Editorial from Dr Afia Ali and Dr Sachin Shah

Welcome to the winter edition of the London Division Newsletter. We asked you to tell us your thoughts on psychiatric diagnosis of public figures and we were pleased with the diversity of opinion we received. We were of course expecting the Goldwater Rule to come up, but the articles we present go beyond this principle dictated by the American Psychiatric Association and delve deeper into the ethical and pragmatic issues at hand.

In our prize-winning themed article, Dr. Gabrielle Pendlebury takes a medico-legal perspective in arguing that there may be circumstances where psychiatric work from a distance can provide useful information, for example within the study of criminal behaviour. Meanwhile, Dr. Benjamin Waterhouse wastes no time in invoking President Donald Trump, and warns against psychiatric assessment being used as a political weapon. Trump was also on Dr. Harold Behr's mind, with Dr. Behr proposing that a debate over the President's mental state is healthy for the global community, and best left to the professionals. Dr. Sachin Shah steers well clear of politics and instead considers if psychiatrists should diagnose the actual most powerful man in America: Bruce Wayne.

Dr.Sachin Shah also serves as the newest member of the editorial team, this being the second issue he has helped work on. He is enjoying the opportunity to engage with such thought-provoking work from across the London Division. We are looking to expand the editorial team even further with new members, so if you are interested, please get in contact!

If Goldwater and Trump gave an American flavour, we remain stateside for our Culture Vulture article, with Dr. Matthew Loughran's film review of The Work. This film shows the vulnerable moments of prisoners undergoing group therapy at Folsom State Prison (of Johnny Cash fame). We've been considering how famous figures might respond to public scrutiny of their mental state, and one wonders how the prisoners in The Work reacted to the presence of the public within these therapy sessions, and how they reacted to the presence of the film cameras.

Finally in our Conference Watch section we hear from members of PsychART who ran a successful conference in South London focusing on the intersection between the arts and mental healthcare.

The theme of our next newsletter is “Raising awareness of mental health”, which we know will inspire some creative takes from you, and we look forward to reading your submissions. You can find the submission template here and you can submit to thepsychiatriceye@rcpsych.ac.uk
@ThePsychEye

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Chair's Message

Dr Shakeel Ahmad, Chair of the London Division Exec Committee

It has been a very interesting and satisfying experience for me to have joined the College team and to have been able to contribute to the functioning of the College. I joined as the Chair of the London Division in June 2014, and my tenure ends in June 2018. I have found the College a great place to be, meeting many inspiring people who carry a passion for psychiatry.

For those wishing to learn more about the Division, I will just summarise the main Divisional activities.

Raising standards – educational events are organised for all psychiatrists, trainees and SAS doctors. Regional Representatives and Specialty Representatives help Trusts develop job descriptions and services in accordance with national guidelines.

Recruitment – Career fairs at medical schools are attended, events for FY doctors and medical students are held and essay competitions are held with prizes given. Pathfinder fellows are students aspiring to be psychiatrists; they are offered mentorship and bursaries to attend College Congress. New consultants are supported by the StartWell program for up to their first five years. College is running a Members Support Service. PsychSocs and their affiliated medical schools are supported. Trainees are also offered mentorship.

Communication and engagement – externally the Division engaged with the London Mayor’s office to collaborate on mental health charity work. Internally a project to liaise with members within the London Trusts has been initiated; MAC Liaison.

Division has representatives from trainees, SAS doctors, patients and carer groups on the Exec.

I also wish to thank all who have helped me in various capacities during these years in together achieving what we did. I will soon be welcoming handing over to the new Chair and saying farewell to the whole team with best wishes.

Dr Shakeel Ahmad | shakeel.ahmad@huntercombe.com

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Themed Article: 'The armchair psychiatrist: Can and should clinicians diagnose public figures from afar?'

Dr Gabrielle Pendlebury

Good Medical Practice paragraph 65 states:
'You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.' [1]

Donald Trump's recent behaviour has prompted speculation on his ability to be President of the United States. Unfortunately, the speculation has included the opinions of psychiatrists and psychologists leading to the American Psychiatric Association restating the Goldwater Rule and indicating that psychoanalysing public figures in the press is unethical and irresponsible.

