provision of Mental Health Services continue to change as politicians use the NHS to win over the public's votes?

References:

1. The conservative party manifesto 2015.
2. What does the College think? Seven-day services. Registrar statement to members (September 2015)
3. 7 day services and psychiatry, Roxanne Keynejad, Clare Holt, Rahul Rao. The Lancet Psychiatry, Vol 3, no. 3 p197-199, March 2016. Published online 3/2/16.
4. The Five Year Forward View for Mental Health (February 2016) A report from the independent Mental Health Taskforce to the NHS in England.

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Facetime with Professor Stuart Carney

Dr Rory Sheehan

"Like all UK medical schools we need to educate outstanding doctors, who are both pluripotential and well-prepared for safe and effective practice."

1. Can you summarise your career history and tell us about your current role?

I am Dean of the GKT School of Medical Education and a Professor at King's College London. I am also a Non-Executive Director of Lewisham and Greenwich NHS Trust and an Honorary Consultant Liaison Psychiatrist at King's College Hospital.

I graduated from Edinburgh in 1996 and went on to complete core training in Oxford. I then moved to Harvard University to study for a Masters of Public Health. I returned to a Clinical Lectureship at Oxford and shortly afterwards was seconded to the Department of Health to help set up the Foundation Programme and the Integrated Academic Training Pathway.

For the last ten years, I have been involved in both undergraduate and postgraduate medical education and training, including as Deputy National Director of the UK Foundation Programme and Clinical Lead for the Shape of Training Review. I became the Dean of Medical Education at King's in 2013.

2. How easy has it been to combine working in medical education with clinical practice?

My training took a little bit longer and there have been times when I have had to put my clinical work on hold. I currently spend a day a week in liaison outpatients which enables me to learn

from patients and colleagues whilst protecting the rest of the week for my university responsibilities.

3. What do you think are the most important personal qualities for a successful career in medicine?

For me it comes down to motivation and values. Whilst often rewarding, medicine is a tough career so it is important not to lose sight of what we are about –making a difference to patients and the public.

I think there are three other important attributes: team-player, dealing with uncertainty and resilience. And finally, a career in medicine is a marathon and not a sprint –we need to develop the skills to take care of ourselves too.

4. What advice do you give to your students at their graduation?

I have two messages at graduation. Firstly, I reaffirm that as doctors, we are called to make patients the centre of what we do. Secondly, I remind our graduates of the importance of friends, family and a work-life balance.

5. How can a medical school promote psychiatry to its students as a potential career?

This boils down to modelling good practice and inspiring our students. We are transforming our undergraduate Curriculum at King's to champion whole-person care which will result in a more than doubling of the time spent in mental health settings. We must exploit every opportunity to demonstrate that psychiatrists, as members of teams, make a real difference to patients' lives.

6. What is your vision for the future of medical education at King's?

Like all UK medical schools we need to educate outstanding doctors, who are both pluripotential and well-prepared for safe and effective practice. We are replacing our current pre-clinical/clinical split with a more integrated model, and embedding mental health learning in all clinical blocks. Our new curriculum is divided into three stages: Foundations of Medicine , From Science to Clinical Practice, and Integrated Clinical Practice. We aim to nurture graduates who are critical thinkers, champions for holistic care, educators, and leaders in service improvement.

7. What do you see as the main challenges for tomorrow's doctors?

The next generation will need to find ways of using our limited healthcare resources more effectively and efficiently to deal with ever-growing demand. The needs of patients and the public are changing. There is increased recognition that we need to help patients better manage their own health without neglecting those who struggle to navigate the complex health and social care systems.

Conference Watch - London Psychiatry Club

Dr Jeffrey Fehler

Almost two years ago, Rory Hutchinson, then F2 at St George's, approached me with his idea about developing a London-wide psychiatry club for undergraduate medical students. I was keen to be involved and to support him in developing the proposal.

