**Regulatory burden in research**

I would like to highlight difficulties we have experienced, in the hope that this will help others. We are taking part in a multicentre study which was approved by the multicentre research ethics committee in August 2005. In Bristol we are studying patients attending hospital clinics and a group from primary care.

Both site-specific assessments and R&D approval resulted in months of delays. Advice that we could not quote the primary care trust as a site (i.e. we needed to list surgeries that had agreed to take part) later turned out to be wrong. It was also unclear from guidance from the Central Office for Research Ethics Committees (COREC) that site-specific applications are not considered by the main ethics committee, but by subcommittees which meet more frequently.

Both R&D departments involved advised that an honorary contract was required prior to any patient contact, in addition to my NHS contract with the local mental health trust. An honorary contract with one was not acceptable to the other, in contravention of Department of Health guidance: ‘where a researcher works across many NHS organisations they should not have to obtain multiple contracts’ (http://www.bartsandthelondon.org.uk/research/honorary_contracts.asp). Both departments required separate Criminal Records Bureau checks and occupational health clearance, causing significant delays.

As an aspiring young academic psychiatrist this has been a discouraging start to my research career. There has been much debate about the regulatory and bureaucratic burden in research and the need to find a balance with safety so that research in the UK is not stifled. Sadly this does not seem to have been put into practice yet.

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**Sexual abuse of patients by psychiatrists**

I was pleased to read Dr Kennedy’s review of the Kerr/Haslam Inquiry (Psychiatric Bulletin, June 2006, 30, 204–206) and Dr Subotsky’s response on behalf of the College (Psychiatric Bulletin, June 2006, 30, 207–209). Dr Subotsky referred to sexualised behaviour between doctors and patients having been made criminal.

The Sexual Offences Act 2003 introduced significant changes to the law by introducing a new offence of sexual activity with a person with mental disorder impeding choice. This offence requires proof of sexual touching and that the individual was unable to refuse because of or for a reason related to a mental disorder. In addition, it must be proven that the perpetrator knew or could reasonably have been expected to know that the victim had a mental disorder (Stevenson et al, 2004). The key factor in determining whether it is possible to bring a safe conviction will hinge around capacity to refuse unwanted sexual activity. This is not defined in the Act (British Medical Association, 2004). For people with mental illness, where capacity is likely to fluctuate, it may be difficult to prove what their mental state was at the time of the alleged offence. Although well intentioned, in practice the law may be difficult to implement.

Clinicians should be aware that they or their colleagues may be arrested on a charge of rape should they decide to have sexual intercourse with their patients. Doctors will always be in the position of having more choice in these situations than their patients. For this reason, it is right that the College continues to deem that relationships of sexual intimacy between doctor and patient are totally unacceptable (Royal College of Psychiatrists, 2002).

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**Psychotherapeutic skills and College requirements**

Pretorius & Goldbeck (Psychiatric Bulletin, June 2006, 30, 223–225) commented on difficulties encountered by psychiatric specialist registrars in fulfilling the College requirements for experience of psychotherapy (Royal College of Psychiatrists, 2003). To determine the extent of the problem in Merseyside, we performed a survey of the psychotherapy experience of 73 trainee senior house officers (SHOs). Only 31 (42%) were aware of College requirements. Five trainees (7%) had conducted a long-term individual case and 41 (56%) at least a short-term case. Of those who had cases allocated, 21 (29%) had one short case, 11 (15%) had two short cases and 9 (12%) had three short cases or more. Of 11 trainees who sat their MRCPsych part II examination in March 2006, only 2 (18%) fulfilled the College requirements for psychotherapy experience. Only 14 trainees (19%) expected to fulfil the requirements by the time they were to sit their MRCPsych part II examination.

Of the 73 placements, 49 posts (67%) had supervision by a consultant psychotherapist. These included a Balint group, which most trainees had to do in their first two placements. The other trainees were not receiving supervision by a psychotherapist at the time of the survey. Our findings are consistent with those of Webb (2005) from Nottingham, Dharmadhikari (2006) from Leeds and Pretorius & Goldbeck (2006) from Scotland.

