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The Royal College of Psychiatrists London Divison Newsletter

Editor:
Fiona Taylor

Editorial

Browsing through the shops one afternoon, I came across a book "Make do and Mend", which is a reprint of the booklet printed during the Second World War by the Ministry of Information. This phrase, together with the posters and cards seen everywhere saying "Keep Calm and Carry on", also issued during the war for motivational purposes, seems to be a response to a hunger by the public to discover how times of recession and lean years can be overcome with the help of using what is at your disposal, and thinking that in some ways, life could be worse. It has filtered into my mind repeatedly at work, often at times when I feel that a patient has not been offered the best service, or when the systems that we work in sometimes feel so circular and complicated. One trivial example was when I arrived at a new post last week, and was shown to my own desk with a PC, but without a working keyboard or mouse. When I asked for these items, I was told successively by 3 different people that it was another person's job but they would do their best to help me, as long as I reminded them later. After 3 days like this, I found that if I swapped the keyboard and mouse with one of my colleagues, who had a different connection at the back of the computer, then everything started to work!

So I started wondering whether in some ways, we feel that we are working in a similar environment to how the NHS was post World War 2, and that the only way to "Keep Calm and Carry On" is to "Make do and Mend". And since I started thinking like that, I have become much more motivated – to do something with the available resources, rather than feeling a loss of what there could be or should be, and this makes me feel less frustrated and, yes, calmer.

In this newsletter, there are many examples of people and groups who have brought innovative and creative ideas to how services can be improved. For example, Dr Reza reports on the development of RiO MH, Dr Kadry writes about the introduction of Payment by Results in CAHMS, and Ewa Okon-Rocha et al give an account of the medication review clinic that they have developed in Bexley. As Michael Maier says in his farewell article to us, it is important to distinguish between the general conditions of work in the NHS and the exciting subject that is psychiatry. I would add that developing or improving a psychiatric service goes a long way to mending some of the holes in the NHS.

Another farewell is from Amanda Owen, who has written about the RCPsych Retirement Conference. At the other end of her career path is Abigail Martyn, a medical student at KCL who has contributed an item on Global Mental Health, and there are articles on tasters in psychiatry for Foundation Trainees, psychotherapy training for core psychiatric trainees, and Dr Myooran Canagaratnam has written about his experience of a Fellowship in Medical Education. A report on the Academic meeting "Who wants to be a psychiatrist?" comments on the image problems that psychiatry suffers with from patients, doctors and the media, and again, the mending that is

taking place, firstly by having a conference like this at all, and secondly from a group of people coming together to think about how to address it.

Diarmuid Nugent summarises the new coalition government's plans for mental health policy in his article artfully titled "The CON-DEM-nation of mental health. Speaking of art, we now have a new arts section, in which we are very fortunate to have contributions from Jeff Roland, a professional artist, with analysis by Melissa Westbrook, and Dr Pauline Cooper writes about her experiences writing and producing a play about depression aimed at service users, carers, and health professionals.

As always, contributions and responses to articles are welcome and can be sent to Susan Ranger at:
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Report on "Who wants to be a psychiatrist?"

London Division academic day

"Who wants to be a psychiatrist?" a London Division academic day, was an interesting day of talks, workshops and discussion examining reasons and solutions for the current problems of UK psychiatric recruitment.

Prof Robert Howard, Dean of the Royal College of Psychiatrists, perhaps summed the current situation the most baldly. "The recruitment crisis is the biggest challenge psychiatry faces". Concerning, he also said that this is leading to an "unacceptable variation in quality amongst trainees and consultants".

The situation does indeed appear to be dire. This year the London Deanery received 250 applications for core training posts, down from 400 in previous years. In the country as a whole the competition ratio of applicants to psychiatric training to jobs available is 1:1. The result, as Michael Maier, head of the London Specialty School of Psychiatry put it, is that "psychiatry is a recruiting, not a selecting specialty".

Yet despite this, a recent Royal Society of Medicine Study found that, alongside general practice, it was doctors who worked in psychiatry who found their lives the most satisfying. The popularity of the study of psychology suggests that, amongst school leavers, a general lack of interest in the mind and its problems is not a problem; however again and again, upon leaving foundation jobs, doctors in training choose other specialities for a career.

How could this have come about? Prof Ania Korszun from Barts and the London suggested three culprits: psychiatry is seen as not 'medical' or 'scientific' enough; psychiatry recruitment suffers by association with the widespread popular stigma surrounding mental disorder; and medical students are discouraged from psychiatric careers by the negative views held by doctors working in other specialities with whom they spend much of their training.

This relentless disparagement directed towards the ears of impressionable medical students appears to be particularly potent. Dr Gianetta Rands, who talked about psychiatry as a part of foundation training, told us that the longer medical students spend in non-psychiatric specialities the less likely they are to choose a career in psychiatry. The split between acute trusts and mental health trusts also means that psychiatrists are rarely present – be it at grand rounds or in the canteen – to put forward an alternative viewpoint. It has been recognised that more psychiatry foundation year placements are required, especially in year one. There are currently 500 placements over both years, but 2000 are needed.

Psychiatry undoubtedly has an image problem and Dr Peter Byrne, chairman of the Royal College of Psychiatry's public education committee, presented a fascinating talk about the profile that psychiatrists have in the media and also our role as 'evidence based public educators'. An interesting insight was that

whilst newspaper stories about physical health most often concerned the stereotype of 'bad patient', those concerning mental health focus on that of the 'bad doctor'. The recent BBC programme "Mental: A history of the madhouse" is an example of this. Dr Byrne encouraged media engagement by psychiatrists and this theme was further examined in a workshop run by Dr Mark Salter, the event's organiser. Other workshops tackled writing skills, running student psychiatric societies and making a psychiatric documentary.

Given the current situation, it might have been possible to find some of the messages of the day dispiriting. Fortunately there were many moments of levity and an overall note of optimism. Dr Chris Manning, a GP with experience of mental health services from both sides, praised psychiatrists and delivered an enthusiastic panegyric: "Minding the brain – the best job in the world". Dr Kate Stein, a foundation doctor, was equally enthusiastic when she told us about her plans for a psychiatric career. The active role of medical students present as delegates was also welcome and encouraging.

Of course it is not simply enough to identify a problem and there is a plan of action, in which - amongst others - Prof Howard, Dean of the College, is taking a special interest. He wishes to raise the profile of psychiatry, especially with medical students, and to make medicine in general 'more psychiatric'.

The day closed with a rabble rousing talk from Prof Simon Wessely "Why psychiatrists still need to be doctors". Prof Wessely convincingly argued that patients both want and need their mental health disorders to be treated by psychiatrists who are also doctors. He spoke of the value of our ability to make a diagnosis and in our use of the biomedical model. Psychiatrists' ability to distinguish physical from psychiatric disease makes us indispensible to our physical medicine colleagues.

Psychiatry has in fact never recruited as many UK trained doctors as it needs to fill its posts and in seeking to reverse this phenomenon we seek to overturn a historical precedent. Improving the situation requires action on many fronts. It particularly concerns me that we may be recruiting the wrong mix of students to medical school, as current science focused selection criteria favours technical knowledge over a candidate's potential to flourish into the practitioner of holistic medicine that psychiatric practice requires and may preclude those who will eventually wish to take the path required by psychiatric practice. A central message of "Who wants to be a psychiatrist?" is that we can all become involved in this debate and every day should regard ourselves as "walking, talking adverts for psychiatry".

STEPHEN GINN
CT3
SOUTH LONDON AND THE MAUDSLEY TRAINING PROGRAMME

The CON-DEM-nation of Mental Health?

