



The Psychiatric Eye

The London Division eNewsletter

'Stories of psychiatry in London over the years'



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Editorial

In 1841, Dr Samuel Hitch, then-resident superintendent of the Gloucestershire General Lunatic Asylum, founded the first predecessor to the Royal College of Psychiatrists. Flashing forward to today, we welcome you to the Autumn 2021 edition of the Psychiatric Eye, in which we join the College in celebrating its 180th anniversary, and look back on the history of psychiatric practice in London.

Our contributors have reminded us of the historic large institutions and asylums and recall past psychiatric practices, some of which would be objectionable in these days of patient-centred care and recovery. Dr Jean O'Hara reflects on her experiences as a younger psychiatrist and being struck by what she saw when visiting a long stay hospital in Leytonstone. Dr Julia Topp writes a fascinating description of the Surrey County Asylum and a tragic case of a patient who died after a cold shower and "tartar emetic". Drs Ayomide Ajayi and Azmathulla Khan Hameed give us an example of a doctor whose experience of treating shellshock during WW1 led him to open a clinic on Harrow-on-the-Hill and, subsequently, the Tavistock Clinic. Miss Pearl Metry discusses the centenary of the well-known psychoanalytic institution Cassel Hospital, with commemorations including a special quilt and a gardening project, no less! We should not forget the importance of the relationship between mental health and artistic creativity, which is highlighted in Dr Emmeline Lagunes-Cordoba's article about the inspirational paintings produced by inpatients from the Bethlem Royal Hospital over the years. And in our prize-winning article, Dr Isabel Marks reflects on reported suicides in London between 1841-1920, emphasising how women were often described in the St George's archives very uncharitably. This is a wake-up call to all of us working in mental health, that we must continue to vociferously address stigma and inequalities for the betterment of our patients.

This issue, we reinforce our local identity by launching the "RCPsych London Eye" section, featuring your stories from across the London area. It's an opportunity to bring together our diverse community and share our successes, difficulties, and noteworthy events. We are so pleased with the initial response to the section! It seems our division members are turning their eye towards media for raising mental health awareness: Dr Azmathulla Khan Hameed and Ms Valma James used the radio to highlight mental health issues related to autism while Dr Parvinder Shergill made a documentary with service users, looking at positivity during the pandemic. Speaking of positivity during the pandemic, Dr Azmathulla Khan Hameed writes about how our diverse healthcare community is uniting to meet the COVID-19 challenge. Of course, the pandemic is not over by a long shot, and Dr Christina Barmpagianni writes about how important the December holiday season will be to give Londoners a sense of hope. Finally, Dr Amit Mukherjee explores the work Southall Black Sisters do to support Black and ethnic minority women who experience gender-based violence, and the organisation's findings regarding mental health.

Our Culture Vulture section features a timely (at the time it was written!) look at the Olympics and the mental health of athletes in the spotlight, in an article by Dr Mayur Bodani. Meanwhile Dr William Rippington reports from a screening of a film about the queer Asian community's experience of increased discrimination during the COVID-19 pandemic, and considers the mental health implications.

We hope our efforts to zoom in even closer to our London area will help foster a sense of closeness between us all, as we head into the dark winter season. Next issue, we want your articles on social interventions in psychiatry, so get your thinking caps on! And we want to expand our stable of editors, so if you'd like to join us, do email ThePsychiatricEye@rcpsych.ac.uk for more info.

Stay safe, and Happy 180th!
Stephanie and Sachin



Chair's Message

By Dr Peter Hughes



In this edition we recognise the history of London and mental illness. The College celebrates 180 years as an organisation dedicated to mental health. This is an amazing achievement that we honour with this edition.

For many of us like myself, we have worked through many years in London and seen huge changes first hand. We have seen a huge program of de- institutionalisation and modernising of health service delivery. In London we have the oldest Psychiatric Unit. We are proud of the famous names of psychiatry that hail from London that have given so much to patient care in the Capital.

In other news, we have appointed to new roles in the division on wellbeing, diversity and sustainability. We also have a new lead for mentoring and a new recruitment lead. All these reflect London's changes and shifts of focus.

I take this opportunity to launch as well our new awards initiative for London. This will celebrate achievements in London and will serve to form to strengthen the identity of the London Division.

We hope you will enjoy celebrating our history and diversity through this edition.

Dr Peter Hughes
London Division Chair

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Winning Article

Congratulation to Dr Isabel Mark for winning Best Article for the Autumn 2021 Edition for their submission:

'Reflections from analysing post-mortem findings from suicide in London between 1841-1920: how were women represented?'

Read all about it on page 5.

Disclaimer

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



'Stories of psychiatry in London over the years'

By Dr Jean O'Hara

On the College's 180th anniversary, I think back to 1981, 40 years ago, when I was a medical student on placement in psychiatry as part of our clinical training. It was the London Hospital in the East End. At the time, the Department of Psychiatry included Sir Desmond Pond (the first professor of psychiatry at the London, credited for bringing psychiatry into general practice; epilepsy into psychiatric practice); Colin Murray-Parkes (who set up one of the first hospice-based bereavement services and specialised in grief and bereavement); Sidney Crown (an adult psychiatrist and psychotherapist in psychosexual disorders); John Cookson (an adult psychiatrist with expertise in psychopharmacology); and David Cottrell (a child psychiatrist with an interest in evaluating psychological treatments). In outpatient clinics we clerked a new patient, presented the case in front of our peers, then invited the patient in to be interviewed by the consultant. I remember my first clerking on the third floor of a rather unwelcoming and shabby outpatient building; a young man debilitated by social anxiety. We were also allocated an inpatient ward. The 'lucky ones' got Rachel Ward, a psychiatric unit on the first floor of the main London Hospital building on Whitechapel Road, its entrance signalled by a well-maintained tank full of tropical fish. Most of us were sent to St Clements, the psychiatric hospital on the Mile End Road. I was with Dr Jeremy Pfeffer, who was little over 5 feet but described by colleagues as 'the smallest giant in psychiatry'.

The day that stuck most in my mind though, was a day trip to Leytonstone, in the London borough of Waltham Forest, to visit a long stay hospital for the 'mentally handicapped' (now known as learning or intellectual disabilities). Leytonstone House was a large Georgian, Grade II listed building, built around 1740, and previously home to two politicians. The hospital itself was mainly a 'dormitory suburb of small houses' built between 1870 and 1910. Big wrought iron gates separated the busy 'Greenman' roundabout from the hospital grounds. After a brief welcome by the consultant in charge, we had a succession of seminars covering the 'causes of mental handicap', the increased vulnerability to abuse and the higher risk of physical and mental disorders. After a coffee break, patients were paraded in front of us, while the consultant regaled us with dramatic anecdotes, shared case histories and demonstrated the physical signs of syndromes and disorders often associated with learning disability. It was a classic 'Tredgold' introduction, with a focus on mental deficiency, the need for segregation and institutionalisation with 'cradle-to-grave' services and an educational philosophy with training centres and sheltered workshops which we visited on site. We heard

stories of women being admitted for life because they had borne illegitimate children; others admitted for petty offences; and others with severe behavioural problems. In those days families were often advised to send their disabled child or relative into such places. It was thought to be the kind and right thing to do. Walking around the grounds and visiting the wards, I saw a woman with Down Syndrome in her 80s being fed. She was their oldest resident. There was also a respite service, an admission ward and in the past, I believe, a children's ward. The prevailing sense I came away with was one of great sadness and lives lost, and I vowed to treat every patient I saw as a person, with their own voice, strengths, and needs.

Eleven years later, in 1992, I returned as a consultant psychiatrist in intellectual disabilities, to the Royal London Hospital (granted its Royal title in 1990 to celebrate the 250th anniversary of its opening on the Whitechapel site). Many consultants from my medical student days were still in the Department, and it felt surreal to be joining as their colleague! I started to know my caseload, the majority of whom were from the Bangladeshi community; the previous locum consultant had been partial to using lithium and almost all were on this medication. I went about doing a medication review for all my patients. I revised the teaching offer to medical students, and then to other clinical students, bringing in people with learning disabilities and their families and colleagues from the voluntary sector, to deliver part of the training; and I set up the first consultant CPD group for the North East London Region, which met monthly, to share case discussions, learning, audits, QI projects and research.