With the current 3- to 4-year training scheme it is difficult for trainees to fulfil College requirements. Pretorius & Goldbeck (2006) found that organisational changes have improved exposure to psychotherapy in different modalities. It is hoped that with improved planning, the
changes proposed in Modernising Medical Careers and stringent record of in-training assessments, more trainees will have the opportunity to fulfill the training requirements and develop the basic psychotherapeutic skills essential for any competent psychiatrist.

We would like to propose that the College makes it mandatory that approval for a training post at SHO, specialist registrar, or even consultant level only be granted if the base hospital has a full-time or part-time consultant psychotherapist. This might apply much-needed pressure to some reluctant trusts and will certainly help to eliminate unequal opportunities which are currently present in psychotherapy in different parts of the country.


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**Medical management and clinical leadership**

Am I alone in finding a distinct irony in the publication of the first two articles in the June issue (Psychiatric Bulletin, June 2006, 30, 201—203 and 204—206) — namely, ‘Medical managers in psychiatry — vital to the future’ and ‘Kerr/Haslam Inquiry into sexual abuse of patients by psychiatrists’? I note in the latter paper comments by Dr Kennedy regarding ‘consultants being “all powerful”’ and that ‘the report challenges the absence of a clear moral and contractual obligation for all mental health professionals to report all such information, and the lack of an NHS system to maintain an accessible memory bank of all such data. Will the professions fear this as a “big brother” scenario or welcome it as an essential protection of their patients and their credibility?’ These comments are made immediately after an article by Griffiths & Readhead who champions the cause of ‘medical managers’ and which sets out clearly their views of how ‘vital’ this role is to ‘psychiatry’.

In my opinion these two articles highlight the inherent danger of the move by the Royal College of Psychiatrists to appoint a vice-president to promote ‘medical management’ with the clear aim that we continue a ‘medical model’ of ‘medical management’ where psychiatrists in these roles are seen as having great influence at strategic board and other levels and indeed over other professional colleagues.

I would respectfully suggest that this move by the College reinforces the stereotype of consultants and of medical managers being ‘all powerful’, as highlighted by the Kerr/Haslam Inquiry. The reality is that if we as a profession are serious about leading services into the future and providing strategic direction, we should only be given this role if we are able to demonstrate the ability to provide clinical leadership to all clinicians working within mental health services. We expect psychiatrists to work and indeed provide leadership to multidisciplinary and often multi-agency mental health teams in a variety of settings, yet at College and other levels we continue to promote a model of ‘medical management’ rather than a model of clinical leadership.

My opinion is that if we are serious as a College in wishing to provide leadership in both the development and provision of services in the twenty-first century then we need to embrace models of clinical leadership in which consultants engage with other professionals and accept that being a consultant gives one no divine right to act in an all powerful, inappropriately wise way. It is unacceptable for consultants’ behaviour to be challenged only by other consultants who are ‘medical managers’. If these models of clinical leadership are not adopted I fear the ‘failures’ identified by the Kerr/Haslam Inquiry will only be repeated in the future.

This surely is the challenge for psychiatrists interested in management roles in 2006, and the College should be promoting a model in which psychiatrists are selected for management roles on merit rather than simply because they are a doctor.

Alastair N. Palin

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**The International Fellowship Scheme and perinatal psychiatry services in South India**

I chose to work as a consultant in Manchester under the International Fellowship Scheme, so that I could gain experience with a view to setting up perinatal psychiatric services in India. The trust accommodated my needs and I was able to spend time working in the perinatal out-patient service at Wythenshawe Hospital and running special services with a perinatal psychiatric nurse in communities around North Manchester. I learnt about child protection issues, pre-pregnancy planning protocols, risk assessments and liaison with general practitioners, nurses and obstetricians. I also had the luxury of caring for several mothers and their babies at home — a novel experience. Thanks to the Fellowship Scheme, my colleagues and I have been able to set up the first formal perinatal psychiatric service for women with severe mental illness in South India.

Mothers who I cared for while in the UK were sad that I was leaving but were happy that I was able to help them briefly and were happy when I told them that mothers in India would now benefit from similar services! I think that I have been able to bring back something valuable from the UK thanks to the Fellowship Scheme.