In the March edition of the Newsletter I reviewed *New Horizons,* the government's ten-year strategy for mental health. Whilst the document was widely criticised for lacking the specifics of how its utopian vision might be implemented, it was nonetheless striking in its commitment to maintaining mental health provision as a focal point of the health and social agenda. There was a sense of momentum to build on the achievements of the National Service Framework.

The weeks that followed saw the historic formation of a Conservative-Liberal coalition government which, whilst an oxymoron in name, heralded "a new era in government". Yet what was striking about the election manifestos of the Conservative and Liberal Democrat parties and in the Queen's speech and Programme for Government that followed their accession to power was the complete absence of any explicit reference to mental health. With the exception of prioritisation of research funding into dementia, a commitment of both the lib dem manifesto and the Programme for Government, and greater access to talking therapies, oddly categorised within the agenda for public health, this new era of government leaves mental health services facing an uncertain future.

The election campaign and its protracted prodrome left no doubt as to the dire straits of public finances. A

record deficit has resulted in the need to find £6 billion in savings in the next year alone, but the government has promised that this can be found efficiency savings so as to guarantee that health spending increases in real terms with each year of Parliament . It is estimated that the cost of NHS administration can be cut by a third and the resources transferred to doctors and nurses on the front line. References to the significant cuts in the number of health quangos aside, the precise division between front-line services and administration remains undefined. This is important because smooth running of our services depends on certain aspects of administration. An efficient booking system for appointments and good secretarial back-up will reduce waiting times and improve access to services by maximising the time that clinicians can spend with their patients and reduce the chance of non-attendance.

There are proposals to attempt to reduce bureaucracy in the form of politically motivated targets in order to "free NHS staff from political micromanagement".

Nonetheless we work in a health service which is increasingly outcome driven, as evidenced by the pledge "to measure our success on the health results that really matter". In psychiatry more than any other speciality we rely on the self-reported symptoms of our clients hence most outcomes will rely on record keeping by front-line staff. There needs to be a genuine commitment to ensure that recording processes for these outcomes are as streamlined and succinct as possible so that measurement does not form an obstacle to care.

Policies on employment and disability benefit are likely to impact hugely on our clients. Previous government strategy already prioritised the need to address extremely low rates of employment in those with mental illness (circa 21% compared to 74% of the overall working population) and the *New Horizons* strategy proposed the need for employment to be regarded as "an important outcome in the treatment of mental illness in health settings", for instance by having employment specialists in PCTs and mental health teams. The economic impetus is clear: the costs in terms of benefits and lost productivity have been estimated at £77.4bn, although it is doubtful that savings in this area would flow back into mental health services! The programme for the new coalition government asserts that jobseekers' allowance claimants "facing the most significant barriers to work will be referred immediately to the new welfare to work programme immediately" whilst all current recipients of Incapacity Benefit are to be reassessed for their readiness to work. These stipulations are likely to increase the workload of CMHT staff called upon to provide assistance to those with severe and enduring illness who find themselves subject to reassessment.

The new government has yet to convey any clear direction for mental health services specifically but plans for the health service in general seem to differ little from those priorities laid out under Labour. An emphasis on prevention and public health, devolution of service provision to local commissioners, greater patient involvement in their treatment: these are all familiar themes with which few politicians would disagree regardless of their affiliation. There have been huge changes in mental health service provision over the last decade. Both patients and staff need time to allow the dust to settle, reflect and take stock of what works and what doesn't. The linguistic anaphora of revolution has become a *lingua franca* of mental health policy. Perhaps the economic austerity of the months to come will offer some breathing space for that overdue period of reflection.

DIARMUID NUGENT
CT1
UCL AND ROYAL FREE
TRAINING PROGRAMME

improving lives

medication review clinic

Why a medication review clinic

Medication review is an increasingly recognised cornerstone of the care management. Patients on psychotropic medications require regular monitoring of symptoms of their illness, side-effects and pharmacological interactions. Over the last few years, as part of the modernisation of the NHS, the Department of Health has focused on the improvement in the quality of services to the benefit of patients [1,2,3]. The Maudsley Medication review clinic has been well known for reviewing medications and assessing side-effects. NICE guidelines [4] and the overarching guideline on medicines adherence [5] recommend that patients should be helped to make informed choices by involving and supporting them in the decision process about prescribed medications. The following is the report of our experience of running a medication review clinic.

Erith Centre Pharmacy Clinic

Following the national guidelines, a number of service innovations have been initiated across the Borough of Bexley in order to improve the service offered to patients. One of them is a Pharmacy Clinic at the Erith Community Mental Health Centre, Bexley. It is jointly run by a Specialist Registrar in Psychiatry, who is not a member of the care team, a Specialist Mental Health Pharmacist and a Community Psychiatric Nurse (CPN), who is a part of the care team. The service is available for all patients, who wish to discuss medication related issues. Referral can be initiated by the patient, the psychiatrist in charge of a patient or the care-coordinator (CCO). Referrals, on a specially designed form, are directly made to the CPN, who is responsible for an overall booking system. Up to three patients are offered review during each clinic. A typical consultation consists of reviewing of the patients' history prior to an appointment. During the appointment an assessment of mental state and a discussion of the medication-related issues, including education, compliance, side-effects and interactions, takes place. A summary of the consultation is entered onto the patients' notes on the trust's electronic data system (RIO), and a letter written to the GP..

Who do we see and why

The recent Pharmacy Clinic's audit data showed the attendance rate of 82%. In relation to diagnosis, the majority of patients (61%) suffered from Paranoid Schizophrenia, others from Affective Disorders (22%) and the remainder had a diagnosis of Anxiety Disorders or Personality Disorders. The most common reason for referrals were: review of side-effects (32%), followed by information and education about medication (21%), in particular Clozapine and Lithium, or medication's pharmacological interactions (16%). Around 12% of patients wanted to discuss discontinuation of medication or other treatment options. Many of the patients seen were also prescribed a number of other medicines for physical health problems alongside psychotropics which contributed to side-effects. 85% felt that their medication was easy to take and almost half of the patients (48%) agreed that they benefited from taking their medication. More than a third of the patients (36%) were not aware of other treatment options and one fifth (21%) found side-effects difficult to manage.

The majority of interventions consisted of education and giving advice to patients on medication as well as on healthy diet, lifestyle choices, sleep hygiene and various activity groups. Careful review of treatment with the patient led to a third being referred to other clinics within the trust (the Physical Health Clinic, the Hearing Voices Group,

psychological services) or outside agencies. Treatment changes were advised in a quarter and a fifth were requested to have additional investigations (blood tests or ECG).

What we have learnt

For over six years since the Pharmacy Clinic came into existence it has attracted a steady number of referrals and has become an established part of the service improvement strategy at the Erith Centre. While it continues to maintain link with the Community Mental Health Team it also provides patients and their relatives with an opportunity to discuss various treatment options in a less pressured setting to what patients are acquainted with. It attempts to make patients directly involved in a decision-making process about the management of their illness, giving them informed choices of treatment options and understanding of medication related side-effects. Furthermore, it offers a link with other outside care services, secondary care specialist clinics and the possibility of medical and laboratory check–ups. Finally, a direct pharmacist involvement gives the unique opportunity for a discussion about medication's efficacy, its side-effects and potential drug interactions.

The effectiveness of the Pharmacy Clinic is currently under evaluation. The audit has just been completed and the Client Satisfaction Questionnaire and the Feedback Form are presently being obtained from patients and their referrers. The initial audit data suggest that more extensive information should be sought prior to the clinic from a consultant psychiatrist, especially when a medication review is required. It is equally important to enhance communication with the referrer when significant changes to medication are made during the clinic.

The way forward

There are plans of expanding the existing service across the whole Bexley Borough and possible throughout the trust. It is our hope that the existing service improves the quality of care for people with an enduring mental health illness, that it empowers them by making them more involved in their care and ultimately promotes their recovery.