The American Psychiatric Association sets out the Goldwater Rule as:

'On occasion psychiatrists are asked for an opinion about an individual who is in the light of public attention or who has disclosed information about himself/herself through public media. In such circumstances, a psychiatrist may share with the public his or her expertise about psychiatric issues in general. However, it is unethical for a psychiatrist to offer a professional opinion unless he or she has conducted an examination and has been granted proper authorisation for such a statement.'

This rule appears to be applicable to UK psychiatrists as well. The standard psychiatric history consists of biographical data, the details of the presenting complaint and the personal history. The history also includes an enquiry about the individual's current social circumstances, family relationships, current and past use of alcohol and illicit drugs, and the individual's past treatment history. It also includes an exploration of the individual's culture and ethnicity and if possible will include gathering collateral information from other sources such as family members and colleagues. It is only then that a sensible psychiatrist would propose a formulation and diagnosis.

Attempts by psychiatrists to analyse individuals without a full examination are deemed unscientific and speculative, they are likely to be wrong as the clinician is not privy to much of the relevant information required to make a diagnosis or they will be biased if the public figure is annoying or disliked. [2]

Speculative formulations on limited information leads to an atmosphere of gossip that demeans those suffering from diagnosed mental illness and weakens the public's trust in the profession. It also risks pathologising what could be normal. Arthur Caplan, a bioethicist at New York University's Langone Medical Center says:

"Positions or attitudes that are outside of the mainstream or outside the pale can be ascribed to mental illness, when in fact there are plenty of racist, sexist, classist bigots all over the place who are not mentally ill". [3]

However, I would argue that there is a place for attempts at diagnosis from afar, if completed in a measured and careful manner. My medico-legal work has been aided by various sources that analyse individuals involved in crime. The most striking of these explorations is that of Dr Harold Frederick Shipman by John Gunn. [4]

The details set out in Dr Gunn's paper are that Dr Shipman was treated for a Pethidine addiction and depression in the 1970s following conviction on 8 charges, including obtaining pethidine by deception, forging prescriptions and unlawful possession of pethidine. A further seventy-four offences were also taken into consideration. The conviction led to his suspension from the register by the GMC and he agreed a voluntary undertaking not to return to general practice. At that time the Home Secretary under the Misuse of Drugs Act 1971 had the power under the Act to prohibit a doctor from having controlled drugs in his or her possession. However, no such direction was made based on the police view that no patients had come to harm (now believed to be incorrect) and on the GMC's decision not to take disciplinary proceedings further.

Dr Shipman did not keep his voluntary commitment with respect to general practice and in 1977 he joined a group general practice. In 1992 he became a single-handed practitioner. It is estimated that he killed 8-10 patients per year as a member of the group practice but this escalated to at least 32 in 1997, while a single-handed GP.

One cannot dispute the value of gaining a better understanding of rare events through the exploration of historic cases, if the exploration leads to changes that can reduce the risk of similar events occurring again.

The question is whether there can be a way of gaining a better understanding of current public figures without the process being unethical or irresponsible.

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Dr Gabrielle Pendlebury |

Medico-legal Adviser and Child and Adolescent Psychiatrist

Themed Article: Assessing a fantasy figure: what can we say about Bruce Wayne?

