## Editorial from Dr Chris Symeon and Dr Rory Sheehan

Welcome to the latest edition of the Psychiatric Eye and we hope you're enjoying the summer so far – whether you are travelling or staying in London. This issue contains a diverse assortment of articles which testifies to the breadth of psychiatric practice and the wide-ranging interests of London Division members. We're surely not alone in considering this a great strength of our specialty.

Dr Yahya and colleagues describe a quality improvement project aimed at ensuring that patients in a community rehabilitation setting are vitamin D replete, following emerging evidence that suggests vitamin D deficiency can contribute to a range of health conditions. Perhaps unsurprisingly the majority of those tested required supplementation and key points for practice are considered. Stephanie Young, a member of our editorial team, continues the theme of physical health in a psychiatric setting by interviewing specialist physiotherapist Dr Brendon Stubbs about his research into the benefits of physical exercise in people with severe mental illness and the interventions that might encourage people to become more active.

The showcase artwork for this edition, entitled "Emotional Cartography" was provided by Mao Fong Lim. Currently a medical student, Mao has already developed an interest in psychiatry is leading some very exciting projects. He has also contributed an article to this edition, updating us on the highlights of this year's IoPPN Summer School.

It's been a busy season for conferences and we're lucky to have so many varied opportunities so close to home. After attending a neuropsychiatry evening lecture at the College, Drs Seth and Verma reflect on the rapid advances in neurosciences research and contrast this with the seemingly slower progress in the development of new treatments for mental illness. Farhana Mann and Rory Sheehan report on the latest Mental Health Question Time event held at UCL, part of an innovative series that brings together clinicians, academics, journalists, policy makers, and experts by experience to discuss topical issues in mental healthcare. Dr Hartley describes a College conference focusing on human rights and how human rights law can inform psychiatric practice – as he describes, this can be a contentious area and the spirited debate that followed the conference has informed the topic of our next

themed edition (read on…). And not to forget our Culture Vulture piece which this month is by Dr Rinaldi who reviews ‘Anatomy of a Suicide’, a piece of modern theatre at the Royal Court. As ever, very many thanks to our contributors.

We’ve had some changes at the Psychiatric Eye recently – Dr Zaubia Alyas and Dr Rowena Carter leave the editorial team to focus on new ventures. We wish to thank them for all their hard work over the years and their commitment and enthusiasm which has been vital in taking the newsletter from strength to strength. But it means that we now have two vacancies on the editorial team – we’d love to hear from you if you’d like to get involved.

We’re always thinking ahead and to the next edition – the theme for the autumn newsletter will be “Sex, sweets, and smoking… How do psychiatrists balance what we believe are optimal lifestyle choices while respecting their autonomy and human rights?” We’re sure this will inspire lots of you to send us your thoughts (in 800 words or less!). And remember you can submit articles to Culture Vulture, Conference Watch, or FaceTime interview sections too. We look forward to hearing from you at thepsycheye@rcpsych.ac.uk

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Back to top

## Chair's Message

*Dr Shakeel Ahmad , Chair of the London Division Executive Committee*

How will advances in psychiatric research and understanding of mental illness change the practice of psychiatry?
Psychiatry is a unique type of medical specialty in terms of working across the spectrum of diverse fields like neuroscience, human psychology and social sciences.

Our attempt to bridge the gap between these sciences goes back a thousand years. Eleventh century Persian physician and philosopher Abu Ali Sina (Avicenna, 980-1037) described in his Canon of Medicine hallucinations and ‘nightmares’ in relation

to dementias, epilepsy and stroke [Safavi-Abbasi 2007] and is probably one of the pioneers of neuropsychiatry.

Overtime our understanding of the human mind has been increasing. Advances in brain imaging techniques over the last half a century has contributed immensely to knowledge in this field. To be able to correlate mental functions with specific brain areas is enabling us to understand mental illness better.

Neuropsychoanalysis is attempting to integrate neuroscientific knowledge into existing psychoanalytic theories thus enriching cognitive neuroscience and neuropsychology. Psychotraumatology has become very relevant in the unfortunate current world climate of violent political strife that has affected millions around the world and does not seem to be coming to an end yet.

In addictions, an understanding is developing that short term pleasure seeking use of illegal drugs leading to antisocial behaviour may still be a matter for the law enforcement agencies, but use of drugs to allay suffering, whether emotional or physical in those who happen to have a mental or physical illness is another matter altogether. Similarly there is development of novel pharmacological agents to treat addictive behaviour or dependence syndromes.
Another fascinating area is the advances in genetic research in psychiatry. Contrary to psychopathological or behavioural presentations, the biological phenotypes, the so called 'intermediate phenotypes', including electrophysiological and structural brain functions may represent the genotype more precisely and is likely to enhance our practice of psychiatry in the near future.

