Rehabilitation and Social Psychiatry Faculty Newsletter

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Co-editors: Louise Petterson
Theresa Tattan

A word from the editors

This is our penultimate edition as co-editors, so we can, we think, start to become a bit controversial. Tom Harrison, in his moving description of invisible heroes, describes people from the 'Forgotten Generation', recalling the people the NSF five years ago forgot to mention. Robin Arnold helps us to find where they are mentioned in the old NSF, but judging from his e-mail to the Exec tonight, the revised version (92pp) doesn't help a lot.

Rethink is on the case, why not the DoH? The people we in specialist Rehab & Recovery services attempt to serve are those who often don't recover within 90 days if they don't have the help to prevent full-blown relapse (therefore becoming 'delayed discharges'), whose loved ones may experience years and years of disappointment with statutory services and who 'cost' the NHS/SS the most money, let alone the 'soft costs'…

Why then are we left out of NSFs???? Must be something about evidence we are so bad at collecting (?was it the clozapine and the music sessions OR the amisulpride augmentation and the new boyfriend????) Or maybe our politicians want easy, measurable interventions as well as short-term outcome figures…

Our Faculty Chair is soon to hand on the baton, after four years of directing her undoubted talents towards College and partnership work. Her energy, achievements and clarity of vision have been inspirational. Thank you, Sarah!

We will soon welcome our new academic secretary. Helen Killaspsy will no doubt welcome YOUR input to the academic sub-group - open to all who wish to help.

See Susan Mitchell's article on getting the carers' agenda happening locally and do consider coming to Trieste. Plus it's all happening in Ireland!

Happy, belated, New Year,

Louise Petterson and Theresa Tattan

Contents

Our Chair sitting in The Chair

The photograph above was taken at The Retreat in York at the Faculty's residential meeting in November 2004. It depicts our Chair, Sarah Davenport, sitting in a chair made for William Tuke. William Tuke was the founder of The Retreat where he developed Moral Therapy from which we trace our origins in rehabilitation and recovery. We can now look back over 200 years and remain inspired by his example of humanity and hope.

Chair's Report

Happy New 2005, our first as a Faculty!

As with most New Year Resolution Lists, our Rehabilitation 'To Do' agenda is both long and challenging - but that then is probably the reason most of us went into Rehabilitation and Recovery in the first place!

So here is that 'To Do' list:

- To make Social Inclusion work for the service users and carers with whom we work
- To promote Recovery throughout the College
- To raise the profile of Rehabilitation and Recovery Services through every avenue known to the Department of Health, Department of Work and Pensions, Department of Education etc, specifically by addressing the issues associated with OATS
- To prioritise and publicise our specialist training within the new Patient-Based Psychiatry curriculum and to influence the changes in postgraduate training to incorporate Recovery
- To develop the evidence base for Rehabilitation Services
- To publish THE Textbook, currently entitled 'Enabling Recovery: the Principles and Practice of Rehabilitation Psychiatry' …It's almost complete and eagerly awaited. A great read!

There are more, but I don't want to overwhelm you!

As many of you know, the Faculty is formally affiliated to the NIMHE Social Inclusion Network (as is the General and Community Psychiatry Faculty). I attended the launch of the Network on 4th December 2004, held at the King's Fund and hosted by David Morris and his NIMHE Social Inclusion team. The meeting was well attended by representatives of the statutory and independent sectors, user and carer organisations, work, education and social services alongside prison and probation services representatives. There was a lot of energy within the group but some disquiet about the lack of specific funding for implementation and the lack of a liaison structure to tie the relevant and disparate government departments together in a shared endeavour. Much of the work is likely to be most effective at the level of the NIMHE Regional Development Centres. The Faculty has the opportunity to work with Rachel Perkins on some of the workforce implications of Social Inclusion. Please let me know if you would like to contribute.

While I carry the torch for Rehabilitation at the Forensic Psychiatry Faculty Conference in Belfast on 2nd February 2005, Steffan Davies will be attending a meeting at the Department of Health with Tony Ryan (from HASCAS.) The consequences of expensive out-of-area placements for service users, their families and for statutory rehabilitation services will be discussed in detail, and we hope some useful recommendations for monitoring, improving repatriation and social inclusion can be agreed.

We all need to think about the Dean's proposals for 'Patient-Based Psychiatry' and the massive change agenda for postgraduate training in psychiatry, as a consequence of Modernising Medical Careers, PMETB, the competence-based agenda and the potential changes to CCSTs. The College and the Faculty will need to consult you all, its members on these important issues. How do you think these changes will affect you and the training you can offer?

Many of you will be aware of the recent change in the position of our academic secretary. Glenn Roberts has handed over the mantle (and that horn) to Helen Killaspy. This is, therefore, a very special thank you to Glenn, for all the inspirational effort he has put into making our residential conferences such memorable events, and for recruiting Helen as his successor. We look forward to being summoned (yes, definitely by that same horn) to Trieste, perhaps in 2006, for a study tour to examine social inclusion and recovery in Italy.