Prabha S. Chandra

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**Changes to the number of CCTs will have a positive impact on training**

I read with interest the eLetter from the President and the Dean of the College about the proposed changes to the number of certificates of completion of training (CCTs) in psychiatry (http://www.rcpsych.ac.uk/pdf/changesMay06Ed.pdf). No doubt these changes will have a significant impact on the future of psychiatric training at a time when postgraduate training is undergoing a radical overhaul with the anticipated introduction of Modernising Medical Careers (MMC) in August 2007.

I believe that reducing the number of CCTs from the current six to two will be beneficial to trainees for a number of reasons. First, it will bring psychiatric training in the UK in line with the rest of Europe, where psychiatrists gain accreditation in either adult or child psychiatry. A major reason for the introduction of MMC was to streamline postgraduate training in the UK, which was considered too lengthy compared with the rest of the world. Second, as reported by Day et al. (2002), many of the issues facing UK trainees are common to psychiatrists in training across Europe.

We have certainly taken the lead in establishing a structured system of training, but we need to continue
strengthening the ties already formed through organisations such as the European Forum for Psychiatric Trainees. In today’s climate of a vast increase in mobility of the global medical workforce we would do well to pay heed to the needs of our prospective employers.


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What’s in an MRCPsych!

There is such passionate debate going on about the award of MRCPsych without examination. Those who have struggled to achieve Membership through examination feel that the value of this has been somewhat lowered or tarnished. I was awarded Membership without examination and would like to share what this means to me and what advantages it has afforded.

Has it helped me to get a job, a promotion, or a higher salary? The answer is no. It is not even recognised in India as a qualification. MRCPsych has not conferred any advantage except receiving the British Journal of Psychiatry and the Psychiatric Bulletin. I definitely did not accept an International Fellowship because of a promise of MRCPsych and I do not mention it on my curriculum vitae.

To me it means the same as my other membership of international and national societies, all of which were awarded without examinations! There is no psychiatric society in the UK of which one can become a member except the College. If one could become a member of a professional body only through their own examination, it would be good neither for the professional nor for the professional body.

MRCPsych is an expensive membership to retain. For the annual fee one could get life membership or life fellowship of at least two or three Indian scientific societies. It is not surprising that some who are awarded an honorary MRCPsych are unable to retain it after some years. As far as I am aware, no International Fellow with Membership without examinations has secured a job in the Gulf or other countries where the Membership is acceptable. I am aware of quite a few with the honorary MRCPsych who have taken up assignments in different parts of the world or international organisations. It would be futile to speculate whether the honorary MRCPsych helped them to gain these positions.

I hope those opposing the award of MRCPsych without examination will view the process from the correct perspective and not feel that MRCPsych is some exalted object which they are being robbed of. I am happy to be a member of the College and enjoy participating in its activities, and will probably retain Membership as long as I can afford it!

Declaration of interest  S.K.C. was awarded MRCPsych without examination under the International Fellowship Scheme in 2004.

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Referral of older adults with dementia, acetylcholinesterase inhibitors and the NICE guidelines

Dr S O’Loughlin & Darley suggest that the rate of referral of older adults with dementia has increased since the launch of acetylcholinesterase inhibitors and the publication of the National Institute for Clinical Excellence (NICE) guidelines for their use (Psychiatric Bulletin, April 2006, 30, 131–134). Although the authors acknowledged the limitations of their findings, there are serious ethical and practical objections to the conclusions drawn.

We are not clear whether the 42,000 people aged 65 years and over in the catchment area was for 1996 or 2003. Fluctuation in the size of this population could easily affect the referral rate. Moreover, the authors do not define criteria used for the diagnosis of dementia in either period.

Nin-Mental State Examination (MMSE) scores in both study populations are ordinal in nature, it is not appropriate for the mean to be presented as a measure of central tendency. For the same reason, it is not appropriate for standard deviation to be offered as a measure of dispersion. Use of the median and interquartile range (IQR) would have been more appropriate. Similarly, use of the t-test as a test for difference between the two groups was ill considered because MMSE scores in both study populations were negatively skewed. The authors should have used a non-parametric test for difference such as the Mann–Whitney U-test.

For the record, the median MMSE score was 20 (IQR 16–24) in the 1996 sample and 22 (IQR 19–25) in the 2003 sample. Running the authors’ data through a Mann–Whitney test on StatCrunch (available at http://www.statcrunch.com) still finds a significant difference between the two groups (P=0.0037).