Acknowledgements

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• Carol Paton, Chief Pharmacist Oxleas, for her helpful comments and advice.

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RiO MH:
Development of a Computerised Record Service for London

As many readers of this newsletter already know, RiO MH is the computerised care records service (CRS) that 34,000 staff now routinely use in 7 London MH Trusts. Starting with South West London & St George's in July 2006, Camden and Islington was the 7th Trust to implement this CRS in December 2008. Tavistock & Portman shall implement it in 2010. This will leave two Trusts outside RiO but these Trusts have already deployed CRS.

Development of CRS for London started in 2004 when the local supplier proposed a single software that all care settings were to use – GPs, PCTs, acute hospitals and MH Trusts. It was readily apparent to the clinicians involved in the consultation process that the proposed solution was impractical. However, the suppliers took 18 months to register this. An alternative approach was then proposed to adopt different solutions for each care setting. RiO MH – a software developed by CSE Servelec, UK and already in use by several NHS Trusts since 2002 – was thus identified as a solution.

BT and LPfIT hosted a series of workshops in September 2005 to agree the configuration of RiO MH for London. Using the latest version at the time (v4.6) as the starting point, 20+ multi-disciplinary front line staff from 7 Trusts worked full-time for a week in workshop setting. This group advised on configuration of the "Commercial Off The Shelf (COTS)" product but was not able to make any alteration in the software.

Five key principles were the basis of configuration workshop:

1. "No like for like!" – CRS must provide a better service than what paper notes offered.
2. CRS must support the best clinical practice.
3. Any screen/form needed must not take more than 2 "clicks" to locate it.
4. One "click" to get back to the start if/when lost in the system.
5. Activity/admin data should be captured while the clinical notes get recorded.

Trusts participating in these workshops used their established processes and forms for clinical and risk assessments under their CPA policies. While retaining the common core features of different assessments and care planning processes, various screens/forms were agreed as meaningful clustering of linked information on one RiO screen. Re-naming these forms/screens was a software change issue. Therefore, screen/form names were retained as developed elsewhere by NHS Trusts.

RiO MH version 4.7 was thus agreed comprising of 120+ "forms" that allow recording of clinical notes as free text. Several of these forms also have drop-down menus that capture admin/activity data for reporting purposes.

It is probably unique in the history of the NHS that seven different Trusts agreed in one week on a single method of recording their assessments and clinical notes despite having different approaches towards care planning and CPA policy for several years prior to this. The spirit of achieving mutually acceptable compromises has possibly contributed to some of the clunkiness in the system that has since been implemented.

RiO MH Users Group was convened in September 2006 to develop and manage the Requests for Change (RfC) and to oversee the future development of RiO. The group comprises of two senior representatives from each London MH Trust and representatives from LPfIT, BT and CSE Servelec.

The Users Group has reviewed nearly 370 RfCs in 3 years. The guiding principle has been that if one London Trust recommends a change in order to deliver better clinical care, this shall be available to all Trusts in order to support the best quality of service for all the patients using services in London. The process of implementing the agreed changes has however been quite slow due to commercial constraints.

Different professional disciplines have adopted RiO with varying levels of enthusiasm. Most in larger Trusts do use the Core Assessment, Risk Assessment and Care Plan as part of routine clinical work. This provides ready access at all times to clinical and risk information in a structured format to support safe delivery of service.

There are some subspecialty teams that have been reluctant to move away from their formats of reports and letters. Instead of noting this information in appropriate parts of RiO MH, these teams upload electronic documents into a folder provided for this purpose. The information thus noted is not readily available for view in agreed format for Alerts, Risk Management, Care Plan, etc. and thus creates potential clinical hazards.

There is need to improve usability of future versions of RiO. Roll out of version 5 has already begun but this too has essentially been reconfiguration incorporating many RfCs but only limited software enhancements.

RiO v4 & v5 are not strong in the "informatics" as codes for reporting purposes are captured in rather limited areas of CRS. This is primarily due to use of free text but this compromise has been the essential feature for its ready acceptability by the frontline clinical staff. The "editable letter" function in RiO allows creating of tribunal reports and summaries, etc. by using the notes recorded in CRS. This function has been very basic in v4 but has been enhanced in v5.

The first opportunity to implement any software changes has been possible in RiO v6. While maintaining a log of such issues identified in various workshops since September 2005 and those noted in RfCs, additional workshops were also convened to review v6 design. Details of RiO v6 road map have been shared with RiO MH Users Group.

The standard format for recording clinical notes that are primarily meant to support the clinical teams remains the core objective of RiO MH CRS. Clinical and admin teams are however able to create reports that can be unique for each service area by using additional software(s) and the data extracted from the CRS.

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Psychotherapy Training in ST 1-3 years across London

Psychotherapy is an essential part of psychiatric training. Both PMETB and the College want trainees to have a psychologically minded approach to all aspects of their work. Along with other training experiences, it is recommended that trainees conduct at least two therapies in two modalities of two different durations. The psychotherapy training in the core training years is overseen by the PsychotherapyTutors of the training schemes. Usually the trainees start with their Cognitive Behavioural Therapy (CBT) training, accumulating at least 2 cases seen for 10-16 sessions. In the second and third years the long case in psychodynamic therapy is added which is usually for 40 sessions. This is in addition to the Case Based Discussion groups (CBDg) which the trainees are expected to attend during the initial years, accumulating at least 30 groups in two years.

In London the training schemes provide high quality psychotherapy training experiences, which exceed the minimum requirements. In the different Trusts across London, there are training opportunities in the Improving Access to Psychological Treatments (IAPT) services providing NICE recommended brief CBT treatments for anxiety and depression, Certificate and Diploma courses in Behavioural & Cognitive Psychotherapy at South West London and St George's, Courses available at Family Therapy leading to nationally recognised qualifications, and experiences in therapeutic community treatments such as the Cassel Hospital, to name a few.

The PMETB curriculum ST1-6 core training and ST4-6 Higher Specialist Training in Psychotherapy now include methods of assessment for psychotherapy competency. These are the Structured Assessment of Psychotherapy Expertise (the SAPE) and Case Based Discussion group rating forms for junior doctors. For higher specialist trainees it includes the Structured Assessment of Psychotherapy Assessment (SAPA), SAPE and a modified case based discussion form. For ST1-3 it incorporates the requirement to undertake two cases in different modalities over two durations for trainees. This means that PMETB now formally require these assessments of competence to be provided for ARCP accreditation.

In London, The Psychotherapy Tutors of the core training schemes have been meeting, in order to work together and work with the School of Psychiatry. We have developed a recording form, that lists all the training requirements across the three years. This form can be signed and ticked off each training experience is completed. It is a useful addition to each trainee's portfolio, which can be used to demonstrate to the ARCP panels that the psychotherapy component of the training is well on course.

The psychotherapy training is aiming to train Psychiatrists who can use a range of psychological theories to understand their patients, who are emotionally literate and curious; that is they can recognise their emotional responses, have an understanding of the development of the therapeutic relationship with their patients and are self reflective and know enough about main models of psychotherapy to be able to refer or work alongside patients in therapy.

At the end of three years trainees are expected to have acquired the following core competencies;

Account for clinical phenomena in psychological terms

Refer appropriately for formal psychotherapies and to explain to the patient the therapy they are being referred for

Jointly manage patients receiving psychotherapy

Deliver basic psychotherapeutic treatments and strategies where appropriate

Display a high level of emotional intelligence and communication skills in your working relationships with patients and staff

Case based discussion groups give the opportunity to explore within a group context the complex interpersonal dynamics involved in working with patients, teams and institutions. These provide an introduction to psychodynamically informed approaches to working with

patients as well as understanding first hand the ways groups work in the first years of training.