In summary, broad knowledge of neurosciences is fundamental to psychiatry. An interesting recent development from the College perspective is the recent review of syllabus in the curriculum for psychiatric trainees. This is being overseen by our new president, Prof Wendy Burns. The program was launched last year, and is likely to take about two years.

Dr Shakeel Ahmad | shakeel.ahmad@huntercombe.com

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*Themed Article: Vitamin D insufficiency/deficiency in patients in a Community Psychiatric Rehabilitation Unit*

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**Dr Ahmed Saeed Yahya Dr Jude Chukwuma Dr Rajiv Karia, Dr Matthew Allin**

## Introduction

Vitamin D deficiency is prevalent amongst patients with severe and enduring mental illness (McCue et al 2012; Rylander et al. 2012). Insufficient vitamin D has been linked to the development of schizophrenia, depressive symptoms and cognitive impairment (Lally et al 2016).

Vitamin D is essential for bone metabolism. Deficiency can lead to osteomalacia, osteoporosis, muscle weakness, and fractures in adults. There is also an increasing evidence base that vitamin D may have a role in the prevention of diseases such as diabetes and cardiovascular disease (Boerman et al 2016). Other diseases with potential connection to vitamin D deficiency include autism, Parkinson's disease, amyotrophic lateral sclerosis, Alzheimer's disease, and multiple sclerosis (Cieslak et al 2014).

There has been an association between the worsening of negative symptoms and cognitive decline in younger adult patients with Psychosis and the levels of Vitamin D (Boerman et al 2016). Negative symptoms are a predominating feature within the treatment-resistant psychotic patients on our unit.

Vitamin D screening has not routinely been provided for patients community psychiatric rehabilitation units in UK. However, Tiangga et al. (2008) found that 100% of a sample of 17 hospitalised male psychiatric inpatients in London were Vitamin D deficient.

The purpose of this study was to quantify the prevalence of Vitamin D deficiency/insufficiency in a Community Psychiatric rehabilitation Unit. Individuals with deficiency/insufficiency of Vitamin D would then be established on replacement therapy as per local guidelines.

## Methods

Informed consent was sought for blood testing from all patients at a community psychiatric rehabilitation unit.
Samples were taken between October and December 2016 as part of routine monitoring (for physical health conditions, to monitor medication side effects, or statutory full blood count monitoring associated with clozapine).
Those with vitamin D deficiency/insufficiency were offered vitamin D replacement therapy according to local guidelines.

Psychiatric diagnosis had already been established in all the patients by psychiatrists, using ICD 10 criteria .
Serum levels of vitamin D were identified via immunoassay. Vitamin D deficiency was defined as total vitamin D levels below 25nmol/L. Vitamin D insufficiency was defined as total levels between 25 and 50nmol/L. A serum level of greater than 50nmol/L was considered optimal.

**Results**

Thirteen out of a total of fourteen patients consented to blood testing. Nine were male and four were female and the mean age was 44 years. Nine of the patients were Caucasian, two of Black Afro Caribbean descent, one of Asian Bangladeshi ethnicity and one patient of Persian ethnicity. Eight patients had a diagnosis of paranoid schizophrenia and 5 had a diagnosis of schizo-affective disorder.
Total vitamin D levels ranged between 13 and 157nmol/L. The mean total vitamin D level was 60. Four of the thirteen patients were already on long term replacement therapy and had higher levels of total vitamin D. Eight out of the nine patients (89%) who were not on replacement therapy had insufficient or deficient levels of vitamin D (levels of 50nmol/L or less). Six patients had insufficient levels of vitamin D (50nmol/L or less) and were commenced on 800 units of daily Colecalciferol, following the local policy. Two patients were found to be deficient in vitamin D (less than 25nmol/L) and were commenced on 7 days of 40,000 units of Colecalciferol followed by a maintenance dose of 1000 units daily.
Three out of the four patients already on vitamin D supplementation had levels over 100nmol/L and replacement therapy was stopped as a result.

**Discussion**

This was a quality improvement project looking at the prevalence of vitamin D deficiency amongst patients in a community psychiatric rehabilitation unit. The majority of patients who were not on long term vitamin D replacement therapy were found to have insufficient/or deficient levels of vitamin D. Replacement therapy was made available to these patients.
Darker skin tones are considered a risk factor for vitamin D deficiency but the majority of our patients were Caucasian - 44% of whom were found to be deficient in vitamin D. Thirty three percent of this group were already on long term replacement therapy so likely had previously low vitamin D levels for replacement to be commenced.