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Authors’ reply The nature of pragmatic research is to examine clinical practice in the manner it happens — that is both its weakness (for example, not using research-standardised diagnostic interviews or detailed cognitive testing) and its strength. The MMSE has been in use in both clinical and research settings since 1975 as a tool for cognitive assessment and Drs Kripalani and Poongan are correct in stating the unreliability of a single cut-off point for any diagnosis. In our study we examined MMSE scores only of those patients with a diagnosis of dementia, and

Statistical assessment of MMSE scores

It is disappointing that the interesting study by O’Loughlin & Darley (Psychiatric Bulletin, April 2006, 30, 131–134) was let down by the use of inappropriate statistics. Since scores on the Mini-Mental State Examination (MMSE) constitute data that are ordinal in nature, it is not appropriate for the mean to be presented as a measure of central tendency. For the same reason, it is not appropriate for standard deviation to be offered as a measure of dispersion. Use of the median and interquartile range (IQR) would have been more appropriate. Similarly, use of the t-test as a test for difference between the two groups was ill considered because MMSE scores in both study populations were negatively skewed. The authors should have used a non-parametric test for difference such as the Mann–Whitney U-test.

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other than commenting on the rise in total number of referrals made no comment on the underlying referral rate.

We agree with Dr Willis that the MMSE, assuming that it measures an actual underlying ‘cognitive ability’ where the intervals between adjacent scale values are indeterminate, is an ordinal rather than an interval or ratio scale and corresponding tests should be used. We are pleased to note that our data still show a significant move towards earlier referral in dementia.

the college

What will one CCT mean for us?

On 3 July 2006 we emailed members and fellows to inform them of Council’s decision that the College should apply to change from six certificates of completion of training (CCTs) to one CCT. We have been asked some questions about this change and here are the answers to the most frequently asked questions.

Why the changes and why now?

Several sub-specialties in psychiatry (e.g. addictions, liaison, rehabilitation and neuropsychiatry) have been trying to obtain specialty status, but the Department of Health has not approved these because of difficulties in getting these changes through the UK Parliament. We have also been told that no new applications for CCTs would receive support from the Postgraduate Medical Education and Training Board (PMETB).

If a single CCT is approved by Parliament then the initiative will be with the College to ask PMETB to approve new sub-speciality curricula as they evolve or change. This gives the responsibility back to the College to determine what is good for patients and the profession.

The time is right now so that trainees entering the unified training grade will know what CCT they will receive on completion of training. However, it is likely to take a long time to go through the UK and European parliaments and the final decision will not be made by August 2007.

How long will it take for a trainee to obtain one CCT?

It will take about 6 years, as now. It might take some trainees longer and some trainees less time to obtain one CCT.

When will trainees complete core training and specialist training?

‘Core’ training will normally take 3 years and will end once the MRCPsych has been passed. Optional training in accredited specialties generally will start at ST4. However, the whole period in the unified training grade will be called specialist training.

When will trainees be selected for specialist training, for example in forensic psychiatry or psychotherapy?

Allocation into specialty training will take place after the MRCPsych has been passed, as now. Every trainee will be expected to pursue specialist training following one of the approved curricula.

If there is only one CCT, what will my entry on the specialist register say?

Your entry should reflect the specialist curriculum you have completed, i.e. if you have followed the learning disability programme your entry will read psychiatry (learning disability psychiatry), and if you have followed the child and adolescent training programme your entry will say psychiatry (child and adolescent psychiatry). In the future the specialist register is expected to include much more information about an individual specialist’s qualifications and competencies.

When will the change take place?

At this stage, the move to one CCT is a recommendation and may not be approved by the UK and European parliaments. There will be extensive consultations by the Department of Health. It may be 6 years before the changes are implemented. These changes should hopefully be in place by the time trainees entering the unified training grade in August 2007 will be finishing their training, i.e. around 2013.

Will psychiatric specialties be dumbed down?

Absolutely not! The Royal College of Psychiatrists is committed to developing the best specialist expertise, as our patients and carers expect. Faculties and their educational committees will submit their curricula and ensure that specialist competencies are clearly identified.