Group discussion promotes reflective practice, and there are plans to have these groups as part of ST4-6 generic training.

I**n Cognitive Behavioural Therapy** trainees learn the principles of:

Exposure and how to apply it effectively in clinical practice.

Reinforcement schedules and their clinical application.

Skill acquisition and how to deliver skills acquisition treatment packages.

Introduction to the concepts of cognitions; how maladaptive cognitions can impact on behavior and mood.

Central to the practice and understanding of psychodynamic psychotherapy is the exploration of the patient's internal world through the therapeutic relationship. In order to achieve trainees learn how to develop and maintain a therapeutic alliance, manage the therapeutic frame, and the importance of adopting a stance of neutrality and abstinence.

They learn through experience about unconscious communication and develop skills for making these conscious. This involves understanding about transference, counter transference and their use in deepening the therapeutic relationship through interpretation. They also look at the management of the ending of therapy and how different people cope with the ending of an intense therapeutic relationship.

Systemic family therapy views the family as a system; key to this will be the exploration with the families of the various roles adopted within the family and the relationship patterns that are set up. It also looks at how the family understands itself through the stories the family has of itself and the various family scripts, explicit and implicit. The social context and its influence on relationships and identities is also an important tenet of systemic therapy (e.g. religion and ethnic identity), and these systemic theories also inform group analytic therapy practice.

Each of the models of training equip the psychiatrist with skills that are generalisable to other areas of clinical work.

Workplace based assessments and annual review of competency

Trainees will be expected to submit their workplace based assessments in psychotherapy as evidence of competency for progression through ARCP process; these are

A summary of the two CBT cases undertaken.A structured assessments of psychotherapy expertise (SAPE) can be used if wished.

Assessment of the Case Based Discussion groups will take the form of two CBD assessments carried out by the group facilitator using the CBD form.

Assessment of psychotherapy long case is through an ACE.

For further information, please see College Website training pages and article in Psychiatrist by Dr Chess Denman, the chair of the education committee of the Faculty of Psychotherapy. The Psychiatrist (2010) 34:110-113, A Modernised psychotherapy curriculum for a modernized profession.

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Chasing my Tale

Well it's about time! Finally, there is specific interest in the Arts in Health! It is good to see partnerships arising that promote the arts as a means of improving the health of the nation. Oxleas NHS Foundation Trust Art Therapy department have linked in with the Tate Gallery to give carers a forum for discussing their role using art works depicting scenes relevant to healthcare.

Another new initiative is beginning with a partnership between myself (Occupational Therapist Dr. Pauline Cooper) and London-based theatre company Flamingofeather. The theatre company organized a lecture *Mental Health and the making of Black Dog* that was held by Professor Jane Plant CBE DSc FRSM (Imperial College), Janet Stephenson (NHS and private psychologist) and Julie Whitehead (Co-Founder of Laughter Network) at The London South Bank University in April 2009. In July, I was intrigued by a flier advertising the performance *'Black Dog'*, which was performed at the Pleasance Theatre in July 2009. The title *Black Dog* was based on the metaphor Churchill used to describe his depression.

The play was billed as the depiction of a woman suffering with depression who had become socially isolated and her attempt to create an inner world to live in by herself. I went along to see what the play had to say about social isolation and the problems of depression and anxiety. The fascinating performance which utilised the actress's interaction with video, inspired the idea that service users would benefit from seeing the show. Depression and anxiety are lonely states and often sufferers consider that no-one else understands or shares their feelings. The potential for seeing the show and the realisation that their symptoms and behaviour are common human reactions to their mental state can be comforting and ameliorating.

I felt that there were things that were not quite authentic and was fortunate enough to have a discussion with Ilana Gorban, the actress and author of *Black Dog* Later, she invited me to become a consultant in a re-write of the play. We discussed the script for many nights on a Skype connection and, at that time, I seemed to have a lot of service users on my caseload who were suffering with depression and anxiety and were either already socially isolated, or in danger of becoming so. I talked with them at length and learned much to inform the progress of the play.

As time went on I could see an increasing potential, not only for service users to benefit from seeing their story portrayed in the performance, and the subsequent reducing of stigma, but also from an opportunity to story-weave with healthcare professionals, carers and anyone who struggled with or beside those who suffered with depression and anxiety (including much of the general public in this day and age!). The play has been re-written and is now called *Chasing My Tale,* which embraces the idea of the negative spiral that depression sufferers experience, but also in the quest for an upward spiral of hope through finding of ways to cope differently and change their story outcome.

Phase One

The first phase of the event will be to healthcare students in universities: comprising a lecture about depression and anxiety, including reference to suing writing in therapy (Cooper, 2008) followed by the performance of *Chasing My Tale*, then a workshop, exploring themes from the play and ways of working more efficiently and empathetically with service users and carers. King's College, London, will host the first showing in March 2010 for students, with a larger audience opportunity planned for later in the year. Negotiations are also underway with the Universities of Sussex, Canterbury and Northampton.

Phase 2 (Funding applied for)

The second phase, about which I am even more excited, will take place within the Oxleas Trust, with 6 events: a shorter talk, then the performance, then a longer workshop, where themes will be discussed, and a workshop will be orchestrated to allow story weaving within the audience and opportunities for service users and carers to practice confidence building and raising of self-esteem. The audience will be healthcare practitioners, service users, their carers, and any other interested parties. It is hoped that this form of story-weaving will improve working and living relationships between all parties. Service users will include people who have poor coping skills, such as those who use alcohol or withdraw from society by watching television/playing on the computer as a way of coping with anxiety and depression that are vulnerable to social isolation. Where these problems can be intercepted by early training in understanding the signs and symptoms and learning alternative strategies, social isolation and/or acute depression and anxiety can be averted.

The sessions will be evaluated before and after the performance/workshop as an outcome measure and to inform the playwright towards improving the authenticity of the play/story being depicted. After the six performances, a final performance will take place, where all attendees and the general public will be invited to view the production, in the hope of raising awareness of mental health issues and reduce stigma.

The play and work involving the use of writing is for all adults (18 plus). This includes clinicians or healthcare workers who wish to increase their knowledge of social isolation, depression and anxiety. They need to be prepared to work collaboratively with clients and carers to identify and problem-solve the difficulties of living with depression and anxiety to benefit all parties and reduce stigma. It is hoped that this may develop into schools and businesses where depression and anxiety affect performance and cause sickness and absence.

Writing in itself is powerful and healing. When other media is added the therapeutic benefits become much greater and widen the potential for learning, reflection and healing

The visual experience, coupled with scripts of words that service users have used to describe their situation, provides a powerful representation of the plight of those whose depression has developed into social isolation. The play provides hope as it charts and opens possibilities for overcoming the difficulties of loneliness and the step forward into society. This portrayal of the struggle and recovery of the character, along with practical workshops to explore and experience innovative models of recovery, and/or ways for clinicians/ practitioners to support service users in their care, makes *'Chasing My Tale'* a tool for developing recovery.

The different arts and media involved increase the potential for engagement of all people in whatever part they play in the act of Recovering Ordinary Lives[1].