We had a number of (perhaps overly) lofty ideas about the objectives of the 'Club' and what form it might take but we ultimately agreed on three key objectives:

- to stimulate interest in psychiatry amongst medical students (ideally not just those with a pre-existing interest)
- to provide an educational forum for medical students to learn about psychiatry in an innovative way
- to unite London-based medical students in an academic forum.

In the meantime, Rory and I co-opted two enthusiastic ST4-6 trainees working in CNWL, Tessa Jones and Tom MacLaren, to help us with this novel and ambitious endeavour and the four of us became the club's organising committee.

The first goal of the club was to arrange an initial educational meeting. Of course, this took time as the Club is not funded and we also needed to get speakers whom students would feel encouraged to come and listen to.

The College was supportive of our endeavour and offered to host the event at College HQ on Prescott Street. Promoting Psychiatry to medical students can certainly help with recruitment and Tom Brown, the College's Associate Registrar (Recruitment into Psychiatry) has spoken before about each student contact with psychiatrists presenting 'an advert for Psychiatry, either for good or ill'.

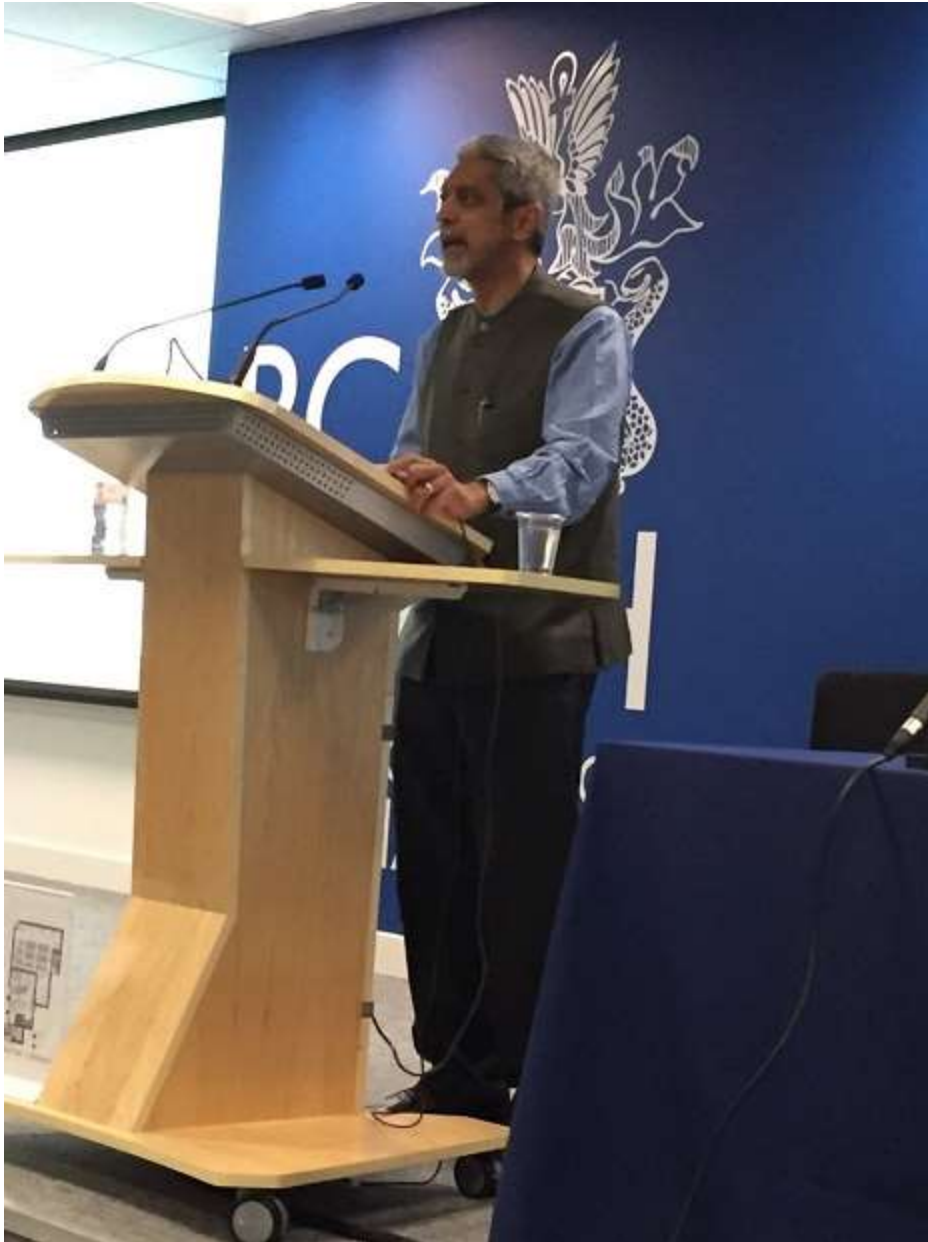
With this in mind we wanted to organise a stimulating event and ensure good attendance and by