**Recommendations**

Vitamin D deficiency was found to be highly prevalent in our sample group. These results are consistent with other studies concerning the prevalence of vitamin D deficiency in patients with major psychiatric illness (Valipour et al 2014).We recommend that total vitamin D levels should be part of the routine screen in community psychiatric rehabilitation units.
As most of our patients have been found to have a deficiency in vitamin D another

recommendation would be consider low dose replacement therapy (800 units Colecalciferol) in all patients admitted to rehabilitation units.

**Key Points**

- Vitamin D deficiency/insufficiency is common in people with severe mental illness.
- Vitamin D deficiency/insufficiency can adversely impact health.
- Routine screening of vitamin D levels should be implemented in psychiatric rehabilitation units.
- Clinicians should consider prescribing low dose vitamin D to at-risk patients in rehabilitation units.

**Acknowledgement(s)**

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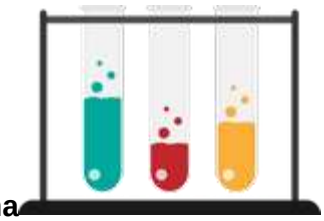

**Dr Ram Seth and Dr Gauri Verma**

I recently attended an evening lecture at the Royal College of Psychiatrists, where four of the top ten neuroscientists in the world spoke about their research. The penultimate question asked was, how much of their research had changed psychiatric clinical practice? Surprisingly the answer was less than10%. Our outgoing President allowed me the final question, how much of their research contributed to the development of artificial intelligence and IT systems? The answer unanimously was a lot more. The entire panel agreed that despite major advancements in neuroscience, only a small proportion translated into better treatments for patients. Not surprisingly First Generation and off-label pharmacological treatments are still commonly used in psychiatric practice in the 21st Century (1)

This raises the questions: What progress has been made in the treatment of mental disorders since the closure of the asylums, and what are the reasons for the slower progress in psychiatric treatments? The first question will be left to academics and clinicians, to debate the clinical effect of advances in brain imaging, psychopharmacology, brain genome etc. This article will focus on the second question to explore the reasons why research in mental disorders has not resulted in the expected treatment advances.

The division between mind and body has an influence over policy decisions, research and resource relating to mental and physical disorders. The brain and mind divide is central to the definitions of mental disorder and mental capacity in the Mental Health Act (MHA) and the Mental Capacity Act (MCA) respectively. Mental disorder is defined as a disorder of the mind, and mental capacity as a disorder of the mind or brain. This reflects the ideological divide between the medical and psychosocial models of psychiatry.  Mental Disorder is not further defined in the MHA, but in the supplementary notes to the MHA, treat-ability is defined as a relief from a symptom or manifestation of the mental disorder.

Consensus diagnoses of mental disorders in ICD and DSM classifications do not reflect the complexity of diagnosing and treating patients. Symptoms of mental disorders often overlap, with patients exhibiting symptoms of two or three disorders at one time. Attempting to fit individuals into predetermined categories, can lead to inefficient or ineffective clinical and research paradigms. Increasing number of psychiatric researchers use symptom dimensions in addition to diagnostic categories. A study of 60,000 people with mental disorders (3) discovered common genetic risk factors between patients with autism, attention deficit hyperactivity disorder, bipolar disorder, major depression and schizophrenia. Brain imaging studies have shown common brain

mechanisms in anxiety disorders and normal fear, and unique mechanisms in Post Traumatic Stress Disorder in processing emotional experiences (3).

The challenge unique to psychiatric research is how empirical science reliant on a posteriori extraction of tangible objective information, can interpret subjective experience? Furthermore, phenomenology of symptoms and signs of mental disorders is interpreted from patient's verbal and non-verbal communication. The patient interprets their experiences and communicates them to the clinician, and the clinician elicits and interprets the patient's communications, what smith refers to as a double hermeneutic (4). Difficulties therefore exist in assessing the functions of the subjective mind within the objective brain. Mental symptoms, like consciousness and decision-making are generated in neuronal circuits of the brain. Mapping between neuronal circuits and subjective experiences remains a challenge. Neuroscience measurements in animal studies can manipulate causally related behaviour, but experience can only be inferred indirectly. Human studies have attempted to link brain function to subjective experience using self-reports, but for ethical reasons these studies are largely correlational. More broadly there is lack of a generally accepted neuroscientific explanation, of how the brain constructs the mind (5).

If one accepts that all subjective experiences arise from activity in brain circuits, then the brain becomes the research focus for mechanisms driving symptoms. However, the brain is also the interface of genetic and environmental influences that produce thoughts, perceptions, beliefs and feelings. Ultimately research and understanding of mental disorders has to integrate a 'mindless' neuroscience and 'brainless' psychology. Mental disorders occur as part of the brain's neuronal circuits, referred to by some researchers as the "connectopathies". An analogy of mental disorders would be arrhythmic disorders of the heart, and a disorder like a stroke with a heart attack.

