

Editorial from Dr Stephanie Young and Dr Matthew Francis



Welcome to the Autumn edition of the London Division Newsletter, our guide to Sex, Sweets and Smoking. Many thanks to all who contributed articles for this edition. We have eight thought provoking Themed Articles for you, which discuss how we balance beliefs about patients' optimal lifestyle choices with respecting their human rights. Is there a paternalistic/holistic divide? We hope you enjoy the discussion as much as we have.

Welcome also to our newest recruit to the Editorial Team, Sachin Shah, whose article [“Where there’s smoke there’s ire”](#) gets us thinking about the current trend for smoking bans in our hospitals, and whether such initiatives come at a cost. If, like Sachin, you want to join the conversation and have an interest in editing, we are still on the lookout for other keen psychiatrists to join the editorial team. Do get in touch.

So, where are the sex and sweets? As [Ram Seth](#) points out, “Sex, Sweets and Smoking... are part and parcel of society,” so what is our role in intervening in such matters? His article highlights the historical stigmatization of patients with mental health disorders, the curtailment of their human rights and the impact this has had on so many aspects of their lives. [Gabrielle Pendlebury](#) and [Ebru Lumley](#) take the discussion further, thinking about patient autonomy, patient priorities and working collaboratively.

[Amit Mistry](#) discusses the sensitive topic of physical inactivity amongst patients. And [Stephanie Young](#) ‘fesses up to missing her 5-a-day target (even with gadget buying to boost her resolve) but asks the question “are we underestimating patients’ capacity to take their own responsibility for better physical health?” And, for that matter, what happened to allowing people to make, what we may consider to be, bad choices? Our prize winning article this edition is [Sally Bramley’s](#) thought provoking article on how best to promote optimal health behaviours amongst patients. Congratulations Sally, you have won two tickets to a London division event.

[Alistair McFarlane](#) takes the discussion to a General Practice consultation, and

reflects on one patient who presented with what initially appeared to be a rather illogical approach to managing his obesity, only to discover a more complicated background to the situation. Paternalism can be over simplistic.

We also have the Conference Watch from [Farhana Mann](#) and two FaceTime interviews in this edition, with [Rajesh Mohan](#) and [Graham Thornicroft](#). Plus there's our regular Culture Vulture article from [Sarah Parry](#) at the Wellcome Collection and Round Up of the London Division.

The theme of our next newsletter is The armchair psychiatrist: Can and should clinicians diagnose public figures from afar?. As the evenings draw in and you find you have time on your hands to pen an article, do tell us what you think. We hope you enjoy reading this edition and don't forget to join the conversation [@ThePsychEye](#)

[Back to top](#)

Chair's Message



Dr Shakeel Ahmad, Chair of the London Division Executive Committee

Patient with above normal BMI goes to his GP with complaints of breathlessness and occasional heaviness in his chest. He gives history of eating lots of fried food and red meat, smoking, heavy alcohol use, cannabis, and occasionally cocaine at the friends' gigs, and evenings spent watching movies in his home cinema, on his favourite couch.

GP could check his lipid profile and ECG and prescribe atorvastatin aiming for cholesterol levels to fall into the recommended range, and hope for the best. Or, the GP could take personal interest in the patient's welfare. Besides carrying out the essential investigations and prescription, the GP could help the patient further by taking a holistic approach, including lifestyle changes.

There is ample evidence that the results of the latter approach are likely to be much better, and of course we have many of our GP colleagues employing this approach for their patients.

That answers our question. In my view, respect of human rights is one thing and taking responsibility as a psychiatrist for the welfare of our patients in a holistic manner does not imply any disrespect of their views, in fact, and not offering such help is disrespecting their right to be advised in the best possible manner.

Dr Shakeel Ahmad | shakeel.ahmad@huntercombe.com

[Back to top](#)

Themed Article: Let them eat Cake

Dr Stephanie Young



Let me start off by saying that I am not a health fanatic. I like crisps and chocolate as much as the other person, but I exercise regularly. I know I should eat more fruit, and purchasing a special smoothie blender has not increased this to the magical 5 a day. However, if anyone outside of my friends and family were to criticise my choice of Pringles over pomegranates, I might reasonably become defensive, although one could argue that they only have my best interests at heart.

What is the right balance to strike when it comes to advising our patients to limit certain practices not deemed conducive to a healthy life? This is a relevant dilemma to reflect on. As psychiatrists, not only do we already exert control using the legislation of the Mental Health Act, but increasingly our interactions with patients are including more about managing physical health and other lifestyle choices, so the boundary is becoming less straightforward.

As I look back on my 11 years as a community rehabilitation psychiatrist, I realise that despite having had some positive influence in my patients' wellbeing, there are huge amounts I can never change. I've seen the amazing effects that antipsychotics have made in allowing patients to reengage with loved ones, yet I've not managed to persuade even 1% of my patients to stop smoking. I've seen psychology input reduce the devastating effects of voices so patients have managed to complete college courses, yet I've not succeeded to get more than a handful to join a gym.

You may understandably ask whether I am just not using the right approach, or just not trying hard enough. I've had training in motivational interviewing and, more recently, coaching skills. I like to think that professionals are now being better skilled up in having these kinds of non-judgemental discussions, so yes, the right training is essential.

But despite this, how much influence can we or should we, as psychiatrists realistically have, over improving our patients' lifestyles? It is now an accepted notion that our medications do contribute to physical health issues like diabetes and other cardio metabolic disease. So it seems reasonable that we have the responsibility to minimise harm. On a basic level, this should include the provision of different educative measures to patients, individually tailored and delivered by a variety of health professionals- that is, GPs, practice nurses, pharmacists, dentists and not just our mental health teams. This of course has resource implications like any other intervention, and open to a larger debate.

Giving advice about healthy eating, weight management, and smoking cessation have now become pretty much accepted as mainstream, and are incentivised through the national physical health CQUIN targets¹. Remember the days before smoking cessation came into force in the NHS? Some of the most resistance came from our own ward staff who were understandably worried that we would be depriving patients of a "human right" when it was bad enough that they were detained in hospital. They were concerned that this would negatively affect the therapeutic relationship. However, we now have good evidence that the incidence of violence and aggression did not increase in mental health units, and the view seems to have shifted that banning smoking in hospitals was a good thing.

For community based patients, the degree to which we are able to intervene in lifestyle choices might be regarded as less clear cut. Who are we to judge whether a patient's decision to spend time with her boyfriend is any less reasonable compared to attending a cookery group where she has to take two different buses to get there? From her point of view, she will say she is getting more social benefit than from attending a group where she knows no-one and where it is more of a hassle to get to. Never mind that she is not "adhering" to her mental health team's view that she could eventually get her own flat if only she would "engage better". Similarly, does it really matter if my patient is not cooking for himself as much as his team would like? Expense aside, he may prefer a ready meal, just as I know his care coordinator does.