January 2016, we had secured two top speakers for an evening event on 17th March. Details were circulated to all five London medical schools via the student unions, PsychSocs and Psychiatry course leads.



The event stimulated lots of interest amongst many medical students and after counting over 50 confirmations in just 1 week, we quickly had to change rooms to one that could accommodate more people. On the day almost 80 signed in!

The College President Prof Sir Simon Wessely was the first speaker of the evening. His talk focussed on the (unfair) stigma associated with Psychiatry, why we need to address psychiatry 'bashing' and the potential benefits of recent initiatives to increase foundation posts in psychiatry. Prof Wessely reflected that whilst psychiatrists are used to witnessing others bashing our profession, a line is crossed when the bashing is directed against our patients.



Prof Wessely was followed by Vikram Patel, Professor of International Mental Health and Wellcome Trust Senior Research Fellow (and author of [Where There Is No Psychiatrist](#)). Prof Patel gave a fascinating talk on global mental health and its exciting prospects as a career for psychiatrists. He shared examples of his work in the developing world and how challenging but fulfilling this has been. He reflected on his work in Goa working with a mental health research NGO in his quest to empower existing community resources to improve mental wellbeing in their community and spoke about his earlier experience of integrating mental health care with 'traditional' medicine in Zimbabwe.

Both talks inspired lively discussion at the drinks (and canapé) reception that wrapped up the event. There was a significant amount of networking amongst students but also with our speakers and other non-students like myself.

At the end of the evening, we felt relieved and pleased that our first meeting had gone so well. There is clearly a lot of interest in psychiatry amongst medical students across London and we hope to build on this in future events. The evening seemed to have left an impression 'for good' rather than 'for ill'. The Club is not just an advert for psychiatry as a profession; it is about embedding in future doctors an open-minded attitude towards mental health. You can find more information about the Club on our [website](#) or by [e-mailing](#) us.

A big thank you from the London Psychiatry Club to the London Division for generously hosting our first event!



L-R: Dr Jeffrey Fehler, Prof Vikram Patel, Prof Sir Simon Wessely, Dr Tessa Jones, Dr Tom MacLaren, Dr Rory Hutchinson

Dr Jeffrey Fehler

Consultant Psychiatrist, CNWL NHS Foundation Trust
Psychiatry Course Leader, Imperial College School of Medicine

Conference Watch - The Convention on the Rights of the People with Disabilities (CRPD) - The End of Psychiatric Practice as we know it?

Dr James Main

The conference was an ideal arena for psychiatrists and lawyers to get to grips with the complexities of each other's discipline – “rugby versus football” as one delegate put it. It concerned the current and future impact of United Nations Convention on the Rights of Persons with Disabilities (CRPD) on the use of the MHA and MCA in England and Wales. Both could potentially be incompatible with international law that the UK signed and later ratified in 2009.

The CRPD re-states human rights law for persons with disabilities with the aim of preventing discrimination. Several articles are relevant, but in particular, Article 12 which states that a disability must enjoy full access to legal rights. The CRPD committee has specified this means even a mental disability cannot be grounds for removal of rights. The problem emerges where the diagnostic tests in the MHA (presence of any "mental disorder") or an “impairment... of mind or brain” in the MCA, can include mental or psychosocial disabilities.