I would be very pleased to hear your views on any of these issues (or other ones too!).

Sarah Davenport
Chair of Rehabilitation and Social Psychiatry Faculty

'Invisible Heroes'

'I had a visitor yesterday. She stayed five minutes and borrowed twenty pounds. She always knows when I get paid. My other friend is Fred, who gives me my injection every month at the clinic.'

George lives on his own, forgotten, scraping along day-to-day and seemingly unaware of the squalor of his flat. Perhaps he's lucky and the voices are friendly most of the time. They can make you feel less lonely.

There are thousands of Georges and Georginas. They are exploited and abused, but cause few problems except to themselves. They may be in contact with mental health services, figuring as 'bread and butter' patients. These are those people who figure on a nurse's caseload, but only receive a visit once a month, with little expectation of change. They often don't even get that and are lost to services.

They do not figure in government policy. The National Service Framework for Mental Health barely mentions them. Certainly no resources are allocated. Indeed, in the scramble to set up Assertive Outreach Teams and the like, staff devoted to their care were taken away.

They desperately need help. People with longer-term mental disorders die earlier through suicide and untreated medical illness. They live ten to fifteen years less than other people. They may live in appalling conditions: filthy, rundown flats and houses. They are always vulnerable to exploitation by property owners, drug dealers and other opportunists. There is always discrimination. This may be restricted to abuse, or it can be a lot worse.

Enabling them to gain friendship, contact with their family, a reasonable quality of life, good physical health and the other expectations shared by any other citizen, takes time and courage. Staff working with them have to patiently build up trust, self-esteem, rebuild skills and encourage them through all sorts of difficulties. An experienced team, given adequate resources, can make all the difference. Rehabilitation and Recovery Teams throughout the UK are carrying out such work, **BUT**, and this is a big **BUT**, they are always last in the queue for resources. Wherever savings are to be made, these are the teams to get the chop.

This vulnerable, courageous and remarkable group of patients are the most deprived and neglected in the community. They deserve better. Severe mental disorder can take away self-respect, health and dignity. It nearly always results in poverty and often in isolation. It does cost time and money to improve the situation; but perhaps it is the measure of a civilised country that the most disadvantaged should get such care.

Dr Tom Harrison Consultant Psychiatrist

This article first appeared in a shortened version in a pamphlet by Pauline Arksey entitled 'Count Me In – Hopes for a Forgotten Generation', published by NIMHE. Readers are also urged to check out the Rethink report on the 50,000 people living with long-term severe mental illness who have been forgotten in recent government initiatives. 'Lost and Found - Voices from the Forgotten Generation' - downloadable from the Rethink website www.rethink.org/publications or call Rethink on 0845 456 0455.

Rehabilitation and the National Service Framework

I have been involved with many others for 15 years in pursuing faculty status. It has taken much effort in many settings, formal and informal, to bring it to fruition. We all have every right to celebrate, but what do we do next after the celebrations die away? Faculty status was never an end in itself. For me, the end has always been increasing our ability to secure and protect the expensive and complex resources needed to truly meet the needs of our patients damaged by disabling diseases we label collectively as Schizophrenia, and like conditions.

These are always threatened because acute packages promising to produce change quickly are more enticing. There also has seemed to be a threat from a perception that Rehabilitation was left out of the National Service Framework for Mental Health (NSF). (That is the title on the cover, even though it only covers adults of working age in England.) We hear many accounts of Assertive Outreach Teams created at the expense of Rehabilitation Teams and every financial crisis (these are widespread now) sees rehabilitation resources perceived as an easier area to cut.

However, the idea that Rehabilitation was left out of the NSF is mistaken, as it refers to Rehabilitation many times. **Standard 5 (page 41**) includes: 'Each service user who is assessed as requiring a period of care away from their home should have:..... a copy of a written care plan agreed on discharge which sets out the care and **rehabilitation** to be provided.....' And then **page 47** states: '**Rehabilitation** teams focus specifically on the housing, income, occupational and social needs of people with serious disabilities resulting from their mental illness.'

While admittedly this does miss out on the recovery/respect/autonomy concept that I believe is truly at the heart of rehabilitation psychiatry, it lists areas that are constantly raised in the NSF as priorities for these patients. **Page 49** contains a recognition that: 'This [30% bed blocking in acute wards] is likely to reflect a tendency for patients to stay longer than needed to, with discharges delayed by inadequate **rehabilitation** services.....' **Page 50** contains the paragraph: 'Concerns about the quality of inpatient care have been documented. While it may be effective in reducing acute symptoms, a review in 1996 reported that the needs for home-based support, **rehabilitation** and suitable accommodation were not always met and contact with both ward staff and community care staff was minimal.'