In conclusion one might liken the challenges of psychiatric research to the field of cosmology and astrophysics- trying to probe our universe using manmade instruments. Understanding the complexity of functions of the mind in the brain is the challenge in the 21st century. It is not surprising that treatments for mental disorder are advancing at a slower pace than developments in the neurosciences. The hope is that developments in artificial intelligence and IT may provide the tools to understand the mind better, and lead to better treatments if not cures for mental disorders in the future.

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Dr Ram Seth| ram.seth@gmail.com

Consultant Psychiatrist, Barrister at Law and MA Education

Dr Gauri Verma| gauriverm@googlemail.com

Academic Clinical Fellow & Psychiatry Trainee Institute of Psychiatry

## *#MHQT – Women's mental health*

**Dr Rory Sheehan & Dr Farhana Mann**

Mental Health Question Time (#MHQT) is a series of public discussions set around contemporary issues in mental healthcare. The events are run jointly by the Division of Psychiatry at UCL, the National Elf Service, and The Lancet Psychiatry. Invited panellists with varied backgrounds in healthcare, academia, policy, journalism, and as experts by experience, briefly give their views on the topic before the discussion is opened questions and comments from the audience. The events are free to attend and are streamed live on YouTube and Twitter, maximising their reach and impact.

After previous successful evenings focusing on risk, dementia care, and digital mental health, the latest event considered women's mental health; whether there are inherent gender biases in how mental health services operate and how we can deliver optimum mental health care for women. Obviously an important topic, but one which tends to be neglected or defined far too narrowly as only perinatal mental health.

The evening was chaired by Professor Louise Howard of King's College London who introduced the session and five acclaimed panellists:

- Katherine Sacks-Jones, director of Agenda
- Liz Hughes, professor of mental health nursing at the University of Huddersfield
- Claudia Cooper, reader in old age psychiatry at UCL
- Sarah Ditum, columnist, critic, and feature writer
- @Sectioned, who draws on her experiences of mental health services to tweet and blog

Katherine Sacks-Jones opened proceedings by neatly summarising why she feels there needs to be a focus on women's mental health: women are more likely than men to experience mental ill-health (with some women being particularly at risk, including those from ethnic minority backgrounds and adolescent/young women), rates of mental ill-health in women are ever increasing, mental distress can manifest differently in women, and women are disproportionately affected by exploitation, abuse, and violence that frequently precipitate mental illness. She called for a new national women's mental health strategy with local leads in each Mental Health Trust to ensure that women's needs are adequately represented, and trauma-informed mental health services that better recognise the links between traumatic experiences (in their broadest form) and mental distress. Barriers to help-seeking, including fears around social services involvement or children being removed from a mother's care, were also discussed.

One of Professor Hughes' major research interests is the sexual health needs of people with mental illness and, in particular, the discrepancy between how male and female sexuality is addressed by clinicians. She highlighted a general lack of confidence amongst professionals in asking women about their sex lives, discussing contraception, or exploring the effects of illness or medication on sexual functioning. There was general recognition from the audience that this is an aspect where a lot more needs to be done.

Several panel members highlighted the data gap in the evidence-base for treatments of mental illness in women. The 'male default' in research was explored: not only are women under-represented as participants in clinical trials, but analyses most often don't separate the effects of interventions by sex, ignoring the biological and psycho-social differences between men and women and thus limiting the applicability of research results. Pregnant or breast-feeding women are routinely excluded from drug

trials and prescribing to these groups is therefore based on limited evidence for safety and efficacy.

Dr Cooper moved the discussion to older women's mental health. As 2/3 of people aged over 80 are women, older people's mental health is necessarily women's mental health but despite this it seems that services don't always work well for women. For example, women with dementia are less likely than men with the condition to be prescribed anti-dementia medication. The role of so many older women as carers was also highlighted.

Sarah Ditum questioned the extent to which mental illness as a social construct had changed over the past century. There is a history, she argued, of treatments for mental illness being used as tools to reinforce rigid gender norms and silence female voices, often in coercive and punitive ways. Freud's 'Dora' case study was used to demonstrate the way in which professionals can undermine and alienate women who are seeking help – although the way in which we practise has changed, the underlying processes might still be relevant.

@Sectioned had used Twitter prior to the debate to gather views about the most important aspects of women's mental health. Amongst a wide range of responses, the routine use of mixed sex wards seemed to be the most pressing issue. @Sectioned added to this with her own experiences of in-patient care and argued that many women would feel safer, not only on a single-sex ward, but also being cared for by female-only care teams. This idea provoked debate and stimulated some lively exchanges with the audience.