I hasten to add that I am being somewhat the Devil's advocate in these examples. Professionalism and duty of care ought to trump our personal views when it comes to patients, so invariably we do encourage them to avoid fatty snacks, walk around the block, see a dietician etc. But governments and larger organisations need to take a broader responsibility too. I don't like the concept of the "nanny state", but it is all very well to give advice about healthy eating when supermarket "bogof" deals make chocolate bars cheaper than fruit.

Lastly, we mustn't underestimate our patients' capacity to take their own responsibility for better physical health. We talk all the time about patient choice. Shouldn't that also include the right to make bad choices?

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Dr Stephanie Young |

South London and Maudsley NHS Foundation Trust

Themed Article: The see-saw of autonomy versus best interest

Dr Sally Bramley



Since the end of the 19th century, causes of death have been gradually shifting from infections and acute disease to chronic illness such as dementia, heart disease and stroke¹. Unhealthy behaviours play a large role in the development of these and by 2020 it is predicted that two-thirds of illness will be a consequence of lifestyle choices².

Arguably the most concerning consequence is the escalating obesity epidemic, attached to astounding health and financial costs. Type 2 diabetes alone takes up 10% of the NHS budget³, yet the World Health Organisation estimates that 90% of cases could be prevented by modifying lifestyle factors⁴.

Last week, I reviewed a young male on an acute ward presenting with severe leg pain secondary to cellulitis. He had a background of diabetes, depression and a BMI of just over 40, a figure associated with a ten-year loss of life expectancy⁵. We discussed his two-year journey from being a happy and active young man, to becoming bed-bound and suicidal.

Above the antidepressants, painkillers and home modifications, it was evident that the key intervention that was going to make a difference to his life was practical and effective advice on weight loss. On his journey, he had made contact with multiple health professionals, including psychiatrists, who were all in a position to offer this. He informed me that many had tried, mostly lecturing him to “eat less” and “move more”. Yet this oversimplification and implicit criticism of his eating habits had only made him defensive and, I expect, more resistant to change.

Having established the importance of promoting optimal health behaviours and finding ourselves in a favourable position to deliver this, the key question then is; how best to do so? As doctors, we aim for evidence-based best practice. Therefore, to promote optimal lifestyles we should seek evidence for, 1) what this ‘optimal lifestyle’ actually looks like, and 2) how to get people following it. The field of ‘lifestyle medicine’ does just that⁶.

Now, before you rush off to read all the latest evidence in this burgeoning field, it’s likely that you and patients alike have a preconception of what ‘bad’ lifestyle habits look like. This may include things like skipping breakfast and sleep, ignoring that gym membership, eating salty foods, and lying around in the midday sun. Then there are all those glasses of wine, the self-medicating, and risky sexual encounters. Yet, for many people, that’s all sounding like a great time.

Typically, there are randomised controlled trials that strongly correlate these habits with morbidity, such as the infamous link between smoking and cancer (whilst for other things, the supposed ‘guidelines’ may appear to change every other week). However, these studies fail to take into account quality of life and the joy and pleasure these ‘bad’ things bring many people. It’s not just doctors who perform risk-benefit calculations. On top of this there’s a multitude of other factors that influence behaviour, including attitudes, values, education, social context and mind-set, all of which can shift over time. In other words, a picture of what it is to be human. These are all things we ought to keep in mind when delivering lifestyle advice, or risk seeming overly paternalistic. Instead of feeling trapped on a see-saw of autonomy versus best-interest, evidence suggests that it’s most effective to push these forward together. Indeed, this is one of the basic principles of motivational interviewing, the efficacy of which is supported by large multisite trials^{7,8}.

Psychiatrists are well accustomed to balancing autonomy with best-interest, for example when undertaking a Mental Health Act assessment. In addition, many of the perceived barriers to delivering lifestyle advice, such as time availability, feeling ill-prepared, and the fear of negatively impacting rapport, are all areas that we have learnt to overcome in the psychiatric interview. This is achieved through skills such as high empathy, theory of mind, a non-

judgemental attitude and reflective listening. Such skills can be used to subtly direct the patient whilst providing evidence-based information, ideally with their permission.

These skills allow us to collaborate with our patients and empower them to achieve behavioural change. In essence, this also means respecting their freedom to change their mind at any time. In doing so, we allow them to open up about shameful situations and the true barriers they're likely to face. Effective strategies can then be developed to overcome these. There is substantial evidence that lifestyle also contributes to the pathophysiology of mental health disorders^{9,10}. Therefore, the approach of balancing autonomy with the promotion of healthy behaviours is applicable to all patients we see. Psychiatrists have the proficiency to do this very effectively and are well-versed gathering intimate details about lifestyles. The only thing left is to face up to our responsibility to make change happen.

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Dr Sally Bramley | sally.bramley1@nhs.net

Foundation Year Two Doctor, Liaison Psychiatry, North Middlesex University Hospital

Themed Article: How do psychiatrists balance what we believe our patients' optimal lifestyle choices should be, versus respecting their human rights? is there a paternalistic/holistic divide?

Dr Alastair Macfarlane

Personal experience



When I was a medical student in my first week of general practice, I was confronted with a difficult situation regarding a patient's lifestyle decision; an obese patient who had decided to gain the necessary additional weight to qualify for bariatric surgery. Needless to say, I was concerned: he was adversely affecting both his physical and mental health, but was nevertheless set on a decision to continue.

Since this encounter, it has become clear that both primary and secondary care is littered with examples of patients making poor health decisions, and as clinicians we must decide when it is acceptable to intervene. Treading the fine line between

persuasion and paternalism is especially difficult in psychiatry, where a person's mental state may preclude them from prudent decision-making.

Historically, medical paternalism – where a patient's wishes or choices are not considered important – was the norm. Doctors were expected to diagnose and manage conditions and lifestyles without patient input. In contemporary practice, this approach is fraught with difficulty as it may damage the doctor-patient relationship, overlook holistic aspects of the patient's condition, and worsen their overall health through inappropriate management.

Some situations in psychiatry may necessitate a paternalistic approach, for example if the patient lacks capacity to consent to treatment or poses a direct risk to themselves or others. Beyond this, however, it is more difficult to justify whether clinicians should impose their judgement. Depriving someone of their autonomy – either by providing treatment for a condition against their will (like an intramuscular depot) or restricting their lifestyle choices – may exacerbate an underlying psychological or physical morbidity. However, if we don't try to change their life choices, they may pose a more insidious risk to themselves through (for example) weight gain, chronic lung disease or sexually transmitted infections. How do psychiatrists battle this dilemma?

One way of answering this is to borrow a concept from policymaking in public health: the least intrusive intervention which achieves a desired outcome is the most appropriate. For example, when trying to improve dietary outcomes at a population level, simply educating people about the dangers of fast food is ineffective, but banning it completely may feel dystopian. As a result, the government take measures to 'nudge' people towards buying healthier food without restricting their autonomy, such as putting vegetables at eye-level in supermarkets. By employing this liberal paternalism, we are able to influence people's behaviours without impinging on individual freedom.