It might be argued that rehabilitation was being described as a process rather than a service but the positive recognition of teams suggests that this is not the case. The killer blow comes on **page 67**. Here are listed 9 local milestones by which progress on Standards 4 and 5 will be monitored. The fifth and sixth milestones state: 'All service users assessed as requiring **rehabilitation** receive access to education, training, occupational and social care support, including supported accommodation' – 'Following an assessment of local need, the range of specialist functions to anticipate and prevent a crisis are available, including early intervention, assertive

outreach and **rehabilitation**.' The last seems explicitly to put rehabilitation on an equal footing with two functional NHS team systems, in unequivocal language. Why did only the first two get into the NHS Plan, which is often confused for the NSF? I can only speculate. Maybe it was because Rehabilitation services already existed, even if only patchily, or that enthusiasts for the others were in a position to influence the right people at a critical moment. Maybe it was an old prejudice associating rehabilitation with the old asylum back wards. Who knows?

Whatever the reasons, it is there in the NSF. Read Standards 4 and 5 of the NSF and you will read values wholly in line with ours. Louis Appleby has conducted a five-year review of progress in delivering the NSF and has ignored Rehabilitation. I believe this is our chance to contribute by producing our own review of progress on the rehabilitation agenda of the NSF. We will have to find a way of doing this, but then your help will be needed to describe what is happening locally. Enthusiasts have set the agenda for what constitutes an assertive outreach and an early intervention service. We are the enthusiasts for social psychiatry and should be able to press our ideas into this process in the same way. You can campaign locally using this knowledge of the NSF. We have a window of opportunity and must use it.

On a related tack, I have heard a number of descriptions of Rehabilitation services being closed only to be reopened several years later because of growing problems. I believe it will be helpful to produce a compilation of these experiences and the problems encountered. I would be grateful to know of any such experiences around Britain, so please contact me via the Royal College Rehabilitation and Social Faculty.

We can build on the achievement of faculty status by using this increase in our influence to put rehabilitation firmly on the current political agendas nationally. The NSF review is one opportunity. Your contributions to these two documents are vital to this process. I look forward to hearing from you.

Robin Arnold, Faculty Honorary Secretary

Faculty of Rehabilitation and Social Psychiatry Residential Meeting

Radisson Hotel, Glasgow
17th – 18th November 2005

Contact College Conference Office
Tel: 020 7235 2351 x 145
ecook@rcpsych.ac.uk

Royal College of Psychiatrists Annual Meeting (20th – 23rd June 2005)
Rehabilitation and Social Psychiatry Institute
Monday 20th June 2005
Edinburgh International Conference Centre

Contact College Conference Office
Tel: 020 7235 2351 x 145
conference@rcpsych.ac.uk

Partners in Care - how to take an active part in the campaign in your area

I hope that you are all aware that the College's campaign for this presidency is **Partners in Care**, a joint venture with The Princess Royal Trust for Carers. The principal aims of the campaign are to raise awareness of the issues of carers and to work in partnership with them in a number of ways, such as improving the provision of information about specific conditions and carer awareness in psychiatrists' training.

As a member of the executive of the then Social and Rehabilitation Section of the College I attended a briefing day at Belgrave Square in May. The aim of the day was to get together a group of psychiatrists, representatives of Carers' Centres and of a number other carers' organisations, to explain the aims of the campaign and to encourage those present to go home and organise local training events, media input and other initiatives.

I don't know about you, but I can get very enthusiastic at events and am liable to make promises about what I can do later that are quite unrealistic. I wasn't at all sure how I could find the time to do any of these worthy things, no matter how important I thought they were, and even though the College had taken some of the hard work out of it by giving us all the references and even the PowerPoint presentations to use. I left early to catch a train and didn't agree to do anything much apart from spread the word.

Then I had an email asking if I would give a presentation about the campaign at a meeting in Leeds on 6th July - 'Winning with Carers'. It wasn't all that convenient but I thought it was important, so I went. It's not the first time that I've been the only psychiatrist in a group of 70 or more, but it's been a while.

The mother of a young man with schizophrenia spoke before me and gave a very moving account of her experience. Having to relate to nine different teams (yes, teams, not individuals) during the four years her son had been in contact with services was just part of her frustration. She made my task easy by highlighting the issues. I was challenged on a number of topics: training of psychiatrists – they wanted to know if it took seven years to become a consultant, how long did it take to become God? Clearly many of the carers did not find psychiatrists approachable. Who were counted as 'professionals'? Why couldn't the carers' views be valued more? Why did psychiatrists not welcome the campaign checklists? When would there be a leaflet for carers on personality disorder?

The director of the Shoestring Theatre Company approached me, asking how she could be more involved in the training of psychiatrists, as she believed that theatre was a powerful way to do this. A carer asked if I knew about financial support for employed carers attending CPAs for relatives in out-of-area hospitals.

I left to return to work at the lunch break and was sorry to have to go. There was clearly a lot we could learn from each other. A number of the delegates told me they thought I was 'very brave to come and talk to them'; the chairman [a carer] said that there was 'baggage' the carers needed to put down, too, if we were going to work more collaboratively together. It made me think a lot about the way I present things, the words I use: I was told I sounded academic and of course I'm not.