The service director had waited until I started then promptly left for another post outside the organisation. I found myself taking on the additional role as clinical head of service with the management team reporting directly to me, and I to the Director of Operations. It was a flat management structure at the Royal London, covering inpatient, outpatient, and community services. My directorate was one of several including medicine, surgery, and psychiatry. It had a large multi-disciplinary community team, a Bangladeshi Parent Adviser service for children and adults, a volunteer parent advisor service, Homes for Life, and a residential respite unit as well as day care. During my 12 years there we went through several major reconfigurations, including a year as the City and East London Family and Community Services (CELFACTS) designed to bring together acute, community, mental health, and primary care under one



umbrella. Around this time, professional general managers were brought into the NHS, separate Acute and Mental Health Trusts were formed, and I was admonished for speaking directly with commissioners.

Why did I stay on in clinical management and leadership roles when it was regarded as 'crossing over to the dark side'? Because I fundamentally believe clinicians need to have a voice in deciding how to make best use of resources, and how to deliver better care. The pendulum has swung, and we are seeing clinicians as an integral part of inclusive leadership teams, taking on transformational challenges, bringing 'mind and body' together, partnership working, and actively listening to the patient voice. The Covid-19 pandemic has not only shone a light on the importance of mental health, but on the importance of public mental health and addressing health inequalities, particularly for those living with severe mental illness and those with learning disabilities.

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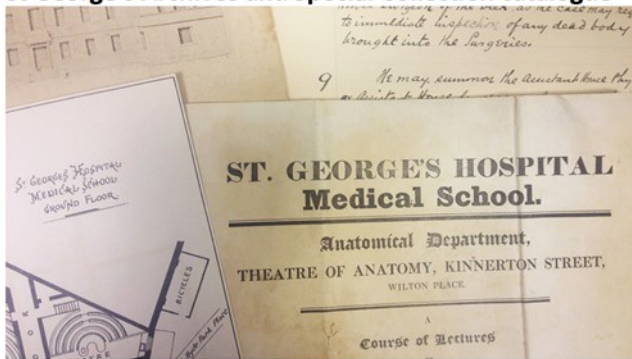
'Reflections from analysing post-mortem findings from suicide in London between 1841-1920: how were women represented?'

By Dr Isabel Mark

There has been a marked decline in suicide rates in England and Wales over the past 50 years, coinciding with its decriminalisation in 1961 (1). Before then, rates had been on the rise (1). Thomas and Gunnell (2010) analysed the trends of suicide in England and Wales over the last 2 centuries, shedding light on potentially preventable factors, as well as the impact of socioeconomic stressors (1). I aimed to do the same by studying how trends in London compared to those at a national level within the same time period.

St George's Hospital is one of the leading hospitals in London, situated centrally in Hyde Park Corner until 1980. By accessing the recently developed St George's University of London (SGUL) archives, entitled "Opening Up the Body: The Post Mortem Case Books of St George's Hospital", I stepped back in time, reading case files dating back to 1841, coincidentally the same year the Royal College of Psychiatrists was founded. The experience opened my eyes to how suicide was previously determined and reported.

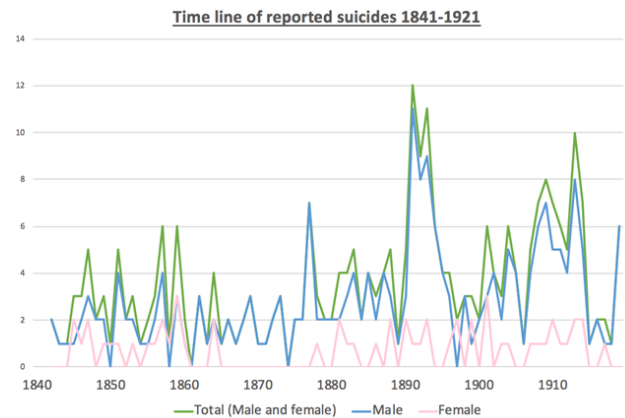
St George's Archives and Special Collection catalogue



General trends of reported suicides in London 1841-1920

Suicide rates in London gradually increased from 1890, with male suicide rates forming 2 distinct peaks, in the early 1890s and then between 1905-14, with a clear trough during World War 1 (WW1). Results were consistent with national trends (1). Perhaps suicides increased over this time because of a limited availability of healthcare and social support during a time of increasing industrialisation. In addition, it may have resulted from less supportive attitudes towards mental health. Thomas and Gunnell hypothesised that high unemployment rates and financial stressors would have affected men in the 1890s, as they more commonly had financial responsibilities (1). Likewise, in the years building up to WW1 there was reportedly less economic stability, followed by the majority of men being conscripted into the war.

Interestingly, I also found that 18.7% (males: 19.5%, females: 14.2%) of entries suggested doubt as to the cause of death, assuming suicide but stating that "murder" or "accidental trauma" could not be excluded. Perhaps some were too quickly labelled as "likely suicide". London was a rapidly expanding city in the 19th century, with high crime rates and fears for personal security, leading to many carrying weapons for protection (2). When studying the SGUL Archives, London appeared to have higher levels of knife use (stabbing/cutting) and gunshots, compared with national figures, potentially reflecting the ease of availability and access at the time.



How did gender affect the reported trends?

Female suicide rates were consistently lower and more stable throughout the 80 years in question. I found that there was a younger age distribution in London for both genders, compared with national data. Maybe this was due to younger individuals living in or near central London at the time, tempted by the prospect of employment opportunities. Prior to 1880, female suicides were on average 10 years younger than that of males, although it is not clear why this would have been the case and was not reflected in the national statistics.

The archives also revealed that women generally opted for the less violent methods of suicide, with poisoning being the most common. National data replicated this, theorising that women favoured poisoning as it was generally believed to be relatively painless and less disfiguring (1). The range of poisons used was significant (opium, arsenic, cyanide, belladonna, oil of bitter almonds, sulphuric acid, prussic acid, hydrochloric acid, carbolic acid, oxalic acid, corrosive sublimate, to name but a few), highlighting the wide range of poisonous substances readily available at the time.



Women's stories in the archives: how were they described?

56 women were reported to have had post-mortems at St George's Hospital following suicide. 4 were post-partum and 2 had experienced a recent bereavement. The rest did not identify any suspected or possible triggers. When describing the suicide, language which would now be considered stigmatising and derogatory was commonly used, and notably more so for the females than males. Terms included "deranged", "insane" and "hysterical".

Some examples were as follows: A 19-year-old was reported to have been "subject to what were considered to be hysterical fits, when she manifested symptoms of derangement" (1845). A woman of no stated age was reported to have "thrown herself out of window about 40 feet from the ground. Her friends say she has been insane for the last 20 years" (1857). A 37-year-old woman was reported as having been "desponding and uneasy, having as her daughter said 'something on her mind'. She had previously had fits of insanity, the nature of which was not ascertained" (1864).

I've read that terms such as these were historically used more commonly for females than males (3). There has been extensive writing on the gender divide with regards to mental health over this period, and many theories have been proposed. For example, in the late 19th century, physicians often attributed mental illness in women to hysteria, stemming from a lack of conception and motherhood (4). In the early 20th century, it was hypothesised that women were more vulnerable to stressors due to their biological make-up, leading to potential psychoneurosis and melancholia (4). Some more recent theories discuss the historical use of psychiatry as a political means of controlling women and restricting their roles in society (3).

The SGUL archives provided me with an interesting opportunity to reflect on the presentations of these vulnerable individuals and how they might have been affected by the sociocultural developments of the time. By highlighting their stories, I hope we will not take current, more understanding and tolerant, approaches to mental health for granted. We must continue to target stigma and stereotypes, aiming to improve mental health care for all.