Clinicians should entertain this concept when it comes to managing patients with hazardous lifestyle choices, whether it be eating their way up to obesity or engaging in risky practices like chemsex. Addressing the issue should first involve a risk-benefit analysis of what would happen were the patient to stop, and what would happen were they to continue. The clinician should then decide how far they need to go to alter a patient's behaviour: is a paternalistic approach really necessary, or are there less intrusive means to achieve change? Crucially, decisions regarding a patient's health choices and autonomy must be made on an individual basis, and consider the long-term biopsychosocial effects.

In the case of my patient awaiting bariatric surgery, I decided to explore why he felt that this was his only option. It transpired there were a variety of complex social issues that were hindering his attempts to lose weight through more conservative means, including an inappropriate housing situation and a poor social support network to facilitate weight loss. Once I had elicited these, we put a plan in place to get him back on track and change his target from surgery to a less sedentary lifestyle and

improved nutrition. This was a multidisciplinary effort, with dieticians, exercise support groups, psychological therapy and ongoing mental health reviews all involved. When I saw him a few months later, he had started to become more active and was no longer set on compulsive eating as a last resort.

Psychiatrists are often presented with a host of considerations that transcend medical management: housing status, drug/alcohol abuse, support networks and safeguarding. Intervening in simple life decisions – such as what a patient should eat or whether they should be allowed to engage in risky activities – may overlook some of their more complex needs. Instead of trying to stop patients from overeating or telling them to cut down on cigarettes, perhaps we need to cultivate a better understanding of what has led them to adopt these behaviours in the first place so we are better able to manage them in the least intrusive way possible.

Dr Alastair Macfarlane | Alastair.macfarlane@nhs.net

Foundation Year 1 Doctor, Community Psychiatry

Themed Article: How do psychiatrists balance what we believe our patients' optimal lifestyle choices should be, versus respecting their human rights? is there a paternalistic/holistic divide?

Gabrielle Pendlebury



Personal autonomy is key to biomedical ethics; most people believe that it is preferable to be your own person and shape your own life rather than living under the control of others. This respect for autonomy in mental health care rarely addresses how difficult health-oriented lifestyle changes can be. However, research does show that when the root causes are addressed, patients can make lifestyle changes, such as stopping smoking and losing weight.

I believe that an assessment of the patient's lifestyle is integral to their treatment. This is not

inappropriate paternalism but rather an acknowledgement of the relationship between mental health and lifestyle factors. Interventions are available, that the patient may not be aware of. This assessment does not have to lead to an infringement of their human rights, if the issues are addressed in keeping with 'Good Medical Practice' (2013):

57 The investigations or treatment you provide or arrange must be based on the assessment you and your patient make of their needs and priorities, and on your clinical judgement about the likely effectiveness of the treatment options. You must not refuse or delay treatment because you believe that a patient's actions or lifestyle have contributed to their condition.

This is incredibly important for those working in mental health as mental health underpins our overall health. Lifestyle factors are known to have a positive effect on mental health, leading to reductions in depression and anxiety and increasing life satisfaction. Mammen and Faulkner (2013) analysed 30 prospective longitudinal studies and identified physical activity as an important protective factor in reducing the risk of developing depression. Cuyppers et al. (2012) reported a small, but positive effect of cultural or creative activities on various mental health outcomes, including depression, anxiety and life satisfaction in both men and women. Smoking has also been identified as a risk factor for psychological distress but the relationship between alcohol consumption and psychological distress is equivocal. Some studies identify elevated risks for depression and anxiety for abstainers and heavy drinkers as compared to light/moderate drinkers, while others did not show any meaningful correlation between symptoms of psychological distress and alcohol consumption. The relationship between BMI and mental health is even less clear.

A number of issues can determine whether these factors are choices for our patients. For example a patient's autonomy may be limited by weakness of will or impaired executive function. Simply advising a patient to change their behaviour is unlikely to succeed. However, education, assessment and working collaboratively to reach a common goal both respects the individual's human rights and provides the foundation for change.

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Gabrielle Pendlebury | Gabrielle.Pendlebury@medicalprotection.org

Medico-legal Adviser

Themed Article: Sex, Sweets and Smoking, whose choice?

Dr Ram Seth



Individuals have the right to make lifestyle choices about sex, sweets and smoking, but do patients with mental disorder enjoy the same rights? Personal autonomy is enshrined in English law. Only an individual with mental capacity can make decisions whether they are wise or not (MCA). Only when an individual loses the capacity to make particular decision(s) others can then make them in their best interests (MCA). The Habeas Corpus Act of 1679, incorporated English Common Law before the Magna Carta. It served to safeguard individual liberty, preventing unlawful or arbitrary imprisonment.

Habeas Corpus is Latin for “you may have the body.” The HRA protects right to liberty, freedom of thought, religion and belief, and respect for privacy, family life and the right to marry. The NHS in its budget-constrained era is increasingly being influenced by politico-economic, and moral-ideological decisions witnessed historically.

“A short history of Psychiatry”¹ illustrates the historical stigmatization and curtailment of human rights patients with mental disorders were subjected to, over the past two millennia. The middle ages witnessed the worst treatment of those with mental disorders at the hands of witch hunters and exorcists. An individual’s capacity to conform to the rules and culture of society was the test as to whether they were possessed by supernatural and evil spirits, seen as a threat to others. Although asylums to house the mentally disordered existed in various countries, progress in understanding mental disorders occurred with exponents like Johann Weyer (1515-1588) who stated that physicians not the priest should examine the patient first, and Paracelsus (1567) wrote about “Diseases that lead to loss of reason.” However it was not until the 20th Century that we witnessed the introduction of psychopharmacology and psychotherapies to treat mental disorders and the closure of asylums and inpatient beds. Pinel blamed Galen for the lack of interest in Psychiatry and therefore lack of progress until the 18th Century, a question we raised in the previous edition of the Psychiatric Eye.

Surveys have shown that twice as many patients with mental disorders smoke compared to the general population. Smoking can affect the functioning of cholinergic nicotinic receptors and the effect of smoking on psychotropic medicines is also well recognized and the need for dose adjustments. Patients with mental disorders not only smoke more cigarettes but are also at an increased risk of morbidity and mortality. Physical health risks caused by smoking are well known. Stopping smoking strategies can be successful in patients with mental disorders as with the general population. NHS Hospitals have implemented the smoking ban, and in-patients who have chosen to continue smoking have to wait for “smoking breaks.” Similar to the past when cigarettes formed part of a “token economy” in asylums, now “smoking breaks” in space constrained inpatient units have become the focus. Inpatient staff have the task of managing and assisting patients wanting to stop smoking, as well as organizing “smoking breaks” for those who don’t.