So why am I bothering to tell you all this? Well, I hope I have interested you enough for you to

- look at the campaign website www.partnersincare.co.uk
- read the checklists and use them

- get hold of the CD-ROM with presentations and references, [No longer available from the person cited on the website – Ed.]
- give a presentation at your local postgraduate teaching session
- get involved with your local carer centre
- write something in the local paper or contact the local radio
- think about how you explain things to carers
- make sure that your trainees understand the carers' perspective
- realise that the carer could be you or me

If you are interested in training using Shoestring Theatre, contact Theresa Smith, Director Shoesrtingtheatre@totalise.co.uk

Susan Mitchell, The Retreat, York
smitchell@retreat-hospital.org

[Ed: This missed our summer newsletter, but is still clearly current!]

Top tips – mainly about 'recovery' — Louise Petterson

- Not sure how to explain the evidence for the difference between coping with real life and symptomatic recovery?? See Glenn Roberts' and Paul Wolfson's paper 'The rediscovery of recovery: open to all' in *Advances in Psychiatric Treatment* (2004), vol 10 pp37 – 49, as well as 'Recovery from psychotic illness: a 15 and 25 year international follow-up study', Harrison G et al in *British Journal of Psychiatry* (2001) 178: 506-517.
- Pat Deegan's talk 'Recovery and the Conspiracy of Hope' (1996) can be found on the National Alliance for the Mentally Ill Santa Cruz County (NAMISCC) website. Thought-provoking on loss of hope by staff, and the processes and practices that may impede or facilitate recovery in residential rehabilitation settings. Not at all out of date, I think! She also has great tips on coping with voices ... type her name into Google and find 'Voices: techniques readers have used'.
- Type in Mary Ellen Copeland and find a wealth of questions for user-focused crisis plans, as well as post-crisis plans, how to get hold of the 'Wellness Recovery Action Plan' book and facilitator training manuals for same. Lots more!
- The DoH document 'The Journey to Recovery – the government vision' - is a collation of not-so-recent government documents and plans. Useful as an introduction to new staff and others. Spotted the word rehabilitation once! See www.doh.gov.uk
- John Curran, an anthropologist working with SLAM, has been raising awareness of the helpfulness of cultural consultancy in mental health, as those who attended the HASCAS Rehabilitation Conference will know. I am reliably informed that some of the places to look for serious training include an MSc in Transcultural Mental Health @ Queen Mary and Westfield College, London (Professor Khan Bhui) and an MSc in Medical Anthropology, University College Hospital, London (Professor Littlewood) p two years P/T, one year F/T.

The nature of illness and implications of the draft mental health bill

Forty years ago the anti-psychiatry movement argued that mental illness was a myth, as there was no evidence for an underlying physical process. Robert Kendall argued the contrary. They both missed the point. The dualism implied (that mind and brain are separate, independent entities that communicate) still lives on in thinking about mental illness. For instance, there is a concept that mental states (such as depression) caused by outside factors are not mental illness and should not be treated with physical treatments.

This dualism is clearly false, as the mind and brain are two aspects of the same entity. Any activity in one is reflected in activity in the other. Any attempt to change one will be reflected in a change in the other.

Illness, therefore, has to be defined in a different way. It is best seen as a social institution. An institution is a social structure with purpose and rules. The purpose of illness is to allow society and an individual to cope with changes to that individual which are usually, though not always, temporary. When an individual is not functioning at their normal level, their rights and responsibilities are temporarily changed, allowing them to retain their social position and society to continue to have access to their capacity, when they return to normal functioning.

When I have a bout of 'flu I can choose whether or not to come under the institution of illness. If I so choose, I can have a brief period off work, while still being paid. I am expected to stay in bed and to seek to get better. If doubts arise about whether I am truly ill, a doctor will be asked to arbitrate and this will often be formalised through a sickness certificate. Much the same can be said about mental illnesses, for instance depression.

If, however, I simply can't be bothered going to work and say so, I will be disciplined and possibly sacked. I will certainly not be paid.

The contract I am under will be very different depending on the circumstances and the nature of my illness. For instance, a person detained in a high-secure hospital after being convicted of murder has a very different contract. They did not have a choice to be considered to be ill and have lost their freedom, in some cases for life. However, they retain the right to be fed and sheltered etc.

Mental illness differs from physical illness because it affects the mind and can therefore interfere with the individual's capacity to make decisions about themselves. This is the reason for the need for a Mental Health Act and powers of compulsory treatment. As Professor Louis Appleby stated on the *Today* programme at the launch of the draft Mental Health Bill (8/9/04): 'The purpose of a Mental Health Act is to provide proper care to people who are too ill to recognise their own treatment needs. It doesn't have any other purpose.'

He differentiated mental illness and personality disorder: 'There are those who don't have a mental illness but still have mental health needs and amongst these are those with personality disorders.'