Dr. Pauline Cooper trained as an Occupational Therapist qualifying in 1974 at the London School of Occupational Therapy and is currently working as Head Occupational Therapist of an acute, adult, inpatient unit for the Oxleas NHS Foundation Trust. She gained a Master's Degree in Creative Writing in Personal Development at the University of Sussex. The outcome of this work, exposed two writing models: creative writing and writing as therapy. Dr. Cooper, wanting to understand how these two models could best benefit clients, embarked on a doctorate to define the difference. The resulting thesis: The Use of Creative Writing as a Therapeutic Activity for Mental Health in Occupational Therapy, is available through Oxleas library. Any enquiries about her work or this article can be directed to her at:
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or telephone: 0208 308 3112

"Psychic Wreck"
Three Paintings by Jeff Roland

"Psychic Wreck" was created in 2009 on paper, and is now part of a private collection in the south of France. It is a work about how we lead our lives like a vessel, from the outside, proudly steering and acting as totally in charge, when the true archaic forces that govern our moves are also hiding below the sea level, even if we are not aware of that. And in this particular painting, we see a pattern of denial, proud impersonation of total command, when the forces from below contradict the movement and drag the whole vessel downwards to the bottom, like old and quiet tortoises, not good or evil, just animal and determined.

http://www.jeffroland.org

Two works analysed by Melissa Westbrook, PhD

The Watchers

(oil on canvas, 2009) and

Chinese Beach

(mixed media on paper, 2009)

The Watchers forms part of a series of paintings which explore symbolic guardians and their function in contemporary society. In this piece Jeff Roland depicts two gargoyle-like figures in thick, loose brushstrokes reminiscent of Andre Masson. The guardian in the foreground dominates the canvas. With a raised arm it stares at its viewer blocking any attempt to engage with the space beyond. The scornful creature in the right mid-ground reinforces this sentiment.

Through these figures The Watchers inverts the traditional artistic relationship between viewer and object. The viewer becomes the viewed as the guardians seize control of the encounter. It is only through them that we able to gain insight into the work as they determine the information being disseminated. The guardian's actions are post-post modern. They reassert an artist's right to determine a piece's meaning.

The space around the guardians only provides hints at the world beyond. Using Rousseau as his inspiration, the artist places a loosely painted jungle around them. It is not clear whether the figures in The Watchers are guarding an archetypal truth or the entrance to utopia. Instead, Roland plays with his audience. The blurred landscape could be a mirage. In this reading the gargoyles are not bastions of knowledge, as traditionally defined, but guardians of illusion and nothingness.

Inspired by the works of Jerzy Ruszczynski, Chinese Beach examines the universal themes of creation, gene manipulation and the destruction of the global ecosphere. It presents a clash between organic human development and the hideous gene mutants created through the rationale of science. A divine form, shown through a prehistoric symbol, watches the journey from single entity to enlightened being.

Organic evolution, from primitive to enlightened being, is symbolized by the primitive masks on the right side of the canvas. Indicative of the artist's interest in anthropology, the masks appear in harmony with the ocean and vegetation that surrounds them. The hovering gold/blue face in the sky above signifies transformation from the physical to the spirit.

The development fostered by science presents a stark contrast with this pure form of evolution. Roland's bunsen burner and test tube, rendered in opaque, thick colour, reveal the tools used to by the modern age to explore the mysteries of evolution. They enable man to fulfill his desire not only to create but also to modify his own image.

The large mutant figure which dominates the centre of the canvas is the product of these experiments. The creature's face is typical of Roland's characters, elongated face, long aquiline nose. His cocooned body and halo makes it clear that he is in the process of physical and spiritual metamorphosis. Yet unlike his primitive counterparts, the mutant's body oozes toxic waste, shown through large splatters of colour, into the sea.

Chinese Beach does not extol the primitive life over one governed by science. It asks its audience to assess the impact of experimentation on the environment. On a deeper level Roland questions whether it is necessary to create modern Frankensteins in order to evolve.

Global Mental Health

The Lancet stated that "mental disorders represent a substantial 'though largely hidden' proportion of the world's overall disease burden" with WHO commenting that "depression is a worldwide epidemic that within a decade will be second only to cardiovascular disease in terms of global health burden"[1]. It is thought that 450 million people suffer from mental disorders across both developed and developing countries, with every year over 30% of the global population developing a mental illness of some kind16,[2]. Many areas of global health are extensively studied and there is a wealth of evidence and literature supporting and detailing these issues, however global mental health is relatively rarely discussed and there is limited data and published reports in this field.

In 2000 – 2001,185 countries were surveyed by The WHO Project ATLAS, which brought to light the extent of the lack of provision of mental health services. The survey found that more than 70% of the world's population had access to less than one psychiatrist per 100,000 people and patients having no access to basic psychiatric drugs in primary care in more than a quarter of the countries. They also concluded that the governments of two fifths of the countries, which covered 99.3% of the population, had no mental health policies at all[3].

At present mental health services rely on western theory and it is necessary to extend our mental health services to non- western communities. It is difficult to make mental health services universal as all psychiatric disorders are caused by a multitude of different factors and societal influences and there is no known biological or pathological cause, unlike other medical conditions. Also the "knowledge base is compiled almost exclusively from North American and European cases" and can therefore not be effectively applied to the other 80% of the world's population[4]. It can therefore be seen that studies need to be published and cases need to be scientifically evaluated from all the different populations and minority subgroups, so that a larger and more representative information base can be used.

Most mental illnesses are diagnosed using either DSM IV (Diagnostic and Statistical Manual of Mental Disorders– 4th edition, 2000), or ICD-10 (International Classification of Diseases – 10th revision) criteria. However DSM- IV which is used in the United States of America is very different to ICD-10, used in Europe. For example to be diagnosed with Attention Deficit Hyperactivity Disorder, ICD–10 requires signs of all three of inattention, hyperactivity and impulsivity to be present whereas DSM IV only requires two of them. The discrepancy between psychiatric diagnoses and classification in Europe and the USA is evident and so it is understandable that further discrepancy and inconsistencies would be present if it was extended to other parts of the world. It is therefore clear to see that using Western diagnostic criteria may not be suitable globally as "presentation, attribution, classification, prevalence, and prognosis of mental disorders vary greatly between cultures"[5].

The other problem is that different countries, cultures and time periods see different things as mental disorders shown by the removal of homosexuality from DSM IV, the addition of Post Traumatic Stress Disorder and the fact that "seizures are seen as a mental disorder in much of Africa"[6]. The evolving nature of the diagnostic manuals and the changing opinions and stigma of different cultures, leaves many people uncertain of the reliability and validity of psychiatric classification and mental disorder as a whole.

Although it is necessary to increase access to mental health services globally, we should also take heed from research, understanding and law in other parts of the country and see how we can apply them here in the UK. It seems topical to discuss khat, an amphetamine-like stimulant, seeing as its derivative mephedrone (also known as meow meow) has been filling the newspapers over the past month as it has been linked with 25 deaths in England

and Scotland and the possible banning of it in the UK[7]. The Home Office has announced that the ban on mephedrone will come into effect on April 16th. Websites selling the drug have already started to close down, in the interest of public safety. However ministers have clarified that the class B status of mephedrone and related cathinone compounds would not extend to khat, the natural plant from which they are derived[8]. Khat possession and sale is already banned in numerous countries including France, Poland, Switzerland, Canada and Somalia. However, as well as it not being banned in the UK it is not illegal in the USA and the Associated Press reported that as there is a low level of usage, it is not a priority[9].

However the "WHO, in 1980 classified khat as a drug of abuse that can produce mild to moderate psychological dependence"[10]. The problem with trying to ban khat is that there is not enough clinical evidence or published cases to support that khat is associated with adverse health conditions or states. One study by Odenwald et al 2009, states that " although current scientific evidence in the field is limited, the available epidemiological studies suggest that, while associations between moderate or socially regulated use of khat and health problems is weak, excessive use may lead to the development of severe somatic and mental disorders"[11]. It has been postulated in the past that khat has been linked to psychosis and indeed that is the picture that has been painted for me by my medical student partner in Somaliland, where khat consumption is large. However only four cases have been reported in the UK and an article by Pantelis et al discusses "three cases of psychotic reactions to this substance in Somalian males, and emphasize the need to be aware of khat as a potential substance of abuse, with both medical and psychiatric complications"[12].