High sugar consumption is linked to increased risk of mental disorders, in particular anxiety and depression. In Britain, adults consume approximately double, and in the U.S. triple, the recommended level of added sugar, and major depression is predicted to become the leading cause of disability in this decade. The rise in obesity attributed to consuming sugar has lead the UK Government to introduce a sugar tax from April 2018. Some researchers view high sugar intake as an addiction and detrimental to learning and memory. Inpatient mental health units have to balance a healthy diet for their patients and accommodate their sweet tooth.

There are not many subjects that are so personal and private than a sexual relationship. The ability to have sexual freedom in patients with mental disorders is often balanced by professionals' duty to protect the patient from harm. Staff in mental health services face the dilemma of balancing patients rights to sexual expression and their vulnerability to exploitation and need for safeguarding. Alfred Kinsey and colleagues, in their studies of sexual behaviour, noted that class and culture also defined what was normal and acceptable behaviour^{2,3}.

Sex, sweets and smoking as human activities are part and parcel of society. An individual choice to partake in these activities is part of their human right to do so. The state has the obligation of protecting its citizens and advising them about healthy living. Professionals managing patients with mental disorders are on the one hand being the instruments of the state on national programmes, and on the other hand assessing each patient's ability to make decisions and/or their judgment. The divide between acknowledging the human rights of a patient and being paternalistic is probably much finer than most would want to admit. What behaviours are normal and acceptable in today's politico-economic and moral-ideological culture, will determine the parameters of the rights patients with mental disorders can enjoy.

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Dr Ram Seth | ram.seth@gmail.com

Consultant Psychiatrist, Barrister at Law and MA Education

Themed Article: A Personal Reflective Exercise on Exercise

Dr Amit D Mistry



Based on the latest evidence base for the benefits of physical activity (PA) in Serious Mental Illness (SMI), I believe we can play a greater role in advertising these benefits to patients, as per chapter 24 of the Mental Health Act Code of Practice that outlines how care planning should address physical inactivity and promote physical activity.¹

Those with SMI such as Schizophrenia, Bi-Polar Affective Disorder and Major Depressive Disorder are significantly less likely to meet the PA Chief Medical Officer guidelines of 150 minutes of 'moderate' PA/week (OR= 1.5, 95% CI: 1.1-2.0, $p < 0.001$).² Despite the severe physical health inequality seen in those with mental illness, sedentary behaviour and physical inactivity are independent yet modifiable risk factors for cardiovascular disease and premature mortality within SMI.² Furthermore, there is a growing evidence base signalling some of these benefits of PA in SMI on mental health, cognition and social functioning.^{3,4,5} For example, in Major Depressive Disorder, PA can have a similar effect size to antidepressants and some groups are calling for it to be recognised as an alternative treatment intervention for depression.^{5,6}

Traditionally, Physical Activity Prescription (PAP) is the remit of medical physicians or qualified exercise professionals and is a key component of a multifaceted societal approach in addressing global physical inactivity. PAP involves a written prescription that consists of a customised PA plan and lifestyle goals.⁷ As psychiatrists with expertise in motivational interviewing and caution for the cardio-metabolic side effects of certain medications, I believe we can champion a role that also optimises patient lifestyle decisions but still respects human rights.

My view on potential PAP within psychiatry would be that clinicians work collaboratively with 'experts by experience' (users of mental health services) to address any potential issues within SMI and tailor support options. For example, a previous qualitative study on 6431 SMI patients highlighted how the biggest barriers in SMI and PA include low mood and lack of professional support.⁸ Additional barriers include high levels of perceived stress, lack of self confidence, poor social support and somatic co-morbidities.²

From an ethical perspective, shared care (between psychiatrist-patient) in improving

lifestyle behaviours would respect patient autonomy and support patients in making informed decisions regarding their care.

If as psychiatrist's we lack the clinical expertise to perform PAP then we could still refer onto skilled allied health care professionals that can deliver personalised PA interventions, which may tackle PA intervention dropout, a known limitation in SMI. This form of teamwork could minimise the risk of a 'holistic divide' as preventative treatment such as PA promotion along with physical and mental health support are given equal priority on the patient care plan. This ability to recognise the limits of our own clinical expertise and refer on to suitable colleagues would respect General Medical Council Good Medical Practice guidelines (2013).⁹

In reference to the Human Rights Act, professionals adopting a coercive approach in tackling lifestyle behaviours within SMI could be in breach of Article 14, protection from discrimination. One cannot enforce PA treatment interventions on people with SMI, if this method is not practiced on the general population, as this difference in treatment could be deemed an act of discrimination. Also, PA interventions would need to be delivered by those who can tailor the exercise dose ('light', 'moderate' or 'vigorous' intensity) to the patient's physical needs. An unpleasant exercise experience could deter patients from future participation and at one extreme could result in inhumane or degrading treatment, contravening article 3 of the Human Rights Act on freedom from torture and inhuman or degrading treatment.

Physical inactivity is only one aspect linked to the complex physical health inequality within SMI. By working collaboratively and openly addressing barriers to PA with patients I believe we are practicing in beneficence. Fundamentally, improved PA can mitigate the risks of cardio-metabolic disease and is a relatively cheap and accessible health intervention.

On reflection of my own consultation habits, I will continue to routinely ask about PA levels on social history exploration. It will be paramount to provide balanced, evidence-based advice on PA benefits in SMI to prevent subjective views on PA having an unduly influence.

I have certainly benefited from the 'bio-psycho-social' therapeutic benefits of regular PA, although my subjective experience and disclosure of this to the patient may not be helpful in motivating someone experiencing SMI. In addition, disclosure of this form of personal information may cross a therapeutic boundary. Hopefully, by psychiatrists being able to

address lifestyle behaviours with patients in a sensitive, non-stigmatising manner we can empower patients in tackling an aspect of the physical health inequality within SMI.

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Dr Amit D Mistry| amist85@gmail.com (@DrAMistryPsych)

ST5 General Adult & Old Age Psychiatry (SpR)

Themed Article: The right to engage in harmful lifestyle choices: the fundamental principal of autonomy

Dr Ebru Lumley



Since the conception of Motivational Interviewing in the 1980s, which emerged as an alternative to the prevailing substance misuse treatments at the time, there has been evidence that coercive, directive or judgmental approaches to behavioural change are ineffective¹. Despite this fact, as mental healthcare professionals we continue, albeit well-meaningly and with understandable concern for the health and mortality disparity experienced by our patients suffering from severe enduring mental illness, to try to exert influence and pressure on them to change their lifestyles.

Aside from this approach being practically ineffective and crude, it also raises a significant moral dilemma, particularly given that our group of patients are not only particularly psychologically vulnerable to coercion but are also subject to physical limitations to their physical freedoms. It is incumbent on us as professionals in a position of such enormous responsibility to ensure that when we, for example, curtail the number of smoking breaks or trips to the corner shop for sugary snacks of a patient detained under the Mental Health Act, that we have satisfied ourselves that this is morally justified.