Professor Sheila Hollins President, Professor Dinesh Bhugra Dean, Royal College of Psychiatrists

Medical Director Initiative

The College Strategic Plan 2005–2010 includes a proposal to harness in a more systematic way the considerable influence of medical directors, and through them to work more effectively with healthcare managers. Peter Kennedy, a former medical manager, chief executive and co-director of the prototype for the National Institute of Mental Health for England (NIMHE) regional development centres was elected Vice-President by Council in January 2006 to lead this initiative.

The founding meeting of the Medical Directors’ Executive (MDE) took place on 6 April and defined terms of reference. Each Division will have two medical director nominations to the MDE, one as main member and one as deputy. The MDE will advise the President and College on key issues that need to be taken forward at College level. The College will be more influential working in partnership
Building and Sustaining Specialist Child and Adolescent Mental Health Services

Council Report CR137, June 2006, Royal College of Psychiatrists, £7.50, 52 pp

This document provides guidance to practitioners, managers and commissioners on the capacity and provision of specialist child and adolescent mental health services (CAMHS) in England, Ireland, Northern Ireland, Scotland and Wales. Evidence is collated from a number of sources, including published and unpublished literature and examples of best practice. During consultation the document was shared with practitioners, non-statutory organisations, policy makers and commissioners from the agencies of health, social care, education and justice across the five jurisdictions. The guidance is designed to be a support for service development that is based on assessment of need. It emphasises that local factors should be taken into account, including deprivation indices, the numbers of Black children and those from minority ethnic groups, and whether the area is rural or urban.

For Tier 2/3 CAMHS, an epidemiologically needs-based service for 0- to 16-year-olds requires a minimum of 20 whole-time equivalent (wte) clinicians per 100 000 total population. Teams must have a range of clinical professionals with cognitive, behavioural, psychodynamic, systemic and medical psychiatric skills. Team capacity should be set at 40 new referrals per wte per year. Clinician keyworker case-load should average at 40 cases per wte across the service, varying according to the type of cases held and the other responsibilities of the clinician. Specialist CAMHS work with Tier 1 professionals is best provided by dedicated primary mental health workers working as a team and closely linked to Tier 2/3 CAMHS. Matching demand and capacity is essential to ensure effective service provision.

Recommendations for the remit and staffing of Tier 4 services are given, including specialist community intensive treatment services, day services and in-patient services. It is recommended that 20-40 in-patient CAMHS beds per 1 million total population are required to provide for children and adolescents up to the age of 18 years with severe mental health problems, and that bed occupancy should be 85% to ensure availability of emergency beds.

The authors did not find sufficient evidence to provide recommendations for staffing levels for CAMHS for 16- to 18-year-olds, but argue that significant extra resources are needed to extend services to include this age-group. There was a paucity of evidence on infant mental health services and mental health services for children and adolescents with learning disability, substance misuse and forensic problems. However, the mental health needs of these groups must be met and should be provided by specialist CAMHS.

This document is recommended to anyone who is struggling to answer the questions, 'what should specialist CAMHS be doing and how many people do they need to do it?'

Role of the consultant psychiatrist in psychotherapy

Council Report CR139, May 2006, Royal College of Psychiatrists, £5.00, 15 pp

This report reviews the range of roles and responsibilities that are undertaken by consultant psychiatrists in psychotherapy. It sets out three core principles.

• Consultant psychiatrists in psychotherapy have a range of roles.
• Consultant psychiatrists in psychotherapy bring to multidisciplinary teams the knowledge, responsibility and ethos associated with the medical profession.
• Consultant psychiatrists in psychotherapy bring specific psychotherapeutic expertise to multidisciplinary teams.

In clinical work these principles mean that consultant psychiatrists in psychotherapy assess and manage complex cases, deal with issues of risk and take special responsibility for patients with a combination of medical and...
psychological issues. Supervision and management of clinical teams are also important clinical tasks. The important teaching role is discussed in relation to both undergraduate and postgraduate medical education and the education of professions allied to medicine. Strategic advisory and clinical governance responsibilities are discussed and the particular remit to bring a psychologically minded approach to these discussions is highlighted.