The audience as a whole were highly engaged and raised a number of topics related to women's mental health in the ensuing discussion, with several questions coming from those following on Twitter. These included: the best ways to improve management of specific disorders (how research can lead to better treatments for eating disorders and improve knowledge of pre-menstrual dysphoric disorder), the need to think much more broadly about gender in mental health services (including issues affecting people of non-binary gender), and the role of ethnicity and culture in influencing care and individuals' experience of services. Many people stayed on for the drinks reception afterwards to make connections and continue discussion in a more informal atmosphere.

We found the evening was enjoyable and thought-provoking. Of course not all the issues related to women's mental health were explored, much less resolved, but the #MHQT series is a stimulus to the conversation and an opportunity to consider important issues that the pace of working life might not usually afford. The inclusive format brings new ideas and perspectives that are, at times, challenging, but certainly necessary if we are to improve mental health services for all. The ability to convene experts from a range of backgrounds with members of the public is an added strength. #MHQT are keen to hear feedback and new ideas for topics and suggestions for future panel members (@MentalHealthQT). Further events are in the pipeline and we'd

definitely recommend attending for an informative and spirited evening. And don't worry if you missed it – you can catch up on the #MHQT on women's mental health here.

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Dr Rory Sheehan & Dr Farhana Mann |

@dr_rorysheehan
@FarhanaMann

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*FaceTime with Dr Brendon Stubbs*

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**Dr Stephanie Young**

***Dr Stephanie Young interviews Dr Brendon Stubbs, Head of Physiotherapy working in the South London and Maudsley NHS Foundation Trust***

***@BrendonStubbs***

**1. Tell us how a little bit about how you came to work in mental health?**

I came in to work in mental health by chance. After qualifying as a physiotherapist in the summer of 2003, I planned to take it easy for a few months. My Mum was head of pharmacy in a mental health hospital and asked me to "go in for a chat" with the head of physiotherapy. Shortly afterwards, I was attending an interview and have never left mental health since.

**2. What aspects do you find the most interesting in your clinical role?**

The most interesting part of my role is the diverse range of patients I see, with an extraordinary array of presentations. There is still nothing quite like helping an individual one on one, who may be in immense pain or unable to mobilise, to becoming safe enough with their mobility to go home to an upstairs accommodation for instance. As a physical therapist, I have always been interested in the physical health of patients and it has been nice to see this area change over the past decade in particular.

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**3. How much do you think that we as health care professionals can influence our patients to adopt more healthy lifestyles?**

I think we have a considerable role in advising our patients to become active. Regardless of why I am seeing a patient for physiotherapy, I will always recommend that they sit less and move more and mention that this is something I am trying to do in my own life also. It is really powerful when a clinical team and health care professionals move from the notion that healthy living is not just a “nice-to-have” / desirable goal, but when it becomes central to our conversations with patients and our advice.

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**4. Tell us about your research into the effects of increasing physical activity in patients with severe and enduring mental illness?**

I first become interested in this area of research around helping people with severe and enduring mental illness (SMI) to be more active in early 2006. I realised for quite some time that this was a very sedentary population and in early 2007, I published the first paper on an audit of physical activity levels among older inpatients with SMI and what factors influenced this. Since then, I and many colleagues have conducted a large volume of work demonstrating the benefits of physical activity, what factors influence physical activity and how we may be able to increase this. At the moment, I am the lead author of European Psychiatric Association guidelines on the benefits of exercise for people with SMI and I am helping to run a small RCT called "Walk this way" to help people with SMI in the community to sit less and move more.

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**5. Promoting smoking cessation in mental health units has largely been welcome, with some good success stories. How do you think a similar message around promoting exercise could be achieved and what would be the challenges? (for example, in inpatient and community settings)**

I think this is an excellent comparison to make. I recommend that we begin by adopting a similar approach, such as using the 5 A's (ask, advise, agree, assist and arrange) around physical activity, and then we can start to get physical activity on the agenda and make every contact count. Naturally, there are a number of unique challenges depending on the setting, but none of these are insurmountable and can be overcome with creativity.

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**6. What advice would you give to trainee psychiatrists about how to motivate patients to do more exercise?**

I would recommend that you make every contact with people you work with an opportunity to discuss physical activity and promote it. This could be following the 5 A format, or by simply recommending that your patients sit less and move more. The latter is something I recommend to all the people I work with and will encourage patients that even making small lifestyle changes (e.g. getting off bus a stop earlier, standing up and walking a short distance every 30 minutes to break up excess sitting) is a great start to becoming more active.

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Dr Brendon Stubbs

Head of Physiotherapy working in the South London and Maudsley NHS Foundation Trust

@BrendonStubbs

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*Culture Vulture: Anatomy of a Suicide*

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**Dr Matthew Rinaldi**

Is suicidality inheritable? That is the question Alice Birch is exploring (among many others) in her new play, ‘Anatomy of a Suicide’ at the Royal Court Theatre in Sloane square. Some free tickets are still available to NHS employees.