With thanks to the [SGUL archives team](#).

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'Surrey County Asylum and the case of Daniel Dolley'

By Dr Julia Topp

In the first half of the nineteenth century, attitudes towards the care of 'pauper lunatics' began to change, e.g. it was less socially acceptable to consign them to workhouses or prisons. In 1845, two bills were passed in Parliament that meant:

- All counties in England and Wales were expected to set up public asylums where patients who were poor and mentally unwell could receive appropriate shelter, care and treatment
- A Lunacy Commission was given powers to inspect and license these asylums and investigate cases of alleged cruelty

The county of Surrey was ahead of the curve. Building of its public asylum started in 1838 'in response to the growing expense of farming out the county's chronic insane to private, licensed houses in the metropolis'. It was set within 100 acres of Springfield Park, close to Wandsworth Common, and was financed by the Surrey Magistrates. Designed to accommodate 350 patients, its doors opened in 1841 to an initial cohort of 299 men and women.

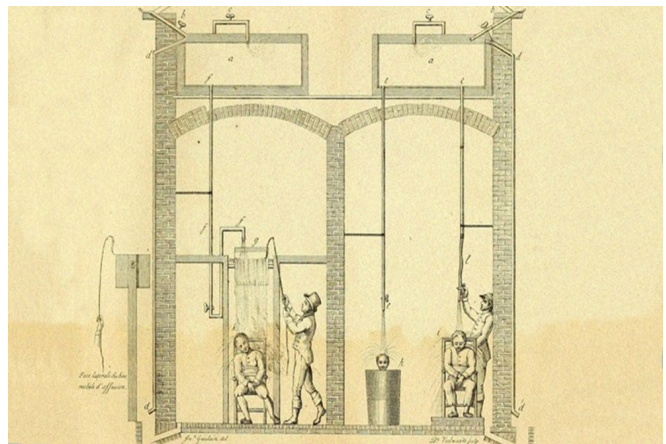
At the time of the 1844 Lunacy Report, the Surrey County Asylum was considered an exemplar, e.g. it had under floor heating and a working farm! The original building, recently converted to luxury flats, still stands within the grounds of Springfield University Hospital in Tooting, the main site for South West London and St. George's Mental Health NHS Trust.

Unfortunately, by the 1850s, patient numbers at the asylum had risen to 800, with no expansion in accommodation. Every spare space was used to house patients, including exercise areas, workshops and basements. A Committee of Visiting Justices had been appointed to control finances, sanction patient admissions, hire and fire staff and dictate asylum regulations. At the time, there were just two physicians: Mr Diamond overseeing female patients and Mr Snape overseeing the male ones. The Committee demanded that the physicians (today's psychiatrists) see every patient on a daily basis!

On 9 April 1856, a 65-year-old patient called Daniel Dolley collapsed and died, shortly after receiving treatment ordered by Mr Snape: a cold shower-bath and tartar emetic. Mr Snape duly carried out a post-mortem and sent a report to the Coroner, describing a finding of extensive heart disease. At the inquest on 12 April, the Coroner attributed Daniel's death to natural causes.

And that might have been where the story ended, but...

A day before the inquest, an anonymous letter was sent to the Lunacy Commission giving an account of Daniel's death. Apparently, he had been in an 'unusually excited state' and had struck Mr Snape, who then ordered a shower-bath lasting 30 minutes, involving three cisterns holding a tonne of water each.



The Lunacy Commission, galvanised by a possible case of abuse, set up an independent inquiry chaired by the leading reformer Lord Shaftesbury. He applied to the Coroner for a transcript of the inquest, asked Mr Snape for a copy of his post-mortem report and called asylum attendants (today's nurses and HCAs) plus Mr Diamond as witnesses. Crucially, Mr Snape was not called to give evidence in person.

When questioned, the attendants said they did not feel the shower-bath had been ordered as a punishment. They acknowledged that 30 minutes was longer than a typical shower-bath but did not think Daniel had displayed any ill effects at the time of the therapy. In contrast, Mr Diamond said he was concerned about the circumstances of the death and so had attended the post-mortem where he had disagreed with Mr Snape over the extent of the heart disease present. He told the Commissioners he felt the treatment, and not a heart attack, had been the cause of death.

On 19th June, Mr Snape appeared at Bow Street Magistrates Court, charged 'that he did feloniously kill one Daniel Dolley', and was committed for trial at the Old Bailey. The press pre-emptively accused Mr Snape of cruelty and warned of a return to the 'bad old days'. The medical profession was alarmed by the implications of the case; would physicians ever be brave enough to try new therapies in such a climate? Shower-baths, albeit in



shorter form, were not uncommon at the Surrey County Asylum and the Lunacy Commission had never objected to the practice during previous inspections. An article in the 'Journal of Mental Sciences' pointed out that Mr Snape's motives would need to be established, or else a 'physician might be convicted because of a treatment honestly prescribed'.

The case came to the Old Bailey at the beginning of July. When initially addressing the jury, the judge himself hesitated at the charge of manslaughter, offering his own opinion that shower-baths were preferable to old methods of restraint, such as straight jackets for 'lowering patients' (reducing their agitation). The prosecution and defence widely canvassed the opinion of medical experts, and the defence also put forward expert opinion from civil engineers and a meteorologist! When Mr Snape gave his own account, he described having used shower-baths and emetics on other agitated patients with good effect. He took the fact that a patient had struck him (the first time in his career) to indicate a high degree of agitation, plus he knew Daniel could be 'dangerous', so felt an extended shower-bath was appropriate.

The jury quickly concluded that Daniel's death did not involve any criminal action on the part of Mr Snape and he was acquitted.

As a result of this verdict, the asylum Committee reinstated Mr Snape, but he was financially ruined by loss of salary and defence costs. Dissatisfaction was expressed with Mr Diamond's conduct, but he kept his post overseeing the female patients. Shower-baths were allowed to continue, but the Committee demanded that the exact duration be entered in the patient notes. The case for extended shower-baths as a legitimate treatment was never properly assessed.

Although we may think that the mental health services of today are very different from the asylums of the 1800s, much about the tale of Daniel Dolley surely resonates. Psychiatrists continue to use therapies where the basis for how they work is not fully understood. Clinical practice is still affected by the prevailing views of the times, with non-clinicians and the media wielding considerable influence. There remain too few clinicians to meet demand effectively and it can still often feel as if the outcome from an investigation is another tick-box to fill in, rather than meaningful change!

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'Once upon a time at Harrow-on-the Hill'

By Dr Ayomide Ajayi, Dr Azmathulla Khan Hameed



The grounds on which stand Cygnet Hospital Harrow today have a long and rich history. In 1911, Dr. Hugh Crichton-Miller bought the property and the adjoining mansion known as The Hermitage for use as his family house and his clinic respectively. The property spanned 6 acres by Julian Lane.

From his university days, Dr. Crichton-Miller showed tremendous interest in the link between mind and body and chose hypnotism as the subject of his MD thesis. He desired to save people from depression, suicide and the 'asylum'. Bowden House, as it was called, became a place of solace for those suffering from 'functional nervous disorders'. It was essentially a private nursing home and a therapeutic community that provided physical and psychological treatment; a practice Dr. Crichton termed 'Binocular vision.' On admission, each patient received psychological treatment and also received a physical examination, including biological and pathological tests. [1]

Dr. Crichton was further influenced by his experience working for the Royal Army Medical Corps (R.A.M.C) during World War 1. He believed that the soldiers suffering from shellshock had broken down from either emotional strain associated with trench life or from the chronic apprehension of danger. The key insight from this work was the idea that the mind could influence the health of the body and that physical health influenced the state of the mind. Armed with this, he reopened Bowden House after the war and also took it a step forward by opening the Tavistock Clinic in 1920, using his military experience and the adaptation of Freud's theories of neurosis to treat civilians. [2]

The clinic continued to function even after World War 2, providing much-needed support to the community. The board chose to remain a private institution following the creation of the NHS in 1948. Dr. Crichton-Miller retained his position as the Medical Director of Bowden House until 1952. By 1974, Bowden House clinic was a 65 bedded ward.