Finally, the report highlights the future development of the role in relation to the changing role of medical consultants within the health service. It stresses the importance of developing a capacity for flexible ways of working, employing a range of therapeutic modalities, learning new evidence-based therapies and participating in the research base for and development of new treatments. In addition, the changing structure of adult psychiatry is discussed in relation to developing therapeutic roles for consultant psychiatrists in psychotherapy more generally, including involvement in developments such as assertive outreach, crisis intervention and home treatment teams.

reviews

The Frith Prescribing Guidelines for Adults with Learning Disability

As a child it was often said to me that 'Good things come in little parcels'. This sentiment applies to this book, which although being slender contains invaluable information to guide clinicians faced with the task of managing adults with learning disability who have additional mental health problems, behavioural problems and/or epilepsy.

Compared with the general population, individuals with learning disability often respond differently to standard psychiatric (and other) medication and may be exquisitely sensitive to such medication and its side-effects. Many clinicians are justifiedly cautious when prescribing for these patients and are often obliged to seek the advice of their more experienced colleagues; advice that may be more anecdotal than evidence based. Thus it was with a sense of professional delight, mingled with relief, that I received this book.

The book covers all the major psychiatric disorders and challenging behaviours that most professionals working with people with learning disability are likely to come across in their daily practice. Each chapter has a clear, logical format and benefits from being succinct with a pleasing absence of verbosity. The authors use sub-headings to full effect and bullet points draw attention to important facts. The authors clarify treatment options/pathways by the liberal use of treatment algorithms in most chapters. Although this strategy is helpful, some of the algorithms are difficult to follow (particularly for the treatment of aggression (pages 59–61)).

Having read this text several times I am convinced that it will become an invaluable aide, not only to my psychiatric colleagues but also to other mental health professionals and general practitioners, all of whom regularly treat people with learning disability. For the future, the publication of guidelines for prescribing for children and adolescents with learning disability and co-morbid mental health problems, epilepsy and/or challenging behaviours would be very welcome . . . please?

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Post-Traumatic Stress Disorder: The Management of PTSD in Adults and Children in Primary and Secondary Care

Post-traumatic stress disorder (PTSD) has its believers and non-believers, but the balance appears to be moving in favour of the former. Despite numerous descriptions of the disorder since the First World War (and before), it was not a formally recognised clinical diagnosis until fairly recently. The increased number of victims of violence within our society, including political refugees and the victims of the recent bomb attacks in London, places PTSD at the centre of the current health and political agendas. All of this makes this book more than welcome, as it responds to the clear need for understanding, training and clinical guidelines. This book introduces the reader to the concept of PTSD, mainly from the medical/clinical point of view and includes some observations about the psychosocial dimensions. We are offered a summary of the majority of well-conducted randomised clinical trials of its treatment modalities, both psychotherapeutic and pharmacological, both in adults and children, in whom its presentation is less well described. It covers disaster planning (very topical) and early intervention, and makes recommendations for future research.

Furthermore, there is a very moving and enlightening chapter dedicated to the views and experiences of sufferers and carers from different backgrounds. It is important to note, however, that anyone looking to gain a thorough understanding of more complex and severe cases of PTSD will not find it here. The main research trials select populations of the more simple cases of trauma – this might be owing to the costs, length and complexity of including studies of the more complicated and severe clinical cases. This book also misses the opportunity to satisfy the reader's curiosity in relation to newer treatments for PTSD such as eye movement desensitisation and reprocessing (EMDR), which is briefly described but only from the perspective of cognitive–behavioural therapy, which predominates in this book.

As a summary of current trends and practices, however, this book is invaluable. It will be useful to a range of health and non-health workers, including general practitioners, psychiatric services, children's services, psychotherapists, and others within the National Health Service and non-statutory services.

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Reducing the Stigma of Mental Illness: A Report from a Global Programme of the World Psychiatric Association

Essentially a factual report upon an international programme to reduce stigma, this book develops many interesting ideas beyond those which might be expected from the title. It gives a detailed account
of the interesting, varied and often difficult initiatives undertaken in 19 countries across all continents in a bid to combat the stigma experienced by those living with schizophrenia and those around them.