Society has always had a problem with concepts of determinism. The concept of determinism is that our actions and fate are predetermined either by logic, our genes or the nature of time. If this is the case, we could not be responsible for our actions. Society cannot function unless it holds people responsible, so it has taken a pragmatic approach and deemed that people will be held responsible. However, some people are clearly not able to take responsibility and this

is why the concepts of disability, capacity and illness were developed.

A core concept in the institution of illness is to differentiate it from personality (ordinary functioning). Below is a brief table of some of the significant differences between personality and mental illness. The word personality is used rather than personality disorder. Personality disorder is an arbitrary subset of personality where an individual's approach to the world and their environment interact to cause problems to the society.

Mental Illness	Personality
Deviation from normal functioning	Normal functioning
Aim of treatment to return to normal functioning	Aim of treatment to move away from normal functioning
Often treatable	Uncertain if treatable
Can be treated against wishes	Probably have to be motivated to change
Has psychological and physical aspects	Has psychological and physical aspects
Ancient social institution	Modern concept
Changes responsibilities and rights of the individual and others	Society holds the individual responsible for actions
Doctors arbitrate	Psychologists measure?

The differences are fundamental. Personality, if it means anything, is about enduring traits that govern our reactions to our environment. They encompass genetic, organic, developmental and learnt attributes. It is likely that only the last can be changed and then only by new learning. Tackling the first two will involve learning to manage personality better, rather than to change it. There is some evidence for people's ability to change with therapy but none suggesting that people can be changed against their will. Indeed, there have been some disastrous attempts at this, using behavioural mechanisms such as electric shocks. The film *Clockwork Orange* explores some of society's concerns about the dangers of pursuing this model.

Mental illness on the other hand can often be treated against the person's will. There is enormous research evidence to show that psychotic illnesses can respond to injectable antipsychotics and severe depression to electroconvulsive therapy.

The major rationale for the proposed changes in the new Mental Health Act, advocated by a small minority of psychiatrists who support treating personality disorder as a mental illness, seems to be to ensure that psychiatrists provide services for people with those conditions. This is not a good purpose of mental health legislation. Ensuring that services are provided is the purpose of National Service Frameworks, NHS plans and targets or equivalent for commissioners and providers. Additionally, a large number of

people would become subject to the Mental Health Act who previously did not.

A 'one size fits all' Mental Health Act was always going to run into these problems. There need to be separate arrangements for capacity (now enshrined in the Capacity Act), mental illness and personality. Mental illness of its nature needs to be differentiated from personality and treated separately. Probably personality should be dealt with under criminal justice legislation, with psychiatric clinicians providing voluntary treatment, as at Grendon Underwood. The Criminal Justice Act 2003 has already moved sustantially in this direction. The Capacity Bill is well on the way to providing ways of managing problems of pure incapacity, such as learning disability and dementia. Capacity, mental illness and personality disorder should be treated separately but in parallel if more than one is present at the same time.

In conclusion: Mental illness is a social institution designed to relieve people of responsibilities and to give them rights during a period when they are not functioning at their normal level. It has grown up in society in order to differentiate it from people's normal behaviour, for which society has to hold them responsible. If people cannot be held responsible because of who they are, then society will be in chaos. By doing away with the differentiation between personality and mental illness through the broad definition of mental disorder with no sub-categories, the proposed legislation risks shifting this difficulty for society over to doctors, who have no authority to resolve it. This already happens in some degree in the courts and elsewhere, which means that if there is a mental illness label then behaviour that may originate from the personality and not from the mental illness is excused. This leads to increased risk to society and continuing uncontrollable violence against staff and other patients.

Dr Robin Arnold FRCPsych

News from further afield - Ireland

The Irish College of Psychiatrists is interested in developing a Rehabilitation and Social Section and we hope to get approval to do so in the next year. Our second Irish Specialist Registrar post has been approved, at St Ita's Hospital, Dublin. We are delighted and hope that the number of higher training posts will continue to grow with the further development of Specialist Rehabilitation Psychiatry in Ireland.

The regional representatives of the Rehabilitation and Social Psychiatry Faculty of the Royal College will be in Dublin for their meeting in May 2005; we look forward to hosting this meeting.

The Irish Psychiatric Rehabilitation Group is currently carrying out an audit of our five Rehabilitation Services and the resources available to them this year.

The new Mental Health Commission in Ireland is in the process of engaging with an Expert Group (Department of Health and Children) to work on developing a strategy for modern mental health services. A subgroup represents Rehabilitation Psychiatry, so we are in a position to highlight rehabilitation issues.

Specialist Rehabilitation services in Ireland are now recognised as an integral part of a modern mental health service and it is hoped that the number of consultant posts in rehabilitation psychiatry will be increased in the coming years.

Ena Lovell, Consultant Psychiatrist

New academic secretary for the Faculty

Glenn Roberts has now handed over the role of academic secretary to Helen Killaspy. We would like to thank Glenn for all his hard work, including organising conferences which inspired us all, especially around recovery and the arts in psychosis; for his vision and dedication to developing a Gaskell book on rehabilitation and recovery; for facilitating an academic subgroup for the Faculty to ensure the academic agenda continues; and for being a colleague who is rich with integrity, creative vision and dedication to helping people with psychosis.