The play explores concepts in a way that only a play can. Alice Birch puts 3 generations of women side-by-side (literally) on the stage, concurrently. The audience see scenes from their young-adult life and how the suicide of the grand-mother (stage left) is processed by two subsequent generations of women (centre stage and stage right).

This leads to joyous cacophonies of noise as the three women interact with people in their individual time-lines, all talking over one another but in an incredibly organised, precise manner; like an orchestra. The moments when their conversations align are things of beauty, reminiscent of synchronicity: the exploration of greater meaning behind simultaneously-occurring events. It is at these times that Alice Birch calls to our attention suicide’s legacy through the blood-line, almost as if we are watching a trans-generational family therapy session.

Psychiatrists rejoice! Finally there is a piece of art which we can watch without sneering at how implausible or unrealistic is and we can switch of our criticism of the doctors and truly experience the impact of mental health problems, faithfully depicted by the small cast. There is even a hyper-realistic ECT scene which shows clearly that the director, Katie Mitchell, has researched the play beyond watching One Flew Over the Cuckoo’s Nest. What really stood out for me was the development of psychiatric practice over the 60 years that the play spans from the dismissive, authoritarian psychiatrist sat behind a desk who insists solely on ECT treatment, to the present-day doctor carrying the weight of a modern, understaffed A&E department.

This is the kind of play that you will want to go back and see time and again and study the script- the acting, scenery, ideas, dialogue and costume-changes are so slick that I am sure I missed half the play’s central themes the first time around as I was so bowled over by the production and experimental nature of

the piece.
And do not fret, despite the title, it is outrageously funny at times.

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Dr Matt Rinaldi| MatthewRinaldi@nhs.net

CT2 Psychiatrist

## *Conference Watch: Mental Health Law & Human Rights Act*

**Dr Matt Hartley**


The London Division teamed up with the Special Committee on Human Rights (SCHR) to organise a half-day conference at the Royal College. It brought together a range of perspectives on how best to respect the human rights of our patients, both in practice and in law.

Dr Abdi Sanati of the SCHR welcomed the delegates and gave an account of the inception of international human rights legislation following the atrocities of the second world war, drawing from the powerful words of a Nuremberg lawyer. He emphasised the fundamental and universal nature of Human Rights and their enduring importance. He went on to introduce the three speakers and the programme for what promised to be an absorbing afternoon.

Dr Tim Exworthy spoke convincingly on the human rights-based approach to healthcare of FREDA; Fairness, Respect, Equality, Dignity and Autonomy. He linked each principle to relevant articles of the European Convention on Human Rights, for example the clear connection between Fairness and the right to a fair trial. The principles should be viewed as a quintet rather than in isolation, he argued. Together they represent a ‘bottom-up’ approach to Human Rights that can guide all healthcare professionals without the need for technical knowledge

of the Human Rights Act. He drew from aspects of current practice and legislation to show that FREDA encapsulates much of what we already do. It was suggested that identifying and raising awareness of 'FREDA moments' could help clinicians offer healthcare that places our patients' human rights at the heart of practice.

Anne-Laure Donskoy spoke passionately about the United Nations Convention on the Rights of Persons with Disabilities (CRPD). She asserted that the implications of the convention are wide-ranging and challenge current psychiatric practices deeply. She claimed the convention demands each individual be viewed as a subject before the law rather than an object of charity. She called for a paradigm shift in the treatment of persons with disabilities related to mental illness "from coercion to respect". Describing herself as a "survivor of psychiatry", Ms Donskoy argued for an end to all compulsory treatment. She spoke of alternatives to the status quo, including a shift towards peer led support, advocacy services and crisis first-responders from a social work background. She concluded by stating that the convention has brought together previously disparate organisations, emboldened to reframe disability in a human rights context.

Finally, Prof George Szmukler gave a timely update on the 'fusion-law' proposal. He argued assuredly that the Mental Health Act of 1983 discriminates unfairly against those with mental disorder because the disorder + risk schema does not give the appropriate respect for autonomy demanded by mainstream medical ethics. The proposed solution is a single comprehensive framework that incorporates capacity into the criteria for compulsory powers and draws from the strengths of existing civil commitment and capacity-based legislation. Prof Szmukler gave a different perspective on the CRPD. He agreed that it called for an end to discrimination and that the Mental Health Act 1983 is "clearly non-compliant" with the convention. However, he denied that the convention precluded compulsory treatment in all forms and claimed that a fusion-law proposal could be compliant because it would be generic, applying equally to all regardless of diagnosis and thereby making it "disability-neutral".