It also, by relating plainly a wide variety of initiatives, gives the reader numerous ideas how they themselves might change their practice to combat stigma; it is worth noting that a recurrent source of stigma reported by those with schizophrenia was their psychiatrist.

The authors, one an eminent psychiatrist and one a senior communications consultant in industry, approach the programme from very different backgrounds, which makes the book more than simply a description of a ‘medical’ initiative. The book embraces the principles of marketing and public relations and attempts to evaluate their use in medicine. The results are interesting, and the overarching idea that we need to work with those within business communities, journalism and the teaching profession (among others) in a meaningful way, as well as with people with schizophrenia and their loved ones, seems an important one.

The results from national programmes show that relatively small, poorly funded initiatives can make a significant difference to experienced stigma, sometimes more so than larger and less local initiatives. The book subtly brings the reader to the conclusion that it is not a matter of having time in our lives to challenge stigma, but rather one of making time. Importantly it also suggests that times of change and upheaval, in services or society at large, are times of great opportunity for challenging attitudes and providing education. The implicit message that stigma is not necessarily a ‘fact of life’ for those living with schizophrenia is a refreshing one, although perhaps harder to believe if you have been experiencing it personally for some time.

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Three Therapists – Approaching Challenges to the Therapeutic Relationship (video)
Manchester: University of Manchester Counselling Service

Very early in the course of psychotherapy training the trainee is introduced to the concept of ‘common factors’ that contribute to successful outcomes in any model of therapy. This video demonstrates such common factors in action within three different therapeutic modalities: cognitive—analytic therapy, psycho-dynamic interpersonal therapy (the conversational model) and cognitive therapy. It was initially shown at a psychotherapy research conference and has been reworked and presented as a training video for ‘therapists and other mental health workers . . . to develop skills for working with challenges to the therapeutic relationship.’

The video includes role-plays of three 20-min sessions with a therapist representing each therapeutic modality and is followed by discussion of the interaction among the three therapists. The role-play is very competently performed by an actress which adds to the verisimilitude of the production. This is particularly welcome since the ‘patient’ material is standardised and hence potentially repetitive.

The video evoked strong reactions from a panel of 'guinea pigs', which included senior house officers in psychiatry and a selection of mental health workers experienced in psychotherapy but not in the specific models of therapy presented. The technical elements of each interaction were not named and those without a grounding in the therapeutic models felt they needed prior theoretical instruction in order to appreciate how the common factors and differences were demonstrated. This could be overcome by frequent pausing of the video and explanation.

The video is 80 min long and it can be difficult to assimilate all the material if watched at a single sitting. However, if watched over three sessions, the comparative aspects of the exercise were diminished. Given the dearth of such resources for psychotherapy supervision, the video is an extremely valuable training tool, but it should be used with some form of teaching on the techniques and interventions used.

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Treating Drinkers and Drug Users in the Community
ISBN: 0632035757

It seems strange to realise that managing drug and alcohol misuse in the community is a relatively new phenomenon. Not that many decades ago most treatment would involve a long hospital stay for detoxification, followed by an even longer period of in-patient rehabilitation. The move to community management has been possible owing to the involvement of general practitioners who, although slow coming forward, now occupy an important place alongside psychiatrists in the management of drug and alcohol misuse.

When I was dipping my toe into the world of drug misuse, Tom Waller was already a major player in the field of primary care. He provided care to people with drug problems, not just as medical adviser to the City Road crisis hostel but also in his general practice. Many fledging general practitioners such as myself turned to one of the only textbooks specifically addressing the management of drug misuse in primary care — Drug Misuse: A Practical Handbook for GPs by Banks & Waller. For many years their book was one of the few to describe the management of drug use within the community. Over the years many have followed, the latest being the excellent book Treating Drinkers and Drug Users in the Community by Daphne Rumball, an addiction specialist, and the late Tom Waller.

The book describes the treatment options for substance misuse — focusing on psychosocial interventions, many of which can be carried out in a community and indeed primary care setting. The evidence in support of the treatments is well presented and the book is superbly referenced, acting as a valuable resource for further study. The book is well written and is accessible to professionals and the general public. It goes without saying that this book will provide an invaluable source of information. Moreover, it is a scholarly text and is extremely well written. Sadly, Tom died last year and will not see how useful this book will be to professionals working in the field of substance misuse. I strongly recommend this book and hope that in time it will become a classic.