That's a hard act to follow, but we are now delighted to introduce Helen Killaspy – Eds

Dr Helen Killaspy
MBBS (1991), MRCPsych (1997), PhD (2001)

I am a senior lecturer and honorary consultant in rehabilitation psychiatry, based at University College London and Camden and Islington Mental Health and Social Care Trust. I have been in post since August 2003 and am therefore relatively new to the world of rehabilitation and recovery, but full of enthusiasm and energy for it. I was delighted to be asked to take up the position of academic secretary for the Faculty and hope to use my time in this role to liaise with rehabilitation colleagues across the UK to build up a research network so that we can effectively focus on the most pressing areas of research interest in our specialty. The other major role embodied in this post is the organisation of Faculty conferences and, accepting that Glenn is an extremely hard act to follow, I will attempt to continue and build on his excellent track record of increasingly popular and well-attended events.

My clinical work involves inpatient and community-based rehabilitation as well as sessions with the Trust's 'Accommodation Team', who provide an overview of the whole system approach to assessment and provision of supported accommodation. Since appointment I have established a nursing research fellow post, which has facilitated the first national survey of rehabilitation services in England (Killaspy et al., 2005) and is now pivotal to the review and standardised assessment of 'out-of-area' placements for Islington through a joint honorary position with the Trust as a 'reviewing officer' for this service user group. This work has involved coherent collaboration with PCT commissioners, allowing reinvestment of savings into high-calibre, newly refurbished, 24-hour supported, self-contained accommodation in Islington. This 'pilot' has led us to apply for further funding for a large research project examining this and other models of review and service provision for this group in collaboration with Faculty members. The many issues of concern for this service user group are currently very topical (Ryan et al., 2004) and of great interest to the Faculty, which has established a working group to address their concerns with the Department of Health; research in this area would be extremely useful for all of us involved in this area.

My previous research has included a prospective study of the outcomes for psychiatric outpatient non-attenders, which led to my PhD thesis on this subject. From 1999 to 2004 I co-ordinated the 'REACT' study (a randomised evaluation of assertive community treatment) which is the first RCT of 'pure' assertive outreach versus usual care from community mental health teams to be carried out in the UK. I have supervised a qualitative study of the content of care delivered to participants in this study (a comparison of care delivered by assertive outreach teams and community mental health teams) and I am currently involved in a comparison of assertive outreach practice in Melbourne, Australia and London. Other research interests include women's mental health, family interventions for people with schizophrenia and the homeless mentally ill.

I am looking forward to the enjoyable challenge of the academic secretary's role and am very keen to receive feedback, suggestions for research ideas, conference speakers or anything else at any time. Please feel free to contact me by email : h.killaspy@medsch.ucl.ac.uk or helen.killaspy@candi.nhs.uk .

Dr Helen Killaspy, Senior Lecturer in Rehabilitation Psychiatry, Department of Mental Health Sciences, Hampstead Campus, University College London, Medical School and Honorary Consultant, Camden and Islington Mental Health and Social Care Trust

Study tour to visit mental health services in Trieste, Italy

In 1971 the Italian Government decreed that all asylums in the country should close (Law 180) and that all mental health care should be delivered in the community. The current model of mental health services in Trieste developed in the wake of Law 180, led by the pioneering psychiatrist, Franco Basaglia, who recruited a group of like-minded colleagues to work with him. The interpretation of Law 180 varies greatly across Italy, from minimal community models such as outpatient services through to the comprehensive services in Trieste. The Trieste model is considered to be a highly innovative and successful example of community mental health services and is renowned internationally. In June 2004 a small group of clinicians and managers from Camden and Islington Mental Health and Social Care Trust visited Trieste for a brief study tour. This report details the services described and visited during the tour.

Trieste is a small city of 250,000 people with an increasing older adult population. It is situated in North Eastern Italy on the border with Slovenia.

To understand the success and culture of the Trieste model it is important to acknowledge that Franco Basaglia's personal charisma and style facilitated a truly co-operative and socially inclusive redesign of services. His vision and interpretation of Law 180 was to create a service that provided a comprehensive model covering all aspects of care and subsistence through a combination of integrated health and social service resources. The local community was actively involved in developing services, and service users were integrated into the community through engagement in community-based social co-operatives. This integration was reinforced by the lack of a separate 'mental institution'. In other words, the closure of the asylum meant that services users were no longer 'dis-integrated' from the community through hospital admissions. A variety of alternatives to hospital are used to support those encountering mental health problems, varying from home treatment with family support to long-term supported accommodation.