The panel Q&A session made patently clear how relevant and polarising the afternoon's issues are in the current climate. The recent commitment from the government for reform of the Mental Health Act was raised and a heated debate ensued on both the value of mental capacity as a criterion for compulsion in psychiatry and the potential destabilising effect of a statutory change. A spirited defence of the Mental Health Act was mounted by some practicing clinicians who claimed that decision-making capacity was already incorporated into their MHA assessments. The idea was put forward by Prof Szmukler that a "shadow of coercion" still hangs over psychiatry and it was suggested that a change in the law could address this. The temperature in the room rose by a few degrees due to the perceived implication by some that clinicians fail to show enough

respect to their patients, although this was strenuously denied. The discourse strayed perilously close to the boundaries of civility but just about remained cordial.

These are interesting yet uncertain times, with increasingly explicit language from those in power about a shakeup of compulsory powers. What form a new law would take is as yet unclear, but perhaps a human rights-based approach could help guide us through the fog of legal reform.

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Dr Matt Hartley

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## *Conference Watch: Reflections on the IoPPN Summer School*

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**Mao Fong Lim**

How does one change the future practice of psychiatry? Cutting-edge research aside, a crucial step to this would be, of course, to start with future doctors like myself. When I signed up to attend the IoPPN Summer School, I wondered what it might have in store for me. As a medical student at King's, fresh out of my 3rd year, I wondered what it might add to my existing experiences – having had the good fortune to have my psychiatry placement across various sites at SLaM.

I've always been drawn to summer schools and conferences – valuing the connections made within a gathering of like-minded and enthusiastic peers (a bit of wishful thinking – the best, the brightest?). The tone of the lectures seems to differ from what is offered on the usual curriculum. While they may be heavy, there is a sense of freedom that we are there for the knowledge – and that none of this will be tested in our exams (yet).

In a very refreshing way, the Summer School gave us all snapshots of what I

love most about being in King's, and in London in general. From day one some of us were thrown into the deep end in Extreme Psychiatry, a teaching program that aims to equip students with the skills to take a psychiatric history anywhere (inspired by Extreme Ironing. Look it up!).

We were treated to a broad range of talks, from a compelling lecture about homelessness and mental health, to the fascinating account of a military psychiatrist's training on the front line. Dr Charlotte Wilson-Jones walked us through several defining moments of her career as a liaison psychiatrist, each a moving account and a lesson learnt – leading up to "The Big Question", while Prof Sir Simon Wessely made us think about our own questions, holding us in dialogue (as his first engagement not as RCPsych President!) in his usual, candid and engaging style. We explored the grounds of Bethlem, with site visits to the forensic units, a great opportunity to learn more – and indeed, challenging many of our preconceptions about forensic psychiatry.

I myself was challenged, in a different way, when I debated against the motion "Should smoking be banned in all psychiatric hospitals?" alongside Dr Tim McInerny. As a non-smoker and a non-debater, it was an interesting exercise in taking perspective and being "the other". While the majority of the audience remained against the motion, the debate went to the proposition, Dr Rob Harlan and Dr Timothy Ghan, whose eloquent arguments had managed to swing more votes to their side.

I also enjoyed how the summer school showcased the broader aspects of psychiatry. As an artist and an appreciator of the arts myself, I particularly enjoyed our tour of the Bethlem Museum of the Mind – a very conscious curation of not just the coloured history of psychiatry, but also art made over the centuries by patients at the hospital. One evening was spent in the Sunshine Arts Café under the railway arches, watching and discussing Woody Allen's "Zelig". While a few days later we ventured out to Frank's Café in Peckham, after a heavy discussion about psychosomatic illness in the "Reading the Mind" Book Club. We were also hosted at the RCPsych for an evening reception – getting a sneak preview of Dr Adrian James' feature in the BMJ, as well as a mini tour of the old books collection.

Interestingly, the event that stood out for many of the students was the "Careers Speed Dating". Organised by Dr Charlotte Wilson-Jones and the KCL Psychiatry Society, it brought together psychiatrists from across different subspecialties to give students some insight into their subspecialty. For some, it was the first time they had been introduced to a certain subspecialty, or had the opportunity to speak to a consultant in that area.

Perhaps this is what makes something like the IoPPN Summer School so special – that there is so much passion (a word that will get you a yellow card

from Sir Simon) exuded by everyone that has been involved, year after year. In fact, the co-chair, Dr Tom Reilly, was a student himself at the very first IoPPN Summer School. It's one thing to tell students that psychiatry is the most fascinating and fulfilling specialty out there. It's another thing, altogether, to show it – and allowing each student to have a glimpse into psychiatry and psychiatrists alike, leaving us with an inkling that this might really be what we want to do, or what we might want to be like, in the future.
Would I add five more days to my psychiatry rotation? Yes. Would I add five more days of the summer school to it? Absolutely. For all the insight and inspiration (sorry, another yellow card) from the wonderful students and psychiatrists – this truly has been an IoPPN-er for me (read, eye-opener).