Clare Gerada RCGP Drugs Training Programme, Hurley Clinic, Kennington Lane, London SE11 4HJ, email: c.gerada@btinternet.com

Coping with Schizophrenia: A Guide for Patients, Families and Caregivers

This book is primarily for people with schizophrenia and their families and gives an overview of the disorder, its treatment (pharmacotherapy and cognitive—behavioural therapy) and the role of the family in management. It contains many case studies, is comprehensive, comprehensible and very well laid out, and the notes at the end of each chapter complement the clear style. My main criticism

Andrew Molodynski
is that although the authors encourage contact with specialist mental health services, the section on the role of the psychiatrist is next to that on compulsory detention in hospital.

The authors try hard to engage a wide audience and the book is more likely to be read by some patients and their families than others. The families of those with severe mental illness will find this book helpful but it is unlikely to be read by the patients who may have been hospitalised for many years. It will be a useful resource for junior doctors who often have theoretical knowledge of cognitive approaches in psychosis but have very little practical experience. They would particularly benefit from the clear advice that families do not cause schizophrenia. Moreover, it is likely to be helpful for those within the voluntary and charitable sector, those involved in residential care and members of assertive outreach and community mental health teams.

J. Fiona Macmillan Consultant Psychiatrist, South Staffordshire Healthcare Trust, Stafford ST16 3AG, email:Fiona.macmillan@ssh-tr.nhs.uk

miscellany

**Request for information**

I am funded by the Economic and Social Research Council and am researching for a PhD on ‘Homosexuality and military authority in the British Armed Forces, 1939–1945’. Principally, I am interested in exploring the experiences of gay and lesbian service personnel during the Second World War. However, part of my research examines medical, social and military understanding of homosexuality and lesbianism in the 1940s. Therefore, I would like to correspond with or interview medical personnel who practised or served during the Second World War. I would like to hear from anybody who encountered or treated homosexual service personnel inside and outside of the Armed Forces in that period or from anybody who served on a medical board.

I would also be interested to hear from anybody who could contribute references to sources or offer any further leads. Complete confidentiality is assured. Please contact: Ms Emma Vickers, Department of History, Furness College, University of Lancaster, Lancaster, LA1 4YG (email e.vickers@lancaster.ac.uk).

The University of Birmingham, in conjunction with the Learning Disability Faculty and the Research and Training Unit of the Royal College of Psychiatrists, and MENCAP have produced a new national guideline on **The use of medication for the management of behaviour problems among adults who have learning disability**. To introduce this guideline, which contains a number of good practice points that aim to improve the quality of care and endorse health gain for adults with learning disability, a series of free nationwide conferences will be held in 2006. Locations and dates are as follows: Birmingham (4 September), Glasgow (11 September), Newcastle (18 September), Liverpool (25 September), London (9 October), Bristol (16 October) and London (23 October). Conference attendance is free but places are limited so booking should be made in advance. For further information please visit [http://www.ld-medication.bham.ac.uk](http://www.ld-medication.bham.ac.uk).

**Corrigendum**

The email addresses given for Drs Harvey Gordon, Peter Cornwall and Ajay Vijayakrishnan in the correspondence of the August issue (Psychiatric Bulletin, 30, 313–314) were incorrect. The correct addresses are

Anna.Kennedy@obmh.nhs.uk,

lenny.cornwall@ntey.northy.nhs.uk

and avijayak@sgul.ac.uk respectively.

**Forthcoming events**

The Royal Society of Medicine, Wessex Region are the organisers of a 1-day conference entitled **Children with special needs – coordinating education, health and social care** which will take place on Thursday 14 September 2006 at the Lees Lecture Theatre, Talbot Campus, Bournemouth University, Poole. This conference will explore ways in which children’s agencies could collaborate to ensure that physical and mental difficulties are identified at an early stage. Proposals for adopting optimum care and educational strategies for children and parents will also be discussed. For further information please contact Mr Simon Timmis, Royal Society of Medicine, 1 Wimpole Street, London W1G 0AE (tel: +44 20 7290 3844; fax: +44 20 7290 2977; email: simon.timmis@rsm.ac.uk).

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