Dr Sachin Shah

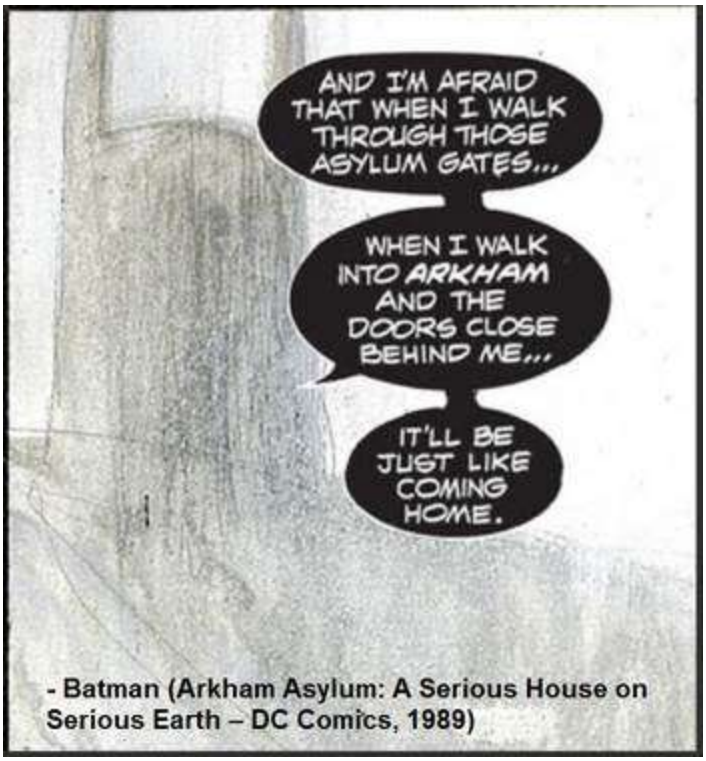
What do we make of a billionaire who, having witnessed the murder of his parents during his childhood, now invests his wealth into dressing as a bat and secretly waging a vigilante war by night, often to the detriment of his personal life?
It would be irresponsible (and probably worthless) to form a psychiatric opinion on a public figure without formally assessing them. With Wayne, however, we are privy to a great deal of his history, more than with most public figures, with over 75 years' worth of detailed material to look back on, including reliable first-person accounts of his thoughts, emotions and perceptions. He has been openly discussed by psychiatrists as possibly having PTSD [1].

But Wayne isn't essentially human like we are, rather a composite of character traits, purpose-built to drive a story and captivate an audience, not to meet any particular set of diagnostic criteria [2]. Indeed, he was created in 1939, in an age before prescription anti-depressants existed, in a culture unfamiliar with trauma and its effects. PTSD was formally recognised in 1980 (and even then was more strictly associated with stresses experienced by combat veterans during the Vietnam War) [3]. To analyse Wayne through our contemporary lens may be nonsensical.

This is not to say that Wayne couldn't have had PTSD just because the concept didn't exist at the time. Historians speculate that the Athenian spear-carrier Epizelus, in Herodotus's account of the Battle of Marathon in 490 BC, is described as having PTSD [4], so Bruce Wayne is hardly precluded from the diagnosis based on chronology alone. But we can be more certain that the idea didn't exist within the minds of his original creators. How much this matters depends on how much weight you place on authorial intent versus the material standing on its own merit.

Modern writers are more open to re-examining Wayne as a man affected by childhood trauma, though he remains unlabelled. It is argued that a psychiatric diagnosis detracts from character development, as any progress the character makes would instead be a function of their mysterious neurobiology [5]. This likely describes a difficulty in how personal progresses can be depicted separately from mental health recovery. I feel that such a distinction is unnecessary. Take, for example, the character of Jessica Jones, a superhero explicitly declared to have PTSD[6], who uses techniques learned through therapy to manage her symptoms, while also, in sync with this, undergoing personal growth. Jones is a fine example of a character with a mental health condition depicted as facing challenges both internal and external (and often these are intertwined).

Nevertheless, a mental health condition would require a reframing of Wayne's character arc: it would be disingenuous to portray Wayne overcoming the trials of PTSD simply by engaging in superhero activity, thus minimising the psychological work that real people with PTSD go through in their recovery process. Wayne doesn't seek therapy, yet he functions remarkably well considering the demands placed upon him [7]. Such a situation might be seen as a dismissal of mental health services, if he had an explicit diagnosis.



But is it even right to analyse Wayne to begin with? We arguably have no ethical obligations towards him (he is fictional and lacks interests) and thus can openly discuss his mental health without concern for his confidentiality. However, damage to our reputation, and thus the public's trust in us, remains possible if we are seen to make rash judgements based on incomplete assessments.

It may also be viewed as insensitive towards people who actually experience conditions such as PTSD if we are seen to trivialise the condition by supposing it onto a fictional character. But we may have legitimate reasons to do so: there is a long tradition of analysing fictional characters through a psychiatric lens, and it can be useful as an educational endeavour, or to raise awareness and understanding.