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Mao Fong Lim

Medical Student,

King's College London

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*Round Up- London Division Executive Committee Meeting, 14 June 2017*

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1. **Feedback from the College Committees** a) The following was reported by the Chair, Dr Shakeel Ahmed
   The College continues to work on the recommendations of the Crisp Commission on Acute Adult Psychiatric Care.
   There is a College collaboration with MindEd, an organisation that produces information about children and young people's mental health – members will be encouraged to get involved in this in the future.
   'Supported and Valued', the trainee-led review of morale and training has now reported results and the authors have made recommendations for Trusts to improve the working life of junior doctors.
   b) Recruitment Committee – Dr David Codling, Trainee Rep
   There is an increasing trend for trainees not to move directly to into specialist training programmes after the Foundation years which has implications for recruitment.
   The support needs of international medical graduates were discussed in light of the lower pass rate in Membership exams. Mentoring and exam preparation groups for international medical graduates could be beneficial.

c) Policies and Public Affairs Committee
The Division aims to keep conversations open with the Mayor's office.
d) Leadership Committee
Dr Sujaa Rajagopal-Arokiadass will continue as the LMC London Division chair. Volunteers for additional LMC rep are sought.
e) Mentoring
The London Division mentoring lead is Dr Therese Shaw.

2. **London Division Projects**
   a) Primary care liaison – Dr Mark Ashraph
   The College wellbeing event for GPs on 12th June was well attended and received very positive feedback. Dr Ashraph and Dr Rachel Duncan were thanked for putting the programme together.
   b) Trainee and Foundation Doctors engagement – Dr David Codling
   The benefit of regular College events for medical students and Foundation doctors was discussed and the practicalities of these will be considered.
3. **London Division Events**
   a) Recent events
   The recent mental health law and human rights act event was particularly successful and attracted over 100 delegates. Dr Ahmed thanked Dr Abdi Sanati for his help in arranging this event.
   b) Upcoming events
   Please follow the link to view upcoming London Division events.
   http://www.rcpsych.ac.uk/workinpsychiatry/divisions/london/events.aspx

SAS Event
Wednesday 20th September 2017
Time: 9:30-16:30
Venue: Royal College of Psychiatrists, 21 Prescot Street, London, E1 8BB

If you have any technical queries, please telephone Tandeep Phull - London Division
Co-ordinator on 020 3701 2711

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< < Back to eNewsletter Summer 2017

**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.

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**London Division Regional Representative Vacancies**

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

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**London Division Events**

The London Division hosts a number of events each year. Take a look at our Events page for details.

London Division first Mental Health Law and Human Rights Act event took place on 23rd May 2017 at the RCPsych with over 100 attendees. The session propose a three way exploration between different perspectives of the interface between Mental Health and Human Rights legislation in the UK. This is a growing debate in the UK but it will be of interest to other countries and to other areas such as physical health.


Speakers for the Mental Health Law and Human Rights Act Event photographed above. Listed Left - Right, Dr Shakeel Ahmad (London Division Chair), Dr Tim Exworthy, Dr Abdi Sanati, Anne-Laure Donskoy, Professor George Szmukler.

Another successful event was a joint event with the RCPsych London Division and RCGP - Wellbeing for GPs which took place on 12th June 2017. The session reviewed and supported doctors on how to manage work pressures. Covering topic areas such as resilience, the ability to develop positively and learn from experience by looking realistically at dynamics at work in healthcare settings and how to build better relationships with the people we work with. Mindfulness, being present in the moment and self aware of your surroundings, thoughts and feelings. How medical doctors can support doctors in difficulty and looking after yourself by identifying the warning sign of compassion fatigue.


Speakers for the Joint Wellbeing Event for GPs photographed above. Listed Left - Right,
Dr Clare Gerada, Dr Jane Marshall, Dr Mark Ashraph.

Back to top

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**thepsychiatriceye@rcpsych.ac.uk**

**London Division Editorial Team**

Dr Afia Ali
Dr Rowena Carter
Dr Matthew Francis

Tandeep Phull (Division Co-ordinator)

Coral Josephs (Divisions Manager)
Dr Rory Sheehan

@ThePsychEye

Dr Chris Symeon
Dr Stephanie Young

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

**"Sex, sweets and smoking "- how do psychiatrists balance what we believe our patients' optimal lifestyle choices should be, versus respecting their human rights? Is there a paternalistic/ holistic divide? "**

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