Presently, Bowden House clinic is now fully run by Cygnet Healthcare, an organization that has successfully developed and implemented a clinical model of care across all its sites and service lines. Cygnet Harrow specializes in treating adult males with autism and mild learning disability. There are three wards dedicated to admitting patients with Autism and co-morbid conditions; a low secure unit, a locked rehabilitation unit, and an open rehabilitation unit. This pathway enables a safe transition for service users back into the community as the need for a secure accommodation decreases during the course of treatment.

From Dr. Crichton-Miller (First Medical Director) to the current Medical Director Dr. Azmath Khan, Bowden House clinic (now known as Cygnet Harrow) has come a long way in providing comprehensive specialist care in autism and acute psychiatry. There is also an autism diagnostic clinic where patients are referred from all over the UK. The acute service, Byron ward, remains till this day as a mixed 20-bedded ward and affiliated with Cygnet Harrow is a female rehabilitation unit, Kenton Lodge.

We have stayed true to upholding the idea that each individual who comes through our doors finds the solace of a therapeutic community. One patient who came to the



service was initially withdrawn and riddled with guilt about the things he had done in the community. He was experiencing insomnia, anxiety, and low self-esteem. It took the collective effort of the multi-disciplinary team, regular sessions with psychologists, and a supportive nursing team on the ward to get him to a point where he began to believe in himself again. Eventually, he reached a point where he was being scouted by a sports team in the local area.

From Bowden House to Cygnet Harrow, the goal remains the same; the successful reintegration of every patient in care into the community with the tools that they need to be as productive and fulfilled as they would like. Adults with Autism, who often do not fit the admission criteria of most services, find a place at Cygnet Harrow and have the opportunity to engage with a rehabilitative framework that enables them to live a more independent life in the community.



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[1] Hugh Crichton-Miller 1877 – 1959, A personal Memoir, The Friary Press, 1961

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‘From asylums to art galleries. A reflection on the intricate relationship between mental illness and art expression in mental health institutions.’

By Dr Emmeline Lagunes-Cordoba

The history of psychiatry in London is closely tied to the emblematic Bethlem Royal Hospital, the oldest institution focused on providing mental health care not only in London, but also in the world. Much has been said about “Bedlam”, including multiple stories of abuse that many people suffered there and its influence on modern psychiatry and psychiatric hospitals all over the world. I would like to focus on an aspect not often discussed when we talk about Bethlem, its influence and inspiration for many people, including inpatients, to create art.

We can argue that the current images we have from the old Bethlam hospital, first located near Bishopsgate and later by Moorfields, are some kind of artwork, as there are some very high quality drawings and painting showcasing the old buildings. I would like to start by talking about one of the first artworks inspired by this institution, “Melancholia” and “Raving Madness” two sculptures by Caius Gabriel Cibber, which were not only commissioned to guard the gates of the hospital, but were apparently modelled on two inmates. Although the original building does not exist anymore, the sculptures are still part of Bethlem, as they can now be seen at the Bethlem Museum of the Mind.

Another well-known piece of art inspired by Bethlem, is a painting by William Hogarth—“The Madhouse”, which belongs to the Rake’s Progress series of paintings in which Hogarth depicted not only the final days of Tom Rakewell in the asylum, but also a cruel reality of that time, the use of inmates as “entertainment”; as back in the 16th and 17th centuries, visiting an asylum was considered a social occasion, a place where people could get amused by the “insane”. You can see the original painting at the Sir John Soane’s Museum in London, a real hidden gem in Holborn that I really recommend.



Figure 1. The Madhouse, c.1732-1735

Despite there being other pieces inspired by Bethlem Hospital, it is the work of those who were admitted there, which I think has helped us understand the impact of this institution on people’s mind. One of the most famous artists who stayed at Bethlem was Richard Dadd, a painter who after killing his father during a psychotic episode, was admitted but encouraged to continue painting, probably due to his talent but also due to the potential therapeutic benefits of continuing his work. During his time at Bethlem, Dadd painted one of his most famous artworks, “The Fairy Feller’s Master-Stroke”, a magnificent painting which has inspired songs, poems and novels due to its richness and details, and which you can admire at the Tate Modern in London.

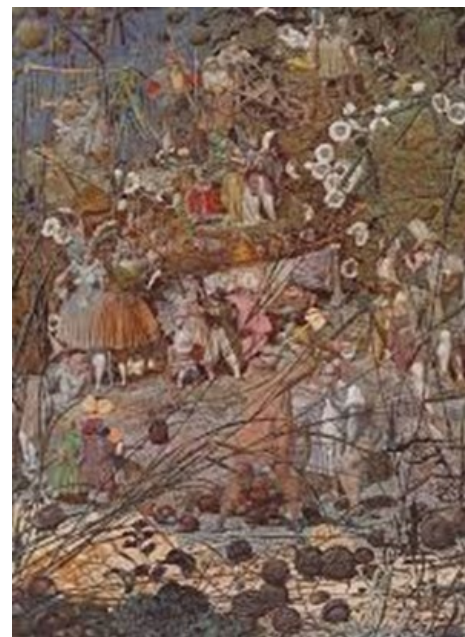


Figure 2. The Fairy Feller's Master-Stroke, c.1864

Another famous painter admitted at Bethlem was Louis Wain, well-known for his drawing of cats in human situations, such as drinking or gaming. Wain was a prolific artist who enjoyed fame in his youth, but later in life developed psychotic symptoms that caused him to be admitted to Bethlem in the 1920’s. During this time, he continued painting his famous cats, however, his style became more abstract, which some attributed to his mental health and as an expression of his psychosis. However, some scholars have refuted this, as they consider he was just experimenting with a new style. Regardless of the cause, his work is worth admiring due to his richness and technique, whether you are a cat lover or not.



Figure 3. Kaleidoscope cat, c.1930

The Maudsley Hospital which opened in 1923 has also become one of the most well-known psychiatric hospitals in London. Over the years it has also had some artists admitted to its wards some of whom have remained working and getting inspiration from their experiences there. In the 1970s artist Charlotte Johnson Wahl was admitted to the Maudsley due to OCD symptoms and during her stay she continued painting and even having her work exhibited there. Some have considered Wahl's work served as a type of art therapy, however, others considered her work was used as a method of self-expression; especially if we consider her piece titled "Ask and Get No Reassurance", which seems to show her cry for help and her frustration of not getting the reassurance and support she needed. An issue many others who have been in contact with mental health services can relate to.



Figure 4. Ask and Get No Reassurance, c.1974

The people I have mentioned so far were already trained artists and were possibly used to expressing their emotions through their work. However, during the 1940's, mainly due to the efforts of Edward Adamson, art therapy started to be considered as a tool to support people's recovery from mental illness. So, over the last decades, many hospitals and mental health organisations have implemented different types of art therapies, encouraging patients to use art and creativity to express their emotions, address conflict and improve their self-esteem, with some hospitals even promoting exhibitions showcasing their work. The success of these exhibitions, which have been

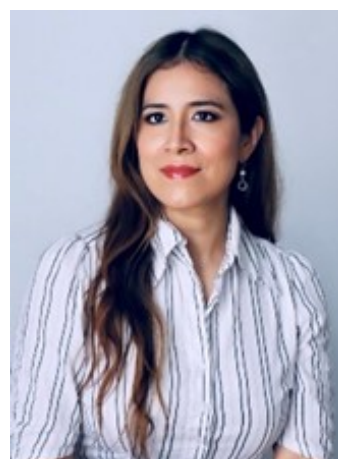
welcomed by patients and the general public, has led to the creation of galleries and permanent exhibitions within the same premises of some psychiatric hospitals, such as the Bethlem Gallery and the Maudsley Long Gallery.