Amid the current controversy and in light of the media hype it is essential not to forget the serious issue of mephedrone and other derivatives of khat which have huge implications for the future field of global health, psychiatry and the law. These issues, brought to the attention of the public by the media, have sparked serious debate over whether khat ought to be recognised as a class B drug and whether it should be banned in the UK as it is in other countries.

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(Endnotes)

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Medical Education

As a Specialty Registrar completing a Fellowship in Medical Education at the Tavistock Clinic, I have been fortunate to gain an insight into some of the current salient issues in training in Psychiatry in London. My Deanery funded post is part of a wider movement to develop medical education as a formal discipline in its own right, by establishing a cohort of junior doctors who may go on to develop careers as clinical educators. The aspiration for the future is for career pathways in medical education to be more clearly defined, with teaching delivered by accredited educators.

Many readers will be aware of the plans by NHS London for the Medical and Dental Commissioning System (MEDCS) which proposes a commissioner provider split in clinical education. It is unclear precisely how such a move will impact on Psychiatry, but it is likely to bring into sharp focus the need for "Providers" (medical schools, NHS trusts, and possibly Royal Colleges) to demonstrate quality in their training programmes. As such, a valuable aspect of my experience has been thinking with Programme Directors about how to improve and evaluate training programmes, and helping to organise Royal College faculty development programmes within the trust.

Alongside honing their teaching skills, clinicians with an interest in Medical Education may wish to study the educational theory underlying practice. In London, the Institute of Education and University College London offer opportunities to pursue a Postgraduate Certificate, a Diploma or, for the particularly keen, a Masters Course in Clinical Education.

In the current climate, levels of funding for training and faculty development programmes certainly cannot be taken for granted. However, London will continue to provide a wealth of opportunities for clinicians to contribute to undergraduate and postgraduate training. As in other fields of endeavour, programmes that can demonstrate themselves to be value for money are those most likely to be sustained.

Myooran Canagaratnam

ST6 in Child and Adolescent Psychiatry at the Tavistock Clinic, Tavistock and Portman NHS Foundation Trust

Payment by Results in CAMHS

The story so far…

Background

Over the past couple of years the government set out a host of initiatives to ensure that the NHS becomes a more efficient, responsive and adaptive organization equipped to face a multitude of changing external pressures. The initiatives set in place were designed to allow more freedom for NHS organizations to manage themselves and conducted their core business of delivering health care. 'Payment by Results' (PbR) was one of the reform agendas introduced to address these issues and was initially introduced in the acute sector in 2003/04. *'High Quality Care for All'* published in June 2009 *(1)* sets out the plan to have a National Mental Health Currency available for use in 2010/11.

Many, if not all, in the mental health economy will by now be familiar with the Adult and Older Adults PbR model. This was brought into more focus when CQUIN published a paper early this year outlining to mental health trusts the financial implications linked to their clustering efforts. In January of this year, the DoH published *'Guidance for PbR 2010-11' (2)* containing a section on mental health. This section highlighted PbR guidance for Working Age Adults and MHOA but excluded CAMHS and other subspecialties from the national scope. In their guidance the Department set out broad outlines for developing a 'Mental Health Currency' but allowed individual Trusts a degree of freedom on how to implement and achieve this.

London CAMHS Currency project

Over the past year there has been a pilot in London, the 'Mental Health Currency Development Project' looking at the introduction and application of Payment by Results in other areas of mental health including Child and Adolescent Psychiatry and Forensic Psychiatry. More recently there is has also been a growing interest in the application of PbR to include areas such as Liaison Psychiatry and Learning difficulties. In brief the currency model entails the development of a needs assessment tool that would allocate service users, according to their needs profiles, to needs based 'Care Clusters' and the development of a 'Care Package' for each of these clusters to address individual patient needs. These care packages could then be costed to produce an initial 'Local Tariff' which would inform the funding and commissioning process.
There are five foundation trusts participating in the London CAMHS Currency project: East London, North East London, Central and North West London, The Tavistock and Portman and South London and the Maudsley (SLAM). The programme board has a multidisciplinary membership consisting of finance, management and clinicians from all disciplines.

Clusters: The team at South London and Maudsley have developed a model that conceptually follows that of the adults but is specifically tailored to the needs of the CAMHS population. There are a total of 24 clusters. These are divided into four main groups: Emotional, Behavioural, Psychosis and Neurodevelopmental / Neuropsychiatric. Each group contains the following 6 needs based clusters: Low severity, Low severity with greater need, Moderate severity, Moderate severity with greater need, Severe, Severe with complex needs.

Needs Assessment Tool: The group at the Tavistock and Portman have developed a prototype tool called 'SENTRY' (Systematic Evaluation of Need and Treatment Responsiveness in Young people). The tool aims to standardize assessments, help in case formulation / monitoring and potentially act as a quality and outcome measure. All five participating trusts in the London pilot are in the process of testing this tool. In addition to this the group at South London & Maudsley have also developed the 'CAMHS Clustering Tool' which is a 25 scale tool consisting of HoNOSCA and 10 additional items. These additional items are believed to be relevant predictors of case complexity and would therefore influence resource utilization and the cost of care packages.

Care packages: As per the adult model, each care cluster will have a standardized care package that describes those care activities required to meet the needs of service users in that particular cluster. Care packages would constitute menus of interventions for service users with similar needs and resource requirements. Interventions offered will be informed by current existing NICE guidelines and where this is not available they would be informed by evidence based best practice and multi-professional consensus.

Challenges for the Future

In the current climate of economic uncertainty it is inevitable that public services will begin to witness a considerable degree of rationing of expenditure which will require an equally considerable shift in organizational culture to survive the crisis. PbR aims to encourage NHS trusts to develop innovative ways to deliver evidence based high quality care that is both efficient and cost effective and best serves the public. It also focuses the responsibility

and accountability of organizations to demonstrate that public money is being spent wisely.

There is much work to be done to test and refine existing PbR models in mental health. CAMHS clearly have some advantage of learning from the adult model but also face a host of challenges in clearly identifying the roles and responsibilities of partner agencies eg social services and education in the delivery of care, understanding the multitude of funding sources and its implications on costing of care packages and developing a model that takes into account the transition period and interface with the adult services. Success will inevitably depend on clinical and corporate staff working collaboratively for a common goal of improving the quality and delivery of care.

References

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'Guidance for PbR 2010-11' Department of Health (January 2010)

Dr Khaled Kadry

Specialist Registrar in Child &Adolescent Psychiatry

South London & Maudsley NHS Foundation Trust

Tasters in Psychiatry

The new Foundation Programme Curriculum and Reference Guides have been launched and will be applied from August 2010. (downloads available from www.foundationprogramme.nhs.uk)

The Royal College of Psychiatrists believes that all Foundation Trainees need at least 4 months in posts that include significant experience of Mental Health services in order to gain competencies and knowledge relevant to mental health, as outlined in the FP Curriculum.

There are currently about 500 of these posts, and about 2,000 are needed.

Until this expansion of FP Psychiatry occurs we need to access the Foundation Programmes via the "Careers Management" part of the curriculum.

This states that "all foundation doctors should have access to local taster programmes".

Each Foundation School should have a Careers Lead whose role includes the development of taster opportunities.

Now is our chance to send Taster Timetables in all branches of Psychiatry to our local Foundation Schools and Foundation Programme TPDs.