Current services and ethos

People can present to services through a variety of routes. The aim is to provide as much treatment at home as possible, but when needed the general hospital also has an eight-bedded ward which provides a city-wide service for very disturbed people, and the CMHCs each have eight beds. Italian mental health law allows for compulsory treatment for a maximum of seven days, after which consent is required. Therefore the need to negotiate treatment plans is integral to successful work. Compulsory orders can be renewed but this has only been necessary on four occasions in Trieste in the last ten years! The teams are happy to attempt treatment without medication if the person in crisis is unwilling to take any. If the team are 100% certain that medication is needed, they use all their negotiation skills to persuade the individual of its benefit. Boundaries between staff and patients are minimised, hierarchical structures are broken down and respect is earned over time. This ethos leads to a person-centered culture in all aspects of the service. This philosophy is fundamental in making the system work.

Instead of selling off the asylum for redevelopment, some of the buildings in the old asylum campus remain in use as part of the mental health service in Trieste in the form of offices, group homes, a rehabilitation day service and a service user co-operative café, but many have been converted into other sorts of community resources, such as a school, university departments and younger people's social service offices. This means that the buildings and grounds that made up the asylum remain alive and are used on a

daily basis by different groups of people, and the co-operative café is frequented by anyone visiting the campus.

The asylum employed 500 staff but now 240 staff across the city are employed for a system that has 3,000 service users. The service is focused on severe and enduring mental health problems (i.e. those who were previously living in the asylum) and around 10% also have substance misuse problems, most commonly alcohol. There are very few homeless people or people with problems associated with illicit drugs.

Community Mental Health Centres

The majority of service users present to services through one of four local CMHCs. Our host (Dr Roberto Mezzina) is the consultant for the Barcola CMHC. There are four sectorised CMHCs in Trieste, each serving a population of 60 - 70,000. Each has eight beds where service users (or 'guests') can stay during a period of crisis if they are unable to be supported at home. The length of stay is defined according to need rather than any fixed rule and has varied from one night to over a year. The CMHC is seen as a community resource and provides a core function and focus point for mental health services. The model is a hybrid of crisis house, crisis team, assertive outreach, community mental health team and drop-in, and the idea is to offer a holistic and comprehensive approach to care during periods of crisis and stability. Each CMHC is staffed by four doctors, 27 nurses, two psychologists and one social worker. Fifty to sixty guests visit the centre each day for a variety of reasons.

One member of staff is assigned to the reception area to receive new referrals. The rest of the team divide the work up into home visits and outreach (about 100 domiciliary visits to private and group homes per day) and two staff remain at the CMHC to nurse any overnight guests, administer medication to any drop-in guests, and staff also carry out group work and family work. A psychologist facilitates a community meeting every day. There are approximately 700 guests registered with each CMHC each year, of whom approximately 180 are new referrals and the rest have more enduring mental health problems and continue to receive care from the CMHC in the longer term. The CMHC runs a rolling programme of psycho-education seminars for families and carers of people using the service.

The CMHC does not provide an assessment service overnight and anyone presenting between 8am and 8pm who needs to be treated as an emergency is admitted to the general ward, at least overnight. The CMHC maintains primary responsibility for anyone admitted to the general ward, and these people are reviewed the morning after admission to try to find an alternative treatment plan, either at home or at the CMHC. There is very little staff turnover within the CMHCs and staff rotate to work in the emergency ward, which is openly acknowledged as the most dysfunctional and least favourite part of the service.

Rehabilitation and Residential Services

This service has responsibility for 75 people with severe and enduring mental health problems who require continuing care from services. The majority of these people live in group homes, with generally no more than six residents. Fifty people live in group homes within the old asylum campus and the rest live elsewhere in the city. Sixty per cent of the homes are 24-hour staffed and over 50% are run as social co-operatives. One of these is run by a local priest and one is a women-only co-op. The residential co-operatives have a 'social habitat' where all residents are encouraged to share in the responsibilities and decision-making in running the home and community living. The aim of the rehabilitation and residential service is to minimize the number of people requiring 24-

hour support by maximising skills and independence. The average length of stay is around two to three years, to prevent institutionalisation, with people moving on to independent or supported tenancies. Over time the number of residents per home has reduced and the service is developing to increase its number of supported tenancies. For people who were considered 'difficut to place' when the asylum closed down, the service holds a 15-year trajectory in mind when considering their rehabilitation. The service has an ethos that people with mental health problems have a right to have their own home, whatever form this takes, and as such they have rights and responsibilities in the running of the home. If somebody becomes unwell in a group home, the service will reorganise its staff to provide extra support to that person as far as possible. If necessary they will call on the local CMHC to offer further support, and rarely, the person may spend time as an overnight guest at the CMHC.

Rehabilitation and residential services also co-ordinate rehabilitation programmes across the city, such as training and employment schemes through the social co-operative system, and they provide occupational therapy within the group homes. They facilitate a triangular relationship between themselves, the CMHC and the social co-operatives in supporting people through social and vocational rehabilitation.