Although the relationship between mental health and artistic creativity is not something new, there are many past and present artists known to have struggled with severe mental illness. The adoption of creative art therapies, including music, drama and writing, has not only become an important part of the treatment of many different mental health problems, including depression, PTSD, and schizophrenia (1), but has also become an important tool to increase mental health awareness and even improve attitudes towards those struggling with their mental health (2). Similarly, engaging with art therapies has been associated with improve mental health, satisfaction with care, and physical and mental wellbeing (2). So, it is important to continue encouraging the adoption of art therapies for our patients in and outside hospital, as this can not only support their recovery, but also because it can help improve their confidence and wellbeing. It is also important to remind people struggling with mental illness that they are capable of creating art and beauty, that their artistic expressions can not only help them manage their emotions, but can also help others understand their world, and sometimes also, help others enjoy life through the beauty they have created with their art.

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'The Cassel Hospital's centenary celebrations'

By Miss Pearl Metry



Originally founded in 1919 as 'The Cassel Hospital for Nervous Diseases' influenced by pioneering work in which shell-shocked war victims were seen as suffering from trauma (nowadays termed as PTSD patients), The Cassel Hospital has developed into a well-known psychoanalytic institution from 1921. It is the only National Tier 4 Specialist Personality Disorder Service that works with patients with complex emotional difficulties who are often diagnosed with 'personality disorder', and it offers an inpatient, and an outreach treatment programme, which form the 'therapeutic community' milieu. The concept of a 'therapeutic community' was created during the Northfield Experiments in 1946, driven by a psychodynamic approach and delivered through a psychosocial structure of nursing, individual and group psychotherapy, and other activities. Unlike other services, patients are encouraged to take autonomy for their own treatment, as opposed to being passive recipients.

Many patients at the Cassel have histories of long-periods spent in acute psychiatric wards, typically managed mostly through physical containment and the use of psychotropic medications. The Cassel takes a different approach in contrast, by managing individuals through a thoughtful and emotionally responsive container (Glyn, 2016). For individuals in the community, the combination of psychodynamic psychotherapy, whilst challenging and supporting each other, have been found to be very powerful therapeutic tools, considered paramount in the treatment of severe personality disorder, and underwriting the hospital's reputation of significantly improving individuals' mental health and well-being over the past hundred years.

In 2021, one of the world's first therapeutic communities celebrates its centenary. The Cassel Hospital Charitable Trust is planning many exciting projects and events to raise awareness of the work of The Cassel, learn more about its impact and history, and most importantly support the hospital's continuing care and treatment of people with personality disorders and complex trauma.





The Eileen Skellern Lecture:

Eileen Skellern was one of the great innovators of mental health nursing. She had worked with Dr Tom Main in 1949 on the pioneering of psychotherapeutic and psychosocial treatments. Psychosocial nursing is still a prominent aspect of treatment at the Cassel, addressing both the psychological and social aspects of a patient’s life. The idea of psychosocial nursing means that staff roles are less about doing things for patients, but instead using a psychoanalytically informed approach to mental health nursing. Having developed psychosocial nursing at the Cassel in the 1950s, The Skellern Lecture is an opportunity to celebrate the work of Eileen Skellern and welcome her “home” to the Cassel. The hospital will be hosting The Skellern Lecture Award, with a garden marquee event.

The Cassel Hospital Centenary Quilt:

One of the exciting projects being worked on in celebration of the hospital’s hundred years is The Cassel Hospital Centenary Quilt. Hannah MacDonald, a former Cassel patient, as well as a nurse and expert embroider, is leading on this project with support from The Royal College of Needlework. The quilt which will be displayed at the hospital, will be made up of 100 fabric diamond shapes. The diamonds will convey messages about what The Cassel Hospital has meant to those who are connected to it. Hannah says, “for me personally as an ex-patient, it was a place that helped me grow so that I had the freedom to finally fly”.



Voices of The Cassel Hospital:

Voices of The Cassel is a film/audio-visual artwork and communications initiative which highlights the centenary of one of the world’s first therapeutic communities. Scenes from a hidden archive and living memory will be activated through a series of archiving, recording and dramatisation workshops. The Cassel Hospital Charitable Trust, West London NHS Trust, The Mulberry Bush Archive and oral history specialists ‘On The Record’ are co-producing this

project with present and former Cassel patients, carers and staff. The aim of this project is to capture a wide variety of individual experiences, whether uplifting or challenging, and showcase the diversity of ‘voices’ that have once connected to the Cassel.

The Cassel Garden Centenary Project:

There are exciting plans for the Cassel Garden to plant borders and trees based on plans from 1949, to restore part of The Cassel’s Garden. The four-acre garden is of huge therapeutic benefit to The Cassel’s patients, which many have strongly valued in their time at the hospital finding it to be recuperative and therapeutic. Nature-based activities have been shown to bring great benefits to people living with mental illness, boosting confidence and a wide variety of skills, from social to creative.



The International Journal of Therapeutic Communities:

There will be a Special (Centenary) Edition of the International Journal of Therapeutic Communities, due to be published in the Spring of 2022. Articles will feature historical papers of The Cassel Hospital by previous and present staff members at the hospital, and former patients with commentary from the modern perspective, as well as modern-day projects, such as a service user coproduced study into the impact of Covid-19, exploring the effects of moving the therapeutic community to remote means.

The Cassel Hospital has made significant and innovative contributions to the service provision for individuals with personality disorder. The hospital structure is seen to offer an opportunity for reality testing, mutual learning, validation, insight, and growth to be gained (Chapman, 1984). Although the hospital has undergone many changes over the years, the core values of relationship, responsibility, tolerance, treatment, and a ‘culture of enquiry’, have always remained at the heart of their therapeutic work and treatment approach. The hospital’s



extensive experience and expertise in the treatment and management of personality disorder has supported other related services and facilitated national training to educate and inform healthcare or institutional professionals on the diagnosis of 'personality disorder'.

I would like to recognise the huge impact The Cassel Hospital has had on many individuals' lives through their continued care, support, and niche treatment approach, their ongoing efforts to tackle the stigma surrounding personality disorders, and their contribution to educating, informing, and reshaping the knowledge around what it means to have a personality disorder.

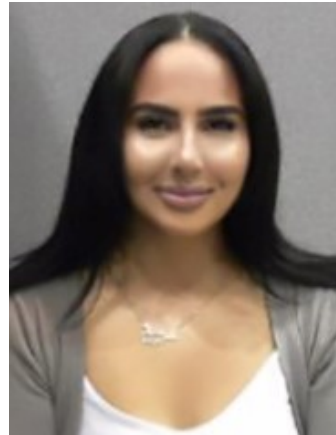
Here's to one hundred years, and hopefully one hundred more to come.

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Culture Vulture: 'Olympic – no Titanic - Madness'

By Dr Mayur Bodani

Naomi Osaka began the trend; Simone Biles continued it; Ben Stokes has added his name to it – but what is this? Elite athletes putting their mental health in the media spotlight. Why would anyone do such a thing? And whilst we're talking mental health, here's a fact; never in modern Olympic history - which incidentally began in Athens in 1896 – has any Games ever gone ahead without an audience, unless we're talking the media one. Cynics, perhaps not wrongly, suggest that it's not the fact that a pandemic has obliterated face-to-face audiences, but the fact that the only audience that really matters is the online/TV one. For that's where the money is made – not ticket sales. In fact, future Olympic Games organizers may never need to build another stadium/auditorium, if a good TV studio/set is at hand.

How is this relevant to the mental health of anyone? The fact is that one minute someone can be a complete unknown, and the next – after an Olympic win – they're household news and everyone knows them. Who'd have ever heard of Duncan Scott, were it not for the fact that the media have made him the swimming superstar that he no doubt is, but a media star too? Yes, he's only 24 years old, and he could easily pass for an 'A'-level student. What is global superstardom going to do to this young man's mental health – except perhaps ruin it.

The media can make and break anyone. Positive coverage is only the flip side of negative coverage, and the two sides can flip in a heartbeat. One minute you're everyone's darling, the next, the villain of the piece. Ben Stokes. Need I say more?