Excerpt from Reference Guide, Appendix F: Embedded Taster Experiences Template:

a. The purpose of a taster experience is to:

- enable the doctor to gain a small amount of clinical experience in a specialty in which they have not worked whilst a medical student or foundation trainee;
- enable the doctor to explore in closer detail what a career in a specialty might entail – skills, attitudes, behaviours, essential aptitudes;
- compare the taster specialty with others already experienced;
- meet clinicians and explore career pathways in "unusual" specialties and settings;
- explore opportunities available in small specialties and those specialties which have traditionally been undersubscribed.

b. The essential components of a taster experience include:

• opportunity to find out what is needed to succeed / progress / enjoy this specialty – skills, attributes and behaviour;

• time with senior clinician(s) in the specialty, observing work, discussing career pathways, future opportunities, work life balance, this should include some time for 1:1 discussions;

• time with current trainees (of various grades) in the specialty, observing work, discussing what life is like as a trainee in the specialty, work life balance, how their career choices were made, current and future shift patterns, exams, curricula, entry to specialty, this should include some time for 1:1 discussions;

• time with key workers who support the specialty e.g. nurse practitioners, professions allied to medicine, community specialists, operating department practitioners, laboratory staff;

• opportunity to participate in hands on activities under direct supervision;

• opportunity to attend specialty education / training events e.g. multidisciplinary team meeting, trainee tutorial, skills lab, audit meeting.

c. Seven steps to developing local taster opportunities:

1. identify a lead contact in a specialty for foundation tasters (this would usually

be a consultant or GP trainer);

2. determine the number of taster weeks which might be accommodated / supported in the specialty;

3. develop a programme which lasts for 2-5 days. This programme should explicitly state where to go for each half day, the start and finish times and who trainees should contact. (See example taster programme timetables);

4. develop a short summary of what the foundation taster will deliver in each component;

5. outline the objectives of the taster experience:

• Include 1:1 time with a senior clinician (clinic, theatre, laboratory, GP surgery); time with the whole team (outpatients, ward round, team meetings) and time with trainees in the specialty.

This should include some evening work which can demonstrate the out of hours experience;

• Include educational events;

6. develop an evaluation form which allows ongoing development of all components of the programme;

7. ensure foundation training programme director locally has full details of all taster opportunities (and any changes which are made following evaluation) and all local foundation trainees have access to this register of tasters.

d. Tips for a specialty: ensuring the best taster experience for the foundation trainee:

• discuss each individual placement in advance to give the foundation doctor the opportunity to identify what they wish to achieve /see /do during the placement;

• welcome at start of day one with person who will be their main contact – explain programme again, introduce to the department, explain who to contact in an emergency, explain trainee is expected to undertake all the agreed activities, encourage reflective notes in the e-portfolio;

• explore why individual is undertaking taster – expectations v. reality;

• meet with foundation doctor regularly during the time to ensure satisfaction with experience so far, anything else they would like to do?;

• at end of the taster, meet to review the experience, review reflective notes in e-portfolio and ensure evaluation form is completed.

The Appendix gives examples of Taster Timetables in Anaesthetics, Cardiology and General Practice. These are easily adapted to Psychiatry specialties. Two or three day tasters are popular because they take less time out of Foundation training.

A 3 day timetable in Old Age Psychiatry could look like this:

Taster in Psychiatry – specialty: Old Age Psychiatry; Three Day timetable

Hours: AM: 9.00-13.00hrs, PM:14.00 – 17.00hrs

Monday

• Day Hospital for Mentally Unwell Older People
- meet Core Trainee, introduction to staff, attend Team handover
- meet Consultant and review plan for taster
- attend Multiprofessional team meeting for patient reviews and CPAs
Lunch. Office space available; local shops/cafes etc.
- Attend Psychotherapy Group (open) at Day Hospital
- Transport with patients

- Handover and Reflection about Purpose and Effectiveness of Day Hospital

Tuesday

• Continuing Care Panel, chaired by PCT member.
• Supervision of Psychiatry Trainee - observation
• In-patient Psychiatry Unit – meet Core Trainee and GP trainee

- observe assessments of mental state

Wednesday

• Liaison Work in local DGH.

MDT meeting

New referrals

Observe new assessments

Time to discuss careers with Higher Trainee

• Local Teaching

• Review meeting with Dr A

• Discuss the taster and career planning for Psychiatry

Complete evaluation and hand in Reflective entry in e-portfolio

Summary:

Psychiatrists need to reach out to Foundation trainees. We need to do this to maintain and develop the interest young doctors have in mental illnesses and the mind. This is important for recruitment and the quality of medical care in the future. One way to do this is to offer Tasters in Psychiatry. Arranging and auditing Tasters is an excellent project for Higher Trainees! Details are outlined in the Foundation Programme reference guide, Appendix F, available via the website:

www.foundationprogramme.nhs.uk

Gianetta Rands
Camden and Islington NHS FT
Deputy Chair, London Division.

Retirement Conference

19th April – A Brief Individual Overview

At my appraisal in February the subject of retirement arose, and I duly contacted our Trust pension officer only to discover I was eligible for retirement in June 2010. In shock, I hastily signed up for the London Division's Retirement Conference and this did not disappoint. I arrived to find a packed audience and sat next to a fellow member from the class of '69.

Dr Emma Sedgwick, Director of Healthcare Performance Ltd and a career coach treated us to a sophisticated critique of the adjustments and life changes that retirement requires. Planning and preparation were essential. 'Forewarned is for forearmed' and I was only faintly reassured to hear that surgeons have most difficulty in coming to terms with this major life event.

Kim Lightfoot from the BMA presented a financial, factual account in which it was demonstrated that it can be detrimental to our bank balances to just carry on working! She praised and envied our NHS pension scheme which is handsome in comparison to the private sector. We can retire for one day, work sixteen hours only per week for the next month and then launch into another contract as long as our total income does not exceed our previous salary. Taxes apply and penalties can be harsh. A Nominee (a partner or family member) is required to receive our lump sum should we die prematurely. In the unhappy event that we succumb to a devastating illness it is advisable to take the pension as lump sum.BMA members are offered individual independent advice

Robert Jackson, Head of Professional Standards at the College confirmed that we need to maintain our CPD commitment and can remain registered at the college .A useful tip was to avail oneself a 360 reappraisal prior to the event. Maintaining a peer group seemed essential and our licence to practice will still have to be renewed every five years in retirement should we opt to continue to work?

Four sessions were devoted to the independent sector. Professor Steven Hirsch, Dr Michal Rowlings, Dr Phil Milln and Dr Jack Steiner gave eloquent, realistic, varying perspectives of life in private practice. Contacts with GPs and a competent secretary are essential, but difficulties can arise–it is difficult to park in Harley Street! I did not find the option of giving ones home number to patients particularly appealing, and acting as an expert witness needs a finite amount of self assurance.

Indemnity issues were addressed by Dr Richard Dempster from the Medical Protection Society. A doctors' estate can be liable even after death. Locum and part time work are more liable to litigation. The Royal Society of Medicine group for retired members provides support. Revalidation would remain a five year process.

Dr Richard Symonds gave a historical and practical account of the tribunal service. I learnt from a fellow member of the audience that there is a phenomenal waiting list for this as it is highly competitive. During the lecture it emerged that one does not need a licence to practice, as one acts as a judge and expert witness. This type of work can be financially and professionally rewarding, there is a lot paper work to scrutinise and people interaction.

Dr Michael Maier summed up this successful comprehensive conference and thanked Susan Ranger for her hard work in it's organisation-hopefully it will be repeated.

Audience participation was encouraged, and having met the fellow member from medical school I learnt of a reunion the following Saturday .There, I discovered a bunch of happy people, the retired doctors were writing books, flying helicopters, taking up English degrees and touring music trails in America.

Contemplation, planning and preparation, were, it seems the keys to a successful future!

AMANDA OWEN

Associate Specialist in Liaison Psychiatry

Outgoing Chair

To my horror the four years as Chairman of the London Division seem to have passed rather quickly. I had been a member of the Executive before I took over from George Ikkos, and at that time the major imperative in our work seemed to me to find ways to involve our College membership in our work. The same faces turned up at the academic meetings and a deafening silence ensued when requests were made about consultation on policies and documents. I believed that the first initiative should be to engage with our membership. Reflecting on the last four years I find it difficult to persuade myself that we are now in a better position. I think this is a problem that not only the Division faces but also the College. London is at some disadvantage as there are too many competing events and distractions in the capital to truly engage with members but we need to keep trying.