Acknowledging mental health conditions among popular fictional characters such as Wayne could be a means of destigmatising mental illness, especially as such discussions are separated from the alarmist "duty to warn" narrative that is typically attached to psychiatric discussion of political/authority figures. He is a character that people facing similar challenges may be able to identify positively with [8], and with his popularity he can facilitate acceptance of such conditions amongst the wider public.

It may however be the creators' intent to obscure the actual diagnosis, if there is any [9]. There are characters in the media who do not have explicit diagnoses but are very much "coded" as behaviourally atypical, for example Sheldon in The Big Bang Theory. This is seemingly so that Sheldon is not reduced to a label and is instead seen to be accepted by the other characters for who he is [10]. Withholding a specific label could,

however, reinforce the idea of diagnosis being shameful. The show gets away with mocking Sheldon's behaviour so long as they don't declare what it is representative of.

For the record, I don't think Bruce Wayne has PTSD, though I certainly feel he has potential to be written that way. DC Comics is beginning to acknowledge and address the importance of the trauma their characters go through [11], and the situation with Wayne will continue to evolve over the coming years as he is viewed through new cultural lenses. Is it appropriate for us to speculate on what, if anything, is ailing Master Bruce? It depends if you think it's possible, if you think it's valuable, and if you think it's ethical, and people will disagree on all three points.

But someone really could write a hell of a paper on a grown man who dresses like a flying rodent.

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Dr Sachin Shah |

ST4 Doctor in General Adult Psychiatry

Themed Article: *The Armchair Psychiatrist: Can and should clinicians diagnose public figures from afar*

Dr Harold Behr

 Public figures whose words and actions generate concern about their mental health are likely to be hostile to the notion of subjecting themselves to psychiatric scrutiny, especially if there is a political backdrop to those concerns.

So is there a role for the armchair psychiatrist who wishes to enter the fray with an opinion based on nothing more than information gained third hand from others about that person's past - biographical and autobiographical data for example - (the 'history') and what might be observed in the limelight of that person's public appearances (the 'examination')?

Psychiatric diagnosis is an end stage in the process of evaluation. An opinion is given in one or two words on where to place this person in a grid, which then opens up the way to ideas about the 'management' or 'treatment' of the problem. Our hypothetical public figure will only be responsive to public opinion (whether by coercion or the ballot box) and the public, while having a mind of its own, will take heed of specialists who have expert knowledge in the field of mental health.

Therefore, if psychiatrists are too coy to contribute their opinions from afar, whether out of ethical scruple (surely inapplicable if there has been no personal contact with the public figure and if the information is already in the public domain) or a perfectionistic fear of insufficient data on which to base the diagnosis, they leave the way open for a range of amateurs to express their views unchecked by knowledge based on clinical experience.

The elephant in the room in this case is, I would guess, the incumbent President of the United States, whose aggressive, contradictory and lying behaviour and obsession with his own image has drawn back the curtain on a raft of possible psychiatric diagnoses including Narcissistic Personality Disorder, Psychopathic Personality Disorder and Paranoia. His every slip of the tongue and memory lapse is now also being hawkishly watched by amateurs and professionals alike, who have in mind the possibility of an Organic Brain Syndrome clouding his already disturbed personality.

The debate around the question of the President's state of mind must surely be healthy for the global community and for the psychiatric profession at

large. For one thing, it heightens awareness of psychiatric entities and helps to normalise them in the public consciousness. After all, if millions of people can vote for someone so patently deranged, there must be something about the man himself which resonates with his supporters and this fact in itself cannot be neatly separated from the question of his ‘diagnosis’.

Those of us who have participated in innumerable psychiatric case conferences will know that diagnostic consensus is indeed a rara avis, even when the patient has been carefully assessed and tested in the ward or outpatient clinic. However, we are steadily evolving a more sophisticated approach to mental health issues and the debate must go on, both in the clinical and public spheres.

This raises the question of the need to examine more closely the nature of mass attitudes towards persons who have risen to positions of leadership and who may during the course of their tenure come to be seen as heroes, villains or simply human beings with failings, treatable or not. Psychiatrists should be in the forefront of these enquiries, even if diagnosis of the public figure under observation is at a distance and unclear.