The first two speakers stepped in at short notice after initial cancellations.

Aswini Weeraratne QC outlined the legal territory and emphasised supported decision-making to replace the threshold in the MCA where a person can be deemed to lack capacity. She noted that the Deprivation of Liberty Safeguards could be replaced with “Protective Care Safeguards” dividing patients into those receiving supportive care and those receiving restrictive care.



EUROPEAN COURT OF HUMAN RIGHTS

Professor Szmukler proposed a “fusion” statute where the MCA and MHA are replaced with a test based on mental capacity to make decisions without needing a diagnostic threshold. He argued this would be non-discriminatory and that any indirect discrimination from persons with mental disabilities being more likely to fail tests of decision-making, may be legally and ethically justified providing the aim is legitimate and the impact proportionate.

Baroness Hale detailed how the CRPD has been expanded on by UK courts, the European Court of Human Rights and various UN bodies. The outcome seems to be that mental capacity and legal capacity should be de-linked; that is, lacking the ability to make a decision due to a mental disability should never mean you lack the legal right to act on decisions. This seems counterintuitive for psychiatrists whose daily practice can involve taking decisions on behalf of vulnerable patients under both the MHA and MCA.

Hale suggested the CRPD could be interpreted to require that greater efforts are made to support people’s participation in making decisions and that a substitute decision (e.g. one made under Best Interests in the MCA) could be allowed in extreme circumstances. It is otherwise unclear how a person with cognitive impairment and poor safety awareness, for example, could be prevented from walking out into traffic.

Whether or not relapsing-remitting conditions such as depression, schizophrenia or bipolar

affective disorder count as CRPD disabilities remains to be tested in law.

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*Culture Vulture: In the Age of Giorgione Royal Academy of Arts, Piccadilly, London 12
March – 5 June, 2016
Paul Crichton*

According to Vasari, the art historian of the Italian Renaissance, Giorgione (“Big George”) was born in 1478 in Castelfranco, near Treviso, and brought up in Venice. He

became one of the greatest Venetian artists, but died of the plague, probably in 1510, in his early 30s.

These very sparse biographical details add to the sense of enigma we see in the paintings, very few of which have survived, and several of which are merely attributed to him.

Giorgione with his followers, such as Titian, Lotto, Mancini and Cariani, revolutionized Venetian painting. His works have a mystical, misty, smoky (“sfumato”), poetic quality, with blurred lines and colours, like Venice itself, a sliver of land between sky and sea. Vasari mentions that Giorgione learnt to depict these “subtle transitions of colour and tone” and to use light and shade from studying the works of Leonardo, who visited Venice in 1500.

In the “Terris” portrait, Giorgione does something new: a man of about 40 has turned his head and is looking straight at us with a calm, but searching gaze. He engages and draws us into the painting. With this new style of portraiture, Giorgione was able to win over a whole generation of patrons.

Another portrait, this time of a younger man who has an androgynous quality, is perhaps of the Venetian poet, Antonio Brocardo. He is absorbed in thought. The gold embroidery on his black damask coat may represent the bands of love – and his slightly melancholic expression may suggest a broken heart. There was a debate at the time about whether poetry or painting better represents love, and Giorgione may be putting the case for painting.