This dilemma can be explored through consideration of the principles of Utilitarianism, commonly defined as ‘the greatest good (happiness) for the greatest number’. Utilitarianism is a guiding principle of Public Health promotion, where the greatest ‘utility’ can often be achieved for a large number by primary prevention interventions that reduce the burden of preventable diseases. Even if the individual patient we are treating does not personally benefit, at a population level the number of lives saved are substantial. It seems on the one hand, therefore, that reducing the excess morbidity of preventable cardiovascular and metabolic disease in our group of patients is a morally good thing.

However, it could be argued that this approach lacks sufficient consideration of one of the key criteria for human well-being and flourishing; namely the principle of liberty, or autonomy, as it is often referred to in medical ethics. In his classic book ‘On Liberty’, the philosopher John Stuart Mill², expounds a theory of utilitarianism that posits the concept of liberty as the ultimate intrinsic good; the highest unit of utility and the fundamental element that any person of sound mind, having had experience of it, would want, and indeed need for well-being, above all else. He writes:

“The only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either

physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinions of others to do so would be wise or even right” 2

One could of course argue that there are instances in this group of patients whereby power over an individual's freedom of lifestyle choice must be used to indirectly prevent harm to others, for example, where the use of illicit substances is known to lead directly to violent psychotic relapse. Furthermore, although one could argue that the group of patients being treated for their own good under the Mental Health Act are not of 'sound mind' and hence the principle does not apply, unless the individual lacks the capacity to understand the risks of a particular lifestyle behaviour, this does not of itself invalidate the principle as lifestyle choices such as overeating are not necessarily a symptom of the psychiatric disorder being treated.

It could be stated that this distinction is so abstract as to be practically meaningless. And yet our work is inextricably linked to questions about what it means to feel that life is meaningful, and the capacity to feel that one has autonomy over decisions in one's life, and the respect for dignity that entails, is arguably one of the most crucial aspects. Indeed, one could argue that in this group of patients, where suicide, as much as physical health inequality, remains a significant cause of excess morbidity, the consideration of existential questions of meaning and purpose are all the more critical. What seems to the professional body an issue of critical importance at a public health level may well seem insignificant or meaningless to a person in the grip of acute psychological distress.

This does not in any way mean that the physical health of psychiatric patients is of no concern, or that we should not provide support, education and advice for patients who do wish to make changes. However, there is a risk that in our pre-occupation with well-meaning public health initiatives, we not only overlook what is of immediate priority or value to the individual patient, but also fail to take sufficient account of one of the key moral components of psychological well being, namely, the dignity of self-determination and autonomy.

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Dr Ebru Lumley| ebrulumley@gmail.com

ST5 General Adult Psychiatry, Fellow in Medical Education

Themed Article: Where there's smoke, there's ire

Dr Sachin Shah



Smoking is disastrous for your health. I feel I need that there as a disclaimer.

I have friends who smoke; I do the whole tut-tut rolling-eyes routine when they get a cigarette out. But I don't lecture them. I certainly don't snatch the cigarette out of their hand. Even if I, from my high and mighty perch, happen to think they are making a bad decision. It's their free choice to make.

I clearly must not believe in absolute liberty, the most obvious exception in my experience being instances where patients with mental illness are detained against their will for their own health or safety, or for the safety of others.

But is the prevention of smoking on hospital grounds a restriction too far? In the case of involuntary patients, they are detained in hospital either for assessment, or treatment, or both. Until it is decided that they can have leave off the ward to smoke, they have no choice but to cessate. From a medical perspective, this seems a noble enough cause: after all, both smoking and passive smoking are harmful, and so what better a time than a compulsory admission for an intervention into smoking behaviour? But this enforcement of lifestyle change seems beside the point of the admission; an opportunistic intrusion.

Legally, the smoking bans in psychiatric hospitals are in line with the ban on smoking in public areas introduced by the Health Act 2006, and with similar bans

in Northern Ireland and Scotland. The ban introduced by this Act is currently interpreted as not applying to state prisons (there is some irony, here), though this has been challenged.¹

While I'm aware that smoking bans in psychiatric hospitals have not resulted in the increase in violence that had been prophesied², and that smoking cessation can be positive for mental health^{3,4}, these are pragmatic considerations that don't address the underlying issue of patient liberty. And of course, just because something is the law, that doesn't make it the right thing, morally.

When it comes down to what we should be allowed to do, what could be more basic than human rights? Article 8 of the European Convention on Human Rights applies, here: it provides a right to respect for one's "private and family life, his home and his correspondence". Broadly interpreted, it prevents public authorities from interfering with what you get up to behind your own doors.

Inpatients at Rampton, a high security psychiatric hospital in Nottinghamshire, had argued that the smoking ban there had infringed upon their human rights under Article 8 because Rampton effectively was their home. However, when the case was taken to the Court of Appeal, a majority of two judges to one decided that the patients' Article 8 rights hadn't been infringed upon because the hospital was still a public place, and because smoking wasn't "sufficiently important to personal identity" to warrant protection⁵.

Within Article 8 are listed limits to the freedom that it provides. It permits public authorities to interfere with a person's autonomy for, among other things, "the protection of health... or for the protection of the rights and freedoms of others". Note that 'protection of health' stands alone, into which the two judges of the majority read an acceptance of paternalistic authority over a person for the sake of that person's own health.

Lord Justice Keene, a non-smoker himself, provided the dissenting judgement. He felt that paternalist reasons were insufficient to justify the ban, and stressed that Article 8 strongly champions autonomy and privacy, including the right to choose to smoke. He argued that smoking was indeed valued enough by people to warrant protection. The only legitimate argument he could imagine in favour of a ban in psychiatric hospitals would be to protect others from second-hand smoke; but to achieve this aim, he felt a full ban was disproportionate⁶.

These are value judgements and are unsurprisingly based upon how each judge weighs the moral issues. The two judges who made up the majority effectively argued that inpatients on a psychiatric ward should expect a reduced autonomy

compared to when in their own homes. The decision, I imagine, could have swung either way, depending on who was making it.

Personally, and as a doctor, I would much rather people didn't smoke. Moreover, people shouldn't have to be subjected to second-hand smoke. But this isn't an easy issue, and no stake I hold in it can be absolute: I can't believe in autonomy and beneficence unconditionally and concurrently. It would be arrogant of me to deny that smoking means something to people and that smoking breaks can hold dear importance. We took away one of the few things some inpatients had to look forward to during their day and I'm not sure what we replaced it with. Is there nowhere--some room, some shelter--that can satisfy the balance of freedoms, both for patients to make that personal choice, and for other patients to be free from it? Walk past the front gates of the Bethlem and see patients, smokers, lined up with lit cigarettes in their hands. Wonder if there isn't some space on those grounds where they still belong.