Dr Harold Behr |

Consultant Child Psychiatrist (Retired)

Themed Article: *The Armchair Psychiatrist: Can and should clinicians diagnose public figures from afar*

Dr Benjamin Waterhouse

One year on from the U.S President's inauguration and we're still engaged in our favourite topic of coffee room chitchat. No, not the Bake Off moving to Channel 4, but trying to psychoanalyse Donald Trump.

Losing his mind or method to the madness?

Trained psychiatrists cannot diagnose mental illness through 140-character tweets and television appearances alone. And contrary to what many a black cab driver may think, we aren't mindreading psychics. When I recently told a cabbie my job he replied: "Go on then, what am I thinkin'?" Diagnosis requires history-taking, examination of mental state (our current best at running a stethoscope over the mind), gathering collateral information and physical investigations to rule out organic causes.

But that hasn't stopped armchair quacks casually throwing around labels ranging from narcissistic personality disorder to learning disability, Alzheimer's dementia to psychopathy.

It's tabloid psychiatry no more rigorous than those people who self-diagnose 'OCD' because they sometimes wash their hands, say they're 'depressed' after their sports team loses or recall how their partner goes 'schizo' if they leave the toilet seat up.

Off-hand diagnoses chip away at the legitimacy of diagnosing mental disorder and our professional credibility. Linking illness to people we just don't like, also stigmatises the ill, whilst perniciously watering down what it's like to struggle with true ICD-10 obsessive-compulsive disorder, bipolar affective disorder or schizophrenia.

Alarmingly it's not just the general population who are at it. Yale shrink Dr Bandy Lee, who edited 'The Dangerous Case of Donald Trump' [1], also weighed in recently showing disregard for "The Goldwater Rule" (which prohibits psychiatrists from passing judgement on anyone they haven't personally assessed).

Diagnosis isn't simply matching symptom to condition. The science of psychiatry, if it is to avoid it's "Sane In Insane Places" humiliation of the 1970's, is to use our experience and expertise alongside classification systems to distinguish pathology from normal population variations. Not everyone with a cough has lung cancer and not everyone 'hearing voices' has psychosis, as Rosenhan showed. [2]

We cannot diagnose from the public snap-shots, not least because humans behave differently when being observed, the so-called Hawthorne effect. When my environmentally conscious housemate went for a jog earlier, I lazily hid my empty Baked Beans can in our normal bin. When he's watching

me I dutifully rinse and recycle. That's the effect of just 1 person, let alone billions.

Trump's behaviour could just be posturing. Patients often look a certain way in the waiting room (the public eye) only to present very differently (either better or worse) once the consultation room door closes.

Gary Speed seemingly joked on BBC's 'Football Focus' in November 2011, only to hang himself hours later. With no overt psychopathology, it left family, friends and the football community bewildered. Recently it emerged Speed was coached by child sex abuser Barry Bennell. Four players under him have now ended their lives. It's not a leap to wonder what might have been different in the sanctuary of a confidential clinic.[3]

Gary Speed (right) on national television hours before his suicide

It would be alarming if video consultations like 'GP At Hand'4 came into psychiatry. To complete a MSE we might have to ask through the airwaves; "tell me Mr Bloggs, are you malodorous?" I remember Skype job interviews I've done, dressed in a shirt, tie and boxer shorts under the table. You only get half the picture.

Soviet Russia infamously used psychiatry to medicalise political dissent. It's possible this is no more than weaponisation of psychiatric diagnoses from the disgruntled left. We must be able to disagree with someone without labelling them mad. There is a difference between ignorance and insanity.

And if Trump did have narcissistic personality disorder, would that disqualify him from office? If so, Winston Churchill would never have led Britain to WWII victory, due to his battles with the 'black dog'. In the fight against stigma and discrimination at work, campaigners have highlighted that a mild psychiatric diagnosis should be no different to a broken arm. Although at least in that scenario, there would be one less presidential paw available to push the big-red-button.

My personal hunch is that he doesn't. Yes he is a world-class narcissist but lacks the distress or impaired functioning that typifies personality disorder. His self-assurance actually serves him well; he's the most powerful man on the planet.

But to stress this can be no more than an inkling, to offer a more formal opinion having never assessed him is about as reliable as a Southern Rail timetable. To borrow from the dictionary of Donald, a clinical impression based on incomplete information = fake diagnosis.