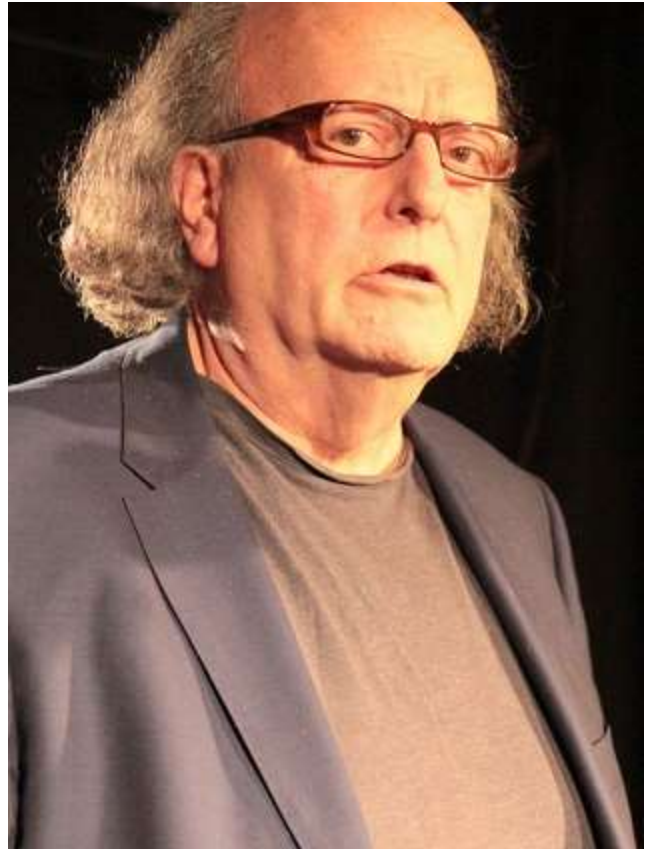
In the *Virgin and Child in a Landscape*, Maria is not enthroned or on a higher plane, but the earthly and heavenly are combined. The tender interaction between Madonna and Child has a quietly unsettling quality, perhaps because the mother is thinking about her child’s fate. The scene has a touching realism, and was probably intended for private devotion.

In *La Vecchia* (The Old Woman) the sitter looks straight at the viewer, with a steady, but troubled gaze. There is no attempt at flattery here: wisps of grey hair stray from under her cap, and her face is wrinkled. The message in her right hand reads: ‘Col Tempo’ or ‘With Time’. This could have been just an allegorical painting, but Giorgione makes the portrait the humane and compassionate representation of a real woman.

This superb exhibition marks a moment in the High Renaissance in which the portrait of an individual living person comes to the fore. It also anticipates the emergence of psychiatry, a discipline which not only embraces whole groups of people by using diagnoses, but focuses crucially on the individual by means of the mental state examination, just as Giorgione is able to show us how, for instance, depressive thoughts and feelings can be expressed in the face of a particular person.

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Culture Vulture: Film Review - "Anomalisa"

*Directed by Charlie Kaufman
Miles Clapham*

Wittgenstein says "I do not respond to you as though you are an automaton, I respond to you as though you have a soul." This quote aims to overcome a vital issue, the solipsistic fear of loneliness, of being the only human in a world of aliens or robots. "Solipsism" is a key question for psychiatry, although rarely understood.

"Anomalisa" is a beautiful film which, by the use of clay puppets and stop motion animation, plays on both our fear that we are machines, and on our loneliness in a world where Sartrean "bad faith" is the mode we are forced to exist in. It refers to the Fregoli delusion when everyone else becomes the same person, exactly the heart of solipsism. What happens when we lose our face, or see through our bad faith, is concretised when part of the main character's face falls off in a nightmare. Read more...

Michael is a motivational speaker for sales personnel, those that read his book achieve 90% increases in output, his book talks of how each person is an individual, had a

childhood, is more or less satisfied with life, how kindness, and putting a smile on your face even when you are on the phone to an invisible customer, changes the feel of the world. CBT to the extreme, positive thoughts achieve positive life changes. Only Michael is teetering on the verge of some kind of breakdown, 'depression?', 'psychosis?'; as a psychiatrist we may leap into the diagnostic categorising game. His marriage is a mess, his child seems only to demand presents, an ex-girlfriend 10 years on still can't understand why he left, he drinks and has unsafe sex with groupies. Everyone else speaks with the same voice.