I am particularly keen to get young members involved and to that end we have started a "Welcome meeting" for new members, held at the College. I hope that this will continue as it proved to be successful with full engagement of the college officers. The new members were given tours of the College premises by Sue Bailey with the combined expertness of a museum archivist and an estate agent trying to sell the property.

We have continued to organise at least two academic meetings a year, many of which have been of exceptional standard. We have established a link with the Institute of Psychiatry where most of the meetings have taken place and there has clearly been a considerable benefit from the IOP branding and access to world-class speakers.

It has also become apparent that we need to be more creative in what we offer and we have now held "pre-retirement planning" meetings which have had positive feedback and again should become part of our regular programme.

During my tenure as Chairman I have worn two hats, that of Head of the London School of Psychiatry as well as the Divisional Chair. Initially I wondered about possible conflicts but have realised that the combination has allowed me to bring the College into Deanery decision making more closely and also to have information, for example about recruitment, that I could bring to the executive and to act on it.

Recruitment into psychiatry has become an important issue. We are facing a falling number of young doctors opting to choose psychiatry as their specialty. There are several reasons for this. One significant reason is that we compete with General Practice for the same candidates and there is currently a large increase in General Practice training numbers. This is siphoning candidates away from psychiatry. The second significant reason that we are struggling to fill training posts is that changes in the immigration laws have made the UK rather unfriendly to our non-EU doctors. These doctors have kept the NHS going over decades and are now going elsewhere or staying in their own countries that are going through rapid economic development.

The reasons why psychiatry is not as popular amongst medical students are well known and I won't rehearse them here. It is important to recognise that there is still considerable prejudice amongst medical and surgical doctors and medical students are naturally influenced by this. This is often made worse by our own Consultant Trainers who express a dispirited attitude when hosting medical students in their teams. It is important to be able to distinguish between the general conditions of work in the NHS and the exciting subject that is psychiatry. Often no distinction

is made between the two. I was particularly impressed by an article in the Journal of the Royal Society of Medicine early this year which showed that psychiatrists and general practitioners were head and shoulders above any of the other specialties when it came to satisfaction in their chosen specialty. We need to convey this to prospective trainees.

I have now endeavoured, both at the Deanery and at the Division, to involve medical students in many of our academic events, to let them see some of the exciting developments in our field and also to let them meet psychiatrists and see that they are on the whole normal, intelligent and pleasant people.

We held a meeting on "Who wants to be a Psychiatrist" with a programme whose quality was exceptional. We had also invited medical students to attend essentially for free. It was truly heartening to hear from many of them that although they had an interest in psychiatry before coming to the meeting they were now convinced that they would choose it as their specialty. At Deanery academic meetings I also now invite medical students, and in November we will be inviting around 100 students to our annual meeting.

Apart from getting medical students interested in psychiatry, we need to be able to hold onto the trainees we already have. Many of our trainees have to leave training because they fail to pass the membership examination. This year we have had to release 24 trainees from London for this reason. The examination has to exist as a marker of quality and there will necessarily be a small number of people that it identifies as unsuitable for the specialty. There are, however, trainees who, with help, can pass and become successful psychiatrists. This autumn the Division will run an OSCE exam training event. Through the ARCP process I will request that each trainee in London who has been given an extension in their training, as a result of not passing the exam, should attend this training event. We will audit the outcomes to see if this intervention is of benefit. I have also committed funding from the Deanery for this event so that these joint Deanery/College initiatives can become more frequent in the future. Finally, we are now in our third year of awarding the Medical Student Essay and Research prizes. They have consistently attracted a good number of applications and the quality has been high. By making students study subjects in psychiatry in depth is one way of allowing them to realise how rich and interesting psychiatry is and how much more there is still to do.

This isn't the place to describe the complete programme that we have delivered over the years but none of this would have been possible without the full and active cooperation of our executive committee, who I shall not name as they appear elsewhere in the newsletter. I am grateful to them.

The position of Chair is now passing to Dr Raji. I have known Dr Raji through her role as Regional Advisor for SW London and her membership of the London School of Psychiatry Board and Executive and I am absolutely certain that the Division is in safe hands and will thrive under her leadership.

I have enjoyed my four years and being given the opportunity to contribute something, if only a little, to the college and to our members.

I wish you all a healthy and successful future.

Michael Maier

Head

London Specialty School of Psychiatry

VACANCIES IN THE LONDON DIVISION

The following Regional Representative positions in the following Faculties are vacant:

Central & North East:	Psychotherapy Forensic Rehabilitation & Social Addictions
South East:	Child & Adolescent Psychotherapy
North West:	General & Community Psychotherapy Learning Disability Rehabilitation & Social Addictions

This is an ideal opportunity to get more involved with the College and an opportunity to work closely with the Regional Advisor in providing specialist advice. You will get the opportunity to attend College meetings. You may also be required to provide advice on Fellowship and ACCEA awards.

If you would like to be considered for any of the above posts, please forward your CV together with a short letter of application to Susan Ranger, London Division Manager, *sranger@londondiv.rcpsych.ac.uk* . A copy of the job description is also available.

EXECUTIVE COMMITTEE MEMBERS

Dr Oyepeju Raji	Chair	E 2010
Vacancy	Finance Officer	E2006
Dr Cyrus Abbasian	Newsletter Editor	C2005
Dr Mark Andrews	Deputy Regional Advisor North West London	C2009
Dr Tim Bullock	General Adult Faculty Link	E2007
Dr Ken Checinski	Addictions Faculty Link	C2009
Dr Andy Cohen	CAMHS Faculty Link	C2010
Dr Frances Connan	Eating Disorders Faculty Link	C2008
Dr Jan Falkowski	Committee Member	E2010
Dr Kim Davidson	Old Age Faculty Link	C2009
Dr Charlotte Feinmann	Liaison Psychiatry Faculty Link	C2006
Dr Emily Finch	Addictions Faculty Link	C2009
Dr Ian Hall	Learning Disability Faculty Link	C2006
Dr Andrew Holwell	Committee Member	E2010
Dr Pamela Jee	Psychiatric Trainee Representative	C2009
Dr Andrew Kent	Perinatal Psychiatry Faculty Link	C2007
Prof Philip McGuire	Academic Faculty Link	C2006
Dr Alan McNaught	General & Community Faculty Link	C2010
Dr John Meehan	Regional Advisor North West London	C2007
Dr Amanda Owen	Affiliate Representative	C2008
Dr Elizabeth Parker	Regional Advisor South East London	C2009
Dr Anne Patterson	CAMHS Faculty Representative	E2006
Dr Jale Punter	Psychotherapy Faculty Link	C2010
Dr Gianetta Rands	Vice Chair	E2009
Dr Nippani Ranga Roa	Education Committee Representative	E2006
Dr Rafik Refaat	Committee Member	E2007
Dr Gillian Rose	Committee Member	E2007
Dr Mark Salter	Public Education Officer	C2008
Dr Iqbal Singh	CPDRC Representative	C2006
Prof David Skuse	CPD Co-ordinator	C2009
Dr Richard Taylor	Forensic Faculty Link	E2006
Dr Bill Travers	Regional Advisor N Central & N East London	C2009
Dr Ian Treasaden	Forensic Faculty Link	C2007
Dr Morris Zwi	Committee Member	E2010
Mr Raymond Brookes-Collins	Carers Representative	C2005

Contact, Susan Ranger (Division Manager and Newsletter Co-ordinator)
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www.rcpsych.ac.uk (follow link to 'Members' and 'Divisions')
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