I think about this Tweet a lot



Theresa May 
@theresa_may

Follow 

I'm clear: if human rights laws get in the way of tackling extremism and terrorism, we will change those laws to keep British people safe.

I think about this Tweet a lot, too



Edward Snowden 
@Snowden

Following 

Want to see a politician clearly? Remove emotional words from their statements.

"If human rights laws get in the way, we will change them."

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Dr Sachin Shah

ST4 Doctor in General Adult Psychiatry

Conference Watch: Campaign to End Loneliness- the 'Kindness Can' Conference 2017

I had the privilege of attending the annual [Campaign to End Loneliness](#) conference this month, held in London. In short, it was great. A far more varied crowd than traditional medical conferences and an opportunity to meet people I would not ordinarily have the chance to. Loneliness will never be a problem for doctors to tackle in isolation, so this was a brilliant chance to inform my research, learn from others and be inspired and entertained by some infectiously enthusiastic people.

The day opened with a reminder of this year's theme: 'kindness can...'. Needless to say, there was a running thread throughout the day of how small/large/medium-sized acts of kindness (in whatever form) can have a major

impact on well-being and, in particular, reduce loneliness. Janet Morrison (a founding member of the Campaign) was MC (and strict timekeeper!) for the day. David McDaid was the first speaker, LSE health economist extraordinaire and world expert on the health and social costs of loneliness. David highlighted very important findings and areas for much-needed improvement in the massive task of trying to put a price on loneliness. Key points included the results of his work with Public Health England, which included a systematic review of 'cost' studies on loneliness. There was much variation in methodology, scale and (perhaps unsurprisingly) conclusions. Potentially very large savings could be made as a result of tackling loneliness, for example by reducing hospital attendances and stays.

The tone of the morning changed gear a little with our next speaker, Deborah Moggach (bestselling author of *The Best Exotic Marigold Hotel*). The Campaign's work focuses mainly on older people, and it was a joy to hear insights on 'love and loneliness in the seventh decade.' Deborah entertained and moved at the same time with her own candid descriptions of online dating for the over-65s. She discussed the steps leading up to the writing of this particular bestseller (she has a few of course), and how the initial idea of outsourcing care homes to the sunny climes of India seemed absurd – but the more she thought about it, the more it made sense. The setting of a sunny hotel in a culture where she felt the elderly were far better respected, and one's pension stretches a lot further, had an undeniable appeal. Maybe not for everyone, though!

I will admit to having a favourite speaker at this point: Kim Leadbeater (sister of murdered humanitarian and MP Jo Cox) shared what life was like growing up alongside Jo. She talked about their collective love of people, and their own experiences of loneliness at university Jo as a new mum. We were reminded of Jo Cox's maiden speech to parliament, in particular that 'we have far more in common than that which divides us.' The Jo Cox commission on [loneliness](#) is a growing national movement to tackle loneliness across the age range; bringing communities together across religious, cultural, and other social divides is at the heart of what they do. I was pleased to see Kim highlight that people with mental health problems are a highly vulnerable group when it comes to being at risk of, and suffering the greatest consequences of, loneliness.

Other highlights of the day included viewing an excerpt from Sue Bourne's 'the age of loneliness' and hearing her reflections on making the film, and the striking range of people who shared their own experiences of loneliness for the project (an elderly woman, a 'successful' 40-year-old divorcee, people with mental health problems, a first year student etc). I'd recommend getting hold of the film if you can!

We also heard from numerous individuals and groups who are using innovative approaches to address loneliness, from developing tech in Norway (Karen Delva) to setting up 'student digs' style communal housing for the elderly (Evermore). We were treated to a dance performance by 'R-Quintessence' and the day ended with encouraging words from Laura Alcock-Ferguson, on the future of the loneliness 'movement', and the need to move beyond 'preaching to the converted' and bring the evidence to the wider public, media, professionals and, of course, policy makers.

I left inspired, and with a few more email addresses and business cards than I had when I went in. I was taken aback by the sheer volume of work being done across the country (and beyond) to tackle loneliness – and just a little disappointed at how disjointed much of this is. There is certainly a need to forge stronger connections between third sector organisations, policy makers and (my particular view) high-quality research institutions. Raising the standards of 'research' being conducted in the field is a priority. This sort of sharing of ideas and expertise is essential for scaling up what are typically small to medium-sized groups working across the country. Keeping things simple was another theme; the nature of interventions that are effective may not need to be that complex, but evaluating them in a meaningful manner is important. Again, of particular interest to me is that, in spite of some very good published work, the extent of the health consequences (especially mental health) of loneliness is not very well understood. Considering it has been compared with the public health impacts of smoking and obesity, we have a long way to go.

Overall, the general feeling was that we, as a society, may well be at a 'tipping point' – after decades of individualism, perhaps now is the time to remind ourselves of the power of healthy social relationships and back it up with solid science and effective action.

Farhana Mann is a Wellcome Trust Research Training Fellow at the Division of Psychiatry, University College London. Her current work focuses on investigating the health impact of loneliness in people with severe mental illness. She is also keen to promote placing loneliness and social isolation higher on the public mental health agenda.

Our papers may also be of interest for background:
<http://www.sscr.nihr.ac.uk/PDF/ScopingReviews/SR14.pdf>

<https://www.ncbi.nlm.nih.gov/pubmed/28528389>

Dr Farhana Mann| @FarhanaMann

Wellcome Research Training Fellow and ST6 in General Adult Psychiatry



[< < Back to eNewsletter Autumn 2017](#)

Culture Vulture: A museum of modern nature

Dr Sarah Parry



The Wellcome Collection is known for its exploration of science, art, and human identity. Several previous exhibitions have directly addressed issues of the mind and mental health, for example “States of mind: tracing the edges of consciousness” in February 2016, and “Bedlam: the asylum and beyond” in September 2016. Their current exhibition is “A museum of modern nature”, a collection of public-brought objects that explores the way we connect with nature and the relevance of this to our mental and physical wellbeing.¹

One of the contributors, Louisa, presented a brain sculpture along with the blurb: “I love being out in nature – it clears my mind and makes me feel more grounded and peaceful... Nature benefits our wellbeing, is a good antidote to mental health issues – such as depression and anxiety – and is good for our physical health, increasing attention and creativity.”

Another contributor, Rosemary, explained her choice of thermos flask by saying: “My life in London is very hard at the moment. I feel trapped in London... For me what nature does, and having my thermos, enables me to have my own space in nature, where I can be myself.”

Though inpatient mental health settings can seem completely devoid of green spaces, the exhibition begins by saying: “Many of us think of nature as something separate to ourselves – something elsewhere, somewhere to visit and not part of our daily lives. Yet, in reality, nature is all around us.” If this is the case, perhaps there are simple ways we can harness the nature that exists all around us in a mental health setting for the benefit of both patients and staff alike. We all have a relationship with nature; this exhibition is a challenge not to let our stories become lost amidst the pressures and busyness of modern life.