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Dr Benjamin Waterhouse|

ST4 General Adult Psychiatry, North London

Culture Vulture: The Work

Dr Matthew Loughran

Set within the walls of Folsom state prison in California, The Work is a documentary that follows four days of intensive group therapy for convicted prisoners seeking freedom and redemption. The film bears witness to gang-members with such ominous names as “Dark Cloud” and “Crazy Snake,” who explore their troubled pasts, fighting through floods of tears and years of pent-up emotion. This is a visceral film that does not shy away from anger and tension, yet manages to have touching moments of humour and warmth.

Alongside the prisoners, members of the public sign up to the therapy; some appear to have a set agenda, whilst others look lost and intimidated by the notoriety of their surroundings. Twice a year, the Inside Circle Foundation, a non-profit organisation, runs a programme bringing together men from either side of the prison fence in an effort to understand how past traumas (most notably, absent fathers) have led to depression, drug abuse, violence, and for some, incarceration.

The immersive nature of the film creates the sense that you are sitting in the circle yourself: you can see every tear, and hear every sob. As two inmates embrace, their pounding hearts can be heard through the muffled sound of their microphones. Howls cry out across the room as those taking part are overcome with emotion and are wrestled to the ground. With some scenes akin to an evangelical exorcism, I wondered whether such dramatic transformations would be witnessed in an English prison. The American psyche seems to lend itself to the power of suggestion, but I never doubted the genuine nature of the experience for those involved.

Part of what makes this an excellent film is the immersive style and the intriguing characters that it documents. But what I found most compelling was witnessing people expose their vulnerability for the first time. In a memorable scene, a prisoner speaks of having never grieved the death of his sister; he turns to the group and says “I fear that I’ll lose my armour that I’ve kept up for so long…I don’t want to bottle up that little kid…I want to feel like me”. A fellow inmate stares him square in the face and says, “Step into that fear”.

A moving documentary, and essential viewing for those with an interest in group therapy or forensic psychiatry, The Work is showing at the Union Chapel in Islington and is available to download on iTunes.

Dr Matthew Loughran|

CT3, Camden and Islington NHS Foundation Trust

Conference Watch: PsychART shifting perspectives

Despite the passion of many clinicians working in the sector, psychiatry continues to be viewed as a Cinderella specialty by many; one that is often as stigmatised as the patients it treats. This has contributed to an unfortunate recruitment crisis [1].

PsychART, a project set up in 2015 by Dr Megan Fisher and Dr Saffron Homayoun and supported by the Royal College of Psychiatrists, aimed to help tackle this crisis by showcasing the specialty in a unique way. They delivered a conference celebrating the creativity that pervades psychiatry.

Following on from this work, on the 3rd of November we delivered PsychART 2017 to a

sell-out audience of 150 in South London. Pitched primarily at medical students and foundation doctors, the conference aimed to demonstrate the diverse opportunities that lie ahead through specialising in psychiatry. The day was an exciting mix of talks, workshops and debates, all provided by leading lights within the world of arts, mental health research and clinical practice. The conference art competition, with the theme of “shifting perspectives”, provided a space for delegates to exhibit a sublimated form of evocative clinical encounters in the form of art.

The power of creativity has long been considered unmeasurable and perhaps, as a result, underestimated. However, PsychART 2017, like the recent Creative Health report from The All-Party Parliamentary Group on Arts, Health and Wellbeing 2, taught us that the evidence has never been more compelling for establishing the role of the arts in healthcare.

This role is not limited to the care of patients. To best serve them it is vital that clinicians create a space to reflect, emotionally debrief and mentally unwind. The creative arts can be pivotal in this personal journey if allowed to be. This was evident in an underlying narrative that filtered through on the day; one of psychiatrists, exhausted from the emotional toll of their clinical work, with a thirst to rejuvenate.

Encouragingly, preliminary quantitative data using the ATP30 demonstrated an increase in positive attitudes towards psychiatry following the event. The qualitative feedback spoke of the value of an event specifically highlighting the role of the arts within psychiatry.

On a more personal level, from members of the psychART committee, the conference day gave something unexpected back. It shifted our own perspectives and helped to remind us as doctors, but more fundamentally as people, of the personal solace that can be gained from the arts.