In a world where money talks even the Olympic Games has succumbed. The "way of the amateur", which originally epitomised Olympic participation – and participation was the key - has been swamped by the way of the professional with programmes, and money to boot in bucket loads. And what is the object of this spendathon? Medals. Lots of them. National pride, the national anthem, the national flag, the national track suit design, the "Medal Table". Countries, and participants – if we can even dare call them that now – are judged solely on "medalling". The more the merrier. The UK rowing programme is soon in for the night of the long knives after failing dismally in the medal stakes at Tokyo.

Athletes are selected on the chances of winning a medal. That's why Helen Glover and Poly Swann went to Tokyo – all expenses paid – and failed; and Charlotte Worthington had to be "crowd funded".

We've got it all wrong here, haven't we? And it's reflected in the mental health – or more precisely the lack of it – in the sports stars who choose to put their head above the parapet. Participation is what it used to be all about. How taking part in sports made you a better person; a better citizen; a team player. It didn't matter as long as you played the game well - like a sportsman/woman. That's the reason for shaking the hand of your opponent even in defeat and wishing him/her well. Whilst it still gets done, I doubt whether it's much to do with sportsmanship now. It just looks good on TV.

The hopefuls who were defeated in Tae Kwon Do, Boxing, Sailing, Rowing, looked the misery that they no doubt felt. And let's not even think about the British 100 metre finalist who got himself disqualified and had to be frog marched off the arena. Wonder how he's feeling? The fact is that the defeated tennis stars at the Olympics like Djokovic; and the golfing heroes, like Rory McIlroy, didn't look too bad at all after "failing". In fact, they took their defeats rather well, no doubt buoyed by the telephone number prize money they usually win at Wimbledon or Augusta. Should such mega-rich professionals even be at the Olympics? Should Golf and Tennis even be sports included at the Olympics? We know of course why it got in - don't we? Tennis and Golf are big media business, and they pay top dollar to the International Olympic Committee – maybe even for some nice spots to meet to discuss the programme in the world's most exclusive locations and hotels – all expenses paid of course.

The fact is that there is an insidious corruption in sport, which includes the reasons for taking part, and who gets to take part. It's driven by money, and money – not power - corrupts, absolutely. Sports is no longer about idealism, heroism, but money, and who's going to make the most for the media companies who pay for TV rights to stream it to a global audience, fuelled of course by "who's at the top of the medal tree?". "Eddie the Eagle" wouldn't stand a chance in today's brave new world.

The Ancients thought up the Games to pay honour to the gods, and to please them. A healthy mind and a competitive spirit were the original ideals – not doping to win at all costs. Winning is all that matters now, not the how, not even the why. Yet the dedication and effort to win is no less than in Ancient Greece. At least the ancients believed in the ideals they raced for. When those same ideals become corrupted by media and money no one really cares about anything other than winning, and celebrity success. Is it any wonder that Naomi, Simone,



and even Ben, worry about what this is all doing to their mental health? Thank goodness I'm no good at any sport. At least the media will leave me alone. Unless, of course, they like this article! What next? A spot on CNN? God forbid.

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Culture Vulture: 'SAFE DISTANCE – the Mental Health Implications of Asian Hate Crime.'

By Dr William Rippington

Jamie Chi is a Hong Kong Filipino independent filmmaker, whose most recent work centres around the difficulties of the queer Asian community, with a sub-focus on the increase in anti-Asian hate crime as a direct response to the Covid-19 pandemic.

Following a viewing and discussion of the film in the Bishopsgate Institute, London, it becomes clear there exists a disparity between the news we hear of the 149% rise in hate crimes towards the Asian community since the pandemic began and the inadequate space we are giving this minority group to voice the effect this is having on their mental health.



Following the film, I spoke to Jamie, who explained how mental health in the Asian community remains a 'taboo topic' of which the importance is rarely understood, particularly in older generations. Depression is not seen as a diagnosis; it's an unhappiness easily overcome and quickly dismissed. If mental health was ever discussed it was done so in whispers, away from other members of the community, for fear of the stigma attached.

Anti-Asian hate crimes are leading to an increase in depressive symptoms, anxiety and sleep problems in the community. An unnerving observation, given this ethnic group are less likely to access mental health services than any other group for a variety of reasons, be it stigma, difficulty accessing services, or the lack of culturally relevant approaches to treatment. Methods tailored to assimilate culturally relevant practices with evidence-based techniques known to improve mood regulation and stabilise mental state are rarely available on the NHS, despite an ever-growing need and calls for an increase in diversity of treatment options.

The film continues to discover ways in which the queer Asian community are not only articulating their emotional distress, but also discovering their own path to recovery in a variety of media, including filmmaking, theatre, dance, and visual arts.

I would recommend this exploration of the intersectionality of the queer and Asian community to anyone looking to broaden their understanding of an often marginalised and overlooked cohort who have a powerful and artistically unique way of expressing their pain and supporting those around them who are struggling with their own complex emotions during an ever-uncertain time.

I will finish with a reflection on the film's title – 'Safe Distance' – a message continually fed to us over the last 18 months; when taken in the context of the pandemic, it feels harmless, or even encouraged. But take a second look: from whom is this community seeking to distance itself? Its violent attackers; its verbal abusers? Or perhaps the title reflects a person's unspoken and unwanted distance from their family who does not understand their mental health needs; or a growing gap between this community and a health system who understands their needs even less?

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London Eye: ‘Horton Haven Film Project 2021’

By Dr Parvinder Shergill



The fear, the anxiety, the confusion, the loss, to name but a few consequences, have been difficult for many to cope with in uncertain times. However, the strength, the kindness, the humanity, and hope has really shone through.

In this film, which is named COMMUNITY, I wanted to show just that: how a global crisis can bring people together from all walks of life. I also shed light on the positives people have found in this time, through the lens of the service users themselves. Therefore, my script focussed on this and asking questions to the service users such as “What positives have you found as a result of COVID?” “How have staff helped you in this time?” I called the film COMMUNITY, as when I reflect on services, that’s exactly what I think of: the staff and the patients, who are, in a sense, their own community. For many, hospitals become their life and home, therefore I wanted to shed light on this and how their own personal community on the wards were a source of support during COVID. It was important that the staff also felt included in the project, as they are the ones who have been the constant trunk of support to the services. Therefore, we kept the film crew limited to NHS staff. This also helped with confidentiality during the recording process, for safety of our service users.

Outside of work as a Registrar, I am also an award-winning filmmaker with my own production company, PINDER PRODUCTIONS, making mental health films and theatre pieces since 2019.

I feel as technology advances, we too as clinicians need to advance in other creative ways to interact with and educate our patients.

The pandemic made me reflect on how we have coped during this crisis, especially from the point of view of service users.

Instead of focussing on the negatives of the pandemic, I wanted to highlight the kindness and inspiring subtle stories of what our service users have found and reflected on. Of course, the pandemic is difficult, not to mention how it must be whilst being an inpatient, but there is always a light found in hard times.

I mentioned my passion of wanting to make a film to highlight the wonderful moments in the pandemic, and luckily I was supported by my consultants.

I was given support by my clinical supervisor in writing up a film proposal, and therefore submitted my film proposal to the relevant Trust governance meetings, along with the service directors and managers, for approval. It took a few months to attend the meetings with the relevant staff for final agreement, in which it was agreed that I could make a short documentary with the service users at Horton Haven, CNWL.

As I sought approval for the film, I thought about what I wanted to ask the service users in the documentary. The last 15 months have been a strange, perplexing one for the world. The impact of COVID has undeniably been enormous, but nowhere more so than the impact felt in hospitals.

After sourcing The Recovery centre, which is a building for recreational use for service users at Horton Haven, which has been beautifully refurbished just in time for filming, we organised a drop in Q&A session for patients at Horton, to inform them about the film. From that we were able to organise information leaflets for patients and their carers, complete capacity and consent forms, as well as involve the MDT in the discussions.

We filmed in May, and luckily for us the Sun was shining, so we were outside for it. Service users involved in the filming were generous enough to share nostalgic memories they had in the units during COVID, funny anecdotes, and thanked staff for their support. They even played Pirates of the Caribbean on the piano, and sang for us!