“A museum of modern nature” runs until 8 October 2017 at the Wellcome Collection, NW1 2BE.

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Dr Sarah Parry| sarah.parry11@nhs.net

Foundation Year 2 Doctor
North Central Thames Foundation School

FaceTime: Stephanie Young interviews Dr Rajesh Mohan

Dr Stephanie Young



Dr Stephanie Young catches up with Dr Rajesh Mohan. He is the new Chair of the Faculty of Rehabilitation and Social Psychiatry and was on the shortlist for this year's Kate Granger Compassionate Care award. He works as a Rehabilitation Consultant in Lewisham, South London, in a busy rehabilitation unit and has championed patient-led CPA meetings. He is passionate about quality improvement and teaching.

His twitter is [@raj_psych](#)

What do you like most about your job?

The best thing is about the whole person approach to care and understanding the interplay of biological, psychological and social factors. Many patients referred to us in rehabilitation services have been in the services for years, and had multiple admissions.

What are the challenges to your job?

The biggest challenge is that services for this group of patients are often not considered a priority, despite the seriousness of their conditions and high rates of mortality. I would add that social care funding and lack of effective integration are big issues in effective recovery work.

You have been praised highly for your work on patient-chaired CPAs. How does this work in practice?

We've presented this at various clinical and academic forums and are pleased that this work has been acknowledged. We have shown that putting patients at

the centre of their care and decision making is possible. It needs a change in focus, and the right level of support to co-produce (in advance) what a patient wants to discuss at their CPA meeting. Then we support them do this in an informal way, and not feel under pressure to have discussions. I guide them with their own written agenda, too. It has been rewarding and we had good feedback from patients who have chaired their CPA meetings.

How did you overcome resistance from staff regarding this approach?

Resistance is usually in the form of staff not believing that patients can lead decisions about their care. We have overcome this through modelling how to have enabling conversations, by changing the language we use in discussions, giving up the jargon and also not putting patients under pressure through questioning them in meetings.

You have talked about non dualistic approaches to care in Serious Mental Illness. What's your approach to this?

We are lucky to have a close link with our local GP practice and use a shared care model, with all patients having a shared care book where they keep track of things. Our work has been to involve patients by talking about 'health' in a non-stigmatising way, rather than the usual physical or mental health separately and focus on healthy living and choices they make. We help people create their personal health passports through co-production and we are constantly surprised by what patients think are important versus what doctors think.

Being under the mental health act, is not really recovery focussed is it?

Being detained is a barrier, in terms of autonomy, but this only applies to treatment aspects. Our conversations are about enabling people to take more control, use medication as one of their resources, and think about how they could manage their safety needs and sustained recovery.

Dr Stephanie Young

FaceTime: Interview with Professor Sir Graham Thornicroft

Dr Julian Eaton

Congratulations on receiving a knighthood recognising your contribution to mental health.

Can you describe how mental health in the UK has changed since you started your career?

I came into psychiatry over 30 years ago now. Psychiatrists worked mostly in wards in psychiatric hospitals. We have seen profound changes in the nature of mental health care over that time. NHS Trusts now spend more of their budgets outside hospitals, not inside. Over time we accumulated evidence that patients generally have a better quality of life living in the community, after having left often neglected Victorian buildings, and they recommend living outside hospital to people still in long-term hospitals. Interestingly, working in these long-stay hospitals isn't even a part of the training of junior psychiatrists any more.

If we think about the physical health sector, there is a discussion in the NHS about moving services out into community settings, but I haven't seen any champions taking this forward in the UK in a significant way. Mental health is way out in front in having actually achieved this in the last 3 decades, which could be informative for other parts of the health service in terms of decentralisation.

If we think about stigma, this is another domain in which England is leading the field, and we need to take credit for that, but also recognise the limits of what we've achieved. This story has taken place over the last decade. The Department of Health has undertaken national mental health surveys related to attitudes relating to mental illness. Up until about 10 years ago, this included Wales and Scotland, and we could compare these 3 countries. Around 15 years ago, Scotland ran an anti-stigma campaign called See Me. Interestingly, attitudes in Scotland didn't change much, but they got worse in England over that period. Since 2008, however, when Time to Change started in England, we have seen slow, progressive improvement in stigma reduction in England. A decade ago, for example, a remarkable survey by the Shaw Trust, found that 1/3 of senior managers in businesses said that there was no one in their organisation with mental health problems, so they didn't need any policies or employee support in their organisations. That level of ignorance has rapidly dropped in recent years. We've seen, in many sectors in society, a progressive increase in willingness to talk openly about mental illness. For example in sports, people are not only talking about their experiences of mental illness, but also often now recognise that in order to perform at peak level, you need to be in peak physical and mental

condition. In other parts of the public domain, we have seen people like Stephen Fry, but also, politicians and captains of industry disclose their experience of mental ill health.

“We’ve seen, in many sectors in society, a progressive increase in willingness to talk openly about mental illness.”

In many parts of the world though this is still not the case. Not only to disclose a problem, but even to acknowledge these issues at all would be seen as career suicide for people in the public eye in most countries. An example of the significant progressive change we have seen is the Heads Together campaign by the UK Royal family - not only endorsing mental health issues, but also disclosing personal experiences in a very constrictive and powerful way.

Do you think these changes have had an impact on the quality of life of people with mental health problems?

In our research related to the experience of service users, most people report that they receive benefit from contact with mental health services. But if you look into it more closely, they also report negative consequences, for example having a psychiatric diagnosis that can act against them for example in terms of employability. I don’t think that we realise that, although those of us working in services intend to confer benefit, there are also penalties or losses sometimes, and it is a mixed blessing that we offer to people who seek our help. In fact we now know that people often delay for months and years before seeking help (e.g. 15 years delay on average from the onset of social phobia to first help seeking) and in many ways I think that this ambivalence about referral is quite understandable.

You’ve painted a picture of quite considerable change in England and the UK. What is your perspective on the situation at a global level?

If we start from a service point of view, we don’t have great data on this. What we do have is a regular survey carried out for the WHO called the Mental Health Atlas. It is mainly process data, but what emerges is a gradual shift from large institutions to a more balanced model of care, that provides community as well as hospital based services. But with stops and starts. This process had been proceeding, for example, across Eastern Europe, but this has stalled

since the recession. So it looks like many countries are willing to consider reform, but when there is a restriction of funds, this does not progress in practice. Where there has been movement over the last decade has mostly been in middle income countries. Mexico, Thailand, even Nigeria now, have seen a slow and progressive movement of resources from hospitals alone, to a mixed pattern of services. The problem is that the total amount available for these services is tiny.

In low income countries, there is often a terrible dilemma, because almost all of the funds are being used for mental health in large hospitals, and if there is to be any reform, there is a problem as to whether to reform these institutions, or shift limited funds elsewhere for community care.