Interested in learning more/taking part in PsychART 2018? Visit www.psychart.co.uk or contact competition@psychart.co.uk.

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Round Up- London Division Executive Committee Meeting, 13 December 2017

1. **Feedback from the College Committees**
   London Chair informed the Committee that the last council meeting was held on 13 October 2017. He provided a summary of salient points from that meeting:
   • Quality Improvement Networking / AIMS accreditation – A very helpful and interesting work - They review the services against the standards set by the College. It also helps to be a member of the networking, to remove isolation within clinical sub-specialities.
   • Mental Health Act Reform- The aim is to have the Mental Health Act reformed and in place by 2020. Members have been asked to complete the survey and add their contribution; this would be valued and taken on board by the College.
   • Learning from deaths - Adrian James, College Registrar, highlighted the importance of learning from deaths that occur within mental health services and the College wants to have a protocol for this purpose. Dr James is leading this, working along with NHS England.
2. **Recruitment Committee Dr Peter Hughes, Vice Chair**
   London division requires volunteers to get involved and help promote Psychiatry. PH has been engaging with PsychSOC throughout the UK. He encourages trainees to get involved with helping promote Psychiatry.
3. **London Division Projects Dr Shakeel Ahmad, Chair**
   3.1 RCGP Liaison- Vacant
   This post is vacant: if you are interested in this post please get in contact with Tandeep Phull or Dr Shakeel Ahmad.
   3.2 Trainee & Foundation Doctors Engagement
   Committee was informed that Dr Codling also wishes to step down from this post.
   3.3 SAS doctors Lead Rep on the Exec - Vacant
   Dr Sukumaran had also sent a message saying he would like to be replaced in this role due to his growing commitments.
4. **Guest Speaker- RCPsych President Professor Wendy Burn (WB)**
   SA welcomed Professor Wendy Burn to her first London Executive meeting. WB thanked the committee for inviting her. Dr Wendy Burn gave a brief background history of her career to date and then went on to speak about her priorities as President of the College.

   She said the Comms team has been a big influence in the media. The College has been the voice of mental health with an increasing profile, there has been an increase of twitter followers and media profiles. WB praised the work the strategic comms team are doing. We have increased member engagement by the new publication of RCPsych INSIGHT magazine.

   She also said that recruitment is a major concern for the College, we have a large amount of psychiatrists retiring and we need more doctors to take up psychiatry as a profession. There has been a lot of investment and time into

recruitment which we believe is paying off in comparison to previous years. There has been less stigma towards psychiatry with high profiled people speaking more on mental health.

WB stressed it is key to promote psychiatry to students/ Foundation Doctors. Psychiatrists on the ground are the ones who will inspire the students and Foundation Doctors, showing genuine concern for the patients' suffering, early intervention with patients and the impact psychiatry can make.

RCPsych is working with HEE to encourage SAS Doctors to become consultants and trying to work with the GMC to help make this process easier for SAS Doctors.

WB will also be focusing on funding for the College, the workforce plan, 5 year forward view for mental health and have been promised a billion pounds by 2021.

The RCPsych has a 2-year initiative to introduce an up-to-date neuroscience syllabus. In collaboration with Gatsby/ Wellcome project, a full review of the core curriculum is taking place at the moment. A lot of new developments are already on the TrOn [Trainee on Line] on the College website, which should help trainees.

Sir Simon Wessely is leading on the reform of the Mental Health Act, a survey was sent to members and the feedback suggested one of many reasons for rising rate of detentions are due to the lack of community support.

SA thanked WB for attending the meeting and her passion on creating change within the College and the profession, and offered her assistance on behalf of London Division.

5. **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

StartWellEvent
Wednesday 7 March 2018
Time: 12:00-16:00
Venue: Royal College of Psychiatrists, 21 Prescot Street, London, E1 8BB

Spring Educational Event
Tuesday 8 May 2018
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

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London Division Info

London Division Executive Committee

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

London Division College Vacancies - Your Division Needs You!

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

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

"Do we need to raise awareness of mental health issues"

Disclaimer:
The opinions expressed in this newsletter are those of individual authors and do not necessarily represent the views of the Royal College of Psychiatrists.

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