The filming process made me feel really proud of what CNWL and the NHS have done overall during this time. I admit it was emotional to make this film, the reason being that all the patients involved stated it had made their year, after struggling with the impacts of the pandemic. They felt seen and heard in the filming. We also dedicated the film to a staff member who had sadly passed away during the pandemic. It made me think how restrictive



recreational activities sometimes can be to those admitted for months or years and how the need to try something different and uniquely creative can be really uplifting and beneficial for people's wellbeing. We need to have empathy and understand that not all patients are the same, and that some thrive under creative conditions. I feel as clinicians we are focussed on guidelines, criteria, and medical management, however what we need to remember is that every person we are working with are individuals, with specific interests and needs. Yes, their medical concerns are incredibly important, but taking an keen interest in their social interests is essential in giving patients autonomy, and participating in creative outlets can be incredibly therapeutic and beneficial to ones mental health, as well as lifting the morale overall for staff. If we have learned anything from this pandemic, it is that we all cope differently in a crisis, but that we can help our community by exploring and reflecting together as a group, and finding the positives of what we have achieved in such difficult circumstances.

I hope this film is the first of many film projects for our mental health services, and that in the future we in turn help educate all with the power of the screen. If Covid has taught us anything, it's that all have looked to the screen for support in this time of lockdown. So why not let the screen come to you?

Hopefully we can organise more creative films for the service users and staff to be part of in the very near future.

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Dr Parvinder Shergill

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London Eye: ‘Lights on the streets of London’

By Dr Christina Barmpagianni

As humans are slowly exiting the pandemic, we are entering a post-crisis recovery state. Not surprisingly, the same holds for the Capital, that is slowly finding its way back to its previous livelihood. Tourists, students, and Londoners are returning to the West End and are filling museums and shops, breathing life back into the previously empty metropolis. Things, however, are still hesitant.

There are whispers of Christmas as October is before us, but some are still afraid. Cautious not to allow themselves to prepare for that time of year that was previously mostly associated with London. And why wouldn't they be sceptical since our innate sense of planning ahead has been shaken to its core? We were asked to live for the moment, to take things a day at a time. We got used to the idea of last-minute plans, last-minute trips, so why not last-minute Christmas? These were my thoughts until recently, when on the first properly cold morning of September on my way to work, I looked out of the bus and saw stars hanging above the west end of Oxford Street. It was the early morning hours following a rainy night and the sky was clear, tinted in those dawn shades of pink and blue. They were not lit nor celebrated, they were merely hanging there overseeing Londoners who, underneath, were opening their shops and going to the office. Sure, department stores are setting up their Christmas floors and mince pies have started to feature on the shelves, but it was not until I glimpsed at those lights that Christmas seemed real.

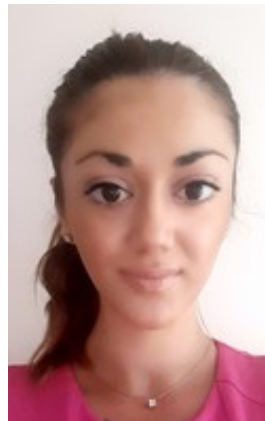
With social isolation, loneliness and an ambience of sadness casting a shadow on our every day, this December is a significant time for many of us and something I am starting to increasingly hear from patients. "I need to be well for Christmas," and "If I'm not able to enjoy Christmas I don't want to live," are some of the comments I heard in one day only. Why is that? Why didn't my patients want to be well enough for Summer, or even Easter? It has nothing to do with "being well" and I am sure my patients are educated enough not to expect a magical recovery, but they clearly feel the need to be emotionally ready to absorb all that the time has to offer. I can only assume it has something to do with the season's warmth; the childhood memories; the associated feeling of joy; the coming of the New Year; while for some there is also a religious element to it. Whatever the reason, Christmas is for everyone a significant period, a time of reflection, an end, as well as a start.

This year, London needs Christmas more than ever, and so do all of us. Our colourful city, that captures the sense of

Christmas probably more than any other place on Earth is preparing itself. Breathing in the orange and cinnamon aroma of winter, listening to the festive melodies, being surrounded by family and friends able to celebrate and experience Christmas as we used to, will almost signify the end of the pandemic; the return to the reality which we now realise we took for granted. At the same time, life will flow into the city saturating it with the sounds, scents and company that it craves.

Although there is still some time to go, seeing that the first signs are out there, that the first lights although not yet lit, are ready and set, brings us close to something familiar and for the first time in what feels like an age, there is hope that humans, London and the rest of the world, have recovered and are ready to celebrate.

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London Eye: ‘Media Perspective using Radio Broadcasting Conversational Interviewing: An Anti-Stigma Campaign’

By Dr Azmathulla Khan Hameed, Mrs Valma James

The outbreak of COVID-19 may have significantly changed the way Public Health England engages the population and communities in understanding the pandemic. All media platforms such as radio, television and social media have been used, so why not use the same media framework to educate the population about other health conditions, empowering individuals by raising awareness of mental health conditions and their management.

During the pandemic we have learnt more about COVID-19 than any other disease; how the virus develops and spreads, and its impact upon individuals and within communities and societies; so why not the same with mental health? This can be a role of psychiatry in community-based awareness programmes through “conversational radio interviewing”, to improve people’s understanding of mental health conditions, diagnosis, treatment, and recovery. This may contribute to early intervention and prevention of crisis management that inevitably impact on health and social care resources, and people’s lives economically and socially. Only if we get it right in the first place, by carers and individuals gaining more insight into how they can positively contribute to their own mental health and their loved one’s health and social welfare.

As a qualified Social Worker and Registered Nurse working in mental health services, it was a unique experience to identify how using the medium of radio can contribute to destigmatising mental health, stimulate creative thinking, and enable groups and individuals to share their experience. Learning from their experience can influence the quality of services, and how individuals access and receive services.

Can conversational radio interviewing destigmatise mental health - what has been the experience? By Dr Azmath Khan - Medical Director, Autism Services Harrow

I was interviewed by Ms James on a couple of radio stations which generated enormous interest from listeners to know more about autism and trauma. When we were doing these interviews about autism, people wanted to know what autism is, about diagnosis, treatment and recovery, and what carers need to know and understand about caring for a child or adult with autism. Someone caring for a husband with dementia shared their experience using conversational radio interviewing - the feedback from listeners was amazing! The most important and extensive discussion was to identify the prodromal symptoms and how carers can access help sooner in these situations. The idea of autism awareness through

conversational radio interviewing proved to be a big success and as a result I have been involved in subsequent interviews about schizophrenia and PTSD.

There are many people who still listen to the radio when at home or driving in a car. If these kinds of interviews improve the awareness of these mental illnesses even to a small extent, the stigma attached to such conditions can be reduced gradually. People caring for patients with mental illness can better understand the illness and support them positively.

We need to expand these kinds of interviews on more popular radio stations so that more and more people gain increased awareness of a variety of mental health disorders. Radio broadcasting can be a very powerful medium for engaging communities in psychiatry, to promote a greater understanding on the diagnosis, treatment and recovery of mental health conditions.

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Valma James
Social Worker and Radio Presenter



London Eye: ‘Dancing Colours’

By Dr Saeideh Malekianragheb

Since my arrival in the UK, I have heard many idealistic things about equality, gender, ethnicity, religion and the acceptance of differences. However, as a woman, who had come to Britain from a Muslim country in the Middle East, I sometimes felt discriminated against, and at some point, I lost my faith in equality.

Prior to the Coronavirus Pandemic, the NHS was already struggling to cope with the pressure of patients in A&E and medical wards. COVID-19 made this problem much worse. That was just the tip of the iceberg. The negative impact of COVID-19 on people’s mental health was now huge, and the burden of this was directly transferred to mental health service staff.