In his hotel the night before a conference, Michael drinks martinis, hears voices, goes looking for a friend he thinks is in the corridor, and meets fans who are coming to hear his keynote speech the next day. He gets drunk with them and ends up in a one night stand, momentarily thinking Lisa, the girl he sleeps with, is the anomaly in the world, one out of millions, the special one he can really make it with – Anomalisa.

He loves her voice, it is individual and makes her special, she sings for him as they move towards momentary intimacy. In the morning, after his nightmare in which everyone loves him for his 'false self', Anomalisa's voice becomes the voice of everyone, mouthing the truisms and received wisdoms of the city he is staying in and the generality of people. Her specialness vanishes, his loneliness and emptiness take him over. His speech goes off track, and he crashes and burns on stage.

Anomalisa achieves with puppets and animation more than real actors could. It could be banal or bathetic in its portrayal of solipsism and the false dream of transcendence with "the one special one". It achieves something poetic and moving, and says more than psychiatry's dominant mode of understanding by categorizing 'illness', by showing something of the alienation that lurks in many, if not all of our lives.

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*AUDIT: Recognition of Hyperlipidaemia and Hyperglycaemia in those on
Clozapine Medication, SW Kent CMHT, September 2014*

Dr E Russell



An audit of patients taking clozapine medication in S.W. Kent CMHT was undertaken, to ascertain the proportion who had been screened for hyperlipidaemia and hyperglycaemias within a 12-month period as NICE guidelines for psychosis and schizophrenia in adults [CG178] February 2014 recommends, routine monitoring of cardiovascular and metabolic indicators of morbidity.

Background/Rationale

Compared with the general population men with schizophrenia die on average 20.5 years earlier and women 16.4 years earlier than healthy peers. Diabetes and cardiovascular disease is a major cause of death in these patients. The development of these diseases is predicted by the presence of the “metabolic syndrome.” This is defined by the presence of 3 out of 5 of the following independent risk factors:

- Central obesity
- Raised blood pressure
- Hypertriglyceridaemia
- Low high density lipoprotein(HDL)cholesterol
- High fasting blood glucose level

There is an increased risk of the metabolic syndrome in patients with schizophrenia. Second generation antipsychotics are known to contribute to this syndrome. There is weight gain, raised triglycerides and HDL cholesterol. Blood glucose is elevated due to weight gain, elevation of serum leptin and an increase in insulin resistance.

However, there are many other possible reasons for the increased mortality:

- People with schizophrenia are more likely to smoke, to have a poor diet, drink more alcohol and to take less exercise.
- The problems associated with schizophrenia may impair ability to recognise and action physical health needs (e.g. they are too distressed or lack motivation)
- Psychiatrists and general practitioners seem poor at recognising and treating physical conditions, such as cardiovascular disorders in psychiatric patients.

- There may be a cortisol imbalance or inflammation, or a common genetic factor predisposing to both mental illness, diabetes and metabolic syndrome
The addition of mood stabilisers can exacerbate the metabolic syndrome

The aim of the audit was to ensure good practice in managing cardiometabolic risk in patients taking clozapine by assessing the number of cases monitored for hyperlipidaemia and hyperglycaemia. The audit standard was set that patients on antipsychotic medication should have a blood glucose and plasma lipids measured at least once a year with the exception of those refusing to have a blood test. Monitoring the parameters of the metabolic syndrome would facilitate effective intervention and reduce mortality. The trust currently routinely screens service users for smoking status, BMI and hypertension but not for the other cardiometabolic risk factors.

Clozapine was chosen for this audit as

- It is the most likely psychotropic to cause the metabolic syndrome
- The need for monthly monitoring should facilitate metabolic monitoring and eliminate patients failing to attend for follow up
- Patients taking clozapine represent a disease group with severe and enduring mental illness

A sample of 42 of 84 patients on clozapine medication under the care of the CMHT at the end of October 2013 was identified. A retrospective data collection from RIO and TelePath (Maidstone and Tunbridge Wells NHS Trust) computer files for the 12 months preceding the last medical review was then undertaken.