I want to raise one of the main critiques of Global Mental Health; that the process has largely been a question of exporting models of MH care that were developed in the global north, and might not be relevant, or might even be harmful, in other countries.

Let's take one example, which is the use of clinical treatment guidelines developed by the WHO - the mhGAP Intervention Guidelines. On the one hand, essentially all the work on implementing guidelines has shown that there is a balance to be struck between using an evidence-base and customising to the local situation. In my view, services must be based on evidence of what works. There is no point in providing services that are harmful, or neutral, because it is money misspent. The question is: how can we use the few resources we have to get the best value in terms of helping the largest number of people to recover from periods of mental ill health? We know that if we seek to apply guidelines in a rigid way, then local practitioners and patients rightly say that this does not fit our local situation; it is irrelevant and won't work. In fact the WHO mhGAP guidelines are quite a remarkable development in this respect.

“The question is: how can we use the few resources we have to get the best value in terms of helping the largest number of people to recover from periods of mental ill health?”

Until 2010, WHO support to countries came under the heading of ‘technical assistance’. This means that WHO provided support to countries at the national level, for example how to develop a mental health law or a mental health policy. This was useful for governments, but not to practitioners on the ground. The new approach though, allows a clinician, like a nurse, to have a handy guide in their pocket to help them in practical care. What the WHO did with these guidelines, is quite different. They said; ‘these guidelines are not suitable in their current form, for any country. They must go through a country adaptation process.’ This involves language translation quite often, but more importantly, it requires changes to the guidelines to configure them to the structures of local services, and also, to what is important and acceptable to the local context and culture. These guidelines are an emerging art, and we need to learn how they can work best in practice. There are hundreds of guidelines now, but we need to know better how to use these effectively so that they can be used to help people with mental illness to benefit most from care.

Where do you see mental health research contributing to global development?

Over the last 10 years, there has been a tremendous growth in research, evaluation, conferences, journals and so on related to global mental health. In fact, by comparison to other fields of global health, mental health is remarkably coherent and collaborative. However, we haven’t seen a significant growth in investment in the field, and we haven’t seen implementation of services on a scale that would fundamentally change the incidence and prevalence of mental disorders. What is it that we can learn from other fields, like HIV, TB, or neglected tropical diseases? One lesson is that those fields have had to go out to wider communities in development, aid and philanthropy, and make themselves relevant by addressing wider targets of fundamental social importance. So what does this mean to the mental health field? It means that we need to cross boundaries, outside of our traditional comfort zones. We need to find common cause across service user groups, psychology, psychiatry, social worker groups and so-on, and form coherent consortia. It

means we have to translate what we say about symptoms and diagnoses, into language that makes sense in other sectors. We may need to speak in terms of disability, or human rights terms.

“It means that we need to cross boundaries, outside of our traditional comfort zones.”

We need to admit some of the historic abuse in our sector. We need to speak to people about the return on investment, value for money, and increase in productivity, that we can show if we intervene with people in the workplace. This means leaving our silos and forming new types of alliance, learning how to build consortia, and forming common cause with philanthropic organisations that are only now starting to hear the compelling case for investment in mental health. It means explaining that supporting better mental health needs a cross-platform approach, but just in services, but across mental sectors of society. By which I mean investing in health of young people in schools, in workplace support, and in other sectors like sport for example, because there are gains not only in mental health terms, but in wider societal good as well. That means thinking about mental health in a much broader framework than we have done until now. For example, seeing how we can contribute to countries’ efforts to achieve the Sustainable Development Goals, and country specific goals. How can we help them to achieve their existing priorities by adding a mental health dimension to their thinking? We need to go beyond just thinking in terms of ‘mental health’ language and silos, but showing what we can make specific contributions across the whole field of social improvement.

Dr Julian Eaton|

Sir Graham Thornicroft|

*Round Up- London Division Executive Committee
Meeting, 13 September 2017*

1. Feedback from the College Committees

- a) SA informed the Committee that the last council meeting was held

on 14th July 2017. He provided a summary of salient points from that meeting:

- Sustainability Strategy (C34/17): –Dr Maughan, presented on the importance of sustainability and its impact on economics, clinical work, social aspects as well as our environment. He quoted examples like travel methods, telemedicine, phone clinics, air-conditioning waste or wasted meds; proposing ‘Future proof mental health services’.
- Quality improvement – Dr Amar Shah, RCPsych College Quality Improvement lead presented to Council highlighting the differences and links between quality assurance, quality control and quality planning and quality improvement.

b) Policies and Public Affairs Committee

The Division aims to keep conversations open with the Mayor’s office.

c) Leadership Committee

Dr Sujaa Rajagopal-Arokiadass previously asked the executive committee for support of another colleague to help attend the LMC meetings. Dr Francis Keaney and Asif Bachlani expressed their interest.

d) Mentoring

The London Division mentoring lead is Dr Therese Shaw has stepped down, and there is currently a vacancy for this role. If there is anyone interested in the mentoring lead vacancy please contact Tandeep Phull.

2. **London Division Projects**

a) Dr Abdi Sanati has been newly appointed to MAC Chair

b) Primary care liaison – Dr Mark Ashraph

Dr Ashraph will be moving on to other things within his career in June 2018 thanked Dr Mark Ashraph for all his hard work and contribution over the year. As a result, the committee will need to recruit for a Primary Care Liaison Lead. If a member has an interest in Primary Care Liaison please inform Tandeep or Dr Shakeel regarding this vacant post.

c) Trainee and Foundation Doctors engagement – Dr David Codling There will be two separate events in 2018, one for medical students and one for trainees which has been put in the 2018 business plan.

3. **London Division Events**

a) Recent events

The recent mental health law and human rights act event was particularly successful and attracted over 100 delegates. Dr Ahmed thanked Dr Abdi Sanati for his help in arranging this event.

b) Upcoming events

Please follow the link to view upcoming London Division events.

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

Winter Educational Event

Wednesday 22nd November 2017

Time: 9:00-17:00

Venue: Royal College of Psychiatrists, 21 Prescot Street, London, E1 8BB

SAS Event

Monday 4th December 2017

Time: 9:30-16:30

Venue: Royal College of Psychiatrists, 21 Prescot Street, London, E1 8BB

If you have any technical queries, please telephone [Tandeep Phull](#) - London Division

Co-ordinator on 020 3701 2711

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.

[Back to top](#)

London Division Editorial Team

thepsychiatriceye@rcpsych.ac.uk |
[@ThePsychEye](#)

Dr Afia Ali
Dr Matthew Francis
Tandeep Phull (London Division
Coordinator)
Dr Rory Sheehan
Dr Chris Symeon

Dr Sachin Shah
Dr Stephanie Young



Look out for the call for articles for the next themed newsletter

"The armchair psychiatrist: Can and should clinicians diagnose public figures from afar?"

Disclaimer:

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[Back to top](#)

[Back to London Division Newsletters](#)