Although it was one the most challenging times for our profession, it was exactly at this difficult time that I saw the gloriousness of the NHS Rainbow within our services. During the pandemic, I was redeployed to a treatment ward that had been turned into a COVID-19 ward where all the COVID-19 positive patients around the Trust were being transferred to.

I will never forget the beauty of equality and humanity that I observed between my colleagues and our patients. I remember the day when all the psychiatry trainees raised money to buy some small gifts for their nursing colleagues to show their appreciation for their hard work. We heard about donations from big companies being sent to the large, well-known hospital ITUs and medical wards around London but the massive pressure on mental health services, where staff had to deal with physical and mental concerns was just neglected .

I also recall the day when my white British colleague, held the hand of our COVID-19 positive, Afro-Caribbean patient as his O2 saturation level was dropping. The patient was experiencing shortness of breath and was panicking. He was crying, saying “I don’t wanna die”, and my colleague sat next to him, holding his hand warmly, and said “I’m here Bro, I’ll stay with you”. He stayed with him, and talked calmly to him until the ambulance arrived. I remember the patient shook hands with him before he left, and said, “Thanks Bro”.

This was just one of many occasions when I witnessed caring and compassion that transcended cultural and religious differences, such as when my Jewish consultant was concerned about a Christian trainee who was on call on Christmas Day and was trying to find a way to send Christmas lunch to the trainee. On another occasion, a Muslim trainee brought in a huge cake for staff and

patients who were isolating in their rooms on our COVID-19 ward on Christmas Eve, to make them feel more at home.

I have also seen changes in the relationships between those receiving care and those delivering it. There have been more mutual, more respectful and more understanding relationships between our patients and staff. I remember the time that one of our patients would not agree to stay in her room and was verbally aggressive towards staff. She kept insisting on repeatedly leaving her room even though she was COVID-19 positive. Our nursing team had been trying to de-escalate the situation, talking to the patient and explaining the importance of self-isolation. Unfortunately, she did not agree and kept saying “I don’t believe in this virus”.

By the end of the day when she had left her room yet again, another patient who was usually challenging towards staff, asked the other patient to stay in her room and tried to explain to her the seriousness of having a COVID-19 infection. The nicest part was that he told her, “these people (pointing towards the nurses) are working so hard to help, and they might catch COVID-19”.

It was a difficult time for everyone, and I am still incredibly proud of how our teams and local communities are meeting the Coronavirus challenge. Those few months have also taught me that diversity, equality and humanity are not just nice, idealistic concepts. People were always talking about the rainbow in relation to the NHS. What I saw was harmony in glorious dancing colours.

*Human beings are members of a whole,
In creation of one essence and soul.
If one member is afflicted with pain,
Other members’ unease will remain.
If you’ve no sympathy for human pain,
The name of human, you cannot retain.
“Saadi, Persian Poet”*

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London Eye: 'Violence is a Crime. Do not suffer in silence'

By Dr Amit Mukherjee

Due to a paucity of resources NHS mental health teams often rely on third sector organisations and charities to provide services to patients. However, many of these have their own limitations, for instance, not being able to provide interpreters for non-English speaking patients or not being competently aware of cross-cultural sensitivities. In the background of these challenges, an organisation which has always stood out for me is Southall Black Sisters (SBS), to whom I have referred patients, namely Asian and Afro-Caribbean women who were victims of domestic violence, some of whom were also refugees or asylum seekers.

I particularly admired the range of services SBS provided including casework, counselling, advocacy, support group work, campaigning, policy development and research. Whilst SBS consistently advocate for cultural and linguistic sensitivity in their approach towards patients, they also have been vocal against religious fundamentalism and harmful traditional practices like the concept of 'honour', that can force women to conform to traditional gender roles and prevent their recovery from abuse and consequent mental illnesses. I noted they also would provide refuge and support to those migrant victims of domestic violence who had no recourse to public funds. This made a huge positive impact as sadly this group of patients would often be flagged up for discharge by the management of community mental health teams.

After receiving funding in 2001, SBS produced their 'Safe and Sane' Report in 2010. This is the most comprehensive, extensive and insightful report commenting on a range of topics related to the mental health of Black and Minority Ethnic (BME) women. Worryingly the report concluded that women from various BME communities experience domestic violence and mental health problems including; religious and cultural pressures, immigration and asylum issues, suicide and self-harm, racism and discrimination, poor housing, low socio-economic status or financial hardship and a health service which medicalises them or ignores their needs rather than providing counselling or social welfare support.

In its report SBS included a statistical analysis of the nature and extent of suicide and self-harm in BME women. Through their survey of patients and caseworkers they observed that depression was a key symptom of the distress experienced, along with a spectrum of symptoms which included: 'self-harm, suicide, classic post-traumatic stress disorder, not sleeping, inability to trust, self-blame, crying, depression, flashbacks'. They noted that mental health and gender-based violence were often treated

separately, and within mental health services, if women were experiencing multiple issues, then gender-based violence would be the last issue to be dealt with. In addition, experience of fleeing war-torn countries, the anxiety of leaving family and loved ones behind in the country of origin, having to negotiate living in an often hostile and different culture, the uncertainty of their future in relation to their immigration status, and the length of the immigration process decision often led to acute mental health crisis and distress.

Lack of community language interpreters acted as a barrier to access appropriate interventions. However, SBS also noted that there had to be an awareness of the fact that some of the existing interpreters may be biased by their own conservative views. SBS also surveyed multiple agencies working with BME women who expressed that their organisations were not often recognised by health professionals and were neither given recognition nor respect.

The report highlighted that women's treatment within the system exacerbated their problems as their stories were not believed by professionals even though they had survived traumatic experiences in their countries of origin and in their own lives. Therefore the report recommended the need for properly funded multi-lingual and multi-cultural services and suggested that there should be more specialist counsellors and therapists reflecting the race, gender, and linguistic background of the patients, with an understanding of the impact of racism and religious, cultural and social pressures on the mental health of abused BME women. It said that therapies which encourage the use of religious leaders and faith healers should be avoided as these can add to pressures on BME women to stay within or return to an abusive situation and prevent their recovery from mental illnesses.

SBS also contributed to the Home Office review of Coroner's Court advocating to link the cause of suicide to domestic violence. In terms of policy matters, the report recommended that there should be better monitoring, data collection and research within the NHS and other public bodies relevant to BME women, domestic violence and mental health. It recommended that community based work within BME communities should be developed in schools, colleges and youth centres and amongst women and men within BME communities more generally. This work should be led by or in consultation with secular BME women's groups with an expertise on addressing these issues, and not simply delegated to community leaders or faith-based groups who have a



history of supporting conservative views on gender roles. The report also made additional interesting observations about the links between cannabis, crack cocaine, psychosis and prostitution and that in some BME communities, women are taken by their families to see Western doctors in order to maintain privacy despite their reliance on traditional medicines for other ailments.

Of interest, therapists in the SBS developed a new hybrid therapeutic model targeting the needs of particularly South Asian women experiencing domestic violence, for use in counselling and psychotherapy sessions. This model combined established therapies (cognitive and analytic work, group psychotherapy, PTSD management) in a fluid way, allowing for some relaxation of boundaries and flexibility in communication and using, when necessary, some directional elements drawn from life coaching. Their therapy included relaxation exercises, mediation, and stress relief techniques in setting short-term goals and developing a list of tasks that must be undertaken on a day-to-day basis: these would include food shopping and cooking; exploring local areas; researching and trying out local transport; practising English, perhaps in a shop, on the buses or another functional opportunity. The model also worked on using role-play with 'scripts' for specific situations and used various SBS support incentives such as creative writing and photographic workshops.

Their website www.southallblacksisters.org.uk is worth a look for information and resources for clinicians, volunteers, policy makers and members of the public. Every page of the website has an 'Exit Website Quickly' bar keeping in mind the vulnerability of individuals who may visit. As community mental health teams in the NHS change their ways of working one can hope that such organisations like the SBS are more integrated into the mainstream NHS.

References:

[1] Equation. (2021). Home / Best Practice Library / Supporting Survivors / Mental Health / Mental Health - Research / Safe and Sane

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