The audit showed that 29% of patients had had a lipid profile and 36% had had a blood sugar analysis performed. Of these 92% and 47% were respectively abnormal and of these only 24% had had any intervention recorded. This is in keeping with the National Schizophrenia Audit 2012 found that only 29% of people with schizophrenia received an assessment of cardiometabolic risk factors and that there was no evidence that necessary treatment was instigated for patients with high blood pressure or cholesterol. Thus screening rates for lipid and glycaemic abnormalities are low despite best practice guidance from NICE. Even when abnormal results are received there is little evidence these are acted upon.

Root cause analysis showed the need for improved screening is required to improve the identification and thereby the treatment of the metabolic side effects of clozapine. The audit also indicates the need to develop standardised form for recording biochemical parameters and to improve access to electronic laboratory results to facilitate the monitoring of investigations.

Next steps

1. The audit results and root cause analysis needs to be communicated widely to staff engaging with this client group

2. A standardised form for recording parameters needs to be developed
3. There is a need for improved access to electronic lab results
4. A protocol for clinical management of monitoring of abnormal lipid and blood glucose .To use The Positive Cardiometabolic Health Resource provided by HQIP and The Royal College of Psychiatrists 2014 to determine the threshold for interventions.
5. To enable patients to attend GP for physical health advice
6. The implementation of actions emerging from the audit needs to be monitored. A reaudit has been set for October 2015.

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Service User and Carer's Corner

Sara Muzira

Recent meetings have spent some time discussing the restructuring at the College. The Department of Communications and Policy no longer exists in that form, and the admin and support of the Carers' and Service Users' Fora will now come within the remit of the Finance and Operations Department.

Alongside this the College have reviewed and improved recruitment procedures for the two Fora and are looking to interview potential members face to face or by phone. A review of representation from these groups on College Committees is being carried out.

New co-chairs of the two Fora will take up their posts in June 2016 – Dawn Lewis and Michelle Long will chair the Carer's Forum and Robert Milligan and Robert Walker will chair the Service Users' Forum.

Royal College of Psychiatrists Operational Plan 2015-8

Both Fora are jointly working on three tasks within the Royal College of Psychiatrists Operational Plan 2015-8. Members have now met in workshops on two occasions in December and February to discuss and generate ideas for the College on three areas:

**Workshop A : Objective 5 –
we will work to make sure that ‘Parity of Esteem means tangible benefits for patients in terms of funding of services, research and the removal of stigma’.**

The group have looked at what ‘parity of esteem’ actually means, as well as what impact it has when it does not exist. It was felt that anecdotal ‘real life’ examples make a powerful statement. For example one member was told there was ‘no room for them’ at a new GP surgery when they disclosed they had schizophrenia. The group hope to use personal experiences to work on a holistic assessment process.

The group are concerned that a prevailing narrative of ‘do more with less’ should be challenged – parity of esteem may well require extra investment to make any real impact on changing attitudes and outcomes. It is strongly felt that parity of esteem should result in improvements for patients, not a lowering of standards. They will use the NHS 5 year plan as a reference point, but look to a UK wide impact.

The group are keen to involve the media, particularly using service users’ and carer’s stories. They plan to come up with a clear and simple definition of ‘mental illness’ (often quoted in the media as 1 in 4 people).

It is hoped that a draft paper on this task will be available by June 2016.

**Workshop B: Objective 9 -
we will work to make sure that we collaborate with other Medical Royal Colleges and with patients, families and carers to develop training.**

The group explored the many ways that service users and carers can contribute to the training of psychiatrists, at all stages. It is recognised that junior doctors appreciate the chance to hear people’s life stories and ask questions directly. This is a chance to challenge stereotypes and reduce stigma. Some members of the group are already involved in this type of training, and were able to talk from experience. The group feels it is vital to recognise and build on existing good practice, and formalise contact with carers and patients across all Royal Medical Colleges.

The group discussed the value of this kind of dialogue with trainees at all stages. It was felt that it leads to better communication and empathy, and consequently better patient care. It was recognised that training may be required for service users and carers involved in the education and training of psychiatrists, and that this should be properly funded.