Social Co-operatives

In Italy there are a total of 2,500 social co-operatives and in Trieste there are thirteen, five of which are run by mental health service professionals and service users. Two of these are run by nurses, one by a priest and one is a women-only co-op which runs a crisis/recovery house or group home. This co-op has the highest proportion of service user involvement of any of the co-ops in Trieste. Others with no specific connection to mental health are accredited by mental health services and employ service users. The largest co-op is the 'Franco Basaglia' which has 266 members. The co-ops employ members through a job grant scheme for up to three years, after which time they can be taken on as a full- or part-time employee or seek employment elsewhere. The job grants for the five mental health co-operatives are paid for through the Department of Health at a cost of 18,500 Euros per annum and have a total of 962 members. The amount each member receives from the grant is 250 - 310 Euros per month. This is on top of any other social security benefits, and most people receive therefore a total of 700 - 800 Euros per month. The co-operatives cover any insurance payment for their members and they pay any overtime due. The CMHC provides support for the member/employee during their placement with the co-op. Around 110 people per year are employed through the job grant scheme, of whom 20 - 30 (around 20%) go on to gain open employment. The co-ops currently employ people in the following areas: cleaning services; catering; laundry; a café/bar; gardening; two hotels (Tritone and Mignon); running the City Council's archives; a theatre; a radio station; media and journalism; sailing/boat refurbishment.

Dr Helen Killaspy
Academic secretary

NB Advance notice

Dr Roberto Mezzina and Dr Pina Ridente will be presenting the Trieste model at our Institute day (Monday 20th June 2005) at the College annual meeting in Edinburgh. This session is planned to be discursive rather than didactic, so please come along and ask them any questions……..

NB Opinions, please

We are considering a proposal to the College to hold our residential Faculty meeting in Trieste, possibly in 2007. Another possibility may be a study tour for interested individuals. Ryanair often has very cheap flights to Trieste at certain times of year. At the Faculty AGM in York in November 2004 there was support for this idea. If you have an opinion either way, please let me know, as I will need to propose this to the College in good time if we have a consensus view. (h.killaspy@rfc.ucl.ac.uk)

Helen Killaspy was the joint winner of the 2004 Douglas Bennett Prize, presented at the Faculty AGM in York. The other winner was Dr Peter Lepping.

Below is the abstract from Helen's presentation. Peter Lepping's abstract will be published in the summer newsletter.

What do mental health rehabilitation services do and what are they for? A national survey in England

Background

The specialty of rehabilitation is under-represented in current national policy, current service provision is unclear and there are no guidelines on what constitutes a standard rehabilitation service.

Aim

To carry out a national survey of rehabilitation services in order to describe current service provision and to formulate a consensus definition of the term 'rehabilitation'.

Method

A structured telephone survey was carried out with consultants in rehabilitation psychiatry or senior service managers in all Trusts in England. As well as information about their services, interviewees were asked to give a definition of the term 'rehabilitation'.

Results

A response rate of 89% (65/73 Trusts) was achieved, constituting interviews with representatives from 93 local authority regions (75% consultants, 25% service managers). The majority (77%) had short-term (length of stay up to 12 months) rehabilitation units, with a mean 13 beds. There were no differences between urban and rural services in bed numbers. Most services had input from all members of a multi-disciplinary team and where services had short- and longer-term units, staff tended to cover both. The majority (79%) had specific referral criteria, 42% had exclusion criteria and 85% carried out a pre-admission assessment. Over half (56%) had a community rehabilitation team and in 29%, assertive outreach teams were considered part of the rehabilitation service. Two models of community rehabilitation service provision emerged and a consensus definition of 'rehabilitation' was formulated.

Conclusions

This is the first national survey of rehabilitation services and due to a high response from those directly involved in their local services, we have been able to describe current service provision in some detail. We have also described two models of community rehabilitation services and formulated a current day definition of 'rehabilitation'.

This paper has been accepted for publication in the *Journal of Mental Health*.

Killaspy, H., Harden, C., Holloway, F. & King, M.

The Douglas Bennett Prize

Awarded annually for the best paper on Rehabilitation Psychiatry presented by a psychiatrist*
(maximum length 2000 words)

For further information contact:
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Royal College of Psychiatrists
e-mail: mbraithwaite@rcpsych.ac.uk

Closing date for applications:
1st October 2005
Please send 3 copies per submission

*Includes consultants within two years of appointment, basic/higher trainees and NCGPs.

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Click on The College, then click on College Structure, then click on Faculties.

We warmly welcome contributions to the Newsletter. These could include letters (up to 200 words), articles (300 – 700 words), short tips, cartoons etc. Suggestions for articles include topical issues, recent developments, personal views, career experiences, articles from users and carers, book reviews or summaries of conference presentations.

If possible, please send contributions to the above e-mail address with the article as an attachment in a Word document. Alternatively, send a hard copy to us by post at the above address, preferably with a copy on disc as a Word document. Thanks.

**********Faculty Name Change**********

Please note the change to the name of our Faculty.

It is now the Faculty of Rehabilitation and Social Psychiatry of the Royal College of Psychiatrists - Eds.