During the second workshop the group were given a presentation on the current education and training of psychiatrists by colleagues from the College's Professional Standards Department. This helped to put the group's discussion into perspective. Potential next steps include: Liaison with medical schools; Training and Education Ambassadors; film and podcasts; involvement in examinations.

**Workshop C: Objective 11 –
we will work to make sure that value of continuity of care for patients is emphasised.**

This workshop has considered the impact of 'continuity of care' on patient outcomes. Continuity of care actually means different things to different people, and a priority of this workshop is to come up with a definition. Issues discussed have included

- Seeing the same consultant over a period of time
- Transparency of planning involving service users and carers
- The importance of communication and record keeping
- The problems involved in moving from secondary to primary care, and the importance of the role of GPs
- A patient-centred approach

It is clear that there are significant overlaps between all three workshops. Parity of esteem between mental and physical health – and a holistic approach to treatment – has been raised in all three. The training of all medical staff including GPs is another key issue.

These workshops all carry on at the April meeting, when members of both Fora will also have an opportunity to take part in College induction, which will clarify the way the College works and help members of the Fora understand the structure of the College.

Carers and Service Users will be involved in the International Congress 'Psychiatry: Brain, Body and Mind' in June 2016. Sessions S39 'Making the most of learnt experience' and S44 'Carry on caring - with links to Sustainability & Parity of Esteem' involve members of the Fora.

Sara Muzira | saralmuzira@gmail.com

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, 16 March 2016

Dr Zaubia Alyas

This feature, which will be linked to the official minutes, serves to highlight in more detail some of the discussions at the Divisional meetings. At the first meeting of this year, a number of new College initiatives, newcomers and upcoming events were highlighted.

New Initiatives

1. **Counterterrorism and psychiatry** - the College Registrar, Dr Adrian James is chairing



- a new group looking at appraising and coordinating the colleges current work and future response in this area. It will look at radicalisation and prevention of terrorism and pull together existing work on improving the experience of trauma in migrants and work on spirituality and diversity. The committee commented on the relevance of Professor Kam Bhui's work in this field and multiagency working with the police, with praise for the **PREVENT** initiative run by the police, which many members had experience of.
2. **Foundation programme strategy** – in line with the programme to increase FY posts, with psychiatry component from 5% to 22.5, a new committee of the college is being set up ,to be chaired by the specialist advisor for foundation trainees, with remit to improve experience of FY's and coordinate new recruitment initiatives.
3. **Community Treatment Orders (CTOs)** – the College Registrar, Dr Adrian James, is setting up another committee looking at and formulating the college's approach to using CTOs .Various criticisms of the quality and demands of tribunals were aired, including

concerns that the recent trends to impose dates for tribunals may escalate risks in other areas.

4. **NHS London leadership academy** – member Dr Sujaa Arokidass, who also sits on the leadership committee, shared her experience of starting an executive leadership programme with this relatively new organisation. The academy has an interest in developing national leaders. Sujaa described a fairly comprehensive and thorough programme. There are also some [bursaries](#) on offer.

New Events

Upcoming [London Division events](#) included the second of the London Division's [Startwell](#) conference on the 5th April.

New Recruits

Chair Dr Shakeel Ahmad also informed us that Dr Sadgun Bhandari (Chair of the Eastern Division) had been appointed the new Chair of the Divisional reps. He also welcomed Vivine Muckian to the meeting, recently appointed Head of Divisions at the College. She described her experience and move from senior educational management and her new role.

MAC Engagement

Dr Ahmad and MAC lead Dr Maja Dujic have sent out a first wave of questionnaires to London MAC chairs to further analyse engagement. They plan to collate agendas of meetings to gain an understanding of common issues London wide and share the minutes of the London Division meetings with MAC chairs in an effort to begin a two way exchange.

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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 Regional Representative Vacancies

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.

London Division Events

The London Division hosts a number of events each year. Take a look at our [Events](#